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The Use of Unlicensed Medical Assistants in the Physician's Office

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A significant number of physicians inappropriately use medical assistants or other unlicensed staff to assist in treating their patients in clinical settings and private offices and are unaware of the dangers of doing so. Although medical assistants can be a valuable part of a physician's staff, they must only be given appropriate responsibilities and tasks that do not require a license.

It is often presumed that "certified medical assistants" can perform any tasks that they may have learned as part of their medical assistant training or that their physician employer has trained them to perform. However, licensure and certification are not interchangeable. Medical assistants are usually certified by a national organization such as the American Association of Medical Assistants and are not recognized as licensed professionals by the New York State Department of Education. Therefore, they may not perform tasks or duties which are reserved only for licensed medical or nursing professionals.

The New York State Board for Medicine, which governs the practice of physicians, physician assistants, and specialist assistants, has clarified the functions that unlicensed personnel may perform. The Board has provided a sample list of tasks that physicians are permitted by law to delegate to such individuals. These tasks include, but are not limited to:

- escorting patients to examination rooms and acting as chaperones in the examination room;[1]
- performing clerical tasks, such as assembling charts, assisting with billing, and obtaining and maintaining supplies;[2]
- performing receptionist tasks, such as answering telephones, scheduling appointments (with written guidelines for how soon different types of patients should be seen in the office) and scheduling ordered tests;
- transmitting a prescription for a medication other than a controlled substance to a pharmacy, if:
  - all of the required information is on the prescription (A non-licensed individual may complete information on an electronic prescription.); and

1. Memorandum from Walter Ramos, R.N., J.D., Executive Secretary to the New York State Board of Medicine to Interested Parties (April 2010, modified October 2014). (On file with author).
2. Id.

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Case Study

Dermatologist Sued for Employee's Negligent Laser Treatment

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A 28-year-old female office worker was seen at the office of a board-certified dermatologist and consulted with an esthetician for laser hair removal. GentleMax laser heat treatment (Yag) was utilized for removal of hair on the upper lip, underarms, navel and lower legs. The procedure was performed by the esthetician.

Two days later, the patient returned to the office and was seen by a physician assistant (PA). She complained of post hair removal burns and the PA noted erythematous burns on the stomach, lower legs, and mid-abdomen. She denied taking medication or oral contraceptives at the time of the treatment, but admitted that she may have taken ibuprofen or Motrin at the time or after the treatment. The PA diagnosed laser burns, advised the patient to use Kenalog daily, and provided her with samples. He took photographs and advised the patient to return in one week.

The patient returned to the office sixteen days later and was again seen by the PA. She was using Halog ointment and improvement was noted. She was advised to use Halog ointment until she was done with the samples then start Cloderm cream. Additional photos were taken and the patient was advised to return again in two weeks.

She returned in three weeks and reported to the PA that the inflammatory hyperpigmentation on the legs and abdomen were improving. Topicort spray samples were provided and she was advised to discontinue the Halog ointment and return in three weeks.

The patient was seen three weeks later by the PA who found no erythema remaining. His assessment was post-inflammatory hyperpigmentation. She was advised to discontinue the topical steroids and start Glycolighten each evening, then return in three weeks.

When the patient returned to the office, she complained that the spots on her legs were still there and did not appear to be healing. The PA noted circular erythematous hyperpigmentation on both legs. The patient stated that it was getting worse and Glycolighten was lightening the surrounding normal skin. She was advised to discontinue the Glycolighten and use Topicort spray each day.

Approximately one and one-half weeks later, the patient called the office and requested additional samples of Topicort. The PA advised her to use Cloderm and arranged to leave samples for her at the office.

She was seen in the office by the PA five days later and continued to complain of burns on the legs and abdomen. He noted improvement of the inflammation and hyperpigmentation and advised her to use Halog ointment, discontinue Kenalog, and return in one week. Two days later, the PA left samples of Cloderm with his staff for the patient to pick up.

The patient returned two weeks later and was seen by the PA. She advised them that she was using Topicort and Glycolighten and the hyperpigmentation remained. Circular areas of hyperpigmentation were seen on bilateral legs, with some improvement noted. The patient was advised to use Melquin 4% cream (hydroquinone) each night only on the areas of hyperpigmentation and Kenalog spray each morning, and then return to the office in two weeks.

