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MLMIC Honored with Old Ironsides Flag

Gerald F. Danaher, DDS, Past President of the Onondaga County Dental Society, recently presented Robert A. Menotti, MD, President of Medical Liability Mutual Insurance Company (MLMIC), with a United States flag. This flag flew over the USS Constitution, affectionately referred to as "Old Ironsides," which was launched in 1797 and is the oldest continuously active ship in the US Navy.

The flag was presented at the MLMIC regional office in Syracuse, New York. Dr. Danaher thanked Dr. Menotti and MLMIC for its continuous service and dedication in representing dentists throughout Onondaga County and New York State. Dr. Danaher referred to the skilled, professional work by MLMIC staff in joint effort with the Society in order to provide the best liability protection available at the lowest possible premiums consistent with fiscal responsibility. Dr. Menotti conveyed his appreciation and thanks on behalf of the Company and its staff. He stated



that MLMIC was honored by Dr. Danaher's thoughtful gift and noted Dr. Danaher's view echoes our belief that MLMIC provides a superior level of personalized service.

Dr. Danaher, a Captain in the US Naval Reserve, obtained the flag and ship's coin on a recent visit to the USS Constitution, which is anchored in Boston harbor. The flag and mementos of the presentation will be placed in a prominent location in MLMIC's Syracuse office. ❖

Physician Office Practice Surveys: Findings and Recommendations – Part I

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Introduction

As part of the ongoing Risk Management activities performed by Medical Liability Mutual Insurance Company (MLMIC), 43 medical office practice surveys were conducted over the past two years. The offices surveyed included numerous primary care, surgical, and specialty practices. The surveys focused on

several areas, including: general office appearance; personnel; office protocols; billing/collection practices; medication control; appointment scheduling; dismissal of patients from care; medical records; telephone coverage;

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Case Study

The Problems with Settling a Disastrous Case with Self Insured Co-Defendants

Kathleen L. Harth

Regional Claims Manager

Medical Liability Mutual Insurance Company

A 29-year-old female had a positive pregnancy test in February 2006. She was seen by her obstetrician one month later for blood work, a PAP smear, and confirmation of her estimated due date, or “EDC,” which was September 16, 2006. The next day, she went to the emergency department (ED) of Hospital 1 complaining of fever and spotting, for which she was evaluated and discharged without any definitive treatment or workup. She subsequently went to Hospital 2 four days later, still complaining of a fever. She was diagnosed with a viral syndrome and discharged. The next day, she returned to her obstetrician, who also diagnosed a viral syndrome and prescribed Zithromax.

The following day, the patient was admitted to Hospital 2. She was seen by an infectious disease consultant, who recommended TORCH studies. Although her amniotic fluid levels were within normal limits, her obstetrician suspected that her membranes had ruptured, resulting in chorioamnionitis. Because of this concern, the physician discussed with the patient the possibility of terminating the pregnancy, but she declined. The physician prescribed broad spectrum antibiotics and, when the TORCH studies were negative, the patient was discharged.

While the patient was hospitalized, the report of the PAP smear performed at the patient’s initial obstetrical visit was received by the obstetrician and was “suggestive of herpes.” She was advised of this result at her next obstetrical visit in April. However, she and her husband denied having any

herpetic lesions. As a result of this response, the physician took no further action. The pregnancy continued to progress normally. At her last prenatal visit with this obstetrician in June, her examination was within normal limits. Subsequently, the patient requested her prenatal records be transferred to another obstetrical practice.

The patient was seen by her new obstetrician in July 2006, when she was at 30 weeks gestation. There was a positive fetal heart rate. Her new physician sent blood to the laboratory for TORCH titers and other tests. Two weeks later, the patient was admitted to Hospital 2 complaining of vaginal spotting and decreased fetal movement. She was admitted by her new obstetrician, monitored for several days, and then discharged. Five days later, she experienced leakage of amniotic fluid and, by the next morning, was in active labor. The patient was readmitted to Hospital 2. The obstetrician did not document in her labor record for twelve (12) hours. Fortunately, the nurses’ notes documented each time her physicians examined her, when they augmented her labor with Pitocin, and when they ordered that an epidural be administered. That night, the patient had a normal spontaneous vaginal delivery of a female infant with Apgars of 9/9. Specimens sent to pathology confirmed the presence of the herpes virus in the umbilical cord and focally necrotizing chorioamnionitis. Whether these results were communicated by telephone to any of the physicians is unclear.

On day three of life, the newborn

developed a rash. She was evaluated by a neonatologist, who suspected either herpes or a staphylococcus infection. He prescribed a course of IV Acyclovir for 14 days. Despite this treatment, the rash remained. The infant was discharged ten days later on oral Acyclovir. When she was taken to her pediatricians for follow-up after her discharge, they documented their concern that the infant had “failed to thrive” and promptly readmitted her to rule out herpes encephalitis. She was placed in a warmer, a lumbar puncture was performed, and an IV started. Her cerebral spinal fluid was negative after 48 hours. While there, she developed a urinary tract infection and was placed on additional antibiotic therapy.

Although she was clinically stable, the laboratory advised the pediatrician that, due to an insufficient specimen, the polymerase chain reaction (PCR) test on the spinal fluid from the lumbar puncture had not been performed. However, despite this communication, the pediatrician did not perform a repeat lumbar puncture until the infant suffered seizures. This spinal fluid was sent to the laboratory for a herpes culture and sensitivity and PCR evaluation. An MRI of the infant’s brain taken shortly thereafter confirmed atrophy of the cortex, dilated ventricles, a right arachnoid cyst, and edema of the brain related to encephalitis. She was promptly transferred to a tertiary facility.

