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How High Costs Can Impact Medical Care

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For patients of limited means, or those with inadequate or no insurance, the cost of medical care and preventative treatment has long been a deterrent to receiving such treatment. Many patients who do not have coverage through their employment have switched to high deductible insurance plans. However, high deductible plans force the patient to bear a much greater cost.

Due to the costs involved, patients frequently fail to visit physicians on a regular basis, waiting until a crisis arrives. They may also fail to fill prescriptions, skip doses of medicine, fail to obtain necessary tests, or fail to keep appointments with specialists.¹ The most dismaying fact is that the United States ranks last among eleven high-income countries when measuring financial access to care for persons with lower income.²

When a patient repeatedly refuses tests that could detect a serious condition because of the cost, and the patient then develops a serious or possibly terminal condition, the physician may be sued, despite the patient's refusals. This places the physician in a very difficult position. Physicians cannot force patients to obtain appropriate or recommended preventative care. While there is no question that patients in New York State have the right to refuse treatment, it is not as clear what the physician's rights and obligations are when a patient is consistently non-compliant.

It is likely that a physician's risk of liability is increased when a patient chooses not to seek care primarily due to cost. In a recent study of

adults 18-64 years of age who have some form of private health insurance, the results were quite revealing. About 19% of patients do not go to the doctor when ill. Eighteen percent do not seek preventative and other recommended healthcare. Eighteen percent of patients deplete all or most of their savings when they become ill or injured and 13% go without basic needs due to medical costs.³ Yet one in four privately insured adults doubt they can pay for a major illness or injury.⁴ Unfortunately, patients do not seem to make the link between their risks and their failure to obtain care. Therefore, physicians should discuss the costs of a test in addition to the risks of refusal, rather than just telling patients to undergo tests or seek consultations. This might be the key to patients making better health care decisions.

Recent studies have confirmed that currently there is little to no communication between patients and physicians about out-of-pocket costs. This is because physicians receive little if any training on how to assist patients to deal with the costs of medical care. Further, patients may well be embarrassed to raise this issue.⁵ However, physicians do need to learn to discuss medical costs

3. The Associated Press-NORC Center for Public Affairs Research, Privately Insured in America: Opinions on Health Care Costs and Coverage, October 2014 at 1, 5-6.
4. BenefitsPro, Paying High Deductibles Weighs on Consumers, October 17, 2014 at 1. Accessed at <http://www.benefitspro.com/2014/10/17/paying-high-deductibles-weighs-on-consumers>, on August 18, 2015.
5. G. Caleb Alexander, et al., Barriers to Patient-Physician Communication About Out-of-Pocket Costs, J. Gen. Intern. Med. August 2004, at 856, 859. Accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1492500>, on August 18, 2015.

1. Karen Davis, PhD. and Jerome Ballreich, M.H.S., Equitable Access to Care - How the United States Ranks Internationally, 371 New Eng. J. Med. 1567, 1567 (2014).
2. *Id.* At 1568.

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Case Study

Failure to Diagnose Myxofibrosarcoma

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The patient in this case was a 47-year-old self-employed contractor who had no medical insurance and who was a long-term smoker. He went to see the defendant, his long-time board certified family physician, for routine blood work. He mentioned he had a bump on his lower back that had been bothering him. The defendant arranged to remove what he felt was a 2-2.5 cm sebaceous cyst. The bilobular “cyst” was dissected and removed from the patient’s back in the area of his beltline. The defendant claimed he bisected the “cyst” and confirmed that it had the usual appearance of “cottage cheese,” indicating a sebaceous cyst. As a result, he did not send the cyst to a pathology laboratory for diagnosis, nor did he document his observations or thought process. Also, he did not document that the patient had refused, for financial reasons, to have this tissue sent to pathology.

Two days later the patient returned to the office for the removal of sutures. However, the wound was swollen and required reopening and the removal of clots. Four days later, the patient again returned to the office. The wound was healing well, although there was still a cavity present. The patient did not return to the defendant due to financial concerns and thus was not seen until one year later for his hypertension. At this visit, the defendant did not examine the area of the biopsy, nor did he ask the patient if he had any complaints about it.

Ten months later, during the course of a regular office visit, the defendant observed two cystic areas on the patient’s

lower back. He referred him to a surgeon for excision. The patient saw the surgeon one month after his appointment with the defendant. He complained to the surgeon of a right anterior shoulder mass as well as a right calf mass. The surgeon scheduled him for removal of the cysts one week later. However, one day prior to that appointment, the patient had a seizure and was taken to the emergency department. A head CT revealed multiple brain masses supratentorially with suspicion of metastases with impending brain herniation. A chest x-ray also revealed possible metastatic lung disease. The patient continued to have seizures after admission to the hospital and was intubated. The lower back nodule was biopsied and a diagnosis was made of a high grade myxofibrosarcoma. The patient was discharged and arrangements made for chemotherapy. However, six months later, the patient died from the metastatic tumor.

The case was reviewed by experts in three specialties (pathology, oncology, and family practice). They determined that the case was not defensible. The experts all concurred that although the specimen was not sent for pathology examination by the defendant because the patient did not have insurance, the defendant should have thoroughly explained to the patient why pathological examination was recommended and given the patient the option to self-pay. That conversation should have been documented but was not. The experts also all stated that the defendant’s failure to record his observations and thought

process on the removal and sectioning of the cyst made the case particularly difficult to defend. They felt there was no legitimate reason for the defendant not to send the tissue to pathology.

The family practice expert concurred that any subcutaneous tissue removed must be sent to pathology. He felt that the failure to send the tissue for pathological examination departed from the standard of care. He further criticized the defendant’s failure to document whether the cyst was fluid filled, fluctuant or could be manipulated. This information also should have been documented, together with the description of the sectioning and contents of the “cyst.”