When the patient returned to the office, she was seen by the PA and complained that the hyperpigmentation was not improving. The PA noted slight improvement with the use of the topical steroid and advised that patient to use Tazorac

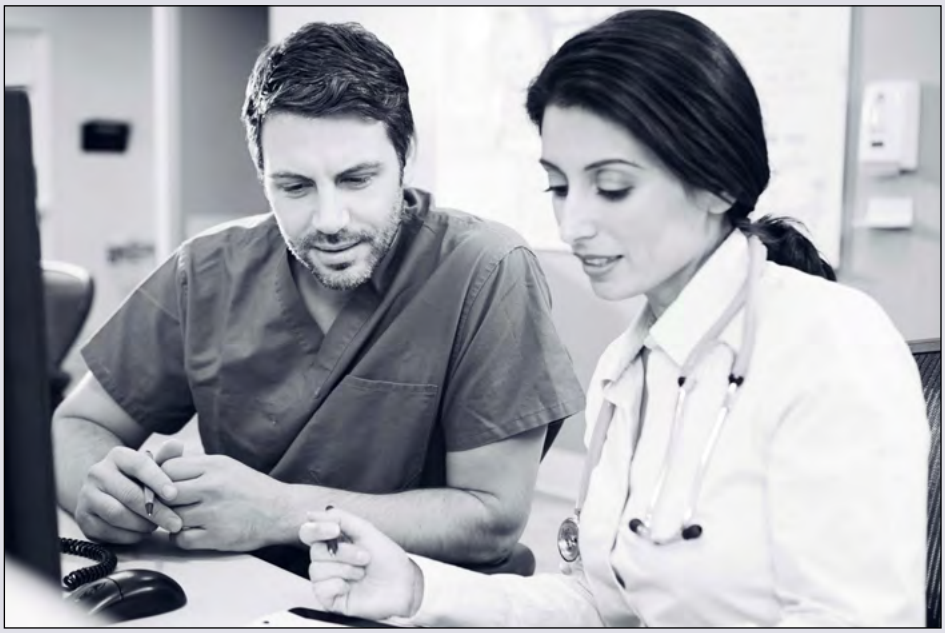
cream and Glycolighten in the evening and Kenalog in the morning. Photographs were taken at that time.

Three weeks later, the PA had a phone conversation with the patient and discussed her current condition. She advised that there had been additional improvement since her last visit and agreed to use a stronger bleaching compound, which the PA called in to the pharmacy. She was advised to use it sparingly in the evening and only on the darker spots. He would then evaluate her progress in two to three weeks. The LPN noted in the chart that day that the compound called in to the pharmacy consisted of lactic acid, citric acid, hydroquinone, kojic acid, and triamcinolone. The practice manager confirmed with the pharmacy that the patient picked up the prescription.

The patient did not return to the office but the dermatologist later received a request for records from the patient's attorney.

The patient was subsequently seen at another physician's office for a cosmetic consultation for removal of hyper-pigmented burn spots and was advised to use NeoStrata Ultra Smoothing Lotion Plus each morning and Melquin lotion to the darker spots each night.

The patient brought suit against the physician's professional entity alleging negligent laser treatment for hair removal, lack of informed consent, and failure to take an appropriate history. In addition, she claimed failure to properly calibrate and test the laser and negligent care and treatment of postop burns. As a result, she suffered second degree burns to the abdomen and legs, permanent disfigurement, scarring, hyperpigmentation, and sensitivity.



She also claimed pain and suffering, mental anguish, and loss of enjoyment of life.

Neither the esthetician nor the dermatologist had a theory as to why the hyperpigmentation occurred. The esthetician used the Yag laser for darker complexions. Her practice was to key in the type and condition of the skin and the laser automatically adjusts the settings. If any adjustment is made, it is downward to be on the "safe side." The laser does not function by default if there is any malfunction. The dermatologist felt that he would have liked to have been aware of the complication sooner but was in agreement with the care rendered by the PA.

At the time in question, the office did not have patients sign a written consent form for laser hair removal. Subsequent to this incident, the office required patients to sign a formal consent as well as a hair removal consultation form. In addition, the esthetician has a lengthy and detailed informed consent conversation with every patient, including whether they have been in the sun and if they are on medication. Patients are advised of potential complications including burning, blistering, discoloration, and bruising. In addition, patients are advised that redness and discomfort following laser procedure is likely, but generally resolves in a short period of time.

Experts reviewed this case for MLMIC and advised that hyperpigmentation secondary to laser hair removal is not rare. Many of these cases occur when the technician raises the dosage of the laser and burns the patient. In this case, the burn occurred during the initial procedure by the esthetician. The expert found that the massive involvement of the burns was a great problem. The skin lighteners also tend to lighten normal skin in addition to the dark spots, thus making the existing problem worse. It was felt that had the dermatologist seen the patient initially, he would have advised against the treatment or he would have done

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Case Study

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a spot test prior to the procedure. In this case, the dermatologist was vicariously liable for the acts of his employees. It was determined that settlement was in order.