The child is severely compromised. She suffers from hearing and visual

impairments, requires a feeding tube, is ventilator dependent, and has limited, if any, cognitive awareness. Her family commenced a lawsuit against both obstetricians, her private pediatricians, Hospital 2 (where the infant was delivered) and that hospital's employed pediatricians. The complaint alleged: failure to diagnose and treat herpes in utero; failure to appreciate and recognize the significance of an infection with genital herpes, and to recommend and perform the delivery by cesarian section; failure to timely perform diagnostic tests and rule out herpes encephalitis; failure to order an MRI and timely perform a lumbar puncture; failure to maintain the appropriate dose of Acyclovir during treatment; and, finally, premature discharge of the newborn.

Multiple experts reviewed this case for MLMIC. All recommended settlement of the litigation by the MLMIC insured physicians. The obstetrical experts were critical of the treatment rendered by her first obstetrician during the admission at Hospital 1 for fever and bleeding. He did nothing to confirm suspected ruptured membranes. In addition, although he had not yet received the results of the abnormal PAP smear at the time of this hospitalization, the obstetrician was very concerned that there was a viral infection related to a possible leak in the amniotic fluid and discussed the possibility of terminating the pregnancy. The patient chose to continue the pregnancy.

After discharge, at the next prenatal visit, the obstetrician advised the patient that the PAP smear revealed a herpes infection and documented this discussion with both parents in her medical record. However, he took no further action, such as repeating the PAP smear or ordering a blood test for herpes. After she transferred her care, the second obstetrician should have reviewed her prior records and then performed follow-up studies, including herpes blood titers. His failure



to order such studies when the patient was admitted to the hospital in July due to vaginal bleeding and abdominal pain was felt to be a clear deviation from the standard of care.

Experts in maternal fetal medicine opined that the PAP smear performed in March of 2006, which indicated a herpes infection, required treatment of the patient. Although the patient had left the care of her original obstetrician, he should have communicated this abnormal test result verbally to her new obstetricians. If she had received oral Acyclovir for the remainder of her pregnancy and had undergone a cesarean section delivery, the infant might have been spared the devastating results which occurred. Once the patient's membranes ruptured, the placenta became infected with herpes over the ensuing 23 ½ hours of labor and this virus was transmitted to the baby.

The infectious disease expert felt the work up of the mother upon admission to Hospital 1 in March 2006 was poor because no one even investigated the cause of her fever. He felt that amniocentesis should have been recommended and promptly performed during that admission. In addition, he was very critical of the care she received during the admission of July 2006 because there was no investigation of the herpes positive result on the PAP smear. He further stated that

a comprehensive infectious disease work up should have promptly been performed on the infant since the infected umbilical cord clearly indicated a systemic infection. This would have revealed that the herpes infection was more extensive than initially suspected.

The neonatology expert criticized the Hospital 2 employed pediatricians for their failure to perform an appropriate diagnostic evaluation of the infant, including a complete eye examination. Their mismanagement of the herpes infection may have led to further brain damage in the newborn, which was confirmed by the neuroradiologist who concluded from the available imaging that the newborn suffered brain damage during her first through fourth weeks of life. Finally, the Hospital 2 pediatricians testified at their depositions that, although they made temporary notes about their care and assessment of the newborn on paper, they did not enter their findings in her medical record. Further, these notes were destroyed after the patient was discharged. Because of this, the plaintiff's counsel intimated that he intended to move for a spoliation of evidence charge during trial because they had destroyed evidence.

The opinions of the experts, and the problems identified for all defendants,

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attested to the difficulty in defending this suit. Therefore, settlement discussions ensued. The plaintiff initially demanded \$14 million to settle the lawsuit. There was also a \$2 million lien from insurers on the potential settlement proceeds. The two obstetricians and the private pediatricians were insured by MLMIC and had a combined \$9.2 million in available coverage. The co-defendant hospital, however, was not a MLMIC insured, nor were its employed pediatricians who treated the newborn in the nursery. The hospital claimed during negotiations that it had limited funds to contribute because it was self-insured. The hospital further indicated to the MLMIC co-defendants that the facility would only contribute “pennies” to the settlement.

After very arduous negotiations, a total settlement of \$4.29 million was reached. The sum of \$3,540,000 was paid on behalf of the three MLMIC defendants from their primary policies. The hospital’s employed pediatricians contributed only \$500,000. The hospital paid \$250,000 over a period of six months.

A Legal & Risk Management Perspective

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This case contained a myriad of problems for the defense of all parties.

Multiple physicians failed to perform any follow-up of abnormal laboratory results. Both sets of obstetricians failed to perform follow-up studies for herpes,

despite the abnormal results of the PAP smear performed in March. The hospital-employed pediatricians failed to perform a complete infectious disease work up on the newborn after the presence of herpes was confirmed in the umbilical cord.

The patient’s first obstetrician failed to investigate the cause of the mother’s fever upon her admission to Hospital 1. He also failed to request an infectious disease consultation. The second obstetrician also failed to act aggressively to confirm the results of the initial PAP smear, which was positive for herpes, and thus treat the mother with antiviral medication and/or perform an amniocentesis. Once labor began, he then failed to deliver the baby by cesarean section. This is a very serious deviation from the standard of care when a patient may be infected with herpes.

Documentation issues were also rampant in this case. Failing to document the labor record for 12 hours is a violation of New York State regulations, which require documentation of the care of patients whose labor is being augmented by Pitocin. New York State hospital regulations, specifically 10NYCRR§ 405.21(e)(ii)(b), provide that augmentation of labor can only be initiated after a qualified practitioner has: evaluated the woman; determined that augmentation is medically necessary for the patient or fetus; recorded the indications; obtained informed consent; and established a plan of management acceptable to the patient. The obstetrician’s complete failure to document his care clearly violated this regulation. He also failed to document the patient’s condition and the rationale for ordering an epidural for analgesia. Substantiation of a patient’s care by a physician cannot be based upon nursing notes.

