MLMIC®

# Dateline®

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A NEWSLETTER FOR MLMIC-INSURED PHYSICIANS & FACILITIES

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*The near-universal implementation of electronic health records by the healthcare industry, and the speed at which this dramatic change has occurred, has brought new challenges and pitfalls to healthcare practitioners in all specialties. The following article is the first in a series in which* Dateline *will examine these emerging exposures and offer practical guidance to MLMIC policyholders on how to safely and effectively mitigate them.*

# *Electronic Health Records – What is Being Recorded?*

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In the age of electronic health records (EHRs), all users should be aware of the electronic "footprint" that is left behind when they log out. All electronic documents, such as word processing documents and spreadsheets, contain metadata, which is the "data about the data." This information does not appear on the face of a document, but it is a part of the document nonetheless.

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# *The Latest Development in the Berkshire Hathaway Transaction*

On July 15, 2016, MLMIC and National Indemnity Company (NICO), a Berkshire Hathaway company, entered into a definitive agreement to acquire MLMIC. The acquisition will involve the conversion of MLMIC from a mutual to a stock company. The closing of the transaction is subject to various regulatory approvals (including the NYS Department of Financial Services), customary closing conditions and the approval of the MLMIC policyholders eligible to vote on the proposed demutualization and sale.

On February 23, 2018, the parties agreed to an acquisition price of approximately $2.5 billion and signed an amended acquisition agreement to reflect the purchase price and closing procedures. The parties currently expect this acquisition will be completed in the third quarter of 2018.

Please visit our FAQs page at MLMIC.com for the most current information. Should you have any questions, please call 1-888-998-7871. ❖

# *Risk Management Strategies for S6800 – Lavern's Law*

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On January 31, 2018, Governor Andrew Cuomo signed S6800, also known as "Lavern's Law," a bill that extends the statute of limitations by applying a date of discovery rule to medical and dental malpractice actions where there is an alleged failure to diagnose cancer or a malignant tumor, whether by act or omission. This is a significant issue for MLMIC policyholders because with a longer statute of limitations, memories will fade, witnesses will become unavailable, and the standard of care may change, so thorough documentation is more important than ever.

The best defense for physicians who face an extended statute of limitations under Lavern's Law for the misdiagnosis of cancers/tumors is to maintain complete, detailed, timely and relevant medical record documentation. Thorough documentation is crucial, and in the electronic health record (EHR), all check boxes must be marked positively or negatively to confirm that the physical examination was complete and that certain conditions/types of cancer relevant to the patient's complaints were considered. If the templates or check boxes on the computer are not appropriate for such documentation, you should discuss with your vendor adapting the program to the needs of your particular specialty and eliminate irrelevant items on the templates.

The following strategies are offered to address the risks inherent with an extended statute of limitations for misdiagnosed cancer cases:

1. Document the patient's history, which should include the following:
   a. The patient's complaint and whether it is a repetitive complaint.

> The best defense for physicians who face an extended statute of limitations under Lavern's Law for the misdiagnosis of cancers/tumors is to maintain complete, detailed, timely and relevant medical record documentation.

   b. Relevant information contained in the records of a prior treating physician.
   c. A family history of cancer, including the type and age of onset.
   d. Risk factors for cancer, including, but not limited to:
      i. diet, exercise and obesity.
      ii. alcohol consumption.
      iii. tobacco use (current, past, and present) in terms of packs per day or use of e-cigarettes for "vaping."
      iv. chemical and environmental exposures including prolonged sun exposure, radon, occupational hazards, radiation, and hormonal therapy including birth control pills and post-menopausal estrogen.
      v. increased number of sexual partners.
      vi. nulliparous status or multiparity of three or more children.
2. Document the positive and significant negative findings of the physical examination.
3. Document a differential diagnosis, ruling out more serious diagnoses, if appropriate.
4. Document the diagnostic tests and consultations that are ordered.
5. Review the incoming diagnostic tests and consultation reports in a timely manner and document both the review and the notification of the patient of both positive and negative findings:
   a. Implement a tickler system to make sure test and consultation reports are received.
   b. Document all patient follow-up efforts if reports of tests/

consultations are not received because the patient failed to comply as recommended.

6. Document the patient's understanding of positive results and the proposed treatment plan.
   a. Follow up by telephone, then mail, on missed or cancelled appointments after positive findings/results are disclosed to the patient. The telephone calls should be made by the physician if the patient has an increased risk of cancer.
   b. Document attempts to get the patient to comply with the treatment plan.
7. Document patient education, including the patient's understanding of recommended cancer screening tests and examinations for colon, breast, oral, cervical, uterine, ovarian, prostate, lung, and other types of cancer (including genetic testing):
   a. Document the patient's compliance or informed refusal to undergo such cancer screening tests and examinations.
8. Document all referrals to specialists to rule out potential risks or conditions, and document all communication with these specialists:
   a. If no referral is made to a specialist, the record must contain the rationale for not referring, including whether this resulted from the patient's informed refusal.
   b. Document the notification to the patient of a positive result, even when the specialist or consultant has also received that positive result.
9. Failed efforts to bring about compliance in a noncompliant patient should be handled with a discharge from practice letter containing a warning of the potential risks to life and health due to the patient's noncompliance.
10. Retain medical records of adults (18 years or older) for at least ten years from last payment or date of last service, whichever is longer.

