Physician, Shield Thyself From Employee Lawsuits

BY BETSY BATES
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PORTLAND, ORE. — As if it weren't aggravating enough to worry about frivolous lawsuits filed by patients, physicians, like all employers, also need to consider their legal liability with regard to their employees.

Fortunately, most employment lawsuits are eminently avoidable, said employment attorney Kathy A. Peck at the annual meeting of the Pacific Northwest Dermatological Society.

Supervisors should follow the "golden rules" of discipline, said Ms. Peck, a partner in the law firm of Williams, Zografos, and Peck in Lake Oswego, Ore.

These include immediacy, consistency, impersonality (targeting the behavior, not the person), and positivism, always remembering that the goal is to rehabilitate employees whenever possible, rather than to punish or ostracize them.

If something does happen that requires action, always listen to the employee's side of the story. Not only is this fair, it might change your perception.

Physicians and office managers also need to watch their language. Ms. Peck said many cases may turn on remarks, perhaps unintentional, that might be interpreted as being derogatory or stereotypical with regard to a protected class of workers, such as older employees, women, or members of a racial or ethnic group.

Work environment harassment claims are on the rise, so practices should respond promptly and definitively to complaints of sexual, racial, ethnic, religious, age, and disability-related harassment. Just as physicians should monitor their own remarks and behavior, they are responsible for their office environment and should take immediate corrective action if that atmosphere is tainted by "unwelcome conduct," she said.

Require applicants to fill out an application form. Great interview skills do not necessarily reflect a solid employment history.

"You can hide things in a resume," Ms. Peck said.

All employees (established and newly hired) should sign an employee handbook documenting policies and procedures. Include within the handbook an "at will" clause stating that the employee is free to resign at any time and that the practice is free to terminate the employee "at will." The manual also should state that this policy remains in effect unless it is changed in writing by the physician or another designated individual at the office.

"There are huge exceptions" to when an employee can be discharged and why—because of pregnancy, for example—but the clause protects employers from being sued by those who assert they were hired until they retired, or some other vague point in time, said Ms. Peck.

Another issue that needs to be addressed is when an employee has a bad attitude. It's a huge mistake to put up with "posturing princesses" or passive-aggressive manipulators who stir up trouble. These employees can sour morale very quickly, leading to turnover problems, excessive time off, stress claims, and grievances, she said.

Offenders should be reminded of policies that require polite and cooperative behavior, and their behaviors should be documented.

When it comes to employee performance, it is important to not allow "soft" evaluations. It will be very difficult to justify in court the dismissal of an employee who received above-average evaluations for the past 6 years.

Many times a supervisor will say, "I thought if I gave her positive feedback it might cause her to change," Ms. Peck explained.

Although every evaluation should fairly point out positive performance examples, inflated praise generally does not compel an employee to work harder. Address shortcomings, establish goals for improvement, and then follow up, she advised.

Any decisions that are made regarding personnel must be documented. An employer who can present a record of fair, reasonable, and consistent evaluations and decisions will fare much better if an employment discrimination case makes it to court.

If something does happen that requires action, always listen to the employee's side of the story. Not only is this fair, it might change your perception of an event, and it also helps to establish an accurate line of documentation right away, said Ms. Peck.

A dismissed employee later may come up with a multitude of supposed claims against you, but if someone listened to and documented his or her initial story, it establishes these facts on the record.

When an employee needs to be discharged, do not call it a layoff, Ms. Peck advised. Softening the blow to an employee by falsely implying that their dismissal was a result of a reduction in the workforce is a good way to get "into trouble with employment law," she said. An incompetent 55-year-old employee who is laid off and immediately replaced with a 36-year-old employee has the makings of a successful age-discrimination suit, she explained.

It is also important to provide a "clean" reason when an employee is discharged. If an employee was caught embezzling money, that's a firing offense and it's enough. Piling on other minor offenses is unnecessary and may clutter up any resulting employment claim against the practice, particularly if other employees had also committed minor infractions without losing their jobs, Ms. Peck said. ■

POLICY & PRACTICE

Cosmetics for Calif. Oral Surgeons

California Governor Arnold Schwarzenegger (R) has signed a bill that will grant new privileges to oral and maxillofacial surgeons. The governor vetoed a similar bill in 2005. Board-certified and licensed dentists who have completed an oral and maxillofacial surgery residency will be able to apply for and receive a 2-year, $500 permit to perform elective facial cosmetic surgery. Every 6 years, the permit holder has to submit evidence of competence to a credentialing committee. Procedures such as facial rejuvenation and contouring must be done at licensed and accredited hospitals or outpatient surgical facilities. The privileges do not extend to reconstructive surgery. The bill was supported by the California Association of Oral and Maxillofacial Surgeons, and opposed by the California Medical Association and the American Association of Plastic and Reconstructive Surgery.

