

# RECENT COURT DECISIONS

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*The following case summaries highlight recent court decisions that affect medical professionals in diverse health care settings. Topics include privacy of medical records, claims involving thrombolytic therapy, dismissal from residency, and criminal liability for illegal prescription of pain medication.*

## **CASE 1**

### **Patient's Medical Records May Be Seized In Criminal Investigation**

*Limbaugh v. Florida (Fla. Dist. Ct. App., No. 4D03-4973, Oct. 6, 2004).*

Radio talk show host Rush Limbaugh was under investigation for violation of the Florida "doctor shopping" statute. Under this state law, it is illegal for patients to withhold information from a practitioner that they had received "a prescription for a controlled substance of like therapeutic use from



another practitioner within the previous 30 days." Investigators had received statements from two individuals that Mr. Limbaugh had obtained large quantities of Hydrocodone and Oxycontin over the course of many years. Recent pharmacy records also showed that four different practitioners had written him prescriptions for controlled substances within a period of five months.

Based on this information, police obtained search warrants allowing them to seize Mr. Limbaugh's medical records

pertaining to narcotics use from multiple medical offices. Police then seized the medical records and notified Mr. Limbaugh, who objected, arguing through his attorney, that the seizure and review of his medical records constituted a violation of his constitutional right of privacy. In his view, the right of every citizen to be left alone, free from governmental intrusion, extends into the realm of medical records.

The Circuit Court disagreed, holding that in this ongoing narcotics investigation, the seizure of medical records was proper. Mr. Limbaugh then appealed to the District Court of Appeal, which heard opposing arguments. According to Mr. Limbaugh, criminal search warrants should not be used to circumvent a medical patient's constitutional right to the privacy of his medical records. He contended that the obtaining of a search warrant by authorities and subsequent seizure of his medical records violated his rights because he was denied prior notice and a hearing before the actual seizure occurred. In other words, he had no opportunity to review the basis for the request and challenge the seizure. Florida authorities, on the other hand, contended that requiring such prior notice and hearing in such circumstances was not practical, as it would compromise ongoing investigations of suspected illegal acquisition of prescription pain medication.

After deliberation, the District Court of Appeal ruled against Mr. Limbaugh, holding that the patient's right of privacy is not violated when medical records are seized as a requirement to a criminal investigation. In the court's view, since Mr. Limbaugh was the target of a criminal investigation, his privacy interests in his medical records were outweighed by the state's need to seize and review such medical information in order to complete its criminal

investigation. Here, the issuance and execution of a valid search warrant for medical records, without a prior notice to the patient and a legal hearing, was appropriate.

**“. . . the patient's right of privacy is not violated when medical records are seized as a requirement to a criminal investigation.”**

Once again, Mr. Limbaugh appealed, this time to the state's highest court. In a close 4-3 decision, the Florida Supreme Court turned down his appeal, and would not consider a motion for a rehearing, thereby letting stand the rulings by the lower courts. Generally, courts in the past have gone to great lengths to protect a patient's medical privacy. In cases of suspected criminal activity, however, as in this investigation of possible violation by a patient of the Florida "doctor shopping" statute in order to obtain controlled substances, even this long-standing, powerful interest in patient privacy can be outweighed by the state's need to investigate criminal activity.

## **CASE 2**

### **Wife Cannot Sue Physician For Husband's Failed Vasectomy**

*Dehn v. Edgewcombe (Court of Appeals of Maryland, 865 A.2d 603, Jan. 14, 2005).*

After the birth of their two children, a couple decided that the husband should undergo a vasectomy. He discussed this desire with his family physician, who then provided the patient with a surgical referral. Following the vasectomy, the patient was advised by the surgeon to

avoid unprotected sexual relations for six months and to undergo three separate semen analyses during that period of time to insure that all analyses were negative for sperm. He was further instructed by the surgeon to contact his office if he had any questions. The patient himself negligently failed to follow these instructions and failed to see the surgeon, and consequently no semen analyses were performed.

Seven months after the vasectomy, the patient was seen by his family physician for an unrelated matter, and he inquired about the need for a semen analysis. He later inquired again at intervals of eight and twelve months after the surgery. At the final visit, the patient testified that he again requested a referral for semen analyses because his wife believed it was important to obtain a negative result before they engaged in unprotected sexual relations. According to the patient's testimony, the family physician replied:

“Jimmy, personally I had a vasectomy seven years ago. I didn't have a sperm count done. Me and my wife [sic] have practiced regular relations. You're not going to get your wife pregnant. Will you go home, [and] tell your wife I personally assure her you cannot father any children.”

Apparently, the patient acted upon this advice, because shortly thereafter, the patient's wife conceived their third child.

Both husband and wife sued his family physician, alleging negligence in his failing to provide a referral for a semen analysis, and

seeking monetary costs for raising their third child. The trial court found the family physician to be negligent, and also found the patient to be contributorily negligent in not heeding his surgeon's initial instructions, thereby denying him relief. As for the wife's claim, the trial court dismissed her suit, finding that she had never been a patient of the family physician and therefore he owed her no duty of care within the context of a doctor-patient relationship. Her claim was seen as merely derivative of her husband's claim, and if his claim failed, she could not raise an independent cause of action. The couple appealed the trial court's denial of their claims, but the Court of Special Appeals, after review, agreed with the trial court's action. The appellate court specifically held that a duty of reasonable care is owed by a treating physician to a patient, but a patient's spouse has no similar relationship and no similar right. The couple again appealed, this time to Maryland's highest court.

**“. . . he owed her no duty of care within the context of a doctor patient relationship.”**

Following further appellate arguments, the Court of Appeals of Maryland agreed with both previous lower court rulings. Since the patient was contributorily negligent in not heeding his initial instructions from the surgeon, his own negligence, under Maryland law, was a complete bar to recovery, despite the family physician's own negligence. Regarding the wife's claim, there was again found no duty by the physician to exercise reasonable care outside of the doctor-patient relationship. A successful

medical malpractice action requires that the defendant physician initially be under a duty to provide reasonable medical care, and that he then subsequently breach that duty by providing negligent care which causes patient injury. Since the patient's own contributory negligence caused his suit to fail against the physician, the wife's derivative claim must fail also, because he had no independent duty toward her. Not only did the family physician and the patient's wife not share a doctor-patient relationship, according to the court, but "the two never met each other until the day of trial, nearly seven years after the vasectomy."

The decision in this case reaffirms, once again, the general principle that no malpractice action can succeed in the absence of a legally recognized physician-patient relationship. Generally, physicians are free to choose their patients and may legally decline to treat patients as well. The relationship may be implied by courts in many cases, such as a routine office visit, or even a telephone call during which medical advice is given. Once a legal relationship is established, then the physician, of course, owes a duty to provide reasonable care. In the subject case, the patient's wife had neither met nor spoken with the physician, and the court correctly held that no physician-patient relationship could be found between the treating physician and the patient's spouse. Any compensation to her would have to flow from the "primary" negligence claim of her husband, which in this case was barred because of his own contributory negligence in not complying with his surgeon's instructions. As the physician-patient relationship is the keystone to every medical malpractice action, the absence of this essential relationship doomed the independent action brought by the patient's wife.

## **CASES 3 and 4**

### **Thrombolytic Therapy Decisions Questioned By Court**

*Arnao v. Teigman* (Nassau N.Y. County Sup. Ct., No. 16701/01, Aug. 6, 2004)

*Healy v. Hymanson* (York County, Maine, Super. Ct., No. CV-00-230, June 11, 2004).

Timely thrombolytic therapy in acute myocardial infarction has relatively recently become an important therapeutic adjunct, since reperfusion of ischemic myocardium can potentially reduce infarct size and salvage tissue. Not only can mortality be dramatically decreased, but associated left ventricular dysfunction can also be limited. Since the maximum benefit is obtained with timely administration, proper timing of thrombolytic therapy is of extreme importance. Moreover, proper patient selection is of equal importance, since thrombolytic therapy carries a risk of intracranial hemorrhage under the best of circumstances. Several recent cases illustrate how courts have questioned whether physicians have properly balanced this risk-benefit equation in thrombolytic therapy treatment decisions. In each of the following two cases, the courts ruled that negligent decisions were made for entirely different reasons, and consequently liability verdicts were returned in both cases.

In the first case of *Arnao v. Teigman*, the 39-year-old female patient had previously suffered an anterior wall myocardial infarction and had undergone angioplasty with stenting of two arteries. In late March, she experienced chest pain, but medical evaluation ruled out a myocardial infarction and a diagnosis of angina was made. On May 8<sup>th</sup> of that same year, she

returned to the hospital at 5:36 a.m. with another episode of chest pain since 5:00 a.m., and an EKG in the emergency department was obtained at 5:47 a.m. which demonstrated ST elevation suggesting an acute inferior or posterior wall myocardial infarction. In accordance with protocol, the emergency department physician telephoned the patient's cardiologist, and requested permission to initiate thrombolytic therapy with Retavase. The cardiologist insisted that Retavase be withheld until he could arrive at the hospital, which was four miles away, and could examine the patient. He stated that he would leave "right away." He did request that the EKG be faxed to him, but unfortunately his fax machine was not functioning properly.

The emergency room physician initiated morphine and nitroglycerine, without Retavase thrombolytic therapy, and made a second and third call to the cardiologist at 6:10 a.m. and again at 6:45 a.m. When called the third time, the cardiologist stated he was leaving his house. He arrived at the hospital at 7:00 a.m. and Retavase therapy was then initiated.

Later studies documented that the patient had suffered a myocardial infarction, and a subsequent echocardiogram demonstrated loss of movement of the posterior wall with a decreased ejection fraction. The plaintiff sued, contending that the cardiologist should have either instituted earlier thrombolytic therapy by telephone, or left for the four mile trip to the hospital immediately when he was notified. The defendant cardiologist argued, on the other hand, that it was reasonable to withhold thrombolytic therapy in view of the patient's prior recent history of angina and the potential adverse side effects of the drug. Besides, he argued, the delay of more than an hour in

initiating the drug was reasonable, and the later echocardiogram only demonstrated insignificant myocardial damage anyway.

The jury found the cardiologist's decision to be negligent and rendered an award of \$532,000. Apparently, the jury sided with the plaintiff's expert, another cardiologist, who claimed that thrombolytic treatment should have been instituted sooner, and that the failure to do so unnecessarily deprived the patient of a chance to avoid or limit myocardial damage.

**“. . . thrombolytic treatment should have been instituted sooner, and the failure to do so unnecessarily deprived the patient of a chance to avoid or limit myocardial damage.”**

In the second case of *Healy v. Hymanson*, a 59-year-old female complained of chest pressure and was taken to the hospital at 4:00 a.m. She was seen by both the emergency department physician and a cardiologist. Based on the history and EKG, a diagnosis of acute myocardial infarction was made, and the thrombolytic agent, Retavase, was initiated. Three hours later, the patient experienced an intracranial hemorrhage and paralysis followed. Her condition worsened and she died several days later.

The decedent's family brought suit, alleging that the Retavase should not have been prescribed, and that its use unnecessarily caused the patient's hemorrhage and death. In support of their claim, a cardiologist testified that the EKG must demonstrate a one millimeter ST segment elevation in two or more

adjacent leads to justify administration. In this plaintiff expert's view, the EKG in question did not contain the requisite ST elevation. When queried, the defendant's own expert witness also expressed doubt that the EKG demonstrated the requisite ST elevation.

The jury agreed with the plaintiff's expert, and returned a verdict against the defendant cardiologist for \$1.66 million. In this case, negligent administration by failing to observe appropriate guidelines proved to be the defendant's undoing.

“. . . negligent administration by failing to observe appropriate guidelines proved to be the defendant's undoing.”

It is anticipated that thrombolytic therapy decisions, especially those with adverse outcomes, will continue to be scrutinized by courts and juries for adherence to generally accepted guidelines. As in the implementation of any new therapy carrying risk, and as demonstrated by these two cases, it is anticipated that future allegations will include both delay in timely institution, as well as negligent use of the same therapy without the appropriate indications.

## **CASE 5**

### **Dismissal Of Anesthesia Resident For Dishonesty In Application Process Affirmed By Court**

*Fenje v. Feld (Seventh Circuit U.S. Court of Appeals, 398 F.3d 620, Feb. 15, 2005).*

During the course of application for graduate

medical education and licensure, all physicians are familiar with the completion of time consuming, lengthy, detailed applications and attestations regarding prior education and prior training, as well as any prior misconduct, drug or alcohol use, and criminal convictions. In the case of *Fenje v. Feld*, the failure to disclose information on a residency application relating to a prior termination from another residency program led superiors to question the resident's credibility and led to his dismissal from an anesthesia residency. A protracted and instructive litigation process followed.

By way of background, the problem originated in 1999 when the resident, Dr. Paul Fenje, having completed medical school in Ireland, commenced a residency in emergency medicine in Scotland. Only twelve days into this residency, his attending physician questioned Dr. Fenje's "competency to deliver patient care." Because his skills were deemed inadequate, he was dismissed from the program. Dr. Fenje sued, alleging that the Scottish hospital had wrongfully breached its contract with him.

The following year, Dr. Fenje applied for admission to an anesthesia residency at the University of Illinois at Chicago. His completed application failed to mention his prior, brief stint as a resident in Scotland, his termination from that program, or his pending lawsuit against the hospital in Scotland. The anesthesia residency director interviewed Dr. Fenje, pointedly inquiring whether he should know anything about his background, including work performed in prior training programs, and whether he had any "skeletons in his closet," which he denied. Subsequently, Dr. Fenje wrote the residency director a letter, which confirmed that there were "no skeletons of any kind in any of my closets," and stating that he

did not smoke, drank alcohol infrequently, did not use illegal drugs, and had never been charged with or arrested for a crime. He was accepted into the anesthesia residency, with a start date of August 1, 2000.