This case settled for $490,000 on behalf of the insured dermatologist. The insured dermatologist did not purchase entity coverage and the esthetician had no individual insurance coverage. The dermatologist was the sole member of his P.C., and he was the supervising physician for the employees in his office. For that reason, the payment was made on behalf of the insured dermatologist and the settlement was reported to the National Practitioner Data Bank.

A Legal & Risk Management Perspective

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In this case, the outcome may have been different if the physician's office used appropriate protocols for laser hair removal patients. The patient initially should have been seen and evaluated by the dermatologist for the procedure. At that visit, the dermatologist should have taken a thorough history from the patient, including pre-existing conditions, allergies, medication history (both prescription and over-the-counter), prior skin treatments, sun exposure, and possible pregnancy. In this case, there was no documentation of the patient's history, or medications, as shown by the confusion during her follow up visit as to whether she had been taking ibuprofen prior to treatment.

Only a properly licensed medical provider can make the determination whether a patient is an appropriate candidate for a procedure. Patient selection is a medical decision and it is inappropriate to delegate this evaluation to a non-licensed individual.

Once the provider determines the patient is an appropriate candidate, the provider must obtain the patient's informed consent to the procedure. Informed consent is the dialogue between the patient and the provider concerning the risks and benefits of the procedure, in language and in a manner which is understandable to the patient. Nurses and non-licensed personnel cannot obtain a patient's informed consent.

During the consent discussion, the provider should advise the patient of potential complications, which could include burning, blistering, discoloration, discomfort and bruising. The patient's questions must be fully answered and the discussion should be fully documented in the patient's medical record. After the discussion, the patient's understanding and consent should be memorialized in a written informed consent document. Although the document is not itself the informed consent, it is evidence that the informed consent discussion took place. A formal written consent may be presented and witnessed by a nurse as long as the actual discussion took place between the provider and the patient.

The New York State Board of Medicine does allow a qualified esthetician to perform laser hair removal in a physician's office. However, all other cosmetic procedures using lasers must be performed by a licensed provider. Therefore, although technically the doctor could allow an esthetician to perform the laser hair removal, the physician must be assured that the esthetician is competent and qualified to perform those procedures, and documentation of training and experience should be retained by the practice. In addition, there should be direct communication between the physician and the esthetician about the patient prior to the procedure. In this case, as the MLMIC experts pointed out, it would have been advisable for the dermatologist to perform a spot test prior to handing off the patient to the esthetician for the procedure.

Once the patient returned to the office with complaints of postoperative burns, she should have been assessed by the dermatologist who ideally would have originally examined her. In this case, a PA who was not previously involved in her care evaluated and treated the patient. Although the patient was advised to return at specific time intervals, she

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UNDERWRITING Update

Physician, Protect Thyself: Do You Have a MLMIC Legal Defense Cost Coverage Endorsement?

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In New York State, the Office of Professional Medical Conduct (OPMC) of the Department of Health is the agency responsible for investigating complaints about physicians and physician assistants. The most recent statistics available indicate that it received as many as 8,762 complaints in 2015. That figure represents the highest number of grievances as compared to the previous five years. In general, the predominant source of complaints has been from the public. In addition, state law reporting requirements generate significant numbers of reports from healthcare facilities when disciplinary actions are imposed on providers, as well as from providers reporting suspected instances of misconduct by another provider. Even a negative online review can prompt an OPMC investigation.

In accordance with Section 230(10) of the Public Health Law of New York State, OPMC must review each and every complaint it receives, regardless of the source. After an initial analysis by OPMC investigative and medical staff, more extensive inquiries are conducted in the vast majority of complaints received about physicians. Typically, a physician may receive a letter or telephone call from the agency with a request for a copy of the patient's medical record and/or an interview. However, an unannounced visit from an OPMC representative may also represent the initiation of a professional licensure inquiry.

Disciplinary proceedings can result in serious implications that potentially impact on a physician's license, livelihood, reputation, and career. Penalties may consist of: censure and reprimand; community service up to 500 hours; probation, which may include monitoring, education/training, and monetary fines of up to $10,000 for each adverse finding; and/or surrender, revocation, or partial or actual suspension of a license to practice medicine. Adverse findings are reportable to the National Practitioner Data Bank. In addition, each final decision, the nature of the charges, and penalties imposed by the professional disciplinary agency will become a matter of public record. All details are posted online at http://w3.health.state.ny.us/opmc/factions.nsf.