The pathology expert also questioned whether the defendant’s diagnosis of a sebaceous cyst was correct, since sebaceous cysts are not usually bilobed. He stated that the size of the cyst alone should have dictated referral to a surgeon for excision. Further, because the cyst was not surgically incised, there was no way to check whether the margins were clear to confirm that the cyst was fully removed. Therefore, the defendant may have worsened the patient’s situation by removing this specimen without using proper surgical technique. Because the sarcoma was found two years after the defendant’s excision, in the same place as the excised “cyst,” it was very unlikely the original cyst was anything other than a sarcoma. The expert also questioned whether microscopic metastasis of the sarcoma occurred during the removal of the cyst. This would not be unexpected and would be the basis for a strong argument against

the defendant in court, even though there was a two year delay between excision and clinical reoccurrence. At least 2-10% of these tumors do metastasize and do so slowly. The defense had no evidence on which to base an argument that the tumors were unrelated.

Because of the patient's age and the fact that he was the primary support of a wife and children, the case was settled for \$1.5 million on behalf of the defendant physician. The settlement required his entire primary liability policy of \$1.3 million and involved a portion (\$250,000) of his \$1 million excess insurance.

A Legal & Risk Management Perspective

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In this case, the primary care physician made several missteps in care which ultimately resulted in an unusually large settlement. The size of the cyst alone should have prompted the physician to refer the patient to a surgeon for excision. It is not entirely clear from the record why the physician chose to remove the cyst himself, but, as the pathologist reviewer pointed out, the physician's failure to use proper surgical

technique could have contributed to the spread of the malignancy.

The lack of documentation was extremely damaging to the physician. He did not document his discussion with the patient or his observations of the tissue. Without any documentation as to the appearance of the cyst or its characteristics, the physician's decision not to send the tissue for pathological examination became a pivotal unanswered question when he was sued for malpractice. The physician's defense was further compromised by the fact that the patient did not return to his office for almost a year. Had the physician scheduled more frequent follow-up visits, the development of new cysts may have been observed earlier and resulted in a more timely diagnosis. The physician also failed to document any attempts to reach out to the patient after the procedure was performed to remind the patient of the need to follow up as well as to ascertain the status of the "surgical site."

All the expert reviewers were highly critical of the physician's failure to send the tissue for further examination by a pathologist. The patient had no medical insurance and was reluctant to pay for this additional cost. However, as this case demonstrates, the consequences of letting the patient's financial concerns dictate the course of care can

oftentimes be disastrous. Here, the physician should have strongly recommended that pathological examination be performed and documented his discussion. If the patient still refused, then the physician should have documented an "informed refusal" by the patient, fully explaining the risks and consequences of failing to follow his recommendation. This discussion with the patient should have been thoroughly documented in the medical chart or, even better, the patient should have signed a form acknowledging he was aware of the risk but was choosing not to allow pathological examination. Had this been done, the physician would have been in a far better position to defend himself against a malpractice claim.

It is always risky when a physician permits patient financial concerns to dictate the standard of medical care he or she provides. In an era of high deductible insurance plans, or high co-payments, patients are understandably reluctant to absorb the added costs of visits, tests, or procedures unless they believe that such services are necessary to preserve their health. However, this reluctance, or outright refusal, should not sway the physician's recommendations for care. If

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Service Animals in Healthcare Settings: What You Need to Know

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The use of service animals by patients with disabilities is protected by the Americans with Disabilities Act (ADA)¹ and the state Civil Rights and Human Rights Laws.² Medical providers must be aware of not only the protections afforded to the use of service animals, but also the limitations on the use of such animals in healthcare settings.

If a patient with a disability is asked to remove a service animal from the office, or if the patient believes that he/she is the object of discrimination, the patient may file a complaint with the United States Department of Justice or the New York State Division for Human Rights. When physicians and staff are unaware of state and federal requirements, their actions can lead to the imposition of civil liability, as well as fines and penalties assessed by both state and federal agencies.³ Therefore, it is extremely important for providers to understand the rights of patients under these laws and regulations, and know exactly what they can and cannot ask the patient.

Under federal law, “places of public accommodation” are required to permit service animals to accompany people with disabilities in all areas where members of the public are allowed.⁴ A private medical office or facility is considered a

place of public accommodation subject to these requirements.^{5,6}

Effective March 15, 2011, except as discussed later in this article, only dogs are recognized as service animals.⁷ The most recent federal definition of a service animal is a “dog individually trained to perform work or tasks for an individual with a disability.”⁸ State law requires that the dog be trained by a recognized or professional trainer, and that the dog is actually used to perform tasks for a patient.⁹ Some examples of such tasks include: guiding blind persons; alerting a deaf person to danger; pulling a wheelchair; alerting and protecting a person having a seizure; reminding a mentally ill patient to take medication; and calming a patient with Post Traumatic Stress Disorder during an anxiety attack.¹⁰ Service animals are permitted in waiting rooms, private offices, patient rooms, clinics, and non-sterile examination rooms. Service animals may be excluded from operating rooms, burn units, and other such areas where the presence of an animal might compromise a sterile environment.¹¹

Within permissible areas, the service animal must be harnessed, leashed, or tethered, unless this interferes with its tasks or the person’s disability. In those limited instances, the dog’s owner must maintain control of the animal by using voice or other signals.¹²

When a patient comes to the office with a service animal, and it is not obvious what service it provides, staff may ask only two questions:

1. Is the dog a service animal required due to a disability?
2. What work or task(s) has the dog has been trained to perform?¹³

Staff cannot request medical documentation of the disability, ask what the patient’s disability is, or request documentation of the training the dog has completed. Allergies and fear of dogs are not sufficient reasons for denial of access, or refusal of service, to persons with disabilities. Instead, both the fearful/allergic person and the disabled person with the animal must be accommodated.¹⁴

Unfortunately, some individuals who are not disabled have purchased vests and tags online for their pets claiming that the dog is being used for emotional support. They may demand to have the dog accompany them in permissible areas. However, “dogs that are not trained to perform tasks that mitigate the effects of a disability, including dogs that are used purely for emotional support, are not

1. 42 U.S.C.A. § 12101 et. seq.
2. Civil Rights Law § 47 et. seq.; Executive Law § 292 (21).
3. Civil Rights Law § 47-c (2); 42 U.S.C.A. § 12188 (b)(2).
4. U.S. Department of Justice, Civil Rights Division. ADA 2010 Revised Requirements: Service Animals, p. 2. (2011). Accessed on August 18, 2015 at http://www.oysterpoint.com/Forms/ADA/ADA%20Revised%20ADA%20Requirements_%20Service%20Animals-8.16.2013.pdf.