A month later, the residency director received an anonymous phone call apprising him of the fact that Dr. Fenje experienced difficulties in a prior residency, which was confirmed through inquiries with the Scottish hospital. Dr. Fenje was confronted with this contradictory new information, and given an opportunity to respond. He replied that his difficulties stemmed solely from a personality clash. He followed this explanation with a letter, writing that he “never considered this incident any kind of a closet skeleton and had thought of it as a personality clash of some kind.” Subsequently, after consultation with and approval of the anesthesia faculty, Dr. Fenje was dismissed from the residency for dishonesty in the application and interview process.

He then sued, claiming not only that his dismissal violated his due process and equal protection rights under the Fourteenth Amendment, but also that it was due to “ill will, animosity, retribution or spite” toward him. The district court denied him relief, and he appealed. Ultimately, the Court of Appeals, after careful review of the evidence, concluded that his dismissal as an anesthesia resident was warranted, and was marked by neither spite nor malignant animosity. According to the court, the action constituted a justifiable academic dismissal. The court accepted the University’s assessment that his lack of candor in the application process undermined his credibility as an information source concerning the care of seriously ill patients. The court found a real nexus between Dr. Fenje’s dishonesty in the

application process and his capacity to be trusted with patient care.

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This case serves as a useful reminder to physicians that in the completion of the many burdensome and detailed applications relating to graduate medical training, licensure, and a board certification, truly, “honesty is the best policy.” Courts will generally not jump to the defense of professionals who have intentionally concealed adverse information in an application process. While the open disclosure of adverse information may allow the physician an opportunity for reasonable explanation, the concealment of the same adverse information almost always leads to negative inferences.

## CASE 6

### **Negligent Nutrition Administration Through Abdominal Drainage Tube Results In Liability**

*Weinberg v. Westchester Medical Center (Westchester, N.Y. County Sup. Ct., No. 12772/02, May 20, 2004).*

A 62-year-old male patient was admitted for a kidney transplant, and developed postoperative gastric bleeding. Endoscopy and cauterization were performed to stop the bleeding in his stomach, but a subsequent duodenal perforation required surgery. A red drainage tube was placed on the right side of his abdomen, while

another red feeding tube was placed on the left side and marked with tape.

Five days following surgery, he was fed by a nurse for the first time. Unfortunately, the nurse administered the nutrition through the abdominal drainage tube, rather than the feeding tube. The surgeon realized the nurse's mistake four hours later, and performed an immediate procedure to clear any nutritional material out of the abdomen. During the procedure, a small amount of purulent material was noticed near the drainage tube, and culture from the procedure grew streptococcus, enterobacter, and acinetobacter. The patient subsequently developed sepsis and his abdominal wound healed poorly. Another surgery to remove infected mesh material was performed, but postoperative complications continued. His body ultimately rejected the transplanted kidney. Shortly after its removal the patient developed adult respiratory distress syndrome, suffered a pulmonary hemorrhage, and died.

The patient's widow sued the surgeon and the hospital, claiming that the medical team negligently failed to properly distinguish the feeding tube from the drainage tube, leading to the patient's infection and death. The surgeon argued that the patient's infection was present prior to the improper administration of his feeding through the abdominal drainage tube. As evidence, he cited the presence of purulent material at the drainage site shortly after the feeding was administered, arguing that adequate time did not elapse for the nutrition administration into the abdominal cavity to colonize into the bacteria which was found and cultured at the time of the operation. According to the surgeon, not only were the two tubes properly marked, but also the nurse's mistake had not caused the infection anyway.

In light of the conflicting evidence, and prior to jury selection, the defendants settled for \$1.45 million before trial. Even though a question of sepsis causation existed, due to the documented presence of positive bacterial cultures so soon after the intravenous nutrition administration, such an egregious error of utilizing the wrong tube for nutrition obviously induced the defendants to offer a pretrial settlement, rather than risk an even bigger loss with litigation. Coming relatively soon after the highly publicized Institute of Medicine's ground-breaking report on medical errors causing patient deaths, this case serves as a useful reminder that the public will remain sensitized to obvious medical errors for some time to come. Consequently, litigants can expect juries to take a dim view of obvious and avoidable mistakes in health care delivery.

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## **CASE 7**

### **Failure To Diagnose Coronary Artery Disease Resulting In \$10 Million Liability**

*Carlson v. Waterbury Hospital (Fairfield Ct. County State Court, No. CV 95 0321321, Feb. 24, 2004).*

Physicians are familiar with the risk of failing to diagnose coronary artery disease during not only outpatient visits, but also preoperative evaluations to “clear” patients prior to surgery. The following case, resulting in a \$10 million

award, only reinforces the need to maintain a high index of suspicion.

In *Carlson v. Waterbury Hospital*, the patient, a 49-year-old truck driver and owner of a snow plowing business, visited his physician for a complaint of recurring, burning chest pain, most prominent after meals and with exertion. His past medical history was remarkable for hypertension, slight obesity, and unfavorable cholesterol levels. The treating physician ordered an EKG, which demonstrated the ambiguous finding of “flat T-waves.” A diagnosis of drug-induced gastritis due to non-steroidal anti-inflammatory medication was made, and antacids were prescribed. The patient was instructed to return if there were further problems, which he did not do.

Seven weeks later, the patient underwent a preoperative evaluation for elective hip surgery, for which he was “cleared.” Following surgery, the patient experienced multiple complications, including anemia and arrhythmia, and subsequently died. At autopsy, evidence of coronary artery disease with 90% occlusion was found, along with evidence of a myocardial infarction.

The patient’s wife sued, claiming negligent evaluations by both the first internist, during the initial outpatient visit, and the second internist, during the preoperative evaluation prior to hip surgery. In her view, the patient’s history and EKG findings warranted the ordering of a stress test, which could have detected his coronary artery disease and therefore led to the canceling of his surgery. The defense, on the other hand, argued that in light of everything, a diagnosis of gastrointestinal pain was still reasonable. The defense maintained that the patient’s EKG contained no significant changes from a prior EKG performed a

year earlier. Moreover, the first internist pointed out that at the time he saw the patient he had no knowledge of and could not have foreseen the upcoming hip surgery.

After considering the evidence, the jury found negligence and returned a \$10 million verdict against both the second internist who performed the preoperative examination and the hospital where he worked. A previous pretrial liability settlement had been reached with the first internist who initially saw the patient.

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Large verdicts and settlements such as this often result when a finding of negligent failure to diagnose coronary artery disease is made, and the patient subsequently dies. This is especially true in cases such as this where the decedent was a middle-aged wage earner, father of three, with a life expectancy of 31 more years. Once again, this case points out that along with a careful history and physical and appropriate diagnostic tests, one of the best risk management tools at a physician’s disposal is a high index of suspicion when seeing chest pain patients.

## **CASE 8**

### **Physician Convicted, Sentenced To 25 Years For Pain Prescriptions**

*United States v. Dr. William Hurwitz (U.S. District Ct., E. Dist. Va., April 14, 2005).*

Dr. William Hurwitz, a Northern Virginia pain specialist, was indicted on numerous counts of illegal prescription of pain medication. Investigators and prosecutors produced evidence that he had prescribed huge amounts of opioid pain relievers for his patients, some of which eventually found their way to the black market. Noteworthy was the presentation of evidence that he prescribed 1,600 pills for one person to take in a single day.

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The defense presented a different view of Dr. Hurwitz. According to his defenders, Dr. Hurwitz’s patients included many suffering from arthritis, chronic back pain, and cancer, and his prescribing practices were those of a caring, compassionate physician who beneficially managed many chronic pain patients. The small number of his patients who subsequently sold narcotic prescriptions for profit on the black market, according to his supporters, represented an inevitable minority who dupe even the most careful prescribers.

This trial focused public attention on a long smoldering controversy regarding a physician’s role in pain management. On the one hand, regulators argue that close scrutiny of physicians and their prescribing practices is necessary to prevent a small but dangerous number of prescribers from seeking to profit by diverting prescription medication into the illegal market, with injurious and even fatal consequences. On the other hand, it is argued that undertreatment of pain has become a national epidemic.

According to this view, growing fear of regulatory scrutiny leads physicians to prescribe smaller doses and lesser quantities of pain medication, and physicians who are courageous enough to undertake the medical care of chronic pain patients can easily become scapegoats in large, aggressive federal crackdowns on pain doctors.

In this case, the jury obviously sided with the prosecution, convicting Dr. Hurwitz on 50 counts of drug trafficking, some resulting in serious injuries according to prosecutors, and an overdose death. He was later sentenced to 25 years in federal prison. However, this case obviously does not end the larger pain prescription controversy. In August of last year, for instance, an arduous consensus building endeavor between the medical establishment and the Drug Enforcement Administration (DEA) resulted in the successful joint formulation of pain management guidelines. Subsequently, in October 2004, the DEA withdrew its support from that document citing concerns about misstatements, particularly regarding refills and reselling of schedule II controlled substances. Problematic prescribing practices open to different interpretations, for example, include the preparation of multiple narcotic prescriptions on the same day with instructions to fill them on different, subsequent dates in order to obviate frequent revisits for prescription renewals. Some would argue that this becomes a subterfuge for physicians to avoid detection while dispensing large quantities of controlled substances for illegal purposes. Others argue that this enables a physician to provide adequate pain medication without requiring inordinately frequent, unnecessary visits by established cancer, arthritis, and other chronic pain patients, along with the redundant signing of prescriptions by physicians at very

brief intervals. Ultimately, closer collaboration between the medical and law enforcement communities may lead to the sharper delineation of what does and does not constitute prescription abuse by physicians. This would benefit not only patients, but also physicians and law enforcement officials as well.

## **CASES 9 and 10**

### **Retained Foreign Bodies Continue To Result In Liability**

*Roberson v. Hernandez – Pombo (Dade County Florida Cir. Ct. No. 03-9007 (CA27), Aug. 3, 2004)*

*McQuillia v. Maryview Medical Center (Portsmouth Va. City Circuit Court, No. CL03-2441, Oct. 18, 2004).*

Two recent cases only serve to illustrate and reinforce the great difficulty in defending a medical malpractice action involving the retention of foreign bodies after surgery. In the case of *Roberson v. Hernandez – Pombo*, the 35-year-old plaintiff, Curtis Roberson, was employed as both a security guard and a landscaper. Prior to the incident which became the subject of this litigation, he presented with abdominal pain, fever, nausea and vomiting. His surgical evaluation led to a diagnosis of appendicitis, and an appendectomy was performed. He followed an uneventful postoperative course and was discharged home.

Unfortunately, a surgical lap sponge had been left in his abdomen, and he returned to the hospital several weeks later with acute abdominal pain and fever. Following suspicious radiologic studies, an exploratory laparotomy was performed and the lap sponge was found

tangled around his bowel, accompanied by a bowel fistula leaking fecal material into the abdominal cavity. The sponge was cut out and the compromised bowel was resected. The surgeon chose to perform an end-to-end anastomosis, rather than a hemi-colectomy.

“. . . the lap sponge was found tangled around his bowel, accompanied by a bowel fistula leaking fecal material into the abdominal cavity.”

Eight days later, further infectious complications arose. Another laparotomy was performed and the original anastomosis was found to have broken down, again resulting in the spillage of fecal material into the abdominal cavity. Another area of compromised bowel was resected and another end-to-end anastomosis was performed. One week later, further complications arose from renewed fecal spillage, and now the surgeon performed a left hemi-colectomy. The patient became septic, and transfer to another hospital was effected with successful institution of an antibiotic regimen.

Following a six-week hospitalization and 45-pound weight loss, the patient was discharged but continued to suffer from abdominal cramping, inability to eat certain foods, and decreased bowel control. He sued the surgeon claiming, among other things, that the lap sponge was negligently left in his abdomen following the first surgery, and also that the surgeon breached the standard of care by not immediately performing a hemi-colectomy, rather than an end-to-end anastomosis, when initial complications arose. A verdict of \$3 million was rendered

against the surgeon to reimburse the plaintiff for his medical expenses, lost wages, and continuing pain and suffering.

In the second case of *McQuillia v. Maryview Medical Center*, the plaintiff underwent an uneventful abdominal aorto-bifemoral bypass graft surgery. Six months later, the plaintiff developed a distended abdomen and radiologic studies revealed an abdominal mass. Exploratory surgery led to the discovery of a small surgical towel, which was then removed from the abdomen. This second surgery resulted in soreness, additional scarring, and the possibility of the development of future adhesions.

**“Ultimately, the jury in this case found both the surgeon and the hospital to be negligent . . .”**

The plaintiff sued both the surgeon and the hospital, claiming that they were negligent in failing to monitor all foreign bodies placed in his abdomen during the procedure, and also in failing to insure that all such foreign bodies were removed prior to closure. The defendant hospital argued that surgical towels, unlike needles and sponges, are not part of the routine operating room counting procedure, and that it was the surgeon’s sole responsibility to account for and physically remove all surgical towels. The defendant surgeon, on the other hand, admitted that he had some responsibility to account for and remove surgical towels, but he went on to contend that the hospital’s surgical nursing staff also shared in this responsibility. Ultimately, the jury in this case found both the surgeon and the hospital to be negligent, and

awarded \$1.2 million to the plaintiff (later reduced to \$800,000).

These cases illustrate the continuing difficulty in defending a medical negligence action involving the retention of a foreign body following a surgical procedure. In fact, many courts apply the legal doctrine of “*res ipsa loquitur*,” or “the thing speaks for itself.” Under this doctrine, the plaintiff does not need an expert witness, but only must show that the adverse outcome was caused by an instrumentality in the exclusive control of the defendant, that the plaintiff did not contribute to the result, and that the injury does not occur in the absence of negligence. It is analogous to another legal concept, the common knowledge doctrine. In such cases, medical experts are unnecessary, as the case involves matters within the jurors’ general knowledge. In short, surgical cases where foreign bodies are unintentionally left behind and subsequently cause painful symptoms, as in these two instances, continue to prove extremely difficult to defend and typically result in liability.