There are many risk management strategies that healthcare providers and practices can implement to decrease the potential risk of liability and improve patient safety. Adopting these recommendations into a well-rounded risk management program will help reduce the risk of patient injury. In the event that there is litigation, detailed documentation will contribute to a strong defense.

The Risk Management Department of MLMIC Services, together with the attorneys at Fager Amsler Keller & Schoppmann, LLP, offer educational programs and presentations that specifically address Lavern's Law. These programs are provided to MLMIC policyholders throughout New York State and offer guidance designed to manage the risks and reduce the exposures presented by this law, all at no additional cost to our policyholders.

For additional resources, please contact the Risk Management Department at MLMIC Services and/or the attorneys at Fager Amsler Keller & Schoppmann, LLP. ❖

# Case Study

## *Ignored Contraindications Lead to Amputation*

*Helen Granich*
*Claims Unit Manager*
*Medical Liability Mutual Insurance Company*

This case involves a then 37-year-old morbidly obese female who presented to our insured health system in early June 2009, and was seen by an employed physician's assistant (PA). She had undergone a Pap smear at Planned Parenthood and examination revealed an enlarged cervix. She was gravida 5, para 5, with one child living for only a short while after delivery. Her chief complaint was heavy menses.

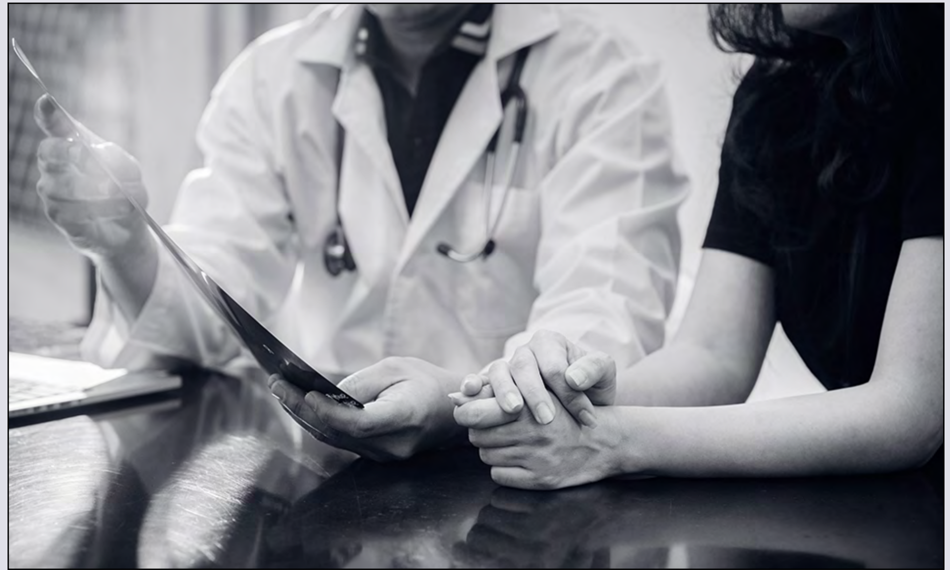
Pelvic and rectal exams were conducted and the diagnosis included back and pelvic pain. Blood tests revealed anemia with a hemoglobin and hematocrit of 11.9 and 36.9, respectively, with microcytosis. A pelvic ultrasound was ordered and read as normal. She continued to complain of pelvic pain, which worsened during her cycle. The record reflects that she advised our PA that her "periods are heavy but regular. She has had a tubal ligation."

The patient was seen again three weeks later and was diagnosed with pelvic pain and possible endometriosis. It was noted that "in regards to her pelvic pain, we will start her on Ortho-Novum 777 (OCP). Did discuss the risk and benefits of this medication with her including the risk of thrombus and breast cancer. She does smoke and I have encouraged her to quit." She was also diagnosed with iron deficiency anemia "probably related to heavy menses" and was started on iron sulfate.

In August, she was seen for follow up and a physical. At this time, it was charted "...placed her on birth control pills hoping that this would help in terms of her heavy menses. She states that she does continue to have heavy menses." The past medical history included asthma, and a review of systems revealed chronic cough and chronic back pain, for which recent injections offered no relief. She was diagnosed with dysmenorrhea/menorrhagia and referred to our insured obstetrician-gynecologist (OB). She was continued on iron for her anemia, inhalers for her asthma, and birth control pills.