5. 28 C.F.R. § 36.104.
6. Executive Law § 292 (9).
7. U.S. Department of Justice, Civil Rights Division. ADA 2010 Revised Requirements: Service Animals, *supra*, p. 1 (2011). State law defines a service dog as a dog that is properly harnessed and has been or is being trained by a qualified trainer. Civil Rights Law § 47-b (4).
8. U.S. Department of Justice, Civil Rights Division. ADA 2010 Revised Requirements: Service Animals, *supra*, p. 1 (2011).
9. Executive Law § 292 (33).
10. U.S. Department of Justice, Civil Rights Division. ADA 2010 Revised Requirements: Service Animals, *supra*, p. 1 (2011).
11. *Id.*, p.2.

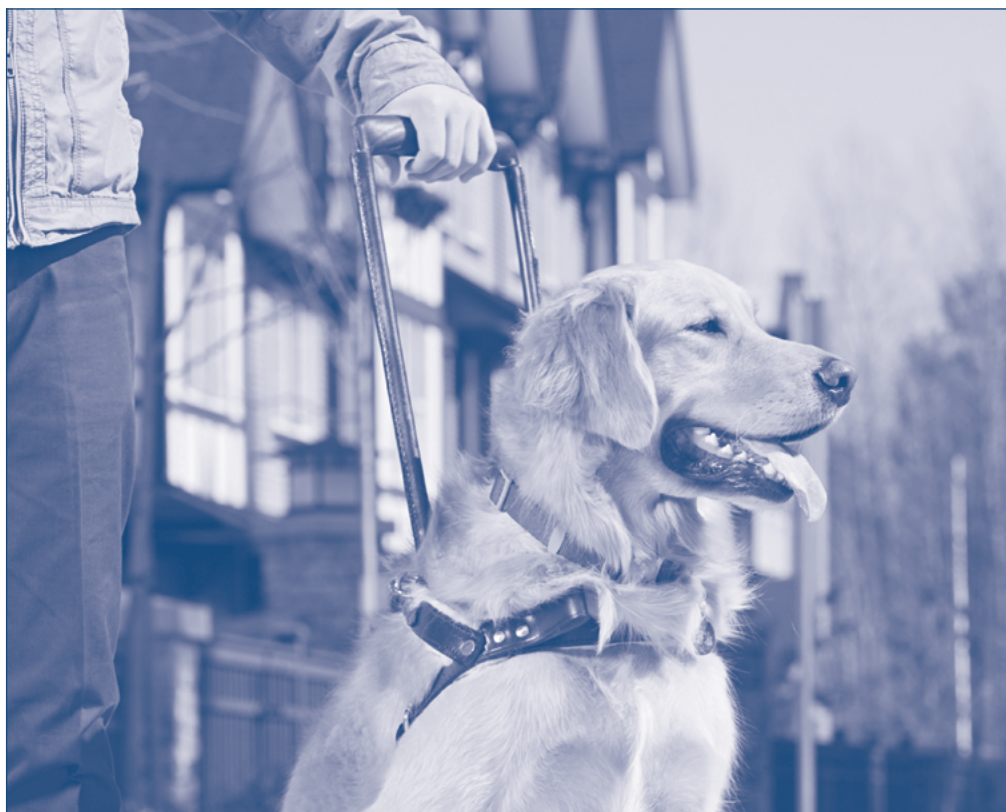
12. *Id.*, p.2.
13. *Id.*, p.2.
14. *Id.*, p.2.

service animals”¹⁵ and, therefore, do not need to be accommodated.

There are very few occasions where a service animal can be excluded from the premises. An animal cannot be excluded on the basis of speculation or stereotyping. However, the patient may be asked to remove the service animal if the animal is out of control and the handler does not act effectively to control it, or if the animal is not housebroken. In such situations, staff can request that the patient remove the dog from the premises, but must simultaneously offer to see and treat the patient without the dog present.¹⁶ Additionally, the patient is responsible for providing care and food for the animal, or making arrangements to do so.¹⁷

In 2009, the United States District Court, Oregon, found that the hospital appropriately prohibited a service dog from remaining with his owner because, on numerous admissions, the dog had a rancid odor which permeated the entire inpatient unit and posed a risk of infection. The owner refused to have the dog bathed. Further, there was no one available to care for and walk the dog when the owner’s spouse was not present on the unit. The dog, a large St. Bernard, often growled at the nursing staff and impeded access to the patient’s bedside. Thus, because the facility showed definite proof that the dog posed a direct threat and actual risk to staff and other patients, the court found that exclusion was justified. The patient was allowed to be admitted to the hospital only without her service animal.¹⁸

In a 2013 United States District Court case in the Northern District of



California, a patient with a disability who used a service dog for independence and mobility was admitted to a hospital psychiatric unit. She was denied the right to have her service dog accompany her. The Court found that the hospital violated the ADA due to its failure to prove that the dog represented a direct threat to the health and safety of others, or that the presence of the dog would fundamentally alter the nature of the facility, and that the patient suffered irreparable harm when the hospital refused to allow the dog to accompany her.¹⁹

In 2011, a patient with a service animal charged a Florida physician with violation of the ADA.²⁰ The patient complained that he was denied access to medical services solely because he was accompanied by his service animal. An investigation by the Department

of Justice revealed that the physician’s staff had inappropriately questioned the patient, objected to the dog’s presence in the waiting room, and demanded written documentation of training and certification. After the charges against the physician were substantiated, he entered a settlement agreement with the U.S. Department of Justice. The key provisions of the signed consent order included:

1. modification of the physician’s office policy to allow patients with service animals access to care;
2. adoption of a written office policy about patients with service animals which complied with the ADA;
3. provision of a copy of this policy to and training of all employees, staff, and contractors;
4. posting a notice of welcome in his office to patients with service animals; and
5. developing a policy to handle complaints involving service animals.

15. U.S. Department of Justice, Civil Rights Division. Fact Sheet: Highlights of the Final Rule to Amend the Department of Justice’s Regulation Implementing Title II of the ADA. Accessed on August 18, 2015 at http://www.ada.gov/regs2010/factsheets/title2_factsheet.html.

16. U.S. Department of Justice, Civil Rights Division. ADA 2010 Revised Requirements: Service Animals, *supra*, p. 2 (2011).