Physicians are afforded due process throughout an OPMC inquiry and are thereby entitled to legal representation during each phase of the investigation. The physician disciplinary process can be emotionally overwhelming and complicated. Therefore, it is essential that physicians retain experienced legal counsel immediately in order to protect their interests, including their license to practice.

It is important to note that attorney fees generated during an OPMC investigation are NOT covered under a physician's professional liability insurance policy from MLMIC. The good news is that physicians may purchase from MLMIC a Legal Defense Cost Coverage endorsement to their malpractice policy which would provide coverage for reasonable legal expenses.

Given the serious nature of misconduct investigations, medical professionals should insulate themselves with all available resources. The supplemental payment provisions in the endorsement offered by MLMIC for the defense of disciplinary proceedings is invaluable to providers who are confronted with these stressful challenges. Endorsement limits of $25,000 or $100,000 are available

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Physician, Protect Thyself: *continued from page 5*

for an annual premium of $300 or $800, respectively. The endorsement will cover reasonable legal fees in the following two types of situations:

1. administrative actions such as OPMC inquiries, as discussed above (only if the underlying allegations relate to the potential basis of a patient-related claim that would be covered by a medical malpractice policy issued by MLMIC); and
2. governmental civil proceedings by a state or federal agency conducting fraud and abuse investigations into allegations of violating established Medicare or Medicaid reimbursement guidelines.

Exclusions in the endorsement include allegations of commission of a crime or misdemeanor. Costs relative to sanctions, fines, and penalties are also excluded from coverage.

MLMIC's optional endorsement provides beneficial coverage for a physician's peace of mind. Should the need arise, a physician who has this endorsement may obtain an experienced medical professional licensing attorney of their choosing, and MLMIC would then pay for reasonable legal fees associated with that representation, up to the available limit purchased by the physician.

To benefit from the coverage available through a Legal Defense Cost Coverage endorsement, it is imperative that physicians obtain it prior to receipt of any investigatory communication. Although most MLMIC insureds have already obtained this coverage, do not wait until you are contacted by the Department of Health or a governmental health payor to verify whether you are protected by this easily available and affordable endorsement. If you would like to ascertain whether you already purchased an endorsement, or are interested in receiving an application for one, please contact the Company at any of the numbers on the back of this edition and ask to speak with your assigned underwriter. ❖

DISCLAIMER: This article is intended to point out certain policy endorsement provisions. It is not intended to substitute for our policy. The insurance coverage afforded by your policy is subject to all of the terms, conditions, limits and exclusions described throughout the policy. It is essential that you read your entire policy because all sections of the policy are interrelated. If there are any conflicts between this article and your policy, the terms and conditions of your policy will prevail.

UNDERWRITING Update

Ensure Your Practice Remains up to Date

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Just as medicine and physician practices evolve, your Professional Liability Coverage must evolve as well; your malpractice policy must reflect your current practice. Therefore, it is important to notify the Company's Underwriting Department of any changes occurring in your practice. Modifications ranging from a new email address to changes in practice locations, employment relationships, and/or legal structures create the need to communicate with the Company in order to keep coverage up to date. For more intricate matters such as questions on healthcare law, resources to deal with complex medical-legal challenges, or guidance with risk management issues, access to attorneys from the law firm of Fager Amsler Keller & Schoppmann, LLP (FAKS) which serves as counsel to MLMIC, is provided to MLMIC Insureds without charge and can be initiated through phone or email contact with 855 FAKS-LAW or hotline@FAKSLAW.com, respectively.

MLMIC's Underwriting Department not only processes applications and policies, but also assists policyholders with any policy or coverage questions that they may have. It is important to contact them when a provider joins or leaves a group or adjusts their hours. It would be unfortunate for an Insured to not take advantage of a Part-Time Discount simply for failure to notify the Company of a reduction in practice hours.

Other changes that could have a similar effect on an Insured's premium include limiting the scope of his or her practice whereas there may be a lower premium class available for that specialty, or a change in primary practice location to another county. Our Underwriters will help guide you to explore options for your practice as it continues to evolve as well as advise on any cost saving measures that may be available.

For the convenience of our Insureds, changes to both email addresses and phone numbers can easily be made by logging into their secure account at MLMIC.com and selecting "Update Profile." Policyholders can also make additional inquiries electronically at the "Contact Us" page.