There were significant communication deficits in this case as well. It is crucial for physicians to communicate with each

other verbally when patients have abnormal laboratory tests, particularly a positive PAP smear. The patient’s original obstetrician should have spoken with her new physician regarding the abnormal PAP smear. Further, the crucial information that the umbilical cord contained herpes should have been promptly communicated to both the obstetricians and especially the pediatricians caring for the newborn in the nursery. Failure to do so led to their failure to perform an extensive infectious disease work up of the newborn. Communication only to the obstetrician is not sufficient, since the obstetrician may have failed to communicate with the pediatrician in the nursery. Finally, the pathologist should have spoken with the obstetrician as well since the mother and possibly the father of the newborn needed to be aware of, and treated for, the herpes virus. In short, this case illustrates how a lack of effective communication can result in death or extensive permanent injury to a patient.

Documentation deficiencies are a continuous source of weakness when trying to defend a high value lawsuit. However, this problem can be calamitous when doctors testify that they made provisional paper notes but failed to record them in the newborn’s nursery record and that they destroyed them after the baby was discharged. When one destroys written or electronic information which may be potentially used in future litigation and never enters the information into the permanent medical record, the parties can be subject to sanctions should a lawsuit be commenced. An attorney for a plaintiff or defendant can ask the court to impose sanctions regardless of whether the loss or destruction is inadvertent or intended. The court can assess a variety of sanctions on the party who can no longer produce this evidence. By destroying potential evidence, even negligently, the

court can assume that there was intent and impose penalties, including: fines and possibly attorney's fees; providing instruction to the jury regarding the intentional destruction of evidence; issuing an order precluding the party from bringing up the lost information; or, at its most damaging, strike the pleading of a party, resulting in either the dismissal of the case or a determination of liability. The risk of plaintiff moving for a charge of spoliation of evidence is often sufficient to push settlement discussions to conclusion.

Finally, this case exemplifies the problems MLMIC has when dealing with uninsured, self-insured, or financially challenged co-defendants and insurance carriers. These entities are sometimes not funded, or can be licensed out of state and are not subject to regulation by the New York State Department of Financial Services. Such defendants and carriers are often unwilling to disclose the full extent of their assets during settlement discussions. They may act to implead insured doctors in order to enhance the availability of funds for settlement, without having to contribute a fair share. The effect can be unfair to other defendants in a lawsuit and may make it very difficult to reach a pre-trial settlement.

Unfortunately, because of the serious risks to insured physicians and facilities by not settling potentially high value cases, MLMIC and others, while acting in the best interests of their insureds, may be pressured to settle a case at a premium in order to extinguish litigation for all parties.

In this case, legal and risk management factors seriously impacted both the outcome of the newborn as well as the outcome of the settlement negotiations. ❖



New MLMIC Website, Blog and Twitter Stream Keep You Informed and Connected

MLMIC policyholders visiting MLMIC.com recently might have noticed that it now looks very different. It had been quite some time since our site originally launched and we decided it was due for a major “renovation.” We hope you’ll find that the clean, fresh, more modern look helps provide an easier-to-navigate experience, allowing you to find the information you’re looking for more quickly and efficiently. If you haven’t seen it yet, please visit and let us know what you think.

In addition to the overall site redesign, we’ve also introduced the all-new MLMIC blog. A blog page enables us to share news and updates with our insureds on a timelier basis. Blog readers also have the ability to engage the Company directly via blog post comments. Please visit the blog at www.mlmic.com/blog today to see all the posts you may have missed. If you would rather have the blog posts come to you, be sure to subscribe to the MLMIC News Digest,

which you can do on the right-hand side of the blog page. You’ll receive a digest of new blog posts about once every three weeks, delivered directly to your email inbox. To receive the MLMIC News Digest, just enter your email address, choose the policy type that applies to you – Physician, Dentists, and/or Hospitals – and click the sign-up button.

Those of you active on social media will be pleased to know that you can now follow MLMIC on Twitter, where we’re sharing the latest Company news, industry insights, and more. Our Twitter handle is @MLMIC. Follow us today!

Please note: we’ll still be mailing out our Dateline, Dental Dateline and Case Review print publications just as we’ve always done, so if you’re not active in the digital or social space, you’ll continue to be informed about MLMIC news, best practice recommendations and medical liability insurance insights. ❖

Surprise Visits from Government Investigators and Agents

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Investigation of a Complaint

It can be quite unsettling to have a government investigator appear unannounced in your office demanding copies of patient records or even an interview with you or your office staff. Several government agencies may authorize such surprise visits, including the Office of Professional Medical Conduct, the Centers for Medicare and Medicaid Services and agencies such as the Centers for Disease Control or the Occupational Safety and Health Administration. Often, you will have no advance warning of the site visit, so there is no time to think and arrange your thoughts. It is important to appear cooperative to show the investigator(s) that you have nothing to hide, but you should always realize the risks of speaking to an investigator without legal counsel and allowing original medical records and documents to be removed from your office.

Agency investigators may demand access to your premises, may ask to interview not only you but also all of your office staff, and may ask you to immediately produce your original patient records. These situations can be frightening to your staff, especially when the agents are demanding or intimidating. It is important that you proceed slowly and cautiously if you are unexpectedly visited by an investigator. Below are some risk management recommendations to help you respond safely and appropriately should such unanticipated situations occur.