17. *Id.*, p. 2.

18. *Roe v Providence Health System*, 655 F. Supp. 2d 1164, (D. Oregon, 2009).

19. *Tamara v. El Camino Hosp., et. al.*, 964 F. Supp. 2d 1077 (N.D. California, 2013).

20. Settlement Agreement, *United States of America v. Berenson*, Complaint USAO No: 2011-VO-0468/DJ No. 202-18-267, August 1, 2012, pp. 2 – 9. Accessed on August 18, 2015 at http://www.ada.gov/berenson_settle.htm.

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MLMIC's Claims Free Discount Survey Results

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In an effort to determine and define the traits that contribute to a favorable claims history for its insured physicians, MLMIC's Patient Safety & Education Committee asked the Risk Management Department to develop an optional online survey. The survey, which was e-mailed to insured physicians in January 2015, was also available on each physician's "My Account Profile" page at MLMIC.com. The survey focused on two physician groups: those policyholders who currently receive MLMIC's claims free discount ("claims free physicians") and those policyholders without the discount ("claims experience physicians"). The goal of the survey was to identify the factors physicians believed help them to prevent claims and lawsuits, and those that they believed contributed to their claims history. This article will address the survey process and the findings.

Approximately 14,500 surveys were sent to MLMIC-insured physicians: 7,189 were sent to the claims free physicians and 7,318 were sent to the claims experience physicians. We had an overall response rate of 15.7%. The claims free physicians had a 16.1% response rate and the claims experience physicians response rate was 15.3%. All responses to the survey were recorded anonymously.

The survey consisted of six questions. The first three were practice-specific. Physicians were asked to identify their specialty, whether they have direct patient contact, and whether they practice in a solo or group practice setting. The top four specialties that responded to the claims free survey were Internal Medicine (299), Family Practice (168), Ophthalmology (90) and Pediatrics (71 respondents). In the claims experience group, the top four specialties identified

were Internal Medicine (281) and Family Practice (120), followed by Obstetrics/Gynecology (113) and Ophthalmology (77 respondents). Both groups reported the same amount of direct patient contact (97%). Additionally, more claims free physicians worked in a solo practice (52%) than in a group practice (48%), where in the claims experience group, more physicians worked in a group practice (59%) than in a solo practice (41%). A number of physicians commented that they were named in a claim due to their group practice setting.

We then asked physicians in both categories to indicate whether they had ever experienced an adverse outcome in their practice that could have led to a malpractice claim but did not. Approximately 35% of the physicians in each group responded "Yes," that they had had such an experience. They were then asked to indicate the factors they believed helped prevent a lawsuit. Whether the respondent was presently receiving the claims free discount or not, the top three responses selected were the same:

- Care and treatment were appropriate following the adverse outcome (75%).
- A good relationship had been established prior to the adverse outcome (70%).
- A relationship was maintained with the patient/family after an adverse outcome (65%).

It is clear from the selected responses that a significant number of physicians believe that developing a good relationship with patients at the outset, and maintaining that relationship after an adverse outcome, are imperative to

reducing the likelihood of a claim following an adverse outcome.

The focus of the questions then turned to the factors physicians believed contributed to their claims free or claims experience status. The claims free physicians selected the following as the top three factors that they feel contributed to their favorable claims history:

- Perceived by their patients as caring and someone they can trust (87%).
- Spend sufficient time with patients during their visits (82%).
- Do not practice beyond their capabilities (74%).

Additionally, over two hundred claims free physicians offered commentary on what other factors contributed to their claims free history. The common themes identified in their responses include:

- Proactive risk management practice principles—including, but not limited to, competence and experience, good communication, thorough documentation and follow up, and accessibility to their patients.
- The need to develop relationships—with patients, their families, other providers and specialists.
- Education for their patients—the claims free physicians recognized the role education plays in keeping their patients healthy and compliant with treatment plans.

When physicians with a claims experience were asked to select from a list of factors that contributed to that experience, the highest response was "other" (46%), followed by:

- I provided appropriate care and treatment: it's the legal system (33%);
- Patient population in my area is probably more litigious than other parts of the state (23%).

The physicians that responded “other” made some interesting comments. Common themes include:

- We live in a litigious society: Family or the estate sues—my patient would not have sued me.
- The medical malpractice system is flawed.
- Advertising by medical malpractice lawyers leads to more suits.
- The physician was named in a case as part of a group.
- The physician was named in the case but later dropped.

Additional comments offered by the claims experience physicians suggest that they feel their patient population impacts their claims history. Specifically, patients who do not follow advice, have unrealistic expectations, or are part of a high risk patient population tend to file claims more frequently than other patients. While these factors do impact the incidence of claims, the comments of physicians in the claims free category indicate that strong relationships with patients, maintaining good communication, and providing education to patients so that they understand their treatment plan may mitigate the risks of claims and suits.

Although the two groups had some specific reasons to explain their individual claims history, there were more commonalities than differences:



- Good physician-patient communication is as important as communication among the physicians in preventing claims.
- Physicians who maintain their competency and practice within their limits avoid liability.
- Physicians practicing in high risk specialties and seeing high risk patients are more likely to be involved in a claim.

However, the respondents in both categories clearly identified that establishing a strong relationship with the patient at the outset, and maintaining that relationship after an untoward event, were crucial to avoiding a malpractice claim, regardless of the physician's practice setting. Providing each patient an appropriate amount of time to address their needs, and practicing within one's capabilities, also were significant factors identified by physicians who receive the claims free discount.

Finally, it has become the norm for a patient to be seen by more than one physician to manage a myriad of health issues. While primary care providers

manage and coordinate care, they do not do so independently. Specialists all play a role in the delivery of care to the individual. The unfortunate reality is that with more contributors to the patient's care, there are more names to add to a claim after an untoward event. In fact, more than twenty physicians in the claims experience category stated that they were pulled into a case in which they felt they were not directly in charge of the patient. It is clear that even if a physician sees a patient only once, his/her expertise was considered necessary to the patient's care and, accordingly, that physician will be held accountable for the patient's outcome. Physicians of all specialties, including the radiologists and pathologists who do not normally have direct patient contact, must be vigilant about their accountability to the patient. However, as indicated in the survey responses, strong documentation, patient education, effective communication with patients, and coordination of care among specialties are the best risk management strategies to mitigate the risks of claims and suits. ❖

Case Study

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the patient chooses not to undergo recommended treatment, then the physician must document an informed refusal. If the physician is highly uncomfortable with the patient's choice, the physician has the option of withdrawing from the professional relationship, as long as the withdrawal occurs in a thoughtful manner to avoid allegations of patient abandonment.