At the end of September 2009, the plaintiff was seen by the OB for the first time. Records from the PA's office were faxed to the OB's office and included the diagnosis of dysmenorrhea/menorrhagia, but there was no reference to treatment with OCPs. However, the patient intake form did indicate that she was taking birth control pills and included a history of smoking ½ pack per day for over 20 years. The OB noted in the margins of the form that the plaintiff had a bilateral tubal ligation, was on "777 birth control," and was a "smoker – needs to stop – counsel." His progress note from this date similarly reflects "needs to stop" adjacent to the listing for Ortho-Novum 777 under the "Medications" heading. The patient noted that her last menses were light and "stringy." The OB's physical findings included 1+ tenderness of the cervix and 2+ tenderness of the uterus and suprapubic area of the abdomen. He felt it was possible she had endometritis, but did not feel she had endometriosis at this time, which was the prior diagnosis made by the PA. The OB noted the patient had dysmenorrhea. Doxycycline was prescribed as a therapy for endometritis and he further prescribed Anaprox, a nonsteroidal anti-inflammatory, for her complaints of pain and discomfort. She was to return to the office in two weeks.

The patient returned in mid-October as planned. Medications were listed as albuterol and Ortho-Novum 777. It was noted that there was some improvement and there no longer was any suprapubic tenderness, but the cervix and uterus were still tender at 1+ and 2+, respectively. The patient now complained of dyspareunia with pelvic pain. The OB also considered scar tissue and endometriosis as possible causes.



Options were discussed, including diagnostic laparoscopy or Lupron Depot treatment. The plaintiff chose a laparoscopic approach and the OB documented a discussion regarding the risks, benefits, and alternatives. The plaintiff filled another prescription for oral contraceptives two days after this office visit. As with all prior refills, our PA was noted as the prescribing provider.

Within several weeks of this office visit, the plaintiff had an onset of headaches at the back of her head and eventually decided to go to the ER. The chart reflects that she presented with complaints of a migraine headache for two days. Her prior medications included "birth control," albuterol, ibuprofen, and Tylenol. She underwent a CT of the brain without contrast that revealed an intracranial mass, specifically a "hypodense sharply demarcated lesion in the right cerebellar hemisphere that measures 3 x 2 cms." Early the next morning, she was transferred to a larger community hospital for neurosurgical evaluation and treatment, where she was diagnosed with an acute cardiovascular accident (CVA). Ten days later, as a result of a brachial artery clot, she underwent an amputation of the right arm at the mid-forearm level. Prior to the amputation, she had undergone a thrombectomy but was not treated with Heparin for the clots due to the CVA. She then re-clotted, resulting in the amputation.

The plaintiff commenced a lawsuit in which she claimed our policyholders: failed to recognize the risk factors and/or her medical/personal history, which indicated that she was prone to the development of thromboses; failed to develop an appropriate differential diagnosis; and prescribed oral contraceptives when they knew or should have known that these were contraindicated in a patient presenting with high risk factors for thrombosis including tobacco abuse, migraines, obesity, anemia, and low iron blood levels. There was also a claim for lack of informed consent.

The plaintiff testified that she had agreed to the surgery, but denied ever discussing the risks and benefits of the procedure with the OB, which was contrary to the medical record. She also admitted to smoking anywhere from one-half pack to one and one-half packs of cigarettes per day, the significant increase of which was never disclosed to her providers. The OB's office records contained a letter he wrote to the treating PA. Unfortunately, the letter bore two dates, one being the date of the first visit in late September and the other date being the day of the mid-October visit. The OB testified that he authored the letter some time after the mid-October visit, but did not know whether or not it was ever sent. There was no copy of this letter in the record of the PA, who denied receipt of it. In the letter, the OB wrote that he "suggested the patient stop OCPs as cycles regular and she is a >35 smoker." He further wrote that he felt she had endometritis, that the bleeding had stopped, and the pain had decreased. The OB also testified about his use of the word "suggested" in the context of instructions to the patient to stop taking birth control pills. He clarified that he did not contact the PA, but did instruct the plaintiff to go see him for the purpose of having the PA

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consider the possible discontinuance of the oral contraceptives.

The matter was reviewed by experts in the field of OB/GYN and neurology. Both our in-house and outside experts were critical of the care rendered by the OB and felt that, based on the plaintiff's history of tobacco use, migraines, obesity, and anemia, he should have discontinued her use of oral contraceptives. They opined that the plaintiff had been referred to him due to heavy bleeding, and oral contraceptives were prescribed for this very issue. In addition, both experts agreed that as of August 2009, the plaintiff's care was essentially transferred to the OB, who should have counseled the plaintiff about discontinuing smoking while taking OCPs.

The defense of this case was further hampered by the fact that the OB was unable to find his chart when a copy was requested by the patient's attorney. In addition, the two different dates on the letter found in his files left him vulnerable to a jury being persuaded that he had altered the records. More problematic, however, was the fact that the OB had been practicing under the terms of a non-disciplinary Order of Conditions during the time he was treating the plaintiff. The OB subsequently surrendered his license during the course of this litigation as he was officially suspended by the State of New York at the end of 2012.

Two and one-half years after the lawsuit began, the plaintiff's attorney made a settlement demand of $2.3 million. Negotiations were undertaken and the case was finally resolved for $850,000, all of which was paid under the OB's insurance policy.

## *A Legal & Risk Management Perspective*

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*Counsel to Medical Liability Mutual Insurance Company*

This case was replete with facts and negative inferences which were adverse to all the defendants. The mismanagement of the patient's care made the lawsuit difficult to defend, and dangerous to present to a jury. The sympathetic overlay of the loss of a limb contributed to the necessity of agreeing to a settlement.