1. Designate an individual in your office to be notified immediately when/if governmental agents or investigators appear seeking information.
2. Before providing any information, ask the investigator to provide identification such as an official ID badge or business card so that you can verify the identities of the agency and the agent. You may also ask for any documentation citing the legal authority which empowers the investigator or agent to carry out unannounced site visits or demands for information.
3. Make copies of all identifying badges or documentation. Request that the individuals sign in so you can monitor who is on your premises.
4. Immediately call your attorney. You have the right to have an attorney present during the investigation and at any interview.
5. If the investigator does not have a search warrant, he/she may make a request for items in your possession, but you are not required to immediately hand them over. You should ask the investigator to wait until you have consulted with your attorney. You should follow your attorney's advice.
6. If the investigator demands your original documents, and if there is no search warrant, you should politely offer to make copies of the documents available. Whenever possible, you should not permit original documents to leave your office, particularly patient medical records. If you must provide records, ask the investigator to accept copies. Failure to retain either accurate originals or copies of the medical records given to an investigator is professional misconduct and could potentially jeopardize the care of your patients and even cause them harm.
7. If investigators wish to speak to your employees, do not forbid or prevent them from doing so. However, you should advise your employees that they are not obligated to talk to the agents and are entitled to have another person present when they do so. Any person who is interviewed is entitled to have his/her own attorney present.
8. Be cautious about speaking to government agents without an attorney present. There is always a risk that the agents may misconstrue your statements. It is also likely that they will record the interview(s) either electronically or in writing. Because of the tension of the moment and the disruption of your office, you may inadvertently make statements which can be construed as admissions against your interest. These statements can and will be used against you if criminal or administrative proceedings result from the investigation.
9. If any employees speak to agents, it is important to document who was interviewed and what questions were asked. That assists you and your counsel in determining the aim of the visit by the agents.
10. Contact MLMIC to determine whether this administrative investigation (such as OPMC or Medicare) would be covered by your defense only endorsement for payment of legal fees.¹

1. Be aware that there may be policy exclusions such as for alleged criminal acts which preclude payment of legal fees pursuant to the defense only coverage.

Execution of Search Warrants

Certain governmental agents and officers (such as the FBI, state, or local police) may be investigating potential criminal charges and may present you with a search warrant. A search warrant is issued by order of a court and therefore it must be obeyed. The intent of the warrant is to search your premises to seize and remove evidence. The legal basis for a judge issuing a warrant is probable cause that a crime has been committed and the premises contains evidence of that crime which must be seized to ensure that it will be available in court. Thus, if you are unexpectedly served with a search warrant, you must do nothing to interfere with the search. In addition to the recommendations outlined above, you should take the following steps:

1. Your staff should immediately notify you if an officer appears with a search warrant, and you should immediately notify your legal counsel. You are entitled to have counsel present at all stages of the search. Ask your attorney to come to your office at once if at all possible.
2. Only a search warrant gives the agent the right to immediately seize items on your property. Agents who remove property from your office must give you a copy of the warrant, an inventory of all property they have removed and a receipt for the property.
3. The warrant will identify the locations where the agents are permitted to search. Carefully review the specific locations subject to the search. If the



agents attempt to go beyond those designated areas, ask them to wait and promptly consult your attorney. However, if the agents refuse to wait for you to consult an attorney, do not interfere with their search. Doing so could be construed as an obstruction of justice, which could be a felony. Document what transpired, as well as what was removed both on and off the list you received with the warrant, and provide that information to your attorney.

4. The warrant will also include an attachment listing all of the items (or categories of items) to be seized. Ask for a copy of the attachment and make sure the agents do not seize any items not covered by the warrant. If the agents attempt to seize items not designated by the warrant, ask them to wait so that legal counsel can be consulted. If they refuse to wait, do not interfere with their efforts.
5. A search warrant authorizes agents to search and seize property only. It does not give the agents the authority to interview employees. However, if agents wish to speak to your employees, do not forbid or prevent them from doing so. Follow the guidelines listed above for agency investigations. If any employee speaks to agents, it is important to document who was interviewed and what questions were

asked. That assists you and your counsel to determine the aim of the visit by the agents.

6. The agents are entitled to take the original documents and items described in the warrant. You should ask for copies of the documents before they are taken by the agents. If the number of documents being taken is excessive, you might consider asking only for copies of the specific documents that are essential to your conducting business. The agents are not required to give you copies of the documents. If they refuse to give you copies, notify your attorney so that you can obtain copies later.
7. The warrant authorizes the agents to use force, where necessary, to execute the warrant. You should instruct all personnel not to impede or obstruct the agents' efforts to execute the warrant.
8. The agents may serve grand jury subpoenas on employees. The grand jury subpoenas require attendance before the grand jury on a specified date for the purpose of giving testimony. The subpoena does not require the employees to speak with the agents during the search. If any subpoenas are served on employees, make a list of all employees who are subpoenaed. In addition, obtain a copy of

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Alternative to Certified Mail

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Whenever you must send an important communication to a patient, it must be in writing and sent by means of a reliable delivery method. In the past, many significant written communications – discharge letters, or warning letters to noncompliant patients – would be sent to the patient by certified mail, return receipt requested. The certified mail process requires a signature from the patient or another person who lives at the address, thus providing evidence that the communication was, in fact, received.

Unfortunately, not only has the cost of certified mail dramatically increased, but it is increasingly common that certified mailings are returned to the physician's office without a signature. This could occur either because the patient refused to sign for the letter, or because the patient was never home to receive it. It can take several weeks for a letter to be returned as "refused" or "unclaimed." The physician must then begin the notification process all over again in order to make an attempt to convey the communication to the patient. This delay could result in additional risk to the physician, especially if the physician wished to discharge the patient from the practice.

As a result of these issues, Fager Amsler & Keller LLP has revised its recommendation concerning the method by which written communications should be sent to patients. It is still suggested that the letter and envelope be marked "personal and confidential." However, certified mail, return receipt requested, is not the only reliable method of mailing which can be used. Instead, the notification should be sent using the "certificate



of mailing" process offered by the US Postal Service. This requires you or a staff member to go to the Post Office to mail the letter via first class mail to the patient's last known address. At the time of mailing, a "certificate of mailing" is purchased. The form (PS form 3817) can be downloaded from about.usps.com/forms/ps3817.pdf, but it must be brought to the Post Office to be placed in an official Post Office depository.