Finally, this case is a good example of how certain factors can influence a high damage award to a plaintiff. Damages are calculated to compensate the injured person, or his or her heirs, for the injuries caused by malpractice. There are

two types of damages. *Economic damages*, which are concrete and quantifiable, include such losses as medical bills, lost employment compensation (wages, profits), loss of potential earning capacity, the cost of obtaining replacement services that were previously performed by the injured party, and the cost of any other out-of-pocket expenses related to the injury. The amount of economic damages is based, in part, on the nature of the injury, and the patient's age, gender, work status, and earnings history. In addition, *non-economic damages*, which are more difficult to calculate, may be awarded.

Non-economic damages are designed to compensate for pain, suffering and loss of quality of life. The geographic location of the trial plays a part in the value of a case, as well as whether the defendant, as well as the defendant's witnesses, will make a good impression on the jury.

Here, the patient was 47 years old and in the prime of his working career. He was the owner of a business and the sole support of his family. For that reason, there were significant economic losses in this case. Non-economic damages were also high due to the many months of pain and suffering the patient experienced before his death. ❖

RISK MANAGEMENT Tip

Tip #18 – How to Properly Discharge a Patient

Discharge of a patient from care can be complex. Below are some guidelines to properly discharge a patient.

1. Discharge should be stated to be effective as of the date of the letter.
2. You may use one of the three most common reasons why physicians discharge patients:
 - a. Nonpayment
 - b. Noncompliance
 - c. A disruption in the physician-patient relationship
3. Become knowledgeable about the requirements regarding any restrictions on discharge imposed by the third party payors with whom you participate.
4. Discharge of each patient must be determined by the physician on an individual basis and based on reasonable documentation in the medical record. We recommend that you contact Fager Amsler & Keller, LLP for specific advice.
5. You must give the patient at least 30 days from the date of the letter to call you for an emergency in order to avoid charges of abandonment. This time period could be longer depending on the patient's condition and the availability of alternative care.
6. Refer the patient to the County Medical Society or a hospital referral source to obtain the names of other physicians.
7. When the patient to be discharged is in need of urgent or emergent care, continuous care without gap, is more than 24 weeks pregnant, or has a disability protected by state and federal discrimination laws, the question of whether the patient can be discharged should be discussed with counsel, since discharge may not always be possible.
8. Documentation of problems which have led to discharge is a must.
9. Use the USPS certificate of mailing procedure, not certified mail, to send the discharge letter so it will not be refused/unclaimed and will be forwarded if the patient has moved.
10. Flag the office computer or other appointment system to avoid giving the patient a new appointment after discharge.
11. Provide the patient with prescriptions for an adequate supply of medication or other treatment during the discharge period.
12. Promptly send the patient's records to the patient's new physician upon receipt of a proper authorization.
13. Form letters and a memorandum on the discharge of patients are available from Fager Amsler & Keller, LLP. ❖

The Risks of Physician Shadowing

This article originally appeared in the MLMIC.com blog on July 8, 2015.

A recent news report indicated that a physician at a New York hospital allowed a college student to insert a tube down an anesthetized patient's throat to help the patient breathe, even though the student had no training to perform the procedure. The student, who was considering going to medical school, was "shadowing" the physician. An operating room employee reported the incident to management, but the hospital did nothing about it until state inspectors showed up to investigate a complaint about the event on behalf of the federal Centers for Medicare and Medicaid Services. Inspectors categorized the incident as "immediate jeopardy," the most serious type of deficiency that can cause serious injury or death to patients.

Therefore, when responding to a request to allow a high school or college student shadow you at an office or facility, consider the following:

- High school and college students may not understand state and federal patient privacy laws, and there is an increased risk that they will share their experiences with friends and family, as well as in college and on job applications. You must ensure HIPAA compliance for any person who is permitted to access patient health information.
- You must be fully aware of the student's medical history/status, including his/her vaccination record.



- Patients must understand and agree to have an unlicensed individual in the room during their encounter with you, and their consent should be clearly documented in the patient's medical record.
- There are liability risks associated with allowing untrained, unlicensed persons to assist in patient care. The "shadowed" physician would likely be held responsible for any injury caused by a student. Likewise, you cannot allow an unlicensed, untrained person to perform tasks that require a license. Improper delegation of tasks may subject the supervising physician to action by the Office of Professional Medical Conduct (OPMC).
- In addition to the potential harm to patients, students and other unlicensed persons are also at risk for personal injury when using equipment that is unfamiliar to them.

Considering the above risks, it is recommended that physicians should only permit individuals such as medical, physician assistant or nursing students in an established training program to "shadow" them. These programs should provide documentation of adequate liability insurance for their students. The programs must also delineate in writing those specific tasks which the students have been credentialed to perform. They may perform those credentialed tasks only if the patient's consent has previously been obtained. ❖



REMINDER:

When discontinuing a patient's medication which has renewals remaining, contact the pharmacy to also discontinue the medication or the patient may continue to obtain the medication for several months.

MLMIC's Physicians' & Surgeons' Claims Free Discount

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Assistant Vice President, Underwriting
Medical Liability Mutual Insurance Company*

As many of our physician Insureds may already be aware, the New York State Insurance Department (which has been succeeded by the New York State Department of Financial Services) has approved MLMIC's Claims Free Discount Program for physicians and surgeons. The origin of this discount stems from a culmination of prior studies conducted by the company's actuaries that show that past favorable claims experience is strongly indicative of what can be expected in the future. Consequently, MLMIC has applied the findings of this analysis to benefit its policyholders by affording a reduction in premium to those policyholders who have been and remain "claims free." The program provides qualified physicians who are insured under MLMIC's Physicians & Surgeons Professional Liability Insurance Policy (commonly referred to as the "PSE" form) with a 7.5% discount applicable to their annual premiums.