# **STANDARDS OF CARE IN MEDICAL MALPRACTICE CASES FOR MEDICAL RESIDENTS: IMPLICATIONS FOR QUALITY IMPROVEMENT**

**By Richard L. Granville, M.D., J.D.**

Medical malpractice liability for residents is an important concern in the graduate medical education setting for the residents themselves, the attending staff, and for the facility. It is also important to the patients who are cared for by residents. To date, courts have gone in several directions regarding the standard of care applied to a medical resident. Some courts apply the standard of a general practitioner. Other courts apply the standard of a fully trained specialist. Other courts, particularly those in Pennsylvania, have applied an intermediate standard for residents. These various standards are discussed below, with ramifications for all involved.

First, however, it should be noted that the standard of care, and the ensuing breach thereof, is

only one element involved in proving negligence in a medical malpractice case. A successful plaintiff must prove all the traditional elements of negligence which include:

1. A duty to perform in an acceptable manner;
2. A breach of the standard of care;
3. Injury to the patient; and,
4. A causal relationship between the breach of duty and the injury.

The standard of care is usually proven by expert testimony. Physicians in general are held to the standard of care of a reasonable, prudent physician in their particular specialty. For example,

an anesthesiologist would be held to the standard of a fully trained anesthesiologist. Most likely, expert testimony establishing that standard of care would be furnished by another fully-trained anesthesiologist. How should the standard of care for a medical resident be determined?<sup>1</sup>

### **National Practitioner Data Bank Information**

Private sector interns and residents must generally be reported to the National Practitioner Data Bank (NPDB) when a medical malpractice payment is made on their behalf.<sup>2</sup> In fact, the National Practitioner Data Bank 2003 Annual Report<sup>3</sup> noted that 1,686 medical malpractice payment reports related to interns and residents. Of the total 1,686 malpractice payment reports, 1,465 were for allopathic interns or residents and 221 for osteopathic interns or residents. While this constitutes barely one percent (0.9%) of all physician malpractice payment reports, it is nonetheless an issue of importance to interns and residents practicing in graduate medical education programs. Involvement in a malpractice case with a finding of liability will undoubtedly require an explanation by the resident when he or she seeks future employment. Thus, the standard of care used to determine that liability becomes an extremely important issue.

### **“General Practitioner” Standard of Care**

The United States Court of Appeals for the Ninth Circuit addressed the issue of medical residents and the standard of care in *McBride v. United States of America*.<sup>4</sup> A navy commander was a patient at a military medical center undergoing tests to diagnose the etiology of chest pain. His evaluation revealed no evidence of heart disease, but it could not be entirely ruled out. He was released from the hospital and

advised to return for follow-up in a few weeks for more tests. Three nights after discharge, the patient had a recurrence of severe chest pain. He went to the emergency department where the physician on duty was a young resident who read the past records of the earlier diagnostic workup and performed an electrocardiogram (EKG). The EKG showed some abnormal changes; however, the patient’s pain subsided. The resident told the patient that the pain was probably due to a gastrointestinal problem, but that heart disease could not be eliminated. The patient preferred to return home since he felt fine and since the previous hospitalization had shown no cardiac problem. The resident told the patient to return immediately should the pain recur. The patient died shortly after reaching home.

At trial, the plaintiff’s experts stated that the standard of care to be applied in the case of a resident was that of a general practitioner and that a general practitioner would have made a correct interpretation of the electrocardiogram. However, the chief of cardiology at the facility testified that many interns and residents would not have correctly interpreted the abnormal electrocardiogram. Relying heavily on the opinion of the chief of cardiology, the trial court ruled that the resident’s misinterpretation of the EKG was not negligence based on the resident’s lack of special training and experience.

The appellate court in this case reversed the decision of the trial court, reasoning that “the duty of care owed to the patient does not vary according to the doctor’s individual knowledge or education.”<sup>5</sup> The court applied the rule that “unless a physician represents that he is greater or less skilled or knowledgeable, one who undertakes to render services in the practice of a profession or trade is required to exercise the

skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities.”<sup>6</sup> The court therefore held the resident physician to the standard of a general practitioner and not the standard of a resident in training.

**“The court therefore held the resident physician to the standard of a general practitioner and not the standard of a resident in training.”**

In *Jenkins v. Clark*, the Court of Appeals of Ohio likewise confronted the issue of what standard of care should be applied to medical residents.<sup>7</sup> There the patient developed chest pain and was sent by the private physician to the hospital emergency room where an electrocardiogram and chest x-rays were to be taken. The physicians on duty were a first year resident and a fully licensed physician who was the attending in the emergency room. The resident performed a history and physical examination, but did not, however, elicit the entire history of chest pain. The patient had endured chest pain for approximately two weeks. The resident was only concerned with the pain that the patient was experiencing on the day of presentation to the emergency department. He found no evidence on the electrocardiogram that the patient was experiencing a myocardial infarction and made a diagnosis of non-specific chest pain possibly due to pneumonia. Unfortunately, the patient suffered a heart attack several days later and died.

The wife of the decedent subsequently filed a lawsuit against the various physicians and

hospital involved in the case. The court addressed the standard of care with regard to the resident, stating that “the standard of care required of a physician is not an individualized one but one of physicians in general in the community.”<sup>8</sup> The appellate court affirmed the trial court’s jury instructions that “the medical care required is that of a reasonably careful physician or hospital emergency room operator, not that of interns or residents.”<sup>9</sup> The court thus supported the rule that the standard of care applied to medical residents was that of a general practitioner and not the standard of a resident in training.

The Supreme Judicial Court of Massachusetts, in *St. Germain v. Pfeifer*,<sup>10</sup> ruled that the standard of care for a first year resident was the same as that for other physicians. In this case, the patient underwent a mid-lumbar osteotomy performed by an orthopedic surgeon and a neurosurgeon to reduce a debilitating spinal deformity. Fixation, hooks, and a rod were placed into the plaintiff’s spine during the procedure. The attending’s plan was for the patient to stay in bed for approximately 4 or 5 days following the surgery. Unfortunately, a first year orthopedic resident ordered that the patient be given a soft orthopedic support and that the patient be moved out of bed to a chair. The attending physician apparently did not see the order written by the resident. Later, the nurse told the plaintiff to get out of bed and walk. As he stood up, he heard a loud snapping noise in his back and fell back in bed. As a result of this movement, hardware slipped out of position. Corrective surgery to reposition it was unsuccessful.

At trial, the orthopedic resident asserted that the plaintiff’s expert did not apply the standard of care applicable to first year residents. The court

noted that he had no support for his assertion that a first year resident should be held to a lower standard of care than more senior physicians. On appeal, the court affirmed the decision of the trial court by refusing to apply a lower standard of care to residents than is applied to other physicians. The appeals court relied on an earlier opinion by the Court of Appeals of Indiana that held that interns and first year residents are “practitioners of medicine required to exercise the same standard of care applicable to physicians with unlimited licenses to practice.”<sup>11</sup>

### “Specialist” Standard of Care

In determining negligent conduct, a number of courts have applied the standard of care of a specialist to the care provided by a resident. In *Valentine v. Kaiser Foundation Hospitals*,<sup>12</sup> the District Court of Appeals for the First District of California applied the standard of a specialist to residents when an infant lost his glans penis during a circumcision procedure performed by an obstetric resident. The court applied the rule that “one who holds himself out as a specialist and who undertakes services in a special branch of medical, surgical or other healing science owes to his patient the duty of possessing that degree of learning and skill ordinarily possessed by a specialist of good standing practicing in the same special field and in the same locality under similar circumstances.”<sup>13</sup> The court stated that even though the resident had finished only one-third of his residency, it was not unreasonable to hold him to a higher standard than that of a general practitioner since the resident admitted to performing 600 to 800 circumcisions. The court noted that it was logical to expect him to have more skill in performing circumcisions than a general practitioner. Additionally, the resident was engaged in a residency program in the field

of obstetrics and gynecology. The court believed that this, too, warranted the higher degree of learning and skill equivalent to that of a specialist. Although this case was later overruled on an unrelated issue, its application of the specialist’s standard of care to residents is similar to that of later case law.

The Court of Appeals of Louisiana also ruled on the issue of the standard of care to be applied to a resident. In *Felice v. Valleylat, Inc.*,<sup>14</sup> a two-year-old child developed dysuria and the foreskin of the penis could not be retracted easily. A circumcision was recommended to correct this condition diagnosed as phimosis. A first year family practice resident under the supervision of a third year surgical resident performed the circumcision. They were the only physicians present at the procedure. The foreskin was stretched past the end of the penis and clamped with a hemostat to hold the foreskin in a position to be severed. Normally the incision is performed with a scalpel, but in this case the supervising resident suggested that the first year resident use a high frequency electrical current through a “surgical pencil” to incise the foreskin. This technique reduces bleeding and eliminates the need to tie off blood vessels. However, the patient sustained a full thickness burn to the penis because of excess electrical current and the procedure was aborted and silvadene cream applied to the burned area. The patient was discharged and the remaining penile tissue sloughed away leaving the patient with no visible penile tissue. The patient had subsequent problems with his urethra and required four additional surgical procedures.

At trial, the supervising resident testified that she had been trained to perform circumcisions in medical school using a scalpel but had never been instructed concerning the use of an

electrical surgical device. The resident never inquired of her attending physicians as to whether the use of such a device was proper for circumcision surgery, nor did she read the literature or the equipment manual to see if there were any dangers associated with its use. She admitted that she had never used such a device to cut the foreskin in a circumcision.

A general surgeon testified that the resident's behavior was below the standard of care—failing to have adequate knowledge of the risks involved and failing to explore the risks with her supervising personnel. The trial court found that the supervising resident was negligent in modifying the circumcision technique. If she had used the method that she had learned in medical school, the burn would not have resulted.

**“. . . some courts will apply the standard of a fully trained specialist to the care provided by a resident when they are practicing within their specialty.”**

The appellate court affirmed the decision of the trial court with regard to the care provided by the resident noting that the resident was a licensed physician, in her third year of residency. Since she was limiting her practice to general surgery and holding herself out as limiting her practice, the court found that she was a specialist. The court noted that “specialists are required to exercise the degree and care and possess the degree of knowledge or skill ordinarily exercised and possessed by physician within their medical specialty.”<sup>15</sup> This case again demonstrates how some courts will apply

the standard of a fully trained specialist to the care provided by a resident when they are practicing within their specialty.

In *Parmelee v. Kline*, the court found that a “medical resident who was limiting her practice of medicine to neurosurgery and was holding herself out as a specialist in that area was to be classified as a specialist for the purposes of determining the standard of care.”<sup>16</sup> In this case the patient suffered a boating accident that resulted in paralysis of the right arm and right diaphragm. He suffered from phantom pain in his shoulder. The patient agreed to have a neurosurgeon perform surgery on his shoulder to relieve the pain. Assisting at the operation was a neurosurgery resident. At surgery, significant scar tissue was encountered resulting in abnormal bleeding and the administration of five pints of blood. The surgery lasted approximately five hours, ending at approximately 8:00 p.m., whereupon the patient was taken to the recovery room. The resident remained with the patient in the recovery room and the attending neurosurgeon left the hospital. He was not contacted again until 2:30 a.m. when he was informed that the patient was not moving his extremities. The patient was immediately taken to the operating room for surgery to remove blood clots, but severe neurologic injury was not prevented and unfortunately the patient died nine days later.

Nursing notes indicate that the resident was notified of the reduced movement at 11:15 p.m. The resident denied being told of this new finding and stated that she had only been notified at 2:00 a.m. In addressing the care provided by the neurosurgical resident, the court stated that she was a first year resident in neurosurgery and not a certified neurosurgeon. However, the court relied on previous Louisiana case law in

determining the standard of care and held that since the resident was “limiting her practice of medicine to neurosurgery and was holding herself out as a specialist in that area, that she was classified as a specialist.”<sup>17</sup> It went on to state that a “specialist must exercise the degree of care and possess the degree of knowledge or skill ordinarily exercised and possessed by physicians within that medical specialty.”<sup>18</sup>

Both the California and Louisiana appellate courts rely in part on the fact that when a resident holds him or herself out to be a specialist, he or she should be held to the standard of care for a specialist.<sup>19</sup> This “holding out” creates an expectation on the part of the patients that they will receive care consistent with that provided by a fully trained specialist.

#### **“Intermediate” Standard of Care**

In *Jistarri v. Nappi*, the Superior Court of Pennsylvania uniquely addressed the standard of care for residents by holding that residents should be held to “a standard higher than that of a general practitioner but less than that for a fully trained specialist.”<sup>20</sup> In this case, appellants contended that the trial court erred in instructing the jury on the standard of care of the orthopedic resident. X-rays revealed a fracture of the left wrist when an 85-year-old woman suffered a fall at her home. An orthopedic resident applied a cast to the patient’s wrist in the emergency room, but failed to put adequate padding under the cast. The patient was brought to the emergency room at a later date with chest pain and was admitted to the hospital. Blood cultures revealed staphylococcus aureus infection. The cast was removed and revealed an area of erythema and exudates which were due to the lack of padding. Several days later an ulcer was found in the area where the cast had been placed, and culture of the area

revealed staphylococcus aureus as well. The patient’s hospitalization became more complicated and she died approximately two to three months after admission.