The defense of the case was severely compromised by numerous errors and omissions, as well as implications of medical record falsification. The physician assistant (PA) was initially responsible for prescribing oral contraceptives on five occasions. He lacked full appreciation of the multiple contraindications for an overweight patient who smoked a reported one-half pack of cigarettes a day for twenty years, and was over age 35. These are the very risk factors that substantially increase the likelihood of a thrombotic event, which this patient ultimately experienced, resulting in amputation of her arm. It is well established that smoking cigarettes while taking birth control pills is a lethal combination, and the odds of facing complications are significantly higher for patients who are over age 35.

The PA was employed by the defendant hospital and appeared to be working autonomously when he established a care plan for the patient. There was no documentation that he consulted with his supervising physician, who was not named in this suit, or that he had any communication with the defendant physician to whom he referred the patient. Although PAs may see patients independently, it should be noted that physicians who supervise or employ them are ultimately responsible for the medical care PAs provide. Failure of a supervising physician to appropriately oversee a PA could result in a finding of professional misconduct by the Office of Professional Medical Conduct (OPMC). 8 NYCRR § 29.2(a)(5).

The defendant physician who saw the patient as a referral noted her use of birth control pills. However, his documentation did not reflect that the patient was instructed to stop taking oral contraceptives. The physician's lack of a thorough assessment and review of medications resulted in failure to appreciate the risks to the patient. As a result, he lost the opportunity to intervene on her behalf after she already took several months of pills prior to becoming his patient. Failure to communicate with the PA and insist

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LEGAL Update

# *Don't Fumble a Hand-Off – Joint Commission Issues Sentinel Event Alert*

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On September 12, 2017, the Joint Commission issued a Sentinel Event Alert on the topic of inadequate hand-off communication. Hand-offs, or transfers of patient care from one provider to another, are a frequent, persistent problem in healthcare because poor communication of crucial patient information during this deceptively "simple" process puts patient safety and continuity of care at risk, often resulting in patient death or serious injury.

As stated in the alert, "A study released in 2016 estimated that communication failures in U.S. hospitals and medical practices were responsible at least in part for 30 percent of all malpractice claims, resulting in 1,744 deaths and $1.7 billion in malpractice costs over five years." The alert contains information about a number of methods and tools that healthcare organizations can utilize in order to standardize and improve hand-off policies and procedures, including the Commission's Targeted Solutions Tool (TST) for Hand-Off Communications, to which accredited organizations already have access.

Healthcare organizations and providers are urged to use this tool to assess the effectiveness of current hand-off procedures, implement a means to collect internal data on hand-off failures and problem areas, and develop forms and processes to standardize the collection and effective communication of crucial patient information. According to the Joint Commission, by using TST to reduce the number of adverse events related to poor hand-off communication, one hospital reduced its overall incidence of inadequate hand-offs by 58.2%.

For assistance with risk management questions regarding the hand-off process, please call an attorney at Fager Amsler Keller & Schoppmann, LLP, in Syracuse (315-428-1380 or 877-426-9555), Latham (518-786-2880) or Long Island (516-794-7340). ❖

# *The Proper Way to Close a Practice*

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When a physician contemplates retiring or closing a practice, there are key steps which must be taken before the practice can be closed. It is particularly important that all of these steps be completed in a timely manner.

The first step is making a firm decision about when you wish to close the practice or when you have to do so, if the closing is not due to retirement. This decision will permit you to carefully plan the closure so that you provide sufficient time to notify patients, staff, vendors, and insurance companies.

Once you have determined that date, you must notify your patients of your decision. We recommend that you provide at least thirty days notice. This notice should be longer if your patients' medical conditions justify a longer period. You also need to consider whether your specialty is immediately available to your patients in your geographical area. This will permit your patients to transition to another practice without having serious gaps in care.

If you practice obstetrics or any surgical specialty, you will need to consider when to stop performing such care before the closing date, since you will be unable to perform postpartum or postoperative visits after your practice is closed.

If you have patients who take medications on a regular basis, you will have to provide sufficient refills for a reasonable time until the patient can make an appointment to see a new physician. However, you must still comply with the laws and regulations governing prescriptions for controlled substances.

You also need to notify the Medical Liability Mutual Insurance Company (MLMIC) Underwriting Department of the last date your office is actually open, since you will need to make certain the staff remaining in the office to provide patients with access to their medical records do not provide medical advice to these patients. If you are going to practice at another site or in another part of the state, you will need to notify MLMIC of that change as well.

If another physician will be assuming your practice, you need to advise your patients of this and enclose an authorization with your letter. This permits this new physician to gain access to the records of patients who choose to transfer care to him or her. If there is no person who is assuming your practice, refer your patients to the local medical society or, as appropriate, hospital referral service or specialty society to obtain the names of other physicians in the area.

If you intend to store your own medical records for the appropriate statutory time periods for adults and minors, you must be able to provide copies of the records upon a patient's request in the manner they request, pursuant to HIPAA and HITECH. If you intend to store your records in your home or space you rent, you must store your records in a safe, waterproof, locked area. Do **not** give your original records to the patient, as that will make it extremely difficult to defend you later in a medical malpractice case.