Eligible, newly formed or existing Professional Entities should consider purchasing Professional Entity coverage from MLMIC with separate limits of liability if they haven't already done so. For a more in-depth explanation of this invaluable coverage, please refer to the Underwriting Update from the Spring 2017 edition of *MLMIC Dateline*® entitled, "Coverage Levels and Options for Medical Practices and Their Employees."

If your practice has grown so that individual invoices are cumbersome, we can easily set up a group billing statement with complete detail for each practitioner within the group including individual policy

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Social Media: Responding to Unflattering Online Reviews

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The number of patients and healthcare professionals using social media has exploded in recent years. Social media is used for social networking, professional networking, media sharing, blogging, and research and information gathering. New sites are popping up with increasing frequency, allowing users to easily connect with each other. Healthcare practices have also recognized the benefits of social media, establishing websites, Facebook pages and Twitter accounts for public relations and marketing.

Many social networking sites invite participation and engagement by the online community. Practice-owned Facebook pages and websites may allow readers to respond to published content by posting their own comments. Some sites, such as Healthgrades, Zocdocs, RateMDs.com, Vitals.com, Google Reviews, Yelp, and Angie's List are specifically designed to solicit patient reviews of their experiences with healthcare providers.

According to a 2015 study of a large accountable care organization in eastern Massachusetts, 53% of physicians and 39% of patients reported visiting a physician rating website at least once. Interestingly, while physicians had a higher level of trust in comments associated with health system surveys compared to independent websites, patients felt just the opposite.[1]

Reviews left by patients can be positive or scathing. They are not based upon any empirical data and reflect the patient's perception of his or her experience. A negative comment about you or your practice will exist in the blogosphere for years to come and could turn up whenever your name is searched online. Thus, when a healthcare provider is faced with a negative review, there is a strong temptation to respond and to defend oneself against the criticism. The fear is that the review is damaging to one's reputation and that it will be relied upon by others. Yet the impulse to immediately respond should be checked for several reasons.

First and foremost, responding to a negative review online runs the very real risk that the provider will divulge details about the patient's care in violation of patient privacy laws. In 2016, The Washington Post reported that Yelp identified 3,500 instances of one-star reviews in which patients mentioned privacy concerns or HIPAA. The report stated that in dozens of instances, responses to complaints about medical care turned into disputes about patient privacy, and it identified at least two instances where dentists were under investigation by the Office of Civil Rights for HIPAA violations.[2] In 2013, a California hos-

1. Holliday, A.M., Kachalia, A., Meyer, G.S. et al., Physician and Patient Views on Public Physician Rating Websites: A Cross-Sectional Study, Journal of General Internal Medicine, June 2017, volume 32, Issue 6, pp. 626-631.

2. C. Ornstein, Doctors fire back at bad Yelp reviews- and reveal patients' information online, May 27, 2016, accessed at https://www.washingtonpost.com/news/to-your-health/wp/2016/05/27/docs-fire-back-at-bad-yelp-reviews-and-reveal-patients-information-online/?utm_term=.c1c4d331433c.

pital was fined $275,000 for disclosing a patient's medical information in response to a patient's complaint to the media.[3] Therefore, a provider cannot generally respond directly to a negative posting without risking a privacy violation. If the patient's complaint is relatively benign, it may be best to ignore the post.

Providers may wonder if they can sue a patient for posting an online review. Aside from the notoriety which accompanies suing one's patients,[4] there is little to gain by diving into litigation. Web site operators are insulated from liability for the content of patient reviews under federal law.[5] Under First Amendment principles, patients have a right to voice their opinions online, no matter how hurtful those opinions may be. An action for defamation will not be successful unless the posting, read as a whole and looking at the overall context, states false facts rather than protected opinions.[6] Finally, if a provider wishes to bring legal action against a patient for a negative review, the provider will have to pay his or her own attorney's fees. Professional liability polices do not cover the initiation of a lawsuit against a patient.

So, what can you do by way of a response to a negative online review? Caution is advised before you make any response. Don't do anything immediate or rash. Take a step back, a deep breath, and think carefully about your response strategy. Remember that one bad review will not destroy an otherwise good reputation and that many readers will just ignore comments which seem malicious or motivated by spite.

Try to determine if the review is from a patient, an unhappy employee or former employee, or a friend or relative of a patient.

If you choose to respond online, keep the comment general. You may speak to your overall policies or procedures without mentioning any patient identifying information. You may reiterate that your office is always available to discuss concerns with patients and that they should feel free to contact you directly. If you are able to identify the patient, you may wish to reach out to that patient with an invitation to personally discuss his or her concerns.