To qualify for the claims free discount (CFD), a physician must:

- have been in practice (following completion of his/her formal training) for a minimum of five years; AND
- have no open claims (or suits) and no closed claims (or suits) with any paid indemnity or expense within the past 5 years, regardless of the accident date or report date.

Some important items to note:

The CFD is automatically applied to the renewal premiums of eligible current physician policyholders who meet the qualifications referenced above, and who have completed their specialty renewal application within the past 2 years (updating any previous carrier's loss experience).

New applicants seeking the CFD must complete and submit an application, as well as provide loss histories that demonstrate eligibility as previously indicated.

The CFD can be combined with the following discounts: Voluntary Attending Physician (VAP), Part-Time, and/or Risk Management. The CFD may not be combined with any other discount, e.g., the new doctor discount.

Reporting an incident will not disqualify a physician insured from receiving the CFD. Such action is encouraged (when warranted) and would be considered an event (not a claim) by MLMIC.

Reporting a "defense only" claim against the optional Defense Costs Coverage ("defense only coverage") will not impact the CFD as it is not professional liability coverage, but rather a separate optional coverage available to our physician Insureds.

The Claims Free Discount is yet another example of MLMIC's continued efforts to ease the burden of professional liability insurance costs for its Insureds, while ensuring the company's long term viability. MLMIC is a respected voice in the State legislature and advocates on behalf of its policyholders on liability insurance and tort reform matters. MLMIC is endorsed by and works closely with the State medical, dental, and hospital associations on insurance and legislative issues.

For additional information on MLMIC's new Claims Free Discount, please contact an underwriter at the office nearest your practice location.

Changes to your Mode of Practice; The Importance of Updating Your Policy with the Company

Given the frenetic pace in today's healthcare environment, practice settings are often faced with change. From minor issues such as a new email address to changes in employment relationships, office locations, and/or legal structures, these events generate the need for Insureds to remain in communication with the Company in order to keep their files and coverage up to date.

As many of our readers may recall, the Company sends application updates to our physician Insureds on a biennial basis. However, as various changes are bound to occur in the interim, it is essential that Insureds communicate them to the Company in a timely manner. One area that practitioners may overlook is a change to their work within their own specialty, such as going from our Internal Medicine including cardiac catheterization classification to that of excluding it, or occasional work as an emergency room physician which would facilitate the need for the Insured to notify his or her Underwriter, in writing, for an endorsement to their policy. Status changes of Insureds who may go from Full Time to Part Time, or vice versa, also warrant a call to their assigned Underwriter to ensure proper coverage, as well as application of any applicable discounts.

Company communications are distributed to our insureds via email in an effort to deliver timely notification when important issues arise. Hardcopy documents of policy related matters are mailed as well, though not received as efficiently as electronic communica-

tion. Consequently, the importance of promptly providing us with notification of any changes to email addresses to ensure uninterrupted communications cannot be stressed enough. Appreciating the fact that companies often inundate email recipients with a barrage of messages, your Company limits use of this medium to only the most important matters.

For the convenience of our insureds, changes to both email addresses and telephone numbers can easily be made by simply logging in to their account on our website MLMIC.com and selecting "Update Profile." For those Insureds that haven't already established an account username and password, one can easily be created by selecting "First time user?" under the

"Member Login" screen after answering a few brief questions.

Equally as important are updates to physical address changes and the distinction between them, i.e. mailing, billing, and principal office. Should Insureds be faced with any such changes, they should contact their assigned Underwriter and request an address verification letter for completion which will enable these updates to be entered in our system.

Another area of importance centers around the issue of Separate Limit Professional Entity Liability Coverage which was first made available to eligible entities in July, 2006 (for additional information, refer to the Underwriting Update in the Fall 2012 edition of *Dateline* by logging in to your account and selecting "Publications"). Whether

you have formed a new professional entity or added/deleted members/employees to your existing one, notification of such changes should be made to the Company to ensure applicable coverage. This is especially true if you have purchased the referenced professional entity coverage for your practice. Such policies require that all members and employees (physician and extenders) be scheduled on the respective professional entity's Physicians & Surgeons Professional Liability Insurance Policy (PSE). Accordingly, premium adjustments will apply for any such changes.

If you have any questions concerning the topics discussed in this article, please feel free to contact an Underwriter in the regional office nearest you. ❖

Service Animals in Healthcare Settings continued from page 5

Miniature Horses

Some patients with disabilities may prefer to use a miniature horse, particularly to pull a wheelchair. The 2010 revision of the ADA regulations includes a new, separate provision for miniature horses. A miniature horse is generally 24 to 34 inches tall and weighs between 70 and 100 pounds.²¹ This animal must have been trained to perform tasks for disabled patients. The new regulations set out four assessment factors designed to assist a place of public accommodation in determining whether or not a miniature horse can accompany a patient.

1. The horse must be housebroken.
2. The horse must be under the patient's control.

3. The facility must be able to accommodate the horse's type, size, and weight.
4. The facility must determine whether the presence of the horse will compromise legitimate safety requirements of the facility.²²

In some situations, a service horse may be excluded. If a patient who uses a service horse to pull his wheelchair enters the waiting room of a provider and the horse then breaks loose from its harness and runs around, frightening other patients and staff, or leaves excrement on the floor, the service horse may be determined to be a direct threat to the health and safety of other patients and excluded from the facility, since the horse is not under the control

of the patient or is not housebroken. Alternative reasonable accommodations must then be offered to the patient so he/she can continue treatment with the provider without facing discrimination.

In summary, you and your staff must be prepared when a patient with a disability is accompanied by a service animal to your office or facility. You should develop and comply with an office policy which meets the requirements of the ADA and state Civil Rights Laws with respect to service animals. Staff must then be trained and reeducated annually about what they can and cannot do when a patient comes to your office with a service animal. If you have any questions about this issue, please call Fager Amsler & Keller, LLP at 877-426-9555. ❖

21. U.S. Department of Justice, Civil Rights Division. ADA 2010 Revised Requirements: Service Animals, *supra*, p. 2 (2011).

22. *Id.*, p.2.

Update Your Physician Profile!

Since 2000, Public Health Law § 2995-a has provided for the collection of certain information on licensed physicians to create individual physician profiles which are available to members of the public. The New York State Physician Profile website can be found at <http://www.nydoctorprofile.com/>.