The Post Office accepts the letter and stamps the form with the date the letter is mailed. Since the letter is sent via first class mail, it does not require a signature, and, if necessary, it will be forwarded to the patient's new address. It cannot be refused by the patient and will not be returned by the Post Office unless the address itself is invalid. The date-stamped certificate is proof that you mailed the letter at the Post Office, and this constitutes presumptive evidence in court that the let-

ter was received by the patient in the normal course of business. Thus, if the first class letter is not returned as undeliverable, you may assume the patient has received the letter and have proof it was mailed. A copy of your written communication to the patient and the certificate of mailing should be retained in the patient's medical record. ❖

Update on Physician Assistant Prescribing Authority

The Spring, 2014 issue of *Dateline* discussed the rules governing the professional practice of physician assistants (PAs). In the article *Physician Assistants: A Risk-Benefit Analysis*, it was stated that PAs could not prescribe any Schedule II controlled substance, citing 10 NYCRR § 94.2(e)(5) (page 3, footnote 10). On February 26, 2014, a Notice of Proposed Rulemaking was published in the New York State Register proposing to remove this restriction. As of this writing, the regulation has not been amended, although the website of the New York Department of Health does state that PAs may write prescriptions for Schedule II controlled substances:

In an outpatient setting, the PA may prescribe all medications, including Schedule II - V controlled substances, if delegated by the supervising physician. PAs may apply to the DEA to obtain their own, individual registration numbers as "mid-level practitioners." Once duly registered by the DEA, they may prescribe Schedules II, III, IV, and V drugs, in compliance with Article 33 of the Public Health Law and Part 80 and Part 94.2 of Title 10 regulations. Such prescribing is also subject to any limitations imposed by the supervising physician and/or clinic or hospital where such prescribing activity may occur. PAs shall register with the Department of Health in order to be

issued official New York State prescription forms. Official New York State prescription forms issued to the PA are imprinted with the names of both the PA and the supervising physician. If a PA utilizes an official prescription issued to a hospital or clinic, the PA must stamp or type his or her name and the name of the supervising physician on the official prescription.

www.health.ny.gov/professionals/doctors/conduct/physician_assistant.htm. If you require further information on this subject, please contact an attorney at Fager Amsler & Keller, LLP. ❖

HIV Law Updates

On April 1, 2014, Public Health Law § 2781, governing consent for HIV tests, and Public Health Law § 2135, regarding confidentiality of HIV reports, were amended. The purpose of these changes was to increase HIV testing and thereby increase the number of HIV positive persons who receive medical care. These new provisions, described below, are applicable to all individuals who are offered HIV testing in New York State, and are not restricted to patients between the ages of 13 and 64 in clinical settings who must be offered testing pursuant to prior legislation.

1. The requirement for written consent to be obtained prior to ordering HIV-related tests has been eliminated with the exception of individuals retained in correctional facilities, who must still provide written consent for HIV testing.
2. Information about HIV testing (pre-test counseling) must still be provided to the patient via posters, brochures, videos or discussions

with providers, so the patient has the information necessary to consent to or refuse testing.

3. Verbal consent must be obtained from the patient or individual legally authorized to consent for the patient prior to the test. The patient's verbal consent should be documented in the medical record.
4. Prior to testing, the patient must be advised each time an HIV test is to be performed.
5. All HIV tests performed must be documented in the patient's medical record. We also continue to recommend that all pre- and post-test counseling be documented in the medical record.
6. A physician can share a noncompliant patient's protected HIV-related information, as well as other necessary information, with local and state health departments and other physicians treating the patient in order to retain that patient in treatment.
7. During post-test counseling, patients

identified as HIV positive must be advised that if they are non-compliant with care, they may be contacted by their medical provider or the health department to promote their re-entry into, and compliance with, care.

8. Post-test counselling must emphasize the benefits of antiretroviral therapy (ART) and the importance of HIV viral suppression.
9. All prior New York State Public Health Law confidentiality protections governing HIV-related information remain in effect with respect to the release of medical records and verbal communications. Protections against discrimination based upon HIV-related information are also unchanged.

Regulations will be developed by the New York State Department of Health to implement these statutory changes. Additional information about the new amendments may be found at www.nyhealth.gov. Questions may be sent to hivtestlaw@health.state.ny.us. ❖

MLMIC's Risk Management and Legal Services

MLMIC is committed to the education of healthcare professionals as an effective means of improving patient care and, ultimately, reducing the number and severity of claims. MLMIC's Risk Management Department has developed comprehensive programs to help minimize the liability exposure of MLMIC-insured hospitals and long term care facilities, as well as its physician, surgeon, and dentist policyholders. These programs are available at no cost to MLMIC policyholders.

CME Programs

MLMIC offers two types of CME programs:

CME Programs for Premium Credit and Excess Eligibility

Satisfactory completion of these CME courses allows physicians to earn *AMA PRA Category I Credits*[™] (dentists earn CE credits) and the applicable premium credit, as well as qualify physicians and dentists for participation in the medical malpractice excess insurance program. MLMIC also may require hospital employed physicians, residents and mid-level practitioners to complete these programs.

Modules for CME Credit Only

These modules, which are derived from MLMIC's previously-released CME programs, address a number of important risk management and patient safety topics. Physicians completing these modules will earn *AMA PRA Category I Credit*[™]. Non-physicians will receive a certificate of completion. No premium credit is offered for the completion of these modules, nor will they qualify physicians for participation in the excess medical malpractice insurance program.