If you are leaving your records in the possession of another physician or group, the patients should be advised where to access these records. Further, we recommend that you enter into a written agreement with that physician or group that allows you to access a copy of these records in the event of a lawsuit, investigation, or proceeding by OPMC, Medical/Medicaid, or another governmental agency. Alternatively, you can arrange to use a medical record storage company to retain the records for the statutory and recommended periods for retention.

All of this written information as well as answers to your specific questions can be obtained by contacting an attorney at one of the offices of Fager Amsler Keller &

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# Recent Insolvencies Speak to the Risks of Insuring with an RRG

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Among the risks of insuring with risk retention groups (RRGs) is a lack of insolvency protection for policyholders. Since RRGs are not licensed in NYS, they are not eligible for protection by the NYS Property/Casualty Insurance Security Fund and their policyholders are not protected by the state's guaranty fund when such an RRG becomes insolvent.

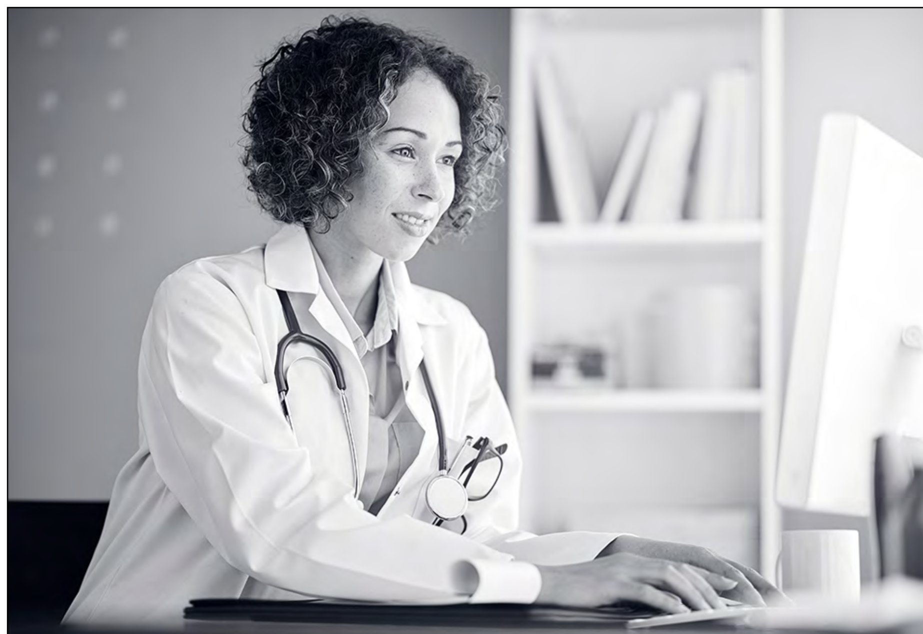
Unfortunately, physicians in NYS will experience this and others risks if insured by an RRG that is declared insolvent. As a service to our policyholders, we are providing information that describes what to expect if your RRG is declared insolvent.

In general, when an RRG is declared insolvent, it will be placed into liquidation by the insurance commissioner of its domicile state. Liquidation is a type of receivership and is similar to bankruptcy. The insurance commissioner will be charged with tasks that include taking possession of the assets of the insolvent RRG, conducting its business, and winding-up the affairs of the insolvent RRG, all under court supervision for the protection of the policyholders, creditors and the general public.

The effect of liquidation on a policyholder creates a series of problems, distractions and disruptions. Foremost is that existing insurance coverage will, at worst, cease to exist before the policy expiration date or, at best, provide far less financial protection than originally agreed to and purchased. Policyholders will be faced with immediately procuring replacement coverage and the accompanying business disruption. For those policyholders actively engaged in malpractice litigation, there will be even more financial uncertainty because they will then be responsible for paying some or all of their defense costs and indemnity payments. Beyond these increased financial obligations, the litigation process will be stayed for an extended period of time, meaning that the lawsuit will remain open for an extended period of time.

In all insolvency events, the outcome is clear: the insolvent RRG will not have sufficient remaining assets to satisfy its obligations to its policyholders, creditors or the general public, and a policyholder will be subject to greater financial exposure coupled with all the attendant distracting professional and business disruption.

MLMIC urges physicians in New York to familiarize themselves with all the risks before opting for coverage from an RRG. In many cases, RRGs fail due to pricing practices that cannot bear the weight of the company's responsibility to protect its policyholders. Ultimately, what appears to physicians to be a more cost-effective option can lead to additional and even higher costs and greater financial risk. ❖



Metadata includes a file's name, location, format, and size, but it can also include the dates and times of its creation and modification, as well as the dates and times of users' access. Similarly, the software and hardware of EHR systems also automatically generate this type of information, which is not readily seen by the user, but is still maintained by the system.