Think carefully before discharging the patient in response to the review because it may be viewed as retaliation and may set off another round of negative comments. However, if the post threatens the safety of you, your staff or your family, you should notify the police.

Finally, if you believe the review raises the possibility of a malpractice action against you or your practice, notify your professional liability carrier to report the event.

Generally speaking, the best course of action in response to a negative online posting is to not spend a great deal of energy refuting it. Instead, encourage all your patients to provide honest feedback regarding their experiences. You will most likely find that most patients are happy with your services and the good reviews will far outnumber the bad ones. ❖

3. Shasta Regional Medical Center Resolution Agreement, https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/enforcement/examples/shasta-agreement.pdf.
4. Caitlin Nolan, Doctor Sues Patient for Writing Negative Review of His Services He Claims Was Defamatory, Inside Edition, November 6, 2015, http://www.insideedition.com/headlines/12838-doctor-sues-patient-for-writing-negative-review-of-his-services-he-claims-was-defamatory; Barbara Ross, Manhattan dentist sues five patients in four years over negative web reviews, New York Daily News July 26, 2013, http://www.nydailynews.com/new-york/manhattan/manhattan-dentist-sues-5-patients-4-years-bad-reviews-article-1.2726895.
5. The Communications Decency Act, 47 USC § 230.
6. E.g., Crescendo Designed Ltd. V. Reses, 2017 Slip Op. 05198 (2d Dep't June 28, 2017).

  - the prescribing practitioner has carefully reviewed the information prior to signing the prescription.[3]
- performing health-related tasks;
- measuring vital signs and/or weight (if appropriately trained) and recording them in the patient's medical record;[4]
- performing an EKG, if trained to do so, but not interpreting it;[5]
- collecting laboratory specimens;[6]
- performing phlebotomy, if appropriately trained;[7]
- acting as a "second set of hands" under the direct personal supervision of a licensed professional; (For example, medical assistants may maintain a patient's body part in the position that the practitioner, not the medical assistant, has established while a bandage is applied or sutures are removed.)[8]
- entering information for the physician into the computer, which must be reviewed and signed by the physician prior to the completion of the entry;[9]
- using a glucometer;[10]
- caring for external catheters only;[11]
- preparing and handing instruments to a practitioner during an office procedure;[12]
- assisting with the placement of braces and prostheses;[13] and
- removing sutures, "but only when the medical assistant has been trained in the procedure, only when ordered by a physician or other appropriately licensed person, and only under the direct suture-by-suture visual supervision of a physician or other appropriately licensed person."[14]

The above are acceptable tasks for medical assistants only if they have undergone the necessary training and the practitioner has deemed them able to safely and competently perform these tasks. Evidence of competency should be documented in the medical assistant's personnel file. Additionally, practitioners should periodically re-evaluate the skills of a medical assistant, particularly if problems, such as consistently abnormal vital signs, are noted. Finally, licensed emergency medical technicians acting in a hospital, clinic, or private office setting are also restricted to only those tasks deemed acceptable for delegation to medical assistants.[15]

The Board for Medicine has also provided a list of tasks that unlicensed personnel or medical assistants may not perform, regardless of training. This list includes, but is not limited to:

- engaging in any activity that could be construed as diagnosis or treatment of a patient, including assessment, evaluation, counseling, giving medical advice or problem solving (such activities are considered to be the practice of medicine and/or nursing);[16]
- performing telephone triage;[17]
- applying or removing casts, or applying sutures (a medical assistant may remove sutures if all of the previously mentioned conditions apply);

3. Letter from Peter D. VanBuren, Deputy Counsel to Bureau of Professional Medical Conduct, to Frances A. Ciardullo, Esq., (September 7, 2007). (On file with author).
4. Email Opinion, State Board for Nursing, December 2014. (On file with author).
5. Email Opinion from State Board for Nursing, June 2016. (On file with author).
6. Memorandum from Walter Ramos, R.N., J.D., Executive Secretary to the New York State Board of Medicine to Interested Parties (April 2010, modified October 2014). (On file with author).
7. Id.
8. Id.
9. E-mail Opinion Carla Wells, State Board for Medicine, June 2016. (On file with author).
10. Guidelines Regarding Utilization of Licensed Nurses (RNs and LPNs) and Unlicensed Assistive Personnel (UAP) in the Delivery of Nursing Care, NYSNA/NYONE, August 2007. (On file with author).
11. Id.
12. Summary of Tasks Requiring Licensure in the Operating Room, New York State Department of Education, Office of the Professions, August, 2013. (On file with author).
13. Guidelines Regarding Utilization of Licensed Nurses (RNs and LPNs) and Unlicensed Assistive Personnel (UAP) in the Delivery of Nursing Care, NYSNA/NYONE, August 2007. (On file with author).
14. Memorandum from the Executive Secretary of the State Board for Medicine to Interested Parties, April 2010, modified October 2014. (On file with author).
15. Public Health Law §§ 3001 (1), (5), and (6), Telephone Interview with the New York State Department of Health Bureau of Emergency Medical Services, November 2010. (On file with author).
16. Education Law §§ 6521, 6522, 6902.
17. Memorandum from the Executive Secretary of the State Board for Medicine to Interested Parties, April 2010, modified October 2014. (On file with author).