Consultative Services

MLMIC's Risk Management Consultants are professionals with diverse experience in the healthcare industry who are skilled in loss prevention. The Risk Management Consultants operate regionally and provide services to policyholders throughout New York State.

Medical and Dental Office and Group Practice Surveys & Assessments

Our office practice surveys can help improve patient care and reduce claims that arise in the private office setting. An on-site review and evaluation of individual office practices is conducted by our Risk Management Consultants, with an assessment of our insured's office policies, procedures, and practices. Some of the office procedures and forms that may be reviewed include informed consent/consent forms, medical record documentation, physician/patient relations, follow-up of referrals and consultations, and professional staff credentialing. Recommendations for improvement of the practice are provided to the physician or dentist upon completion of the survey.

On-Site Education Programs for Group Members and Staff

An informed and highly motivated staff is a group's best resource for reducing the potential for patient injury and subsequent financial loss. Educating staff members to assist them in providing quality care in a safe environment is a major element of MLMIC's risk management program. Another advantage of staff education is that when employees are comfortable with the loss control concept, they will more readily notify management of patient incidents.

Risk Management Consultants can provide your practice with presentations on a variety of educational topics at no cost. These presentations may include: Office Safety and Risk Management including follow-up of missed and cancelled appointments and tracking diagnostic test results and referrals; Telephone Communication; Medication Safety; Infection Prevention; Disruptive Behaviors; Use of Social Media; Medical Record Documentation; Lessons Learned from Claims; Patient Experience; Handling Patient Complaints; Scope of Practice and Supervision; and other risk management concerns.

Legal Advice and Services

Policyholders may access a variety of legal services provided by Fager Amsler & Keller, LLP, counsel to MLMIC. Fager Amsler & Keller attorneys are located in our Latham, Long Island, and Syracuse offices.

The firm's experienced attorneys specialize in healthcare law, including professional liability issues, medical malpractice defense litigation, and regulatory compliance. They have broad experience analyzing significant regulatory information relating to the health professions.

The attorneys monitor current statutes, regulations, and case law and keep our insureds apprised when there is an impact on potential liability. They are available to serve as featured speakers at medical and dental society member programs as well as health care practices and facilities. Fager Amsler & Keller also provides MLMIC insured physicians with a selection of legal forms and documents for use in their practice.

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Telemedicine Resources

Robert Pedrazzi

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As alluded to in the Underwriting Update of our Spring 2014 edition of *Dateline*, “Advertising and Providing Medical Advice over the Internet: Cautions and Concerns” electronic communications in the field of medicine amongst healthcare practitioners, commonly known as telemedicine, is expanding at a rapid pace. Recent advancements in technology and equipment have made possible the delivery of healthcare services from practically any geographic location. While the MLMIC Physicians and Surgeons Professional Liability Insurance Policy (PSE) affords coverage for these activities under its provisions, it is nonetheless equally important for our insureds to arm themselves with the necessary knowledge to utilize these new healthcare delivery methods in an appropriate manner.

To assist them in this endeavor, we recommend that our insureds properly acclimate themselves to this new environment by consulting with a number of resources relating to the field of tele-

medicine. The MLMIC Library’s collection, which focuses on healthcare risk management, quality and patient safety issues, is available for the exclusive use of MLMIC’s policyholders. From this collection, we have compiled the following resources for our readers who plan on engaging in telemedicine.

American Telemedicine Association (ATA)

(www.americantelemed.org/home) This organization is described on its homepage as being the leading international resource and advocate promoting the use of advanced remote medical technologies. The ATA and its diverse membership work to fully integrate telemedicine into transformed healthcare systems in order to improve the quality, equity and affordability of healthcare throughout the world. The ATA is named as a resource on the Agency for Healthcare Research and Quality’s (a Public Health Service Agency in the U.S. Department of Health and Human Services) website.

Federation of State Medical Boards (FSMB)

(www.fsmb.org) This organization is described on its homepage as a national nonprofit representing the 70 medical and osteopathic boards of the United States and its territories. This site contains their “Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine – April 2014,” which can be directly accessed using the following link: www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf

One final resource providers may wish to consider consulting would be their individual specialty societies, which may offer some additional insights on the proper telemedicine practices of their specific specialty. ❖

Hospital-Acquired Infections Still a Concern

The Centers for Disease Control and Prevention (CDC) recently released data (www.cdc.gov/media/releases/2014/p0326-hospital-patients.html) on a 2011 study that indicated one in 25 patients in the U.S. have suffered from at least one infection contracted during their course of hospital care. This equates to about 722,000 healthcare-associated infections annually. In addition, approximately 74,000 hospital patients had to fight

more than one nosocomial infection annually and about 75,000 patients with hospital acquired infections (HAIs) die during their hospitalization every year.

The most common healthcare-associated infections identified by the CDC were pneumonia (22 percent), surgical site infections (22 percent), gastrointestinal infections (17 percent), urinary tract infections (13 percent), and bloodstream infections (10 percent). The CDC also

points out that although there has been some progress in preventing nosocomial infections, much more needs to be done.

The CDC and its partners have developed strategies to assist healthcare providers prevent healthcare-associated infections. For the latest models and standardized tools relating to infection control as well as comparison data for hospitals, visit the CDC website at www.cdc.gov/Washington/ or call the CDC at (202) 245-0600. ❖

and office equipment. While numerous recommendations were made in many areas, this article will focus on, and offer solutions to, the top five areas of concern. The next five areas of concern will be addressed in the Spring 2015 issue of *Dateline*.

