Evaluating Attorney Part of the Lawsuit Process

Be knowledgeable and prepared when selecting and working with lawyers on malpractice lawsuits.

BY SHERRY BOSCHERT
San Francisco Bureau

KOHALA COAST, HAWAII — You're a physician, not a lawyer. How do you know that the lawyer defending you in a malpractice suit is doing a good job?

When a physician gets sued, the malpractice insurer assigns the case to a legal defense firm. According to Annette Friend, M.D., a psychiatrist, physicians should expect five basic things from a competent lawyer: a plan of action; clear communication; ongoing communications; management of your expectations; and clear explanations of billing policies.

A review of disciplinary actions against lawyers suggests that more than half stemmed from clients' complaints that the lawyers were neglectful or failed to communicate or represent clients diligently or competently. Another complaint—that failure to communicate billing policies led to fee disputes—is an increasing cause of disciplinary dockets, Dr. Friend, who also is a lawyer, said at a conference on clinical dermatology sponsored by the Center for Bio-Medical Communications Inc.

"We want to satisfy you, but you have to insist on being satisfied," Dennis J. Sinclitico, J.D., a defense lawyer, said in a separate presentation at a conference in Cabo San Lucas, Mexico, on obstetrics, gynecology, perinatal medicine, neonatology, and the law.

Get a copy of the malpractice insurance company's guidelines on expectations of lawyers to know what the insurer expects for your case, said Mr. Sinclitico of Long Beach, Calif.

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To get your lawyer to do the best job for you, Dr. Friend and Mr. Sinclitico advise thinking about the following factors:

► **Plan.** The physician and lawyer jointly plan a course of action. The lawyer should explain what is involved in the case, what needs to be done, what may happen next, and various means of resolving the case. The client makes the final decision about how to resolve the legal matter, said Dr. Friend of Fort Lauderdale, Fla.

She suggested asking whether the lawyer has ever handled this type of case before, and if there is some other way to settle the matter other than going to trial. Your bill for an inexperienced lawyer may be higher as more hours are needed to learn the matter.

► **Communicate.** Expect plain speaking, clear writing, and good listening skills from your lawyer. When a complex legal issue can be explained in a way that one's grandmother might understand, that's clear speaking, she said. If you don't understand something your lawyer wrote, chances are the judge and others won't understand it, either.

If your lawyer isn't communicating well and regularly or you just don't get along, demand a new lawyer from the firm's associates or from the insurer's panel of lawyers, Mr. Sinclitico said.

Communication is a two-way street, he added. If you see an article in the medical literature that's pertinent to your case, send it to the lawyer. Insist on participating in selecting the medical experts whom your attorney will rely on.

► **Communicate some more.** The legal process can drag on for years, so expect ongoing communication from your legal team, preferably from your lawyer personally, Dr. Friend said.

Request regular, periodic status reports from the lawyer, Mr. Sinclitico advised. If the flow of paper stops, or if you call three or four times without a response from the lawyer, that's a red flag that something's wrong.

► **Manage expectations.** As the lawyer continually analyzes and updates you on the pros and cons of the legal proceedings, options should be articulated in a commonsense way without exaggerating the probable success of the case and without painting an overly bleak outcome.

► **Explain billing.** Demand an up-front, detailed accounting of billing policies. Law firms may bill for face time with the client, phone calls, conversations between firm members, time spent reviewing documents, legal research, preparation of forms or documents, revisions, travel time and expenses, and many other services.

If the lawyer in charge of the case changes while the case is in progress, the client should not have to pay for the firm to bring a new lawyer up to speed on the case, Dr. Friend said. ■

CMS Will Use Performance Measures, Surveys to Monitor Medicare Part D

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — Medicare intends to use performance measures to monitor cost, quality, and access issues related to the new prescription drug benefit, a research analyst said during a meeting of the Medicare Payment Advisory Commission.

However, Medicare has not yet "determined what those measures will be and how they will be used," said MedPAC analyst Cristina Boccuti. MedPAC makes recommendations to Congress on Medicare payment issues.