- administering or "drawing up" any type of medication, including immunizations, injections, eye drops, allergy shots, and/or nebulizer treatments;[18]
- administering oxygen or blood;[19]
- performing sterile or invasive procedures or techniques, including urinary catheter insertion;[20]
- performing any type of respiratory care, including tracheostomy care;[21]
- initiating or documenting prescription refills;[22]
- updating a patient's medication list;[23] and
- initiating or documenting laboratory tests and radiology studies ordered by a physician.[24]

A common misconception continues to exist that if a physician trains a competent unlicensed person to perform an act or task which is reserved for licensed personnel, the physician may then delegate that task to the unlicensed individual. However, this is not true, despite the unlicensed individual acting under the direct supervision of the physician.[25]

Physicians need to be aware that State law defines professional misconduct in two ways that pertain to the use of medical assistants. First, it is professional misconduct to "permit, aid or abet an unlicensed person to perform activities requiring a license."[26] Second, it is professional misconduct if a physician delegates "professional responsibilities to a person" when they "know or has reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them."[27] Therefore, any physician who inappropriately delegates any task or procedure to an unlicensed person risks an investigation by the Office of Professional Medical Conduct (OPMC) and potential charges of professional misconduct, up to and including revocation of the physician's license. OPMC Counsel has indicated that OPMC investigations are often commenced when a patient is injured due to the inappropriate delegation of tasks to unlicensed individuals.

Improper delegation of duties to medical assistants may also result in malpractice claims or lawsuits by patients. MLMIC has seen an increase in such litigation.

Finally, medical assistants who perform inappropriately delegated tasks may face allegations of practicing medicine or nursing without a license, and may be charged with a Class E felony.[28] The Department of Health may choose to investigate and penalize the physician employer based upon such allegations, and criminal proceedings could potentially be commenced for aiding and abetting medical assistants to "prac-

18. Id.
19. Guidelines Regarding Utilization of Licensed Nurses (RNs and LPNs) and Unlicensed Assistive Personnel (UAP) in the Delivery of Nursing Care, NYSNA/NYONE, August 2007. (On file with author).
20. Id.
21. Email opinion, NYS Board for Nursing, June 2, 2016. (On file with author).
22. Email opinion, NYS Board for Nursing, December 16, 2014. (On file with author).
23. Id.
24. Id.
25. Memorandum from Walter Ramos, Executive Secretary to the State Board for Medicine to Interested Parties, April 2010. (On file with author).
26. Education Law § 6530 (11).
27. Education Law § 6530 (25).
28. Education Law § 6512 (1).

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tice medicine or nursing" without a license.[29]

In summary, it is in the best interests of both physicians and medical assistants to function solely within the confines of state law and the guidance provided by the New York State Boards for Medicine and Nursing to avoid allegations of professional misconduct, medical malpractice, or even criminal acts against the physicians and the potential consequences to licensure and professional medical liability insurance coverage.

Risk Management Recommendations

1. Physicians and other licensed professionals must comply fully with New York State laws governing the delegation of tasks to medical assistants.
2. Medical assistants must wear badges identifying themselves by both name and the title "medical assistant."
3. Medical assistants must be allowed access to only those portions of patients' medical records that are necessary to perform their job function.
4. Medical assistants must never be permitted to perform any task that is considered the practice of medicine or nursing, particularly administering or "drawing up" any type of medication or injection.[30]
5. Medical assistants must be strictly limited to performing those tasks deemed acceptable by the New York State Boards of Medicine and Nursing. Further, tasks that are limited to licensed cosmetologists and estheticians must also not be inappropriately delegated to medical assistants.
6. Non-licensed individuals may complete information on electronic prescriptions. However, all providers must understand that they have assumed a serious risk by allowing non-licensed individuals to do so and must carefully review all input prior to signing the prescription and sending it electronically. Providers are ultimately responsible and liable for any and all errors made by medical assistants.[31]
7. Physicians' offices must have a written policy regarding prescriptions and communication with pharmacies, and all staff must know, understand and comply with that policy. When pharmacists question the dosage of a drug written on a prescription, only the licensed provider who prescribed the drug may adjust the dosage. Pharmacists must speak directly with licensed prescribers to avoid errors in communication.