**“. . . the trial court did not err in instructing the jury to apply a standard of care for the orthopedic resident that was less than a fully trained orthopedic specialist but greater than a general practitioner.”**

Appellants in this case challenged the trial court’s instructions regarding the standard of care to which an orthopedic resident should be held, arguing that a resident must be held to the same standard as an orthopedic specialist. The trial court’s jury instructions had stated that a resident is a licensed physician in training in a specialty in a hospital. He is not a fully trained orthopedist nor is he a general practitioner. He therefore is “held to exercise that degree of skill, learning and care possessed by an orthopedic resident in the circumstances.”<sup>21</sup> On appeal, the court concluded that the trial court did not err in instructing the jury to apply a standard of care for the orthopedic resident that was less than a fully trained orthopedic specialist but greater than a general practitioner. The court felt that “this instruction recognizes that the resident has more training than a general practitioner but the same amount of training as a fully trained specialist.”<sup>22</sup> To insist that a resident meet the standard of care of a fully trained specialist is “unrealistic.” It would be unfair to judge care of a resident, who may be years away from completion of a residency, according to the standard of a fully trained specialist. The court stated that “to require the

resident to have the same skill and training of a specialist would be asking the resident to do the impossible.”<sup>23</sup>

While it may seem logical, the “intermediate” standard of care for residents used by Pennsylvania courts has not gained wide popularity in other states. In fact, in the future residents might be more widely held to the standard of care of a specialist, thus reflecting societal expectations.

When residents present themselves as specialists at tertiary care centers and teaching

institutions, their patients most likely expect medical treatment according to the standards of fully trained individuals. The application of the higher “specialist” standard should encourage residents to consult with their supervisors and should encourage the facility’s attending staff to actively supervise the residents.<sup>24</sup> Applying the “specialist” standard of care can promote the public good by encouraging a higher quality of medical care and patient safety. The analysis of the evolving standard of care for residents in medical malpractice cases deserves further attention as future case law provides additional guidance.

## References

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3. National Practitioner Data Bank. 2003 Annual Report. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Practitioner Data Banks Branch. Rockville, MD. Available at [www.npdb-hipdb.com/annualrpt.html](http://www.npdb-hipdb.com/annualrpt.html). Accessed May 4, 2005. It should be noted that of the residents and interns reported, 1486 had just one malpractice payment report while one individual had 45 malpractice payment reports.
4. *McBride v. United States of America*, 462 F.2d 72 (U.S. Court of Appeals 9<sup>th</sup> Cir. 1972).
5. *Id* at 3.
6. *Id* at 2.
7. *Jenkins v. Clark*, 7 Ohio App.3d 93, 454 N.E.2d 541 (1982).
8. *Id* at 10.
9. *Id*.
10. *St. Germain v. Pfeifer*, 418 Mass. 511, 637 N.E.2d 848 (1994).
11. *Centman v. Cobb*, 581 N.E.2d 1286 (Ind. 1991).
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14. *Felice v. Valleylat, Inc.*, 520 So.2d 920 (La. 1987).
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# Ethical Considerations When Prescribing Pain Medication

By Judson J. Somerville, M.D.\*



hronic pain and the opioid pain medications used to treat it have recently received a tremendous amount of publicity. Like all things in the “public

eye,” this can be both good and bad. It can be good because millions of Americans who suffer from chronic pain are now legitimized and outspoken in their search for appropriate pain relief. The publicity is unfortunate, however, because it chronicles the rise in the abuse of opioid pain medications like Oxycontin. This causes federal and state authorities to “crack down” on abuses, resulting in still more bad publicity.

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Unfortunately, this leaves the legitimate public, patients, physicians, and other health care professionals perplexed as to how to ethically proceed. The question in the prescriber's mind is: "Do I treat with opioids and risk losing my license, or do I abstain and risk losing not only my license but also patients who genuinely need these strong medicines?" The public and patients are equally confused because they are getting mixed messages: 1) that chronic pain treatment opioids are necessary, effective, but under-delivered, and 2) that opioids are abused and create addicts.

So what to do? As a physician, it is critical to understand your own and the public's fears, questions, expectations, and understanding of chronic pain and its treatment with opioids. How can a professional health care provider be protected from individuals who attempt to procure opioids for illegal purposes, adequately document these incidents, and communicate to his or her patients the risks, benefits, and options of taking opioid medications to treat chronic pain? This article attempts to answer these ethical questions and provides three case studies as examples.

### **The Patient Perspective**

Patients who suffer from chronic pain are in many ways like any other patients suffering from chronic illness. Often they are in denial or somewhere along the Kubler-Ross steps of acceptance of their illness. Their chronic pain may have financial, familial, and social implications associated with the loss of a job, breakdown of a marriage or other family relationship, or decreased physical or mental functions. Situations like these can exacerbate the psychological stress patients may suffer as a result of the disease of chronic pain. Those who suffer from chronic pain with not only physical ailments but also psychological suffering are more

challenging for the physician to treat. This combination increases patient suffering, often resulting in sleep deprivation, pain behavior, and symptoms of depression and anxiety.

All of this leads to an overwhelmed patient who may have a difficult time hearing, much less understanding, what a physician or other health care provider is saying, particularly when the patient's condition is discussed in "medical terminology." Even when clear and simple layman's terms are used, the patient's condition may be totally new and alarming to him or her making understanding difficult. Continuing to educate the patient and documenting the record are critical both to the physician's protection from charges of malpractice and to the patient's well-being. The better informed the patient is, the more compliant with treatment he or she is likely to be. Additional factors to consider when educating patients about chronic pain are their intelligence level, education level, and social background. One must communicate with patients in whatever way will allow them to better understand their disease, its treatment, and the risks, benefits, and ethical options of treatment.

**"The better informed the patient is, the more compliant with treatment he or she is likely to be."**

Generally speaking, the patient should first be given a broad, uncomplicated explanation of their condition and they must be allowed to ask questions. Even if they initially appear to grasp what is said, it is important to reinforce their understanding as this often results in a better medical outcome. Not to do so may result in noncompliance with the treatment plan,

followed by poor outcome and the physician's ensuing possible exposure to litigation. Ask questions and then focus on the patient's particular areas of ignorance concerning their condition or treatment plan. This must be accomplished, however, with diplomacy and tact taking into consideration the best use of the physician's and the patient's time constraints.

During both the initial and follow-up visits it is important to emphasize key components of the patient's disease, to discuss how opioid treatment may help, and to answer all questions. Documentation is always of utmost importance. Patient misunderstandings concerning addiction (psychological dependence), physical dependence, and physical tolerance must be cleared up and properly explained. It has been widely noted that physicians are quick to interrupt the patient early in the visit and often do not let the patient communicate issues that are important to them. This can lead to patient resentment and a feeling that the physician or other health care provider does not really care. Let the patient ask questions, particularly at the end of the visit, as it may enhance bonding between the provider and the patient, reduce "callbacks," and again reduce the possibility of litigation. All of these methods can help physicians to better understand, communicate with, and provide ethically appropriate treatment for their patients, with a side benefit of reducing their own risk of ending up in a court of law if a problem develops later on.

### **The Physician/Health Care Provider Perspective**

Physicians today are swamped with more and more paperwork and more patients to see to make less income to pay increasing malpractice insurance and other expenses. Patients now seem to be even more demanding, reading everything on the Internet, assuming it is

gospel, and presuming that the treating physician is clueless. Physicians must spend inordinate amounts of time documenting all that is said during the patient visit and must keep themselves up to date on pharmaceuticals and treatments currently in favor or simply in the news. These conditions unfortunately can create a defensive, exhausted, and stressed out physician or health care provider who may be less tolerant of patient conversations and patient care. The provider may ask, "How can I be more tolerant when there is more pressure on me? How can I treat my patients in an ethical manner, and still protect myself from litigation exposure?" The answer is not **if** you want to, but that you **must** to survive.

**"Physicians must spend inordinate amounts of time documenting all that is said during the patient visit . . ."**

Things will change, hopefully for the better, but until they do health care providers must be patient. The more efficient physicians become in communicating with patients, and this is achieved by consistent practice, the fewer other problems they will encounter, and the more time they will have to accomplish additional things. This model improves patient care and reduces liability. Patience and practice can also enable physicians to consistently and ethically handle difficult patients in any number of situations they may encounter.

### **Case 1**

"Mrs. Smith" visited the clinic one day as a walk-in, wanting an initial evaluation for chronic low back pain. She checked in at the front office and completed paperwork that asked for, among other things, her current

# CONTINUING MEDICAL

Using the printed answer sheet provided at the insert, answer all 20 questions below. Each question has only one correct answer. An answer key is provided on page 4.

1. Patient medical records are always considered to be private protected documents which cannot be seized with a search warrant, even in circumstances of criminal investigations.
  - A. True
  - B. False
2. A physician assumes a legal duty to provide a patient with reasonable medical care based on
  - A. Medicare regulations.
  - B. Hospital by-laws.
  - C. A recognized physician-patient relationship.
  - D. General principles of the "Good Samaritan."
3. Under the legal doctrine of "res ipsa loquitur" the plaintiff must show that the instrumentality was in the exclusive control of the defendant, that the plaintiff did not contribute to the adverse outcome, and that
  - A. The manufacturer issued an express warranty.
  - B. The injury does not occur in the absence of negligence.
  - C. The physician was grossly incompetent.
  - D. The insurer gave prior authorization.
4. Under the "common knowledge doctrine," experts are unnecessary as the case involves matters within the jurors' general knowledge.
  - A. True
  - B. False
5. To date, courts have gone in several directions regarding the standard of care for residents. Those standards include all of the following except
  - A. The standard of a general practitioner.
  - B. The standard of a fully trained specialist.
  - C. An intermediate standard for residents.
  - D. The standard of a medical student.
6. A successful plaintiff must prove the traditional elements of negligence which include all of the following except
  - A. Duty to perform in an acceptable manner.
  - B. A breach of the standard of care.
  - C. A causal relationship between the breach of duty and the injury to the plaintiff.
  - D. Criminal activity by the defendant physician.
7. According to the National Practitioner Data Bank 2003 Annual Report, how many medical malpractice payment reports are related to interns and residents?
  - A. 1,686
  - B. 204
  - C. 897
  - D. None
8. In *Jistarri v. Nappi*, the Superior Court of Pennsylvania applied which standard of care to medical residents?
  - A. No standard of care.
  - B. An "Intermediate" standard of care that was higher than that of a general practitioner and less than that for a fully trained specialist.
  - C. The standard of care of a 3<sup>rd</sup> year medical student.
  - D. The standard of care of a fully trained board certified practitioner.
9. The annual number of retained foreign bodies estimated to be accidentally left in patients after surgery in the United States is
  - A. Less than 100.
  - B. 1,500.
  - C. More than 20,000.
  - D. 18,760.

# EDUCATION QUESTIONS

10. Medical consequences of retained foreign bodies can include
  - A. Small bowel fistula.
  - B. Visceral perforation.
  - C. Sepsis.
  - D. All of the above.
11. The Association of periOperative Registered Nurses (AORN) recommends
  - A. Utilization of magnets to remove sharps.
  - B. Four separate counts.
  - C. One count of sharps only at the conclusion of surgery.
  - D. None of the above.
12. In a retained item case, the statute of limitations does not start to run until the patient has discovered that an item was retained.
  - A. True
  - B. False
13. Credentialing involves obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services.
  - A. True
  - B. False
14. In privileging, the health care organization
  - A. Relies primarily on NBME or USMLE percentile ranking.
  - B. Restricts consideration to medical licensure verification.
  - C. Authorizes a specific scope and content of patient care services for a practitioner.
  - D. Warrants that a practitioner will not engage in negligent patient care practices.
15. A Credentials Verification Organization (CVO) can do all of the following except
  - A. Provide applicant with the application for appointment and privileges.
  - B. Enter data from the application into the credentials file.
  - C. Verify selected data from primary and additional sources.
  - D. Assess completed, verified data.
16. A Health Care Organization can delegate its health care practitioner appointing authority
  - A. To a certified CVO.
  - B. To any nearby tertiary care hospital.
  - C. To Medicare in the case of geriatric medicine only.
  - D. To no other entity.
17. Chronic pain patients
  - A. Are often in denial.
  - B. Often suffer sleep deprivation.
  - C. Often manifest symptoms of depression and anxiety.
  - D. All of the above.
18. When educating chronic pain patients about their condition, it is important to consider
  - A. Their intelligence.
  - B. Their education level.
  - C. Their social background.
  - D. All of the above.
19. During their career, one in three physicians will be involved in some type of litigation.
  - A. True
  - B. False
20. The approximate number of medical malpractice claims resulting in payment to the claimant is
  - A. One in ten.
  - B. One in five.
  - C. One in three.
  - D. One in twelve.

physician's name (who was out of state), medicines she was taking, and preliminary medical information. Being a new patient, she read and signed an opioid contract.

After performing a complete focused history and physical exam, the physician discussed possible treatment options with her at which time she said, "Save your breath," and that the only pain medication that worked for her was Dilaudid. She was currently taking two 4 mg tablets, four times per day. One needs to be exceedingly suspicious of patients who come from out of state, particularly those for whom only high doses of opioids provide adequate pain relief. Suspicions should be particularly keen when their treating doctor will no longer refill the patient's opioid medications because it has been too long since they were last seen. This said, however, one must try to give all patients the benefit of the doubt.

The out-of-state physician was telephoned and the nurse recognized Mrs. Smith's name, providing a litany on Mrs. Smith's behavior. According to this particular staff member, Mrs. Smith had stolen opioid prescription pads and then attempted to procure opioid medications with forged prescriptions. Additionally she had "lost" previous prescriptions, gone through her month's worth of medicine weeks early, and in general made life in that physician's office extremely difficult. This telephone conversation was documented, of course.

Armed with this information, the physician politely told Mrs. Smith that opioid medications would not be prescribed for her. Other treatments for her low back pain were offered, but needless to say once Mrs. Smith heard that no refills of her opioid medications would be forthcoming, she lost any interest in alternative treatment plans. The point offered here is to

always check, if possible, with the patient's past medical provider or staff. If in doubt, do not prescribe opioids when the situation appears suspicious.

## Case 2

"Mrs. Johnson" came to the pain clinic as a self-referred, scheduled appointment. As in the above case she gave all her important information at the front and subsequently a complete focused physical history and exam was performed. Her complaint, too, was low back pain. She had come to the clinic this day, she said, because she was moving into town to open up a new business and needed to find a physician as her current physician in Louisiana was no longer going to be able to treat her after she moved.