In fact, both the state and federal regulations dictate what type of metadata must be maintained when an EHR system is used.[1] These regulations require medical centers to have certain technical capabilities within their technology to ensure security and confidentiality. The regulations require the assignment of a unique identifier, usually the username, and the user must certify in writing that the account is confidential and accessible only to the authorized person.[2] These provisions ensure that any activity is performed by the assigned individual and allows for the tracking of a particular individual's activity.[3] This authentication is also meant to prevent unauthorized alteration or destruction of protected health information.[4] The act of sharing usernames is not only a violation of a medical center's policies, but it impedes the purpose of these regulations.

Within New York's regulation for the authentication of medical records, the state requires each electronic entry, order, or authentication to be recorded in the medical record as to: (1) date, (2) time, (3) category of practitioner, (4) mode of transmission, and (5) point of origin.[5] Likewise, the federal regulation imposes the use of hardware or software that records activity in the information system.[6] The federal audit log must contain: (1) the "exact date and time of the access event and the exit event," (2) "[u]nique identification of the patient," (3) "[u]nique identification of the user of the health information system," (4) specific "inquiry, any changes made, and a delete specification," and (5) "[s] pecific category of data content, such as demographics, pharmacy data, test results, and transcribed notes type."[7]

This mandatory metadata is recorded in an audit log, which is required to be accessible by the medical center. As attorneys, administrators, and regulators become increasingly aware of the existence of an audit log, this information is playing a larger role in legal proceedings. When a user logs into the medical record system, nearly every action is recorded, as well as the location of the access, e.g., residence, hospital, or office. This means that any alteration of an EHR is recorded in detail and no information can be deleted permanently. Some of the logged data that is less conspicuous includes the length of time of a user's activity or the areas of the record that were accessed.

In legal proceedings, audit logs can be used to authenticate a medical record.[8] For example, this information could be used to verify or disprove a user's testimony regarding the time he or she was present at the hospital or the time the lab results were viewed. In one medical malpractice action, the audit log was used to quantify the level of involvement of the emergency department physician in a plaintiff's care.[9] Users should be aware that their memories of events can be verified or nullified with more than just the EHR; the

audit log behind the record can also be used.

It is safe to assume that every action taken on an EHR – from access to exit – is recorded and, thus, capable of being produced. Accordingly, users of EHRs should approach their access to these systems with the acknowledgment that their actions can be examined. Any abuse or inappropriate access can be recalled by the medical records system. To avoid actions being wrongly attributed to him or her, a user should never leave a work station without logging out and should never share password information. ❖

ENDNOTES

1. See 45 C.F.R. §§ 164.312; 170.210 (The objective of the Health Information Technology for Economic and Clinical Health Act is to protect electronic health information) and 10 N.Y.C.R.R. § 405.10(c)(3-4).
2. See 10 N.Y.C.R.R. § 405.10(c)(4)(i-ii); see also 45 C.F.R. 164.312(d).
3. See id.
4. See 45 C.F.R. 164.312(c)(1-3).
5. See 10 N.Y.C.R.R. § 405.10(c)(3).
6. See 45 C.F.R. 164.312(b).
7. See 45 C.F.R. § 170.210(e)(1)(i).
8. See Vargas v. Lee, 2015 N.Y. Slip Op. 31048(U) (June 10, 2015); Gilbert v. Highland Hosp., 52 Misc. 3d 555 (Sup. Ct. Monroe Cty. Mar. 24, 2016))
9. See Gilbert, 52 Misc. 3d 555.

# UNDERWRITING Update

## *MLMIC Physicians and Surgeons Professional Liability Coverage for Dispensing Medical Marijuana in Accordance with Law*

MLMIC insured physicians and extenders who meet NYS DOH requirements set forth in New York Codes, Rules and Regulations "10 NYCRR §1004.1(a)," which addresses practitioners seeking to issue certifications for their patients to receive medical marijuana products, and who so prescribe such in compliance thereof, can rest assured that their medical malpractice coverage (known in the industry as Medical Professional Liability Insurance or "MPLI") through MLMIC is applicable for such activity under the terms and conditions of their policy. While our Physicians and Surgeons Professional Liability (PSE) policy contains an exclusion for "Unapproved Drugs, Substances or Medical Devices," in part and parcel for "liability arising from the use or prescription of drugs, substances or medical devices which have not been approved by the U.S. Food & Drug Administration for any use," recent legislation as referenced above now approves the use of medical marijuana for certain "severe, debilitating or life threatening conditions" as further described therein. Consequently, this policy exclusion as applied against the above criteria would not be applicable and therefore coverage, under the provisions of the MLMIC PSE policy for the rendering of such professional services is otherwise afforded to our Insureds. ❖

https://www.health.ny.gov/regulations/medical_marijuana/practitioner/

Schoppmann, LLP (FAKS). For instance, there are: memoranda containing guidelines for the closure of a practice and the retention of records; a template letter for notification of patients; and a template agreement for retention of your records by another physician or group which should be reviewed by your business counsel before proceeding with it. If the office closure is due to an unanticipated health condition or the death of a physician, FAKS can also provide additional advice about closing the office.

Finally, you will need to contact your business counsel about how to notify all medical insurers with whom you participate, your premises liability insurer, and any other relevant carriers, as well as what your responsibilities are with respect to your employees and office. ❖

# Case Study

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that this contraindicated prescription be discontinued resulted in the PA's additional renewal, followed by the amputation one month later.