The Centers for Medicare and Medicaid Services will be collecting a large amount of data on the new drug benefit—or Medicare Part D—including drug utilization and plan benefit information, to construct these performance measures, Ms. Boccuti said. In addition to the agency's need for the data, "congressional agencies will need Part D data to report to the Congress on the impact of the drug benefit on cost, quality, and access," she added.

MedPAC commissioners recommended that the Health and Human Services department establish a process for the timely delivery of these data to interested parties. Individuals, employers, and government agencies currently use performance measures to evaluate how well health plans and pharmacy benefit managers manage drug benefits, Ms. Boccuti said.

To identify how policy makers could use these measures to monitor the Part D program, MedPAC convened a panel of 11 experts representing health plans, pharmacy benefits managers (PBMs), employers, pharmacies, consumers, quality assurance organizations, and researchers. The panel analyzed measures such as cost control, access and quality assurance, benefit administration and management, and enrollee satisfaction.

Based on the panel's findings, CMS plans to collect data on the following:

► Dispensing fees, generic dispensing rates, aggregate rebates, drug claims, and drug spending by plans and beneficiaries.

► Pharmacy networks, formularies (including prior authorization and exceptions), appeals rates, and drug utilization.

► Claims processing, including plans' out-of-pocket calculations.

► Beneficiary satisfaction, grievances, call center operations, and disenrollment rates.

Measures to track beneficiary satisfaction—such as member satisfaction surveys and performance of customer service call centers—are common types of performance guarantees that health plans and PBMs offer to their clients, Ms. Boccuti said.

CMS plans on conducting its own consumer satisfaction surveys to provide comparative plan information to beneficiaries when they're making enrollment decisions, she said. In addition, plans will submit data on grievances filed, and call center performance measures, such as abandonment rates and hold times.

MedPAC commissioner Nancy-Ann DeParle, a health care consultant in Washington and former head of CMS' predecessor agency (the Health Care Financing Administration), asked whether CMS would be looking at these data at a physician level, in terms of who did the prescribing.

"In our pay-for-performance discussions around physicians, [MedPAC indicated that] it would be useful to have this," she said.

On the issue of collecting data on cost, Ms. DeParle said that she wondered whether CMS would be able to assess whether particular plans were getting a "good deal" on the drugs they purchased. "Will they know by drug?" she asked. ■

Small-Area Analysis Reveals Hidden Health Disparities

WASHINGTON — It doesn't surprise most physicians to hear that populations in certain cities have higher rates of chronic disease. But new work in small-area analysis can help pinpoint exactly which areas of a city suffer from a higher disease burden, Robert Bonow, M.D., said at a meeting sponsored by the Alliance of Minority Medical Associations, the National Association for Equal Opportunity in Higher Education, and the Department of Health and Human Services.

For example, Dallas turns out to be a complicated area when it comes to cardiovascular mortality, said Dr. Bonow, chief of the division of cardiology at Northwestern Memorial Hospital, in Evanston, Ill. He and Sean Cleary, Ph.D., associate professor of epidemiology and statistics at George Washington University, performed small-area analysis on the city using data from state Vital Statistics offices and the 2000 U.S. Census.

Data were based on the U.S. Postal Service's definition of a "minority Zip code" consisting of 50% or greater African American, Native American, Hispanic, Asian, or Pacific Islander residents.

The data showed that there are disparities in cardiovascular disease mortality not only between minority and nonminority populations, but also within minority Zip codes.

"Is one area more Hispanic, and one area more African American?" Dr. Bonow asked. Of course, there could be other factors driving differences in mortality, such as differing opportunities for exercise or lesser or greater availability of fresh fruits and vegetables in one community than in another, he added.

Dr. Bonow noted that the maps produced by small-area analysis could be a useful lobbying tool for health care advocates. "Imagine walking into [a Congressman's office] with a map showing that minority areas in his district have very high rates of cardiovascular disease," he said. And if the analysis also found that there were few health centers in the area, advocates could argue that services are not being offered where they are needed.

—Joyce Frieden