1. Follow-up of Test Results

The highest number of recommendations (56) were made in this category. The majority of the recommendations stemmed from the practice surveyed not having a system to track laboratory tests, diagnostic studies, and consultations ordered. A policy and procedure should be developed outlining this tracking system (e.g., blood work, x-rays, mammography) and consultations that are ordered. A tracking log should be maintained that includes the date, patient identifiers, and the type of study or referral requested. Results received should be documented by date. This log, whether in electronic or paper form, should be reviewed on a weekly basis to ensure that results are received and patients are properly notified of their results. Instances of non-compliance or delays caused by the patient should also be documented. All logs should be kept for ten years.

Additional recommendations in this area addressed the need for medical record documentation of patient non-compliance, and all follow-up efforts taken to contact the patient. Significant test results that are noted in the final reports should be documented in the medical record. All incoming test results should be read, signed, dated, and timed prior to being filed in the patient's record.

With respect to consultation reports, providers must document in the medical record the rationale for treatment should they disagree with the recommendations of the consultant. To further enhance

patient care, a process to notify patients about routine yearly checkups and preventative health maintenance should be developed.

2. Telephone Calls

Fifty-three recommendations were made regarding the management of patient telephone calls both when the practice is open and after hours. Policies and procedures should be developed that address the directing of clinical phone calls to an appropriately licensed practitioner or a physician, as well as the handling emergency calls (e.g., instructing patients to call 911). Telephone triage should be conducted, at a minimum, by a registered nurse as it is not within the scope of practice for LPN's or non-licensed staff to handle this responsibility. All calls taken, whether after hours or while in the office, should be documented in the patient's medical record. Documentation should include: the patient's name and other identifiers; the date and time of the call; a thorough explanation of the patient's concerns; the advice and instructions given; and any orders/prescriptions provided. The content of follow-up telephone calls should also be documented. When possible, pharmacy orders should be electronically sent or faxed instead of being called in by telephone.

Written policies and procedures should be developed to address telephone contacts with patients after hours, including those handled by a covering provider. There should be a written agreement between the physician and covering providers regarding the arrangements made for the care of the patient. Documentation of the covering provider's patient contacts and interventions should be placed in the patient's medical record. There should also be a system in place for the physician to review this information.

There should also be a written contract with your answering service. Answering services should submit a record of calls to the office on a daily basis, and the records should be maintained by the office for ten years. This information should also be incorporated into the patient's medical record in a timely fashion. Test calls should be conducted periodically to determine the accuracy, timeliness of response, and professionalism of the answering service. The answering service should include a message to "hang up and call 911 if this is an emergency."

3. Documentation in the Medical Record

There were a total of 50 recommendations made involving medical record documentation. Accurate and complete documentation is the most valuable contribution to risk prevention and the mitigation of liability. Attorneys will use your documentation to identify a possible failure to meet the appropriate standard of care, an injury, and a link between the two. The three most common findings identified in this category involved legibility and consistency, documentation of the patient history, and documentation of patient education.

Illegible handwriting is a common issue found in paper records. Identifiable signatures with credentials, dates, and times should be present for all entries. A written policy and procedure should include the use of an approved abbreviation list. An additional policy and procedure should be developed for making proper corrections in the paper medical record. This includes drawing a single line through the incorrect entry, labeling it "error," and initialing and dating it. The correct entry should then be documented after the last note in the record.

Physicians utilizing an EMR system must remember that there will be an audit trail that records the time and date when each entry is made. Addenda to the medical record are generally not recommended unless significant information pertaining to the patient's care is missing. A properly timed and dated addendum that adds information which is relevant to the patient's future care is reasonable, provided it is done within a short time of the patient encounter.

With respect to the medical record content, there should be a process for reviewing and documenting the patient's medical, surgical, family, and social history. This information should be reviewed with the patient by a licensed clinician on a routine basis. A patient history form can be developed for the patient to elicit or update this information.

Documentation of patient education should include any verbal and/or preprinted instructions given to the patient, plus documentation of the patient's understanding of the instructions. Verbal instructions should only be provided by appropriately licensed staff. Preprinted instructions for patients should be developed, and older versions of these handouts should be maintained on file when these are updated. All printed materials (educational and otherwise) given to patients should be referenced and/or scanned into the computer system or filed in the medical record, as the standard of care at the time the information was provided may be different from the standard of care at the time a lawsuit is commenced. For offices that utilize electronic medical records, make certain that all aspects of the EMR are printable, and verify that all documents scanned into it are legible before the originals are destroyed. Fager Amsler & Keller recommends retaining all paper records for ninety days before destroying them.



4. The Medical Record

There were 48 recommendations made in this category. Appropriate record keeping practices support good risk management programs. The most common issues identified with respect to medical records involved policies and procedures, patient identification, and security.

In many of the physician offices surveyed, there were no policies and procedures addressing the critical areas of: identification of allergies and sensitivities; outline of the chart order; and the maintenance, storage, and destruction of medical records. Allergies should be highlighted on the cover of every chart and on each screen of an EMR for quick identification. Each chart should present in the same order and contain the same tabs identifying where information is to be filed. We recommend that medical records should be maintained for ten years from the date of last payment. Medical records for minor patients should be maintained until the age of 22 or ten years from the date of last payment for treatment, whichever is longer.

Patient identification is essential to ensuring the correct information is in

the right chart. Each page or screen of the medical record should have specific patient identifiers.

Security of the medical record is equally as important for both paper and electronic records. All records should be organized and secured. When using an EMR, consider the use of a secondary, off-site backup system.

5. Human Resources

Forty-one recommendations were made in this category. The main focus was the verification of employee credentials. Employee files should be organized, secured, and should contain: written job descriptions; signed confidentiality statements; written documentation of reference checks; documentation of licenses; training records; and performance appraisals.