The patient indicated she was taking three Oxycontin 80 mg twice a day. She had brought with her a single A-P view lumbar spine x-ray. The x-ray showed mild degenerative disc disease throughout, L4-5 and L5-S1 facet arthropathy, and mild osteoporosis. The patient's name was on the x-ray which showed the usual findings one would expect for an obese 50-year-old female. The film was reviewed with her. It was not convincing one way or the other that she did or did not have back pain, and the physician became concerned that his new patient was shopping for Oxycontin. Then Mrs. Johnson stated that the only medication that worked for her was—you guessed it—Oxycontin. Other opioid medications had either caused her nausea with vomiting or did not reduce her pain. Again, patients deserve the benefit of the doubt, but it is important to clarify the facts of previous treatment.

The office telephone number she had provided for the out-of-state physician was called. There was no staff to answer the phone, and only a

voice-mail answer stating the physician's name. This was in the middle of a normal workday. Suspicions were aroused, and not being satisfied with only a voice mail, telephone information for that locale in Louisiana was contacted and the number for the local hospital was obtained. This was a small parish with only one hospital and the hospital secretary for the Vice President of Clinical Affairs who answered the call said she had never heard of the physician whose name Mrs. Johnson had provided.

**“... patients deserve the benefit of the doubt, but it is important to clarify the facts of previous treatment.”**

Needless to say, Oxycontin was not prescribed for this patient. She even stopped payment on the check she wrote for that initial evaluation. Of interest, a little over a year later the same patient contacted the clinic once again to set up an initial evaluation and an alert staff member recognized the patient's voice and name. When Mrs. Johnson was reminded we had seen her before, she hung up the phone. Apparently she was still “shopping.”

### **Case 3**

A 55-year-old woman, “Ms. Jones,” was referred from a local general practice physician for pain management of her cervical spine pain. When this patient was first evaluated in the pain clinic, she was taking hydrocodone 5 mg acetaminophen 500 mg tablets at the rate of four per day with minimal pain relief as her pain level was 8 of a possible 10. She complained of poor sleep and other symptoms of depression as a result of the pain she had suffered for 3 years. All of her questions were

answered and treatment was discussed before she signed the opioid contract. This contract spells out patient risks and responsibilities associated with taking narcotic medications, as well as physician responsibilities when prescribing opioid medications. If a patient does not want to sign the contract, opioid medications will not be prescribed.

Mrs. Jones signed the contract and her treatment plan included a prescription for Oxycontin 20 mg two tablets twice a day to try and better control her skeletal muscular cervical spine pain. This was prescribed with a SSRI and a muscle relaxant. A home exercise program was recommended. With this combination she was able to reduce her pain to 6/10 with a significant increase in activity level over the several months she was treated in the clinic. She then moved out of town.

Nothing more was heard from her until a year and a half later when a subpoena was served against the treating physician for a malpractice lawsuit. The suit alleged that the prescribed treatment had resulted in Mrs. Jones' addiction to opioids. With all the negative advertising and media coverage concerning abuses to Oxycontin at the time, one could only assume that her attorney was taking advantage of the timing, since over the course of treatment Mrs. Jones never questioned or complained about her treatment plan or the opioid medications she had been prescribed.

The physician's malpractice insurance carrier offered to provide a defense lawyer of their choice, but instead the physician asked for and hired his own attorney. His malpractice insurance carrier did everything in its power to dissuade him. Their rationale was that its attorney had more experience in these types of cases. Additionally, Mrs. Jones' attorney was

suing four other Texas physicians covered by the same medical malpractice carrier. From the physician's perspective it was very important to have an attorney represent him personally, and it is strongly urged that, if necessary, other physicians obtain their own representation. (It would be wise to check one's malpractice policy and learn the carrier's policies on this.) As the suit progressed, the physician felt it was well worth the additional expense to be assured that the legal advice he was receiving had his best interests at heart and not necessarily that of his malpractice carrier. The physician's part in the case dragged on for more than a year at which time he was dropped from the suit. Ultimately, plaintiff's attorney seemed to only be concerned with the "deep pockets" of the pharmaceutical company that marketed and sold Oxycontin.

### Litigation Outcomes

Though no physician or other health care provider ever chooses to be the subject of malpractice litigation, current statistics indicate that approximately one in three physicians during their medical careers will be involved in some type of litigation. The Physician Insurers Association of America (PIAA) has collected information that shows one of every three medical malpractice claims results in a payment to the claimant. See Figure 1.

So how do you steer clear of this mess? Documentation is one of the keys. It is vitally important to document the reason for prescribing or not prescribing opioids and, for that matter, all medications. Patient/physician communication is another key to avoiding litigation. Listening to and answering a patient's concerns, educating him or her about the chosen treatment plan, and being available for questions all help to decrease the chances that a physician will be sued by a patient who

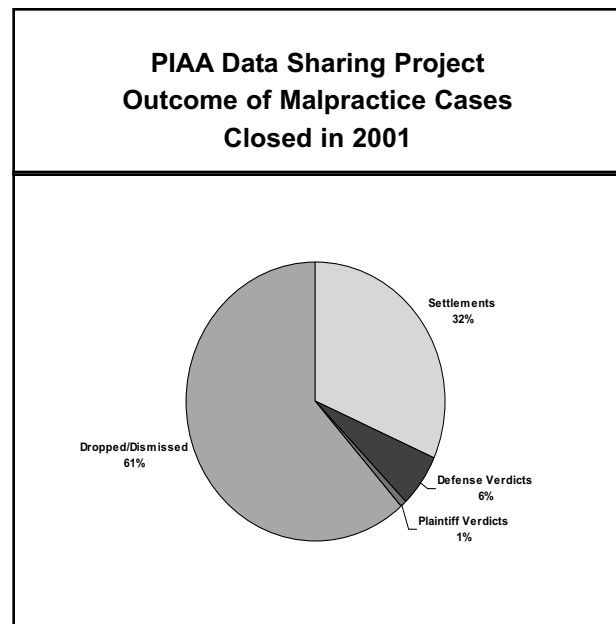


Figure 1

feels alienated or resentful. A patient who genuinely likes his or her physician or other health care provider is much less likely to involve them in a legal dispute.

Ethical considerations involved in prescribing pain medication begin with the initial patient meeting, and continue through to a good medical outcome. It may be ethical to deny opioids to a patient; it may be ethical to prescribe a low dosage combined with other therapies; or it may be ethical to prescribe higher opioid doses when mandated. Only a qualified physician, together with his or her patient, can make this important decision and it should only be made in conjunction with sufficient documentation to support it. "Ethics" is not simply the name of a class to be taken or avoided in law school or medical school, but it is of necessity a way of life for all involved in today's medical process.

# Retention Of Foreign Bodies After A Procedure



**By Alan Cash, R.N., J.D.**

Retention of foreign bodies such as instruments, surgical sponges, and sharps after a surgical procedure is of concern for both patient safety and risk management reasons. Aside from the potential for injury to the patient, a retained foreign body presents a potential liability risk. One study's results suggest that each year in the United States more than 1500 retained foreign bodies are accidentally left in patients after surgical procedures.<sup>1</sup> The study further indicates that the incidence of retained items ranged from 1 in 8,801 to 1 in 18,760 inpatient operations for five hospitals from 1990 to 2000.<sup>2</sup>

Although an uncommon occurrence, retained items have caused serious medical consequences ranging from an additional operation to remove the item to other injuries including small-bowel fistula, obstruction, visceral perforation, abscess, sepsis and even death.<sup>3</sup> Plaintiffs have received damage awards for pain and suffering based on causes of action such as medical malpractice and negligence.

## **Prevention**

One method for preventing the unintentional retention of a foreign body after a surgical procedure is to do counts of all sharps (suture needles, syringe needles and scalpel blades), sponges, and instruments introduced onto the sterile field for use during the procedure. Since a primary goal of the counts is to prevent foreign bodies from being retained, all items that could potentially be introduced into the patient should be counted.<sup>4</sup> Counts should be performed uniformly throughout the health care facility for consistency in practice, regardless of the location or type of procedure.<sup>5</sup>

Four separate counts are recommended by the Association of periOperative Registered Nurses (AORN) in the following order: 1) when the instruments are set up and the sterile sponges and sharps are added to the sterile field in order to establish a baseline; 2) before the closure of a cavity within a cavity; 3) before closure of the wound begins; and 4) during the skin closure or when

the procedure ends. It is suggested that a count should be done any time a member of the nursing staff is permanently relieved.<sup>6</sup>

The AORN recommends that counts be made audibly and concurrently by the circulating nurse and scrub person, with each viewing the item as it is counted to help ensure accuracy.<sup>7</sup> Counts should begin at the incision site and progress outward to the surrounding area, the Mayo stand, the back table, and then to items already removed from the sterile field.

**“The AORN recommends that counts be made audibly and concurrently by the circulating nurse and scrub person, with each viewing the item as it is counted to help ensure accuracy.”**

When counting sponges, each type should be counted as a group before beginning the next type. Each sponge should be separated as it is counted and soiled sponges should be separated and unfolded when counted to ensure that no other sponges are included within them. Sharps should also be counted by type. Instruments should be counted in the order they appear on the instrument sheet that is enclosed in the sterile instrument set and, as with sponges and sharps, all of the same type should be counted before moving on to the next. Finally, all miscellaneous items such as vaginal or rectal packing should be counted. As each type of sponge or sharp is counted, the number should be recorded on a tally sheet or on a count board. Each time a sterile item is added to the field, that item needs to be added to the count.<sup>8</sup> Although the AORN does not recommend using sterile towels to pack the viscera, if this

occurs the towels must be included in the count.<sup>9</sup>

If an instrument or other item breaks during a surgical procedure, all parts of the instrument or item should be located and accounted for. When the patient’s condition does not allow for an extensive search or if the broken piece would be impossible to find, such as a small needle in fibrous tissue, only the surgeon can determine whether the risk of a continued search outweighs the risk of leaving the item in the patient.<sup>10</sup>

At the end of each procedure, the instrument count should be the same as on the instrument sheet and the sponges and sharps count should be the same as on the tally sheet or count board. Any discrepancy between the counts and the recorded amounts should be considered an incorrect count and the facility’s incorrect count policy should then be followed.<sup>11</sup>

For additional safety, sponges with radiopaque strips are recommended. If the sponge count is incorrect, an x-ray of the operative site should be done to detect any retained sponges. Radiographic screening is the best method currently available for detecting retained foreign bodies. However, one study indicated that in 3 of 29 surgical cases with an incorrect sponge count, intraoperative x-rays used to detect radiopaque sponges were falsely negative. Reasons given in the study for this result include poor-quality films, multiple known radiopaque operative densities, and the radiologist’s not knowing the reason for the x-ray, i.e. the incorrect count and the surgical team’s concern of a retained sponge.<sup>12</sup>

Another study reported that 69% of retained foreign body cases involved surgical sponges and 31% involved instruments.<sup>13</sup> Although it

was found that foreign bodies were left in virtually every major body cavity, 54% were left in the abdomen or pelvis, 22% were retained in the vagina, and 7.4% were left in the thorax. Almost 17% were retained elsewhere.

### Case Law

Case law involving retained items includes both procedural issues (statute of limitations) and substantive issues of law (duty).

#### Statute of Limitations

Procedural issues primarily relate to the running of the statute of limitations. Most states recognize that the statute of limitations in a medical malpractice case starts to run, i.e. the cause of action accrues, once the patient learns or reasonably should have learned that an injury he or she sustained may have been caused by the negligence of a health care provider.<sup>14</sup> Once this occurs and the time period begins, for example 3 years, the patient has that period of time to file a lawsuit or the suit will be barred. In a retained item case, the accrual of the plaintiff's cause of action generally does not occur until the patient has discovered that an item was retained after a surgical procedure. Until then, the time period of the statute of limitations does not begin to run, i.e. the statute is tolled, even though this discovery occurred many years after the original surgery.

For example, in *Lindsay v. Romano*<sup>15</sup> the plaintiff discovered in March 1992 that a piece of fabric had been left in her body during a surgical procedure that took place in July 1988. It was determined that this piece of fabric had probably been the cause of her symptoms. The court, noting that none of the plaintiff's treating physicians pointed to the defendant surgeon's care in 1988 as the possible source of the plaintiff's injury until 1992, reversed the

summary judgment granted to the defendant on statute of limitation grounds and remanded the case for trial.<sup>16</sup>

#### Duty

Substantive issues related to retained items involve questions of whether the surgeons, nurses, scrub nurses, technicians, or any or all of them should be held liable for negligence associated with retention of a foreign body following a surgical procedure.

**“. . . it is generally held that the surgeon has a non-delegable duty to remove any foreign item used during a surgical procedure from the patient's body before the end of the procedure.”**

In any medical malpractice case the plaintiff must prove three issues: 1) that there was a duty of due care owed by a health care provider to the plaintiff; 2) that the provider breached that duty by failing to meet the applicable standard of care by either an act or omission; and 3) that the breach was the proximate cause of the plaintiff's injuries. In a retained item case, it is generally held that the surgeon has a non-delegable duty to remove any foreign item used during a surgical procedure from the patient's body before the end of the procedure.<sup>17</sup> Some courts have ruled that the surgeon, since he or she bears this responsibility, cannot relieve himself or herself from liability for a patient's injury by delegating the task of counting to the nursing staff.<sup>18</sup>

Generally, however, there is an independent duty of the circulating nurse and scrub nurse or

technician to accurately count surgical sponges, instruments, and sharps used during the surgical procedure so as to prevent an unintentional retention. In *Romero v. Bellina*,<sup>19</sup> the court stated that since the nurses had an independent duty to account for sponges, they could be held concurrently liable with the surgeon for leaving a sponge in a patient after surgery. The court determined that the nurses did not bear the sole duty to account for all sponges because the nurses' sponge count was a remedial measure that could not relieve the surgeon of his independent non-delegable duty to ensure that all foreign objects were removed from the patient before the incision was closed.<sup>20</sup>

“When *res ipsa loquitur* is applied as a rule of evidence, it allows the jury, on its own, to infer negligence . . .”