Specialty Drug Demand Is Inelastic

Patients who need expensive specialty drugs will keep using the products even if they have to pay more—and that can drive up the cost of health care, said RAND Corp. researchers, who argued against tight restrictions and higher patient cost-sharing for such drugs. The researchers used 2003-2004 data covering 1.5 million beneficiaries from 55 health plans to gauge private coverage for patients with four conditions—cancer, kidney disease, rheumatoid and/or psoriatic arthritis, and multiple sclerosis. They included drugs administered at physicians' offices and other nonhospital health care facilities. Health plan spending ranged from $3,200 per user for Lupron (leuprolide acetate), to $10,000 per user for Enbrel (etanercept), to $100,000 per user for recombinant factor VIII. Patients spent between $3,301 and $8,878 out of pocket on these four conditions. Writing in the September/October issue of Health Affairs, the researchers said their data showed that even if a plan doubled the patient's share, overall spending on specialty drugs by insurers would drop by only 1%-21%, depending on diagnosis. They concluded that increasing patient copays only transfers more of the burden to the patient and will do little to cut overall spending. The study was supported by Amgen, the National Institute on Aging, and United Healthcare.

Psoriatic Arthritis Resources

The National Psoriasis Foundation has partnered with Abbott to provide psoriatic arthritis patients with online tools to manage their symptoms. The Web site, found at www.psoriasis.org/PATH, offers information on diet, exercise, and reducing stress. The content was designed with input from a rheumatologist, psychologist, dermatologist, dermatology nurse, cosmetology instructor, and patients with psoriatic arthritis. "It is essential that health care providers form a partnership with patients to facilitate a comprehensive treatment plan that addresses the medical, emotional, and social impacts of the potentially crippling disease psoriatic arthritis," Dr. Lester Miller, of the division of immunology and rheumatology at Stanford (Calif.) University, said in a statement.

Coalition Seeks More FDA Funds

A coalition of strange bedfellows has joined together to call on the White House and Congress to increase funding for the Food and Drug Administration, saying that the agency's mission and responsibilities have expanded hugely while its appropriations have failed to keep up with inflation or with the growing largess going to other agencies like the National Institutes of Health. That NIH investment will likely result in a large number of new products, all of which the FDA will have to regulate, according to the Coalition for a Stronger FDA. The agency also needs help coping with growing pharmaceutical, medical device, and food safety issues, the group said. The Coalition includes the Consumer Federation of America, the Center for Science in the Public Interest, the Grocery Manufacturers Association, the Biotechnology Industry Organization, and the Advanced Medical Technology Association, among others. Serving as cochairs of the Coalition are the last three secretaries of the Department of Health and Human Services: Tommy G. Thompson, Donna E. Shalala, and Louis Sullivan.

Low Physician E-Mail Use

Physicians rarely use e-mail to communicate with patients, according to one study, and yet patients overwhelmingly report that they would like to use e-mail to set appointments, talk with the doctor, and receive test results, according to a separate poll. The Center for Studying Health System Change found that only 24% of physicians said they used e-mail to discuss a clinical issue with a patient in 2004-2005, a 4% increase from the previous study period of 2000-2001. Almost half of physicians in academic settings and staff or group HMO practices use e-mail for clinical discussions, compared with about 20% in practices of 10 or fewer physicians. Physicians in nonmetropolitan areas, or who have large numbers of Medicaid and/or Medicare patients, say they are less likely to use e-mail because of patients' lack of access to the technology. Some other reasons for not using e-mail: lack of reimbursement for consultations, cost of implementing a secure system, and fears that e-mail would add to workload. A recent Wall Street Journal–Harris Interactive poll of 2,624 adults found that 74% want to communicate directly with doctors by e-mail, 67% want to receive test results, and 75% want to schedule appointments via the Internet.

—Alicia Ault