Recent revisions to PHL § 2995-a(4)

now require that in addition to reporting verdicts, settlements, or other specified occurrences, each physician must update his/her profile information within six months prior to the expiration date of the physician's registration period. Updating one's profile is required as a condition of registration renewal. As part of its professional misconduct investiga-

tions, the New York State Department of Health Office of Professional Misconduct (OPMC) is asking whether physicians have updated their profiles on the Physician Profile website. Failure to do so can result in a separate charge of professional misconduct pursuant to Education Law § 6530.

The Proper Use and Supervision of Certified Registered Nurse Anesthetists

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Many healthcare facilities and practices utilize certified registered nurse anesthetists (CRNAs) to administer anesthesia to patients. While these professionals may be highly competent in their area of expertise, physicians must be aware of the restrictions on a CRNA's scope of practice.

A CRNA is a licensed registered nurse who has completed additional training in anesthesia in an accredited program and is certified by a national organization to give anesthesia to patients. A CRNA is authorized under regulations to administer anesthesia as part of a medical regimen. Despite national certification, CRNAs are considered to be registered nurses in New York.¹ Therefore, they can only execute medical regimens under the supervision of a physician. As long as they are properly credentialed by a health care facility, CRNAs are permitted to perform a variety of functions under the supervision of a physician, such as:

- perform diagnostic spinal taps;

- place an endoscope in the esophagus and advance it while the surgeon directly visualizes the scope, and manipulate the scope from below to ensure it is in the right place;
- insert bronchoscopes to observe placement of double lumen endotracheal tubes;
- insert a "Bougie" device for bariatric procedures; and
- insert an epidural catheter for pain control in the labor and delivery area of an Article 28 facility.²

A CRNA does not have the authority to independently prescribe.³ He or she may

suggest to an authorized prescriber medications and related doses for a specific patient. He or she cannot write medical orders.

The regulations of the New York State Department of Health governing the administration of anesthesia within a hospital address the role of CRNAs. These regulations permit the governing body to grant privileges to administer anesthetics to:

*"certified registered nurse anesthetists (CRNAs) under the supervision of an anesthesiologist who is immediately available as needed or under the supervision of the operating physician who has been found qualified by the governing body and the medical staff to supervise the administration of anesthetics and who has accepted responsibility for the supervision of the CRNA..."*⁴

Therefore, a CRNA must be supervised either by an anesthesiologist who is

1. Education Law § 6901(1).

2. Email opinion from Barbara Zittel, RN, Ph.D., Executive Secretary, NYS Board for Nursing to Fager & Amsler, LLP, dated May 20, 2010; Email opinion from Laureen O'Brien, MS, RN, Nursing Associate to the Executive Secretary of the NYS Board for Nursing, to Fager & Amsler, LLP, dated August 3, 2009; Email opinion from Barbara Zittel to Fager & Amsler, LLP dated July 28, 2011.

3. Opinion letter from Barbara Zittel, RN, Ph.D., to Fager & Amsler, LLP dated September 9, 2004.

4. 10 NYCRR § 405.13.

“immediately available,” or by an “operating physician” who is specifically credentialed and who has accepted responsibility to supervise the CRNA. There is no authority for CRNAs to be supervised by non-physician practitioners such as podiatrists or dentists.

This regulation dates back to 1989. That year, then Commissioner of Health, David Axelrod, MD, issued a “Dear Administrator” letter to explain the new regulation relating to the supervision of CRNAs within a hospital, particularly the circumstances where an operating physician supervises anesthesia care by a CRNA.

“We do not require that supervisory physicians be able to perform the specific activities they supervise. ... The regulation does require an operating physician to accept responsibility for the supervision of CRNAs when there is no anesthesiologist supervision. In our opinion, this requirement does not affect the respective legal liabilities of the operating physicians and CRNAs...”

... The regulation is not intended to change existing precedent and case law with regard to the division of responsibility between operating physicians and CRNAs. The regulation is not intended to create “strict liability” for operating physicians. The sole purpose of the regulation is to assure that operating physicians who act in a supervisory capacity have been found qualified to do so by the hospital and understand their responsibility for supervision of CRNAs.”

The New York State Society of Anesthesiologists issued a memorandum at or about the time the regulation was enacted discussing at length the distinction between the “medical direction” standard for anesthesiologists with regard



to CRNA practice versus the “supervision” standard applicable to operating surgeons.⁶ The memorandum stated that anesthesiologists who medically direct CRNAs will be held to a higher standard of care than an operating surgeon supervising a CRNA.⁷ An anesthesiologist is required to be “immediately available” when supervising a CRNA, which is generally interpreted as being physically present within the hospital, and preferably within the operating suite. The anesthesiologist must remain physically available for the immediate diagnosis and treatment of emergencies. Specific duties are imposed upon the anesthesiologist throughout the anesthesia care process.⁸

On the other hand, a surgeon’s liability for injuries resulting from the wrongful administration of an anesthetic is more limited. The surgeon does not have the recognized technical expertise of CRNAs in administering anesthesia, nor does the surgeon have expertise in the use of specific anesthetics to correct the harmful effects of other anesthetics. Further, Department regulations do not require a surgeon to attend to a patient during emergence from anesthesia, although an anesthesiologist must be present.⁹ Therefore, the duties imposed upon an operating physician are less, and his or her potential liability is not as broad. The operating physician, however, would still be liable for his or her own negligence in an anesthesia-related injury.¹⁰ ♦

5. Letter from David Axelrod, M.D., Commissioner of Health, dated February 1, 1989.

6. Any operating physician may supervise a CRNA, pursuant to 10 NYCRR § 405.13, not just a surgeon.

7. Memorandum, New York State Society of Anesthesiologists, undated, p.3

8. *Id.*, p 5-6.

9. 10 NYCRR § 405.13(b)(2)(iii)(b).

10. *Id.*, p. 4.

New Regulations Impacting Visually Impaired Hospital Patients

Recent amendments to the New York State Public Health Law which impact the admission and the discharge of a blind or visually impaired patient from a hospital are now effective.

A hospital must offer to provide the patient with a large print copy of the discharge plan. If the patient or the patient's legal representative instead requests an audio recording, the hospital must provide the plan on a CD or other such medium. The plan may also be provided in an electronic digital file in addition to a written copy. PHL 2803-i(9).