### Standard of Care and *Res Ipsa Loquitur*

The primary issue concerning negligence of the surgeon, nurse, or technician is the applicable standard of care. In a medical malpractice case, proof of negligence generally requires expert testimony regarding the standard of care, whether it was breached, and whether the negligent act or omission caused the injury. However, in retained foreign body cases the doctrine of *res ipsa loquitur* is often applied, meaning that expert medical testimony is not required to establish the standard of care or to prove that the standard of care was breached.<sup>21</sup> When *res ipsa loquitur* is applied as a rule of evidence, it allows the jury, on its own, to infer negligence and creates a rebuttable presumption of negligence that may shift the burden of proof to the defendant or defendants.

For *res ipsa loquitur* to apply, the plaintiff must prove that three conditions existed: 1) the incident is of a kind that ordinarily does not occur in the absence of negligence; 2) the incident was caused by an agency or instrumentality that was under the exclusive control of the defendant; and 3) the incident was not due to any voluntary action or contribution of the plaintiff. In a medical malpractice case, the doctrine applies if the medical procedure is relatively ordinary and simple, thus allowing a jury to rely on its common knowledge to determine whether the incident would have occurred in the absence of negligence.<sup>22</sup>

However, when courts apply the doctrine of *res ipsa loquitur* they generally do not impose strict liability or negligence per se on the surgeon. Instead courts would allow the surgeon to present expert testimony to rebut the presumption of negligence and explain how the retained item was overlooked.<sup>23</sup>

In *Kissinger v. Turner*,<sup>24</sup> a Kelly clamp was left in the patient after a portacaval shunt operation. The court applied the *res ipsa loquitur* doctrine since leaving a foreign object in a patient after a surgery fell within the doctrine. Negligence as a matter of law was not determined, however, since this was a difficult surgery and far from ordinary. A portacaval shunt was performed to stop bleeding in the digestive tract by reducing the pressure in the veins in that area. During the procedure the surgeon encountered an abnormal amount of bleeding, including severe arterial bleeding in the upper operative field. In order to stop the arterial bleeding, the surgeon had to stop working in the pelvic area.

Even though the nursing staff did not perform instrument counts, the surgeon explored the abdominal cavity before closing. Plaintiff

expert witnesses testified that, within the county where the hospital was located, it was the standard of care to perform instrument counts. Defense experts testified that it was not. The jury found neither the surgeon, nor the nursing staff, nor the hospital negligent. The appellate court affirmed the jury verdict even though the hospital did not have a policy requiring instrument counts and no instrument counts were performed. The court noted that due to a lengthy, difficult operation and “the unusual condition of the operating field”<sup>25</sup> the jury could have determined that the surgeon and hospital were not negligent when a Kelly clamp was left in the patient despite the use of accepted procedures to prevent it.

In the same decision, the court distinguished between this case and a prior case in which the jury found the surgeon, nurses, and hospital not negligent for leaving a sponge in the patient after a routine caesarean section as a result of an incorrect sponge count by the nurses. The appellate court in that case overturned the jury verdict with respect to the nurses only, holding that the jury’s failure to find the nurses negligent was so against the weight of the evidence as to be wrong. The court in *Kissinger* was able to distinguish between the relatively short, routine caesarean section operation of the prior case and the lengthy, complicated operation in *Kissinger*.

### **Captain of the Ship Doctrine**

The “captain of the ship” doctrine formerly allowed plaintiffs to hold the physician vicariously liable for any negligence of hospital personnel assisting the physician, including nurses, in the operating room. The initial theory was that the surgeon was in control of all activities in the operating room. Even though a nurse was employed by the hospital where the

surgery occurred, the nurse was in effect under the control of the surgeon. Therefore, due to the surgeon’s non-delegable duty to remove all foreign bodies from the patient before closing, any negligence of the nurses while under the direction of the surgeon would be deemed the vicarious liability of the surgeon.<sup>26</sup> Although most courts have discarded the “captain of the ship” doctrine, a few states still continue to apply it in some form.<sup>27</sup>

For example, in *Truhitte v. French Hospital*<sup>28</sup> the plaintiff had a vaginal hysterectomy during which a “GYN tape” was left inside the patient even though the nurses reported correct sponge counts. This long narrow sponge was specifically manufactured by the hospital and included in the instrument tray for the surgeon who performed the vaginal hysterectomy. This sponge was introduced to the sterile field separately from the rest of the sponges. The trial court found the surgeon liable, but not the hospital or nurses, based on the “captain of the ship” doctrine. The plaintiff and the surgeon appealed on separate issues. The appellate court, in discussing the “captain of the ship” doctrine in relation to the sponge count of the scrub and circulating nurses, noted that courts in more recent cases:

“have adopted an ad hoc approach in determining whether the assistant was a temporary employee, looking to the question of actual control or direction by the surgeon over the particular function under the facts of the case.... The clear rule derived...is that agency is a question of fact for the jury.”<sup>29</sup>

The court also stated that the theory of the surgeon directly controlling all activities in the operating room is not realistic in current medical care. Hospitals, not individual physicians, hire, train, supervise and fire nursing staff. Hospitals also implement and enforce compliance with policies and procedures that govern safe surgical practices and techniques.<sup>30</sup>

Thus the court held that, even though a surgeon had a non-delegable duty to remove all sponges and other foreign objects from the patient after a hysterectomy, the hospital could also be held liable not only for failing to devise adequate sponge counting procedures but also for the nurses' independent negligent performance of the sponge count as employees of the hospital rather than temporary agents of the surgeon. The court noted that the evidence suggested that the negligence occurred during the initial sponge count when the "GYN tape" was omitted from the count and before the surgeon arrived to theoretically assume control of the operating room.<sup>31</sup>

**"Some courts have been reluctant to hold the physician vicariously liable for another person's negligence in retained foreign body cases."**

Some courts have been reluctant to hold the physician vicariously liable for another person's negligence in retained foreign body cases. As discussed in *Lewis v. Physician Insurance Company of Wisconsin*,<sup>32</sup> the plaintiff had a surgical removal of the gallbladder in November 1993. During the procedure, the circulating and scrub nurses

counted the sponges used in the case four times and thought they had a correct count at the end of the case. However, two months later, during a second surgery to determine the cause of the patient's continuing problems, a retained sponge was found and removed. The court in that case refused to hold the surgeon liable for the negligent sponge count of the nurses, especially in light of the fact that the plaintiff stipulated that the surgeon was not negligent and that according to the hospital procedure it was the nurses' responsibility, and not the surgeon's, to correctly count the sponges.

**". . . working as a team is key to preventing a medical error such as a retained foreign body."**

#### **Risk Management Issues**

Because of the potential liability not only for the surgeon but also for the nursing staff, an accurate system accounting for all the instruments, sponges, and sharps used in a procedure is necessary. Every health care facility's policy should be consistent wherever procedures occur that could result in a retained foreign body. Documentation of initial counts for a baseline and counts done at closing should include the names or initials of those doing the count. A tally sheet or count board should include all items added to the sterile field and items counted and removed from the field. Documentation should occur whenever the closing counts are incorrect, as well as the efforts made to locate the lost items. The facility's incorrect count policy should recommend an x-ray of the operative field before the patient is transferred from the operating room whenever an item cannot be found and the patient's medical condition allows it.

As with any medical procedure involving multiple professions and personnel with varying responsibilities, working as a team is key to preventing a medical error such as a retained foreign body. Taking the time to address unresolved counts as a team with emphasis on patient safety could ultimately decrease the overall risk of a retained item. As noted by one author, “If the goal is to prevent a retained foreign body, everyone should be committed to a process that ensures the count is correct.”<sup>33</sup>

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# CREDENTIALING: A CURRENT PERSPECTIVE

*By Alfred S. Buck, M.D., F.A.C.S.\**



For the past two decades the United States has expended a notable effort to improve processes through which qualified physicians are appointed or reappointed to the medical staffs of various health care entities. Despite the rational focus on credentialing which is vital to patient safety, challenges remain. Some critics argue that credentialing is too time-consuming and too costly. Others argue that improvements achievable through automation technology are not being pursued aggressively enough. Still others believe that risk mitigation through the credentialing process is not sufficiently predictable nor is it comprehensive enough. Some believe that appointments, reappointments, and privileging of all health care professionals should include a credentialing process that is uniformly stringent. These and other views have become the “discussion of the day.”

This article offers a perspective of major achievements, highlighting key phases of the credentialing process. Today’s current environment will be considered together with several major elements of, and compelling reasons for, continued refinement. Finally, opportunities will be identified that can offer enhanced benefits for all.

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## **Background**

While it is not possible to provide a “birthday” for credentialing, the longstanding goal of credentialing and privileging has been to match qualified physicians (now to include all licensed independent practitioners) to suitable practice activities in specific health care entities through a process that enhances mutual accountabilities. Yet a lack of consensus about important

concepts, spotty implementation of processes, oversight inconsistencies and weaknesses, and examples of egregious failures with equally egregious results (for example, the appointment of “imposters”) have all contributed to diverse national efforts that became identifiably focused approximately twenty years ago.

Serving as the nation’s catalyst was the Joint Commission on Accreditation of Health Care Organizations (JCAHO).<sup>1</sup> Through its established standards development and accreditation survey processes, the Joint Commission developed and implemented a set of consensus-based standards for evaluating accredited hospitals. This in turn provided health care organizations a rational, robust framework through which to appoint and privilege its medical staff members.

**“Serving as the nation’s catalyst was the Joint Commission on Accreditation of Health Care Organizations (JCAHO).”**

Today’s young health care providers who grew up with this structure and its defined processes in place may not be aware of what a significant achievement this implementation represented nor how dynamic and responsive it continues to be. One only has to recall the emergence of businesses based on needs and efficiencies—namely credentials verification organizations (CVOs), automation products for credentials management or new regulatory requirements, e.g., PL 99-660 mandating the National Practitioner Data Bank (NPDB)<sup>2</sup> to gather liability settlements and adverse privileging actions for physicians and dentists, to better understand the challenges that have been addressed, even if they are not fully resolved.

Many other positive achievements have been realized. Overall, perhaps the most helpful additional actions have come from the Federation of State Medical Boards (FSMB)<sup>3</sup> and its member medical boards. They have increasingly been a vital force for achieving more regulatory uniformity and for balancing legitimate needs for variance with credibly comparable and effective oversight for all of our licensing jurisdictions.

Another notable entity is the National Credentialing Forum (NCF),<sup>4</sup> a group of volunteers from various state and national organizations, businesses, and professional groups. The NCF has been a helpful forum for contributing standardized credentials content and format for a nationally useful application for appointment.

Unfortunately, there remain individuals in the health care field, and others who are lured to it, who embrace fraud and disingenuous presentations for their own personal benefit. By these actions they put the public, patients, medical staff, and health care entities at great risk. Thus the imperative behind credentialing has not been diminished. Experience shows that organizational vigilance, attention to detail, selective redundancies, periodic reassessment, proactive clarification, communication, and associated regulatory refinement related to credentialing are still essential to public safety.

### **The Process of Credentialing**

Despite the promulgation of definitions (see Figure 1), there remains some confusion about the difference between credentialing and privileging. Perhaps this has resulted partly from the exuberance of some vendors marketing credentials management products. More serious is the contention that core credentials never change (depending on one’s definition of “core”). This contention or conclusion,

<b><u>IMPORTANT TERMINOLOGY</u></b>	
Credentials:	Documented evidence of licensure, education, training, experience, or other qualifications.
Credentialing:	The process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization.
Privileging:	The process whereby a specific scope and content of patient care services (i.e., clinical privileges) are authorized for a health care practitioner by a health care organization, based upon its evaluation of the individual's credentials and performance.
Appointment:	(e.g., to a hospital medical staff or to a health practitioner panel) The process whereby a health care organization authorizes a health care practitioner to provide patient care services in or for the organization.

Figure 1

however, if consolidated early on would have produced automation support with inadequate capacity, virtually no analytic power, and grossly inadequate capacity to add content or value for reappointment and flexible career management over time. It is important to remember that the reappointment review of performance *today* is an essential credential for *tomorrow*. To put it another way, credentials files are anything but static.

The credentialing process is centrally positioned within the overall process of appointment, reappointment, privileging, or other personnel actions, as outlined in Figure 2. An important understanding, confirmed over time, is that there are mutual but discrete accountabilities involved. Perhaps the most important is that, for those with clinical privileges, appointment is the responsibility of organizational governance and cannot be delegated out of, or separated from, this organizational component. Another is that the final

assessment of credentials information from all sources and material development of recommendations for action on appointments and privileges requires professional, objective expertise that should be delegated only *within* the accountable entity (e.g., to the HCO's organized medical staff).

A working, reasonably successful "85% solution," a plateau of sorts, has been reached given the relative steady-state of diverse factors such as regulation and case law pertaining to credentialing. This includes cases of adjudicated negligent credentialing resulting in inappropriate appointment and privileging that have resulted in claims paid for patient injuries.

Structured through contracts with the accountable HCO, responsibilities of CVOs can be varied. As shown in Figure 3, CVOs can be authorized to manage most of the application process and to prepare an actionable credentials file. They can even function as the "first line of

**WHERE THE CREDENTIALING PROCESS “FITS”**

- Identification of Applicant
- Credentialing Process
  - Providing applicant with application for appointment and privileges with related information and instructions
  - Completing application and attestation statement by applicant
  - Generating a credentials file with information provided by the applicant and from other sources
  - Verifying selected data in credentials file
  - Assessment of completed file by an office of the Appointing Authority [Accountable Health Care Organization (HCO)] concerning appointment or reappointment and privileges
- Recommendation for action by an office of the Appointing Authority (HCO)
- Action regarding appointment and/or privileging by the governing body of the HCO or hiring or contracting decision for non-privileged personnel

Figure 2

defense” to identify inconsistencies and other discrepancies of credentials and can, if authorized by contract, attempt clarification when needed. The recommendation for appointment (pro or con) cannot be delegated, however.