Many other factors compromised the defense of this lawsuit. The patient stated at her deposition that she was not informed by either the PA or physician that smoking while on birth control pills increased her risk for blood clots, or that she should discontinue one or the other. The PA documented a discussion of the risks and benefits of oral contraceptives, but the physician's chart lacked any reference to addressing this very issue with the patient. His documentation also failed to address that the patient was told to stop smoking. The physician's note simply stated that he "suggested" this to the patient. Although the patient's credibility was certainly questionable, entries in the physician's medical records were too paltry to unequivocally refute the patient's assertion regarding lack of informed consent.

The physician's consultation letter, which was dated with each of the patient's two visits to his office, also presented many difficulties for the defense. This letter was absent from the PA's records, and the PA denied receiving it, which added to the speculation as to when it was actually written. These circumstances were strongly suggestive of professional misconduct by the physician based on a falsified medical record. In addition, he was working under a non-disciplinary Order of Conditions during the time he treated the patient. Since the physician was already under investigation by the OPMC for reasons unrelated to this patient's treatment, it was too dangerous to put him on the stand in his own defense at a trial.

The physician wrongly presumed that the patient was no longer his responsibility when he, in fact, had a non-delegable duty to manage her care. Referring her back to the PA, a mid-level practitioner, was further indication that he failed to appreciate the potential dire consequences of the patient's treatment regimen. As the more senior and experienced medical professional, it was his obligation to take control, manage the patient's course of treatment, and make appropriate referrals.

The physician was responsible for reviewing, continuing, and/or changing the treatment plan that was initiated by the PA. Although the PA handled the original plan of care, the physician had the last clear chance to alter the course of events. His lack of any communication with the PA, inadequate and/or lack of discussions with the patient, insufficient and questionable documentation, and attempt to shift responsibility of the patient's care to the PA, resulted in a settlement solely on his behalf, without any monetary contribution by the other defendants. Lack of support from any defense experts who reviewed the case, and the physician's difficulty in finding his records, coupled with his licensure issues, contributed to the conclusion that settlement was the only available option. ❖

# EVENT Calendar 2018

*In 2018, MLMIC will be participating in the following events throughout New York State. For more information on MLMIC's involvement in these events and others, please contact Pastor Jorge, Manager, Marketing Services, at 212-576-9680.*

**March 22-25** MSSNY House of Delegates - Buffalo

**April 11** Monroe County Medical Society Ask The Carrier Event - Rochester

**April 12-15** New York State Osteopathic Society - Regional Osteopathic Convention - Hauppauge

**April 27-29** New York State Pain Society Annual Meeting and Scientific Sessions - West Harrison

**April 28** MSSNY-MSCK New York Health Information Technology Symposium and Expo - Brooklyn

**May 2** Monroe County Medical Society 197th Annual Meeting - Pittsford

**May 3** Westchester County Medical Society Networking Event - Elmsford

**June 1** ACOG District II 2018 Regional Meeting - Rochester

**June 2** New York Chapter American College of Physicians Annual Scientific Meeting - Rye Brook

**June 7-8** New York MGMA 2018 State Conference - Syracuse

**June 23-24** New York State Academy of Family Physician's Annual Congress of Delegates - Troy

**June 27-29** HANYS Annual Membership Conference - Saratoga Springs

**September 21** New York State Ophthalmological Society Annual Meeting - Garden City

**September 26-28** New York State Bones Conference - Saratoga Springs

**September 22** New York State Society of Orthopaedic Surgeons Annual Meeting - Rochester

**October 3** Westchester Academy of Medicine Annual Golf Outing and Fundraiser - Rye

**October 19-20** ACOG District II Annual Meeting - New York City

**December 7-11** New York State Society of Anesthesiologists' Post Graduate Assembly in Anesthesiology (PGA) - New York City

# RISK MANAGEMENT Tips

## *Tip #23: Managing Patient Noncompliance*

**The Risk:** Patient noncompliance is one of the most difficult challenges for healthcare providers. Noncompliance may include missed appointments and the failure to follow a plan of care, take medications as prescribed, or obtain recommended tests or consultations. The reasons given by patients for noncompliance vary from the denial that there is a health problem to the cost of treatment, the fear of the procedure or diagnosis, or not understanding the need for care. Physicians and other healthcare providers need to identify the reasons for noncompliance and document their efforts to resolve the underlying issues. Documentation of noncompliance helps to protect providers in the event of an untoward outcome and allegations of negligence in treating the patient.