Pre-admission information must now be offered to a visually impaired or blind patient in the same manner described for discharge plans. PHL 2803-t. ❖

2015 Event Calendar

MLMIC representatives will be in attendance at the following events:

OCTOBER 2015

- 7 29th Annual NYS County & Specialty Medical Society Executives Conference (*Canandaigua*)
- 16-17 MSSNY Third and Fourth District Fall Retreat (*Hunter, NY*)
- 18 Bronx County Medical Society Annual Gala & Physician Expo (*Throgs Neck, NY*)
- 23 JTM Foundation One Enchanted Evening (*Hauppauge, NY*)
- 23-24 ACOG District II Annual Meeting (*Manhattan*)
- 24 Medical Society of the County of Queens Masked Ball & Physician Expo (*Flushing, NY*)

NOVEMBER 2015

- 7 Medical Society of the County of Kings President's Dinner Dance (*Brooklyn, NY*)
- 20 Northstar Network's Cracking the Code on Healthcare (*Pittsford, NY*)

DECEMBER 2015

- 12-14 NYSSA's PostGraduate Assembly (PGA) in Anesthesiology (*Manhattan*)

JANUARY 2016

- 21-24 New York State Academy of Family Physician's Winter Weekend (*Lake Placid, NY*)

For more information on MLMIC's participation at these events and others, please contact Pastor Jorge, Advertising/Marketing Administrator, at 212-576-9680.

The MLMIC Library – Fall 2015 Update

The MLMIC Library's services are available to all policyholders on a complimentary basis and may be accessed via MLMIC.com under the Risk Management tab. Books and DVDs are regularly reviewed to provide up-to-date answers and guidance for your risk management and patient safety questions. In-depth research services are also available to all policyholders.

The following resources are newly acquired and/or pertain to topics featured in this issue of *Dateline*. Visit the MLMIC Library to learn more about these titles and borrow up to five items from our extensive collection. Or, contact Judi Kroft, Library Services Administrator at 800-635-0666, ext. 2786 or via e-mail at jkroft@mlmic.com.

- **AMDA 2015 - The Society for Post-Acute and Long-Term Medicine Annual Conference: Quality on Track in Long-Term Care.** AMDA. The Society for Post-Acute and Long-Term Care Medicine; 2015 (LTC 104-136 2015).
- **Core privileges - a practical approach to developing and implementing criteria-based privileges.** Sally Pelletier. HCPro; 2014 (Med Staff 113-086 2014).
- **Core privileges for AHPs: Develop and implement criteria-based privileging for nonphysician practitioners.** Sally Pelletier. HCPro; 2015 (Med Staff 113-093 2015).
- **Digital doctor: Hope, hype, and harm at the dawn of medicine's computer age.** Robert Wachter. American Society of Healthcare Risk Management; 2015 (QA CQI 148-124).
- **Guidelines for perioperative practice.** Association of Operating Room Nurses, Inc.; 2015 (Surgery 167-003 2015).
- **Health care credentialing: A guide to innovative practices.** Fay A. Rozovsky. Aspen Publishers, Inc.; 2015 (Med Staff 113-085).
- **HIPAA privacy - compliance scenarios.** Coastal DuPont; 2010 (DVD 002-456 2010).
- **HIPAA rules & compliance.** DuPont Sustainable Solutions; 2013 (DVD 002-611 2013).
- **Risk management in healthcare institutions: Limiting liability and enhancing care.** Florence Kavalier and Raymond S. Alexander. Jones & Bartlett Learning; 2014 (R M 151-143).
- **Tools for an efficient medical practice: Forms, templates, and checklists.** Kathryn I. Moghadas. American Medical Association; 2009 (Phys 539-066).
- **The top 15 policies and procedures to reduce liability for physician practices.** James W. Saxton, Esq. HCPro, Inc.; 2005 (Phys 539-042).

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Fager Amsler & Keller's attorneys 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.

Healthcare law, regulations, and practices are continually evolving. The information presented in Dateline is accurate when published. Before relying upon the content of a Dateline article, you should always verify that it reflects the most up-to-date information available.



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How Costs Impact Medical Care continued from page 1

and co-payments for tests and appointments with specialists with their patients. The physician does not always have to conduct the discussion with the patient, particularly if he/she is not comfortable with or lacks specific knowledge about costs. Instead, the physician's billing or financial staff could accomplish this. Further, physicians and their staffs should become aware of, and educate patients concerning, available programs which might assist with certain costs, such as pharmaceutical company programs which subsidize certain medications. In addition, agencies such as the County Departments of Social Services may be familiar with other resources which might assist patients with certain medical costs.

Unfortunately, failure to seek care because of financial concerns often leads to bad outcomes for patients. When this occurs, the best defense is a well-documented medical record, including documented attempts to provide follow up to a noncompliant patient. We recommend

aggressive follow up with noncompliant patients. First, the physician's staff should make at least one or two attempts to call the patient. If the patient does not respond to telephone calls or messages, the physician should send the patient a letter reiterating the risks of noncompliance and the reasons why compliance is strongly recommended.

The patient must be informed in plain English about the risk of refusal, the ramifications of the refusal, and alternatives to the recommended care, if any exist. It is crucial to have a discussion about costs when recommending necessary preventive tests, and also crucial to document at each visit that a test was offered and declined. Further, a tickler system must be in place so that if the patient fails to undergo the test or see a specialist, for whatever reason, the fact that a report has not been received within a reasonable time is identified and documented in the patient's medical record.

At some point, if the patient's non-compliance continues, the physician may no longer be comfortable continuing to see the patient in the practice. When that occurs, the physician must decide whether to discharge the patient. However, before making a decision to discharge a patient, the physician must assess whether the patient requires urgent or emergency care, requires certain medications, or has a condition requiring continuous care without a gap. If so, the physician must make arrangements for the patient to be seen by another provider so there is no gap in care. In certain situations, however, the physician might not be able to discharge the patient.

For any questions about the discharge process, we recommend that you read the Risk Management Tip on page 8 or contact Fager Amsler & Keller, LLP for assistance. Sample discharge letters and an informative memorandum are also available. ❖