While it is appealing to conjure up an automated checklist of appointment criteria that can be evaluated and acted upon electronically, it is premature to rely on such a system alone in the current environment. Together with the verification of specific credentials (*e.g.*, successful completion of professional education and training), evaluation of the applicant’s credentials by the appointing health care entity continues to be an essential part of the credentialing process.<sup>5,6</sup>

**Key Factors**

Key factors in the current environment that must be considered to assist continuing evolution of the credentialing process include automation, credentials information, policy consensus and regulatory refinement, money matters, and risk mitigation.

Automation

In “broad brush,” current technologies, including those of much needed biometrics for personnel identification over time in various sites and circumstances, are adequate to address all current and projected credentialing needs. Further, the application of these technologies is being rapidly enhanced by improved standards for authentication, data quality, security,

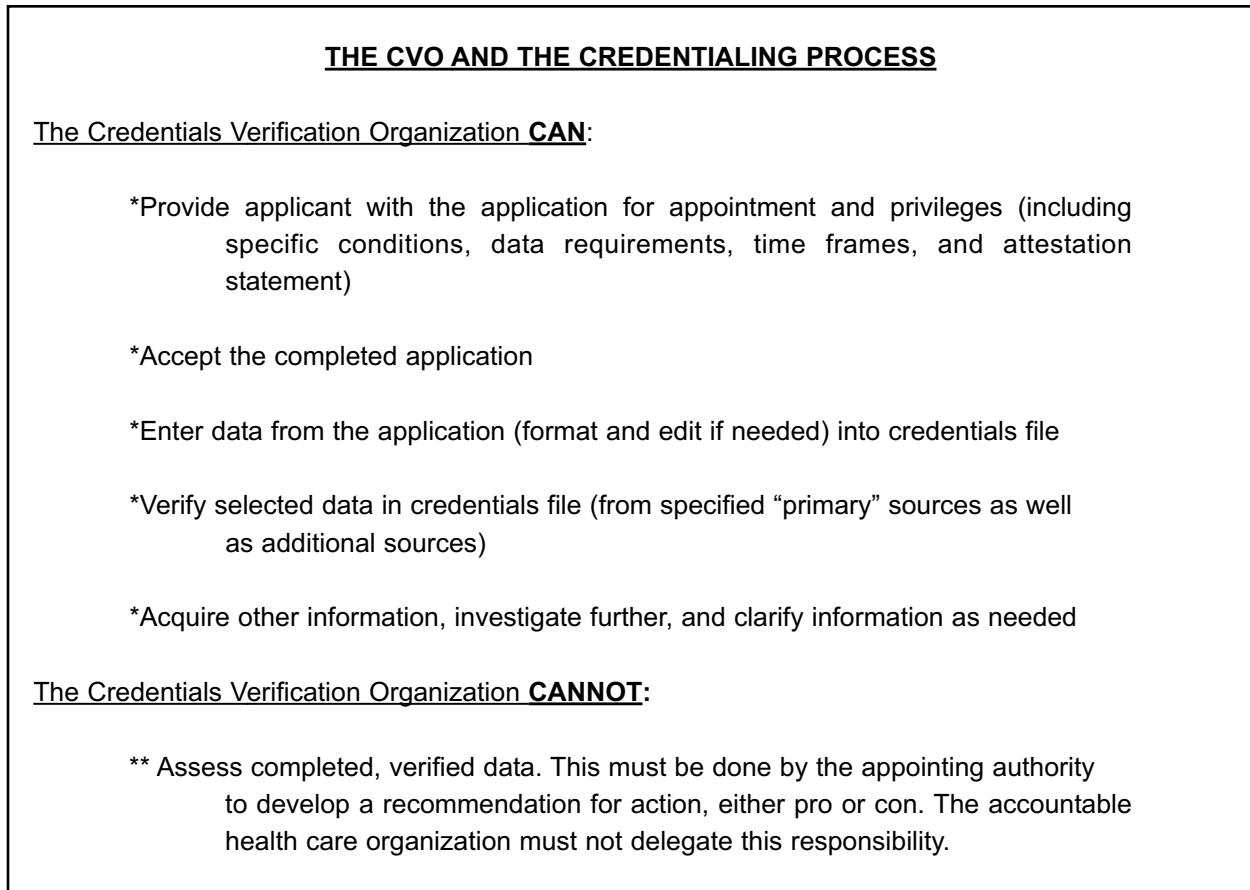


Figure 3

messaging, storage, and confidentiality. On the other hand, the policy umbrella structuring the implementation of these enhanced technologies has not kept pace.

#### Credentials Information

To date, the primary use of credentials information has been to support appointment. Reappointment, especially with enhanced clinical privileges or additional specific scope of practice, has increasingly required updated, documented evidence of an individual professional’s preparation for, experience with, and evolution in pertinent health care activities or services. Over time, credentials information must become cumulative, providing in essence a *curriculum vitae*—but with a difference.

Information in an individual’s credentials file is specified and is required to be pertinent, accurate (some validated by primary sources, some reviewed and approved by an appropriate authority or agency, and some generated from other trusted sources), comparable with identical or analogous professionals, and effective in addressing organizational and individual accountabilities to the public for performance evaluation.

Credentials management is maturing in an environment mandating the highest levels of system security, data integrity, access control and confidentiality. Technology is creating great efficiencies in the production and maintenance of credentials files. These focal work

products of the credentialing process, if kept securely distinguishable from marketing tools that often use some of the same information, could support expanded utilization to address such things as license renewal, recertification, and career management—and not just for physicians. Also one might hope that capabilities for analysis across file data fields (e.g., details of scope of practice) would prove of great assistance in organizational management such as investments in educational products for the continuing education of various staff.

“... current technologies, including those of much needed biometrics for personnel identification over time in various sites and circumstances, are adequate to address all current and projected credentialing needs.”

#### Policy Consensus and Regulatory Refinement

It would be a stretch to maintain that anything in the credentialing arena is “broken,” yet there are significant constraints to process improvement that lie mostly in the realm of policy consensus and of regulatory refinement. For example, it is worrisome that even today one cannot, nationally, advise health care entities of a uniform, prudent, protective process to complete criminal background checks on the broad range of potential health care personnel for hire or appointment. Too often the data is not available or is not readily retrievable. Thus, it is up to the organization to develop its own policy with appropriate legal counsel, and to remain somewhat wary of applicants presenting from a distant or unfamiliar state. This is a known, complex bag of regulatory issues for federal and state agencies, automation and data

challenges, and resource priorities. Much work is needed here.

#### Money Matters

“Economic credentialing” and “core privileging” are misleading terms that actually describe contentious activities associated with some appointing authorities. These areas of policy-driven action may signal items for regulatory relief and oversight, guided by case law. In economic credentialing, often a non-reappointment decision by an appointing and privileging authority (e.g., a health maintenance organization or HMO), action is based primarily on considerations of the professional’s impact on profit margins instead of the traditional reliance on qualifications and competencies of the provider. On the other hand, some suspect that such appointment or reappointment decisions have occasionally been used to provide a mechanism to address poor quality performance of practitioners and to avoid potential costly litigation and NPDB reporting requirements.

Unfortunately, core privileging can have conflicting connotations. One circumstance arises when appointing authorities, usually hospitals, require applicants for medical staff membership to apply for specific emergency-room coverage privileges even when they are not desired by the applicant or when, in the opinion of some, not viably supported by appropriate credentials. These privileges are then transformed into requirements by the hospital to address real difficulties in providing emergency-room services that may be a needed community benefit as well as a hospital business “feeder.” Such hospital requirements can also carry known difficulties for the practitioner associated with the services, such as frequent lack of reimbursement, higher litigation risk, and perhaps less certain clinical outcomes.

Basically, however, the interjection of money matters into the credentialing process, from various perspectives, is creating a major area of concern. It begs constructive, mutually equitable, consensus-based policy development and implementation.

### Risk Mitigation

In years past, a few may have hoped simplistically that a conscientious organizational credentialing process would screen out “bad apples,” thereby assuring a high-quality staff that would, among other things, eliminate litigation risk. Experience has shown the credentialing process, rather, to be a keystone for accountable organizations seeking performance excellence, gaining in value with repetition, *i.e.*, the reappointment or reprivileging process.

The uniform, reproducible process for periodic assessment of training, skills and competencies offered by the credentialing process has utility for all health care professionals whatever their position. Accordingly, as accountabilities have become more diverse and many organizations have become larger and more complex, the alignment between the credentials process and more traditional personnel administrative functions needs to be rethought to capture the benefits of both through appropriate refinements in policy and implementation.

Optimal risk mitigation in the complex, demanding environment of health care requires other tools comprehensively integrated with the credentialing process. Such other tools and processes must complement well-functioning, constructive credentialing and personnel management activities. Specific examples include programs for rehabilitation of health care providers, training for disruptive staff members, and educational programs ranging

the gamut from acquisition of new technical, clinical, or administrative skills to mentoring opportunities to assist new staff members or other personnel.

### **Forces For Change**

Forces for change in the credentialing process in today’s environment include an expanded scope of competencies, reconfiguration of health care services, performance measurement, geopolitical disparities, disaster response, and cost containment. These forces for change will have an impact on the key factors discussed above.

### Expanded Scope of Competencies

The Accreditation Council for Graduate Medical Education (ACGME) has endorsed an expanded set of general competencies for all residents in all of its accredited programs.<sup>7</sup> In addition to the traditional areas of patient care, medical knowledge, and practice-based learning and improvement, it has defined additional competency areas of interpersonal and communication skills, professionalism, and systems-based practice. The member boards of the American Board of Medical Specialties (ABMS) are incorporating these requirements into their certification processes for candidates (individuals who desire to achieve and maintain board certification and who have successfully completed full training requirements). These expanded requirements, therefore, must be identified and addressed appropriately with more emphasis during the evolving credentialing process.

### Reconfiguration of Health Care Services

The pace of mergers, acquisitions, closures and other structural reconfigurations of health care organizations seems to be abating somewhat. Even so, the value in centralizing the

credentialing and privileging processes for organizations, especially very large ones, seems to be increasing. Primary reasons for this include uniformity of process, better management data with expanded use of the credentials information, more sophisticated automation support, and efficiencies that can bring lower costs. At issue are questions such as how “site specific” derivative practicing privileges can or should be to retain credibility while assuring a proper match between individual skills and practices with specific sites and resource capabilities. Also at issue is the frequency with which a reappointment process with recredentialing should be required.

“. . . questions relate to the transportability of credentials and derivative privileges within or across organizations, such as, for example, Army to Navy or VA to military.”

Other questions relate to the transportability of credentials and derivative privileges within or across organizations, such as, for example, Army to Navy or VA to military. Transportability issues also apply to a variety of sites and circumstances including emergency deployments or disaster responses utilizing military or civilian personnel. Similar questions are being raised with telemedicine, especially when it is used in an interstate clinical interface. Another growing area of concern involves unregulated office surgical practices for practitioners who are not part of accredited credentialing and privileging processes that offer credible peer review oversight.

#### Performance Measurement

At what levels and with what mechanisms can

an organization be accountable for addressing accreditation standards that have structured essential aspects of the credentialing process? These essential aspects include:

- an expert, objective evaluation of an individual professional’s continued ability to provide quality care, treatment, and services for the privileges requested;
- mechanisms for an equitable hearing and appeal process for addressing adverse appointment or privileging decisions when such decisions are related to quality of care issues; and,
- professional oversight of professional practice with appropriate recommendations, especially those that involve focused outcome reviews.

These important mechanisms must be addressed with performance measures that include appropriate data quality, case risk adjustment, and professional consensus. As organizations build necessary infrastructure, success stories are accumulating. Excellent examples exist and some such capabilities today are being held as proprietary products. Still the United States needs to achieve greater uniformity and scope of such implementation—and more rapidly than seems to be occurring.

#### Disparities Between Geopolitical Boundaries and Functional Health Care Regions

The landmark report, The Dartmouth Atlas of Health Care,<sup>8</sup> noted national and regional depictions of approximately 300 functional health care regions within the continental United States. Striking is the graphic reality that

so very few of these functional regions bear congruence with geopolitical boundaries at the county or state levels. This fundamental disconnect may help to explain why consensus and policy development of a regulatory nature have been so difficult to streamline, coordinate, and implement. It seems to offer a root cause for difficulty in achieving more uniform and readily comparable ground rules for regulatory oversight. Knowledge of these challenges, however, and how they relate when mapped against real demographics and utilization information, should strengthen even further regional and interstate communication and coordination of legislation.

In the area of credentialing process, regulatory consistency such as criminal background checks and utilization of performance measures to produce improvement of population-based resource allocation could likely be done in a more effective fashion. This could also help with other health efforts such as education.

#### Disaster Response

While concern about disaster response has been long-standing, recent experience with natural and man-made catastrophes has elevated planning and action to higher levels. The result has been research and innovation over a broad range of areas that cover design concepts to building components and community responses to communication technologies.

The JCAHO once again has served a forward-looking, facilitative role in aligning needed credentialing safeguards for some health care professionals with organizational disaster response and management. Even so, a more comprehensive and more inclusive policy-driven regulatory structure must be established. It is unfortunately the diversity of state and

federal legislative approaches to date rather than technological limitations that exert real inhibition to a more rapid implementation of uniform credentialing process for all health care professionals. Related areas that have also been hampered include biometric identification, transportability of verified credentials and authorized scope of practice (clinical skill sets are not identified in licensing data), liability protections, and, of course, mechanisms for family protection and reimbursement of disaster responders. These knotty problems are undergoing careful scrutiny within the Department of Homeland Security and its Federal Emergency Management Agency (FEMA).