**Recommendations:**

1. Establish an office policy to notify providers promptly of all missed and canceled appointments. We recommend that this be done on a daily basis.
2. Formalize a process for follow up with patients who have missed or cancelled appointments, tests, or procedures. This process should include recognition of the nature and severity of the patient's clinical condition to determine how vigorous follow up should be.
   a. Consider having the physician make a telephone call to the patient as a first step when the patient's condition is serious.
   b. If the patient's clinical condition is stable or uncomplicated, staff should call the patient to ascertain the reason for the missed or canceled appointment.
   c. All attempts to contact the patient must be documented in the medical record.
   d. If no response or compliance results, send a letter by certificate of mailing outlining the ramifications of continued noncompliance.
3. During patient visits, emphasize the importance of following the plan of care, taking medications as prescribed, and obtaining tests or consultations.
4. Seek the patient's input when establishing a plan of care and medication regimen. Socioeconomic factors may contribute to the patient's noncompliance.
5. To reinforce patient education, provide simple written instructions regarding the plan of care. Use the teach-back method to confirm that patients understand the information and instructions provided.
6. With the patient's permission, include family members when discussing the plan of care and subsequent patient education in order to reinforce the importance of compliance.
7. When there is continued noncompliance, patient discharge from the practice may be necessary. The attorneys at Fager Amsler Keller & Schoppmann, LLC are available to discuss patient noncompliance and the discharge of a patient. ❖

# THE MLMIC Research Library

## Spring 2018 Update

The MLMIC Research Library's services are available to all policyholders on a complimentary basis. Policyholders may submit a research request at the library link on MLMIC.com's homepage. Listed below are some of the customized services available to answer your research request according to your specialty, facility and practice type:

- Literature and Internet Searches
- Medical Textbooks
- Docline Retrieval Service
- LocatorPlus Book Loans
- Standard of Care/Practice Guideline resources

Along with offering research services, MLMIC owns a large collection of medical malpractice risk management book and DVD titles available to borrow for a five week loan. Please visit the MLMIC Research Library online to learn more about newly added titles, process a loan request or send your risk management research question using Ask the Librarian at the website. To contact the Library directly, please contact Judi Kroft, Library Administrator, at 800-635-0666 ext. 2786 or jkroft@mlmic.com.

### Recent Additions:

- **The EMTALA answer book 2018.** Jeffrey C. Moffat. Wolters Kluwer; 2018. (Medicolegal 330-023 2018).
- **Guidelines for perioperative practice.** Association of Operating Room Nurses, Inc.; 2018. (Surgery 167-003 2018).
- **HIPAA compliance handbook 2018.** Patricia I. Carter. Aspen Publishers, Inc.; 2018. (Medicolegal 330-019 2018).
- **HIPAA for managers: Meeting your responsibilities under the law.** Kantola Training Solutions; 2016. (DVD 002-612 2016).
- **Legal manual for New York physicians.** Patrick Formanto, Joel M. Greenberg & Donald R. Moy. New York State Bar Association; 2018. (Medicolegal 330-032 2018 v.1 & 2).
- **Obstetrical risk management playbook**; American Hospital Association; 2017. (R M 151-152).

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*The attorneys at Fager Amsler Keller & Schoppmann, LLP are available during normal business hours to assist MLMIC insureds with a wide range of legal services, including, but not limited to, advisory opinions concerning healthcare liability issues, liability litigation activities, lecture programs, and consulting services.*

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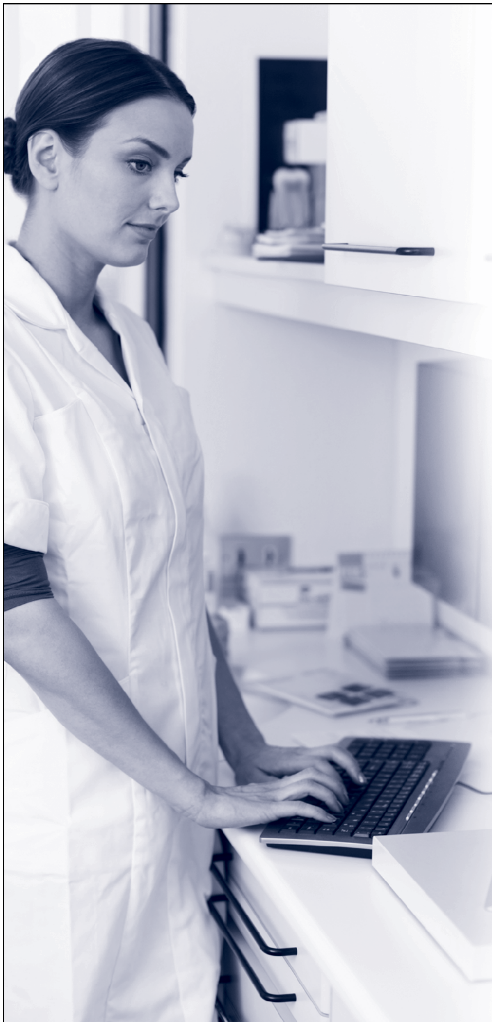

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### Blog

**MAR 1** **Case Studies Highlight Importance of Veracity, Communication and Detailed Medical Histories**

The March 2018 edition of MLMIC's Case Review includes case studies highlighting the importance of veracity, communication and detailed medical histories.

**FEB 28** **CMS to Enforce Hand Hygiene Guidelines in Ambulatory Surgery Centers**

Infection transmission in healthcare facilities is strongly associated with poor hand hygiene. Starting this year, CMS surveyors will issue citations when they observe any ambulatory surgery center employee failing to follow proper hand hygiene protocol.

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