If students are being trained on site, there should be an agreement with the educational institution regarding scope of practice for the student and the supervision required. Additionally, the practice should confirm that the institution pro-

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Tip #16 – Medication Regimen Adherence

The Risk:

Patient non-adherence to a prescribed medication regimen is a common problem for physicians of all specialties. Patients and/or caregivers should be aware of the importance of taking medications exactly as directed as well as any potential drug-related problems that may warrant emergency care.

Recommendations:

1. Prescribing providers should educate patients about each medication, including its name, appearance, purpose, and effect. This education should include any potential adverse effects and interactions of each medication, as well as the importance of contacting a healthcare provider should any questions or concerns arise.
2. The importance of using only one pharmacy to obtain all medications should be stressed with patients or their representatives.
3. Patients should also be advised to:
 - a. keep an accurate list of all medications, including generic and brand names, dosages, dosing frequency, and the reasons for taking the drug;
 - b. keep a complete list of medical providers and their contact information;
 - c. post the name and telephone number of the local pharmacy in a prominent location (e.g., EMS personnel have been instructed to look for the above three items on refrigerator doors);
- d. not “split” medications to save money as, in doing so, they may not be taking an effective dose;
- e. establish a daily routine when taking their medications, following their prescribing provider’s instructions; and
- f. bring a list of all medications you are taking, including over-the-counter medications and herbal supplements, to each and every physician appointment.
4. Additionally, physicians should help patients manage their medications, caution them to not share medications, and advise them to follow storage recommendations and dispose of old medications properly. ❖

Surprise Visits *continued from page 7*

- the subpoena, because it is likely to reflect the names of the government attorneys involved in the investigation and their phone numbers.
9. To the extent attorneys are not available on site at the time of the execution of the warrant, you should assign one employee to each agent or group of agents who are conducting the search. These people should accompany the agents during their search. They should observe the agents’ conduct and take notes regarding where the agents searched and what documents or items were taken from particular locations. The employees should be instructed that they are not to volunteer information. Their sole purpose in following the agents is to observe the agents’ conduct and take detailed notes. Again, it cannot be stressed enough that the employees are not to attempt to interfere in any way with the agents.
 10. The agents may try to seize legal files or other attorney-client privileged materials as part of the search. A search warrant typically should not be used to obtain attorney-client privileged materials. If the agents attempt to seize any attorney-client privileged materials, ask to speak with the lead agent. If the lead agent will not cooperate on this issue, counsel should be notified so they can attempt to contact the agency attorney overseeing the investigation. Ultimately, if the agents decide to take privileged materials, you should not try to stop them.
 11. After the search is completed, you should make a list of all areas searched by the agents. For each area that was searched, identify the personnel who would have knowledge as to what items are missing. Each person should make their own list of all items they believe to have been taken by the agents.
 12. When the agents have completed the search and seizure, promptly escort them off your premises and confirm that all of them have in fact left the premises.
In sum, it is always disconcerting to have investigators or law enforcement personnel appear unannounced in your office. The best approach in these circumstances is to proceed methodically and document all the activities taking place. It almost goes without saying that you should make certain that you promptly retain an attorney with experience in dealing with agency investigations, search warrants, and criminal investigations. ❖

The MLMIC Library – Fall 2014 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.

- **10 Steps to Improve Patient Safety in the Practice.** Frank Chapman. Medical Group Management Association; 2013 (Phys 539-069).
- **The CMS Compliance Crosswalk.** Cheryl A. Niespodziani. HCPro, Inc.; 2014 (Hosp Adm 312-041 2014).
- **Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: Roadmap for Hospitals.** The Joint Commission; 2010 (Hosp Adm 312-053).
- **AMDA Long-Term Care Medicine 2014 Annual Symposium: Creating Harmony in Long-Term Care.** AMDA (The Society for Post-Acute and Long-Term Care Medicine); 2014 (LTC 104-136 2014).
- **Art and Science of Telephone Triage: How to Practice Nursing Over the Phone.** Carol Ruterberg and M. Elizabeth Greenberg. Medical Group Management Association; 2012 (Nursing 556-146).
- **In the Name of the Patient: Patient Advocate Role in a Healthcare Facility.** Beryl Institute; 2014 (Pt Rights 131-016).
- **NPP (Non-Physician Providers) Utilization in the Future of US Healthcare.** Medical Group Management Association; 2014 (Phys 539-070).
- **The Other End of the Stethoscope: 33 Insights for Excellent Patient Care.** Marcus Engel. Ella Press; 2006 (Pt Rights 131-017).
- **Physician Perspectives on Patient Experience.** Latha R. Shankar and Jason A. Wolf. Beryl Institute; 2014 (Phys 539-068).

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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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Physician Office Practice Surveys continued from page 13

vides indemnity for any professional acts of the student while at the practice. The medical record should contain documentation indicating that the patient agreed to have a student present during their encounter.

All employees, students, and volunteers need to have job descriptions on file. These need to specify the responsibilities that are allowed under state regulations in accordance with their professional scope of practice. All personnel should wear visible ID's that include their name and appropriate credentials or title.

Adopting these recommendations will assist in the development of a well-rounded risk management program that can reduce the risk of patient injury and, in the event that there is litigation, will contribute to a strong defense. The remaining five findings and recommendations will be presented in the Spring 2015 issue of Dateline.

MLMIC's medical office practice surveys can help improve patient care and reduce the risk of claims that may arise in the physician office setting. An on-site review and evaluation of individual office practices and procedures may be conducted by our Risk Management Consultants, with recommendations to improve the practice provided upon completion of the survey. Requests for this service can be made either through our website, www.mlmic.com, or by calling the Risk Management Department at the MLMIC office closest to your location. These services are provided to physicians at no cost, as a benefit of their membership with MLMIC. ❖

MLMIC's Risk Management and Legal Services

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Fager Amsler & Keller, LLP attorneys are available during regular business hours and can be reached at the following telephone numbers:

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