#### Cost Containment

It seems likely that competition for resources will remain a prominent feature of our health care landscape. The balance point between operational efficiencies partly stimulated by policy refinement but mostly achieved through available automation technologies will shift somewhat toward consolidation of credentialing services. Nevertheless, it will continue to be essential that credentials data be scrutinized and periodically updated by expert individuals working objectively on behalf of appointing and privileging authorities to support public safety.

#### **Today's Major Issues**

Finally, among almost any group of health care professionals and other participants in the processes of health care (including politicians), one can imagine a substantial list of key issues. Yet, if one were to sort through them carefully, there would likely be some repetition and certainly some overlap. In attempting to anticipate such lists, perhaps the following four issues or problem areas will suffice.

### 1. National Health Care Policy

The continuing lack of consensus about access and basic health care benefits for all citizens and legal residents is exerting an increasingly chilling effect on rational, effective policy refinement, business efficiencies, and budget planning. Current credentialing activity on the part of HCOs could be enhanced to assist in matching population needs to health services skill sets.

**“The continuing lack of consensus about access and basic health care benefits for all citizens and legal residents is exerting an increasing chilling effect on rational, effective policy refinement, business efficiencies, and budget planning.”**

### 2. Health Care “Culture” in the United States

It seems that discussions of health care needs in this country devolve into an “either/or” situation: either market-driven, for-profit (good, cheaper, more efficient) or government, not-for-profit (not as good, more costly, less efficient). These value judgments are debatable. On the contrary, in the current environment both models should be available to achieve sufficient options to address proven needs. Interestingly, both approaches are accumulating credentialing experience that is helpful and, perhaps not surprisingly, that is more recognizably similar than discordant. Efforts to embrace “lessons learned” in the credentialing process in both sectors should be pursued.

### 3. Timely Refinement of Legislation

The evident difficulty in developing consensus for policy implementation at various legislative

levels is not unique to health care, but perhaps it is the most vexing issue facing health care in this country.

### 4. Tort Reform

Tangible group self-interest among the insurance industry, lawyers, and health care professionals seems to prevent resolution of this destructive problem at the congressional level despite some promising examples of success in the federal sector and certain specific state projects. The helpful thread that links these examples of success is not doing away with the option of litigation, but rather offering an arbitration option with rational settlement plans such as annuities. Successful examples of this approach in some states (for example with obstetrical services) have been modeled on experience with workmen’s compensation programs for occupational injuries.

In most of these unfortunate cases and when fair to patients, it seems reasonable to utilize credentials files in an evidentiary fashion to portray cumulative experience and proven competence in a protective way for the health care professional and the HCO, especially when associated with meaningful, risk adjusted outcome performance measures. To put it another way, the “no fault” option for injury resolution related to health care (useful in many instances) could function even better with such credentials utilization. It could also be consistent with enlightened safety analysis and improvement efforts.

### What Now?

The current environment offers real opportunities to evolve the process of credentialing. Some options that could be pursued to enhance benefits include:

- Use of a uniform credentialing process for all health care professionals with special certifications or licensing boards;
- Establishment of standards for implementation of biometric identification data for use by professional schools, specialty boards, licensing jurisdictions, and appointment authorities;
- Better integration of personnel information with credentials data; and
- Proactive policy refinement based on evolutionary efforts, especially as examples of “best practices” in credentialing and related data collection are established.

While the credentialing process seems more advanced in health care than most other industries, optimal efficiency and usefulness have not been achieved. Broader utilization of the credentialing process for non-physician clinical and administrative individuals would likely offer benefits for career and organizational management, as well as for public safety and the enhanced incorporation of biometric data for identification of selected personnel in various settings and circumstances over time is an urgent priority.

Effective forums to assess cumulative experience, identify “best practices,” develop pertinent policy and delineate specific legislative initiatives are in the public interest and could serve to benefit all participants in health care in this nation and in others. Products of all such forums need dissemination, coordination, and

consolidation. Any major activities such as these that evolve the credentialing process require a national focal point, most likely a private/public partnership guided by an appropriate mission charter.

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# A Profile Of Veterinary Pathology At AFIP

By Dale G. Dunn, DVM, COL, VC, USA\*

**Utilizing a “Question and Answer” format, COL Dale G. Dunn, Chairman of the Department of Veterinary Pathology at the Armed Forces Institute of Pathology (AFIP), briefly discusses the mission and accomplishments of this vital department with Legal Medicine.**

**Legal Medicine:** What activities does the Department of Veterinary Pathology perform today at AFIP in keeping with the three traditional areas of consultation, education, and research? Approximately what percentage of time and manpower are spent in these activities?

**COL Dunn:** The short answer is that our efforts—that is, the efforts of everyone in the department combined—would break down something like this: 25% consultation, 50% education, and 25% research. We provide pathology consultation on a daily basis to a multitude of veterinarians and physicians on a variety of species from A to Z (aardvarks to zebras, I like to say). However, our education mission is where we spend most



of the time since we have the Department of Defense (DoD) veterinary pathology residency here and we have 13 residents at the moment. Most of the research is involved with providing support for animal-based research conducted at the AFIP.

**Legal Medicine:** How long has veterinary pathology been at the AFIP? Why was it initially included and by whom? Who were the first specialists?

**COL Dunn:** AFIP has had a veterinary pathology section since World War II. During the war years, the AFIP (then the Army Medical Museum) (AMM) expanded its role as the central pathology laboratory in a network of Army hospital and regional laboratories.<sup>1</sup> Under the leadership and direction of Colonel James Earle Ash, an Army Medical Corps officer, the AMM recognized a need for and sought out highly competent specialists in all areas of pathology to serve terms as consultants

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at the AMM. This included the discipline of veterinary pathology.

We know from his papers that Dr. Ash was an enthusiastic supporter of comparative pathology. He understood and embraced the concept of “one medicine.” Dr. Ash recognized that to fully comprehend and provide for human health one would need to understand diseases occurring in other species. He encouraged the development of comparative and veterinary pathology. To back up his beliefs, he established the Registry of Veterinary Pathology, which he described as “one of great possibilities.”<sup>2</sup> Considering the threats we face in today’s world in terms of potential biological weapons, all of which with the exception of smallpox are zoonotic (transmissible to man under natural conditions) diseases, his early decision to include veterinary pathology at AFIP seems prescient.

Dr. Charles L. Davis of the U.S. Department of Agriculture was brought on active duty from the Army Reserves to be the first veterinary pathology specialist at the AMM, serving from October 1943 to December 1945.<sup>3</sup> Dr. Davis is credited with creating a greater appreciation for veterinary pathology at the AMM and attracting talented veterinarians to the field of pathology. The C. L. Davis DVM Foundation—an international organization dedicated to the advancement of the veterinary pathology profession around the world—was named in his honor. Following Dr. Davis was another giant in the field of veterinary pathology, Dr. Thomas Carlyle Jones. Dr. Jones was twice the leader of the department and co-authored a pivotal text on veterinary pathology that remains a standard to this day. He was a prime mover in the effort to establish and incorporate the American College of Veterinary Pathologists (ACVP) in

Washington, DC in 1949.<sup>4</sup> Today it is one of the oldest and largest specialty groups in the veterinary profession and we can trace its roots back to this department.

**Legal Medicine:** How has the veterinary pathology department changed over the years?

**COL Dunn:** The original veterinary pathology section consisted of one person. Today, we are one of the largest departments at AFIP with more than 40 members filling responsibilities in consultation, education, and research. Looking back, however, our biggest growth area has been in education and training. A preceptorship program was developed in 1967 to meet the growing demand for veterinary pathologists in military medical research and diagnostic medicine. By the early 1980s, the leadership of the veterinary pathology specialty in the Army recognized that training could be more effective and the DoD better served by a formal residency program consolidating all training under one roof. That goal was realized in October 1983 when then Surgeon General LTG Bernhard Mittermeyer authorized the establishment of the DoD veterinary pathology residency at AFIP.<sup>5</sup>

**Legal Medicine:** Can you give us some details on the residency program?

**COL Dunn:** Now in its 22nd year, our residency program is one of the largest and most successful in the world. We currently have 13 pathology residents in the department. To be eligible for the 3-year veterinary pathology residency program, applicants must first be active duty officers in the Army Veterinary Corps. Our goal is to prepare them to pass the certifying examination of the ACVP at the end of the residency.<sup>6</sup> This means a fast-paced

three years of study, including lots of case work and postmortem examinations at AFIP, the National Zoological Park in Washington, DC, the National Institutes of Health in Bethesda, MD, and the Maryland Diagnostic Laboratory.

It also means didactic training in systemic veterinary pathology at AFIP. We have one of the most (if not the most) extensive collections of histopathology training materials on the planet—the Registry of Veterinary Pathology today is approaching 100,000 cases. Our histopathology training collection includes more than 750 disease entities and is now on the Internet available to other training programs the world over. Residents participate in a weekly international comparative histopathology conference, the Wednesday Slide Conference, which we have been running continuously for more than 50 years and which includes 134 institutions in 22 countries. Residents also attend our annual or bi-annual training courses in gross pathology, descriptive pathology, and the pathology of laboratory animals, as well as our current laboratory animal science seminars. These courses are a staple in our program and are important to others, too, as they are well attended by residents from training programs around the world.

**Legal Medicine:** What do the residents do and where do they go after completing the program?

**COL Dunn:** As members of the Army Veterinary Service (AVS), Army veterinary pathologists end up doing a variety of things in a variety of locations. This includes diagnostic pathology, disease detection and surveillance, and forensic investigations of military and other federal working dogs and marine mammals here at AFIP. It also includes filling critical

roles in all areas and at all stages of biomedical research for the DoD.<sup>7</sup>

Research efforts are largely directed at mitigating or preventing the effects of biological, chemical, radiological, and nuclear weapons and combat injury. Veterinary pathologists continue to do ground-breaking research on agents like the Ebola virus at the U.S. Army Medical Research Institute of Infectious Disease (USAMRIID). It should be noted that a veterinary pathologist at USAMRIID was the first to identify West Nile virus in a bird from the Bronx Zoo when that disease hit our shores a few years ago.

The majority of our pathologists are assigned to the Medical Research and Materiel Command with sites at USAMRIID, Walter Reed Army Institute of Research, U.S. Army Research Institute of Chemical Defense, U.S. Army Institute of Surgical Research, and the Armed Forces Research Institute of Medical Sciences in Thailand. Other DoD sites include the Air Force Research Laboratory, Armed Forces Radiobiology Research Institute, Naval Medical Research Center, U.S. Army Veterinary Laboratory Europe, DoD clinical investigation directorates, the Navy's marine mammal program, and of course the AFIP.

We have some very unique qualifications. Army veterinary pathologists are the only comparative pathologists in the U.S. trained to conduct postmortem examinations in the biosafety-level-four environment. Most Army veterinary pathologists are also trained in the detection and identification of foreign animal diseases that may be potential biological weapons. We also have two pathologists serving in the Army's new deployable Area Medical Laboratories (AML). These

individuals perform rapid diagnostic tests for detection of biological agents in the field. One of our officers spent nearly a year in an AML in southwest Asia in support of Operation Iraqi Freedom and Operation Enduring Freedom. Right now we have one officer on a medical staff in Afghanistan and another supporting the Navy's marine mammal program in Bahrain.

**Legal Medicine:** You mentioned the Army Veterinary Service. Just what are its responsibilities?

**COL Dunn:** The AVS is an executive agency under the Army Surgeon General (like AFIP) with responsibility for all of the DoD's veterinary needs.<sup>8</sup> This includes the historical and traditional roles of the veterinarian that are firmly established in the minds of most Americans, as well as the latest and more modern roles that are perhaps not as well known, some of which I've mentioned above. The mission of the AVS can be broken down into four large but overlapping areas: 1) food safety; 2) medical care for government-owned animals; 3) control of animal diseases that present a public health threat, and 4) support for biomedical research and training activities. The AVS is comprised of nearly 3000 military and civilian personnel on more than 250 Army, Air Force, Navy and Marine Corps duty sites around the world. The approximately 420 uniformed veterinarians of the AVS service serve in the Army Veterinary Corps.

**Legal Medicine:** Would you please tell us a little more about military working animals?

**COL Dunn:** Working animals come in all sizes. Among them are the caisson horses across the Potomac River at Ft. Myer in Virginia doing daily duty in the Arlington

National Cemetery. Best known of all, however, are the working dogs serving with the DoD, Customs Service, Secret Service, U.S. Department of Agriculture, and other federal agencies. Military working dogs (we have more than 2500 of them right now) are specifically trained to perform two traditional roles: patrol and detection. All are trained to serve as patrol dogs, but some dogs are also further trained to detect either explosives or drugs.



The DoD is working hard to build new programs for mine detection, specialized search, and combat tracker dogs. This effort is in its infancy, but is already bearing fruit in Afghanistan and Iraq. Along with military working dogs, there are military working marine mammals serving in southwest Asia. The Navy has dolphins trained to assist with the protection of ships and harbors. We are here to provide pathology support for all of these animals.

**Legal Medicine:** Is veterinary pathology here to stay at AFIP?

**COL Dunn:** After 60 years of service to this great institute and our nation, I'd say we are here to stay. We have long enjoyed the encouragement and backing of the leadership of the AFIP, the American Registry of Pathology, and the Army Medical Department, not to mention many more veterinary-specific organizations like the American Veterinary Medical Association, C. L. Davis DVM Foundation for

the Advancement of Veterinary Pathology, and the ACVP. By providing for the diagnostic and medical surveillance needs of military working animals and supporting critical military medical research—all the while constantly regenerating our own personnel inventory—we fill a unique niche for the DoD. It's a role that is

highly relevant to our nation's defense. We are a resource that is greatly valued by the veterinary profession in general and veterinary pathology community in particular, and they and the DoD have come to depend on us being here.

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