Several factors should be considered when deciding whether to assign activities to a medical assistant, including:

1. Potential for Harm: Is the patient at risk of harm if an unlicensed person performs a particular task or procedure he or she is legally permitted to perform? As the risk of harm increases, a registered nurse should perform the task. The risk of harm for a particular task or procedure may vary from patient to patient.
2. Complexity of the Task: What skills are required to perform a particular activity? As the level of skills required grows more complex, a registered nurse should perform the task.
3. Problem Solving and Innovation: Activities that require assessment and judgment or special adaptation, an innovative approach for certain patients or evaluation of the outcome, must be performed by a registered professional nurse.
4. Unpredictability of the Outcome: If the patient's response to an activity is predictable, a medical assistant may be able to perform the activity. If the outcome is unpredictable, or unknown, it should only be performed by licensed personnel.[32] ❖

29. Education Law § 6514.
30. Education Law § 6522. The practice of medicine is limited to those individuals licensed under Education Law Article 131. Education Law § 6903, No person shall use the title "nurse" unless the person is licensed or otherwise authorized under this article. Memorandum from Barbara Zittel, RN, PhD., Executive Secretary to the New York State Board for Nursing, (2001) (On file with author).
31. Letter from Peter D. VanBuren, Deputy Counsel to Bureau of Professional Medical Conduct, to Frances A. Ciardullo, Esq., (September 7, 2007). (On file with author).
32. Guidelines Regarding Utilization of Licensed Nurses (RNs and LPNs) and Unlicensed Assistive Personnel (UAP) in the Delivery of Nursing Care, NYSNA/NYONE, August 2007. (On file with author).

Ensure Your Practice Remains up to Date *continued from page 7*

numbers and premiums for ease of reference and payment.

Group practice administrators that prefer to manage coverage for an entire group through a single policy administrator may want to consider a Multi-Risk policy. Not only does this afford the group with the simplicity of one bill for the entire practice, but it also provides the ability to track loss trends which may afford the group the opportunity for a discount, or the benefit of targeted Risk Management services if desired. It is important to note that there are several "policy level" conditions that must be met for this policy format:

- Every person named on the policy must have the same type of coverage, either occurrence or claims made.
- If a deductible applies, it applies to all individuals on the policy.

- If a waiver of consent provision applies, it applies to all individuals on the policy.

Taking some time to evaluate the status of your practice may unveil a few unaddressed items as described in this article. To discuss any of the above matters in further detail, please contact the Company at any of the numbers on the back of this edition and ask to speak with your assigned underwriter. ❖

This article is intended to point out certain policy provisions that relate to potential gaps in professional entity coverage. It is not intended to substitute for our policy. The insurance coverage afforded by your policy is subject to all of the terms, conditions, limits and exclusions described throughout the policy. It is essential that you read your entire policy because all sections of the policy are interrelated. If there are any conflicts between this article and your policy, the terms and conditions of your policy will prevail.

2017 Event Calendar

September 21 New York MGMA – Central New York Chapter *Syracuse*

September 23 New York State Society of Orthopaedic Surgeons Annual Meeting *Manhattan*

September 26 New York State Osteopathic Society Board Meeting *Garden City Park*

October 6-8 ACOG District II – 2017 Annual Meeting *Bermuda*

October 14-15 New York State Neurological Society (NYSNS) *Manhattan*

October 28 Medical Society of the County of Queens Autumn Gala Dinner Dance *Queens*

November 6 NYS Society of Plastic Surgeons Annual Meeting *NYC*

November 9 New York State Osteopathic Society Board Meeting *Westbury*

December 8-12 NYSSA Post Graduate Assembly in Anesthesiology (PGA) *NYC*

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

RISK MANAGEMENT Tips

Tip #22: The Proper Use of Patient Portals

The Risk: Patient portals are an effective tool to actively engage patients in their care to improve health outcomes. However, healthcare professionals must be aware of the potential risks presented by this technology. Some of these risks include: reliance on the patient portal as a sole method of patient communication; patient transmission of urgent/emergent messages via the portal; the posting of critical diagnostic results prior to provider discussions with patients; and possible security breaches resulting in HIPAA violations. Implementing appropriate policies and procedures in the use of portals will enhance patient communication and mitigate liability risks for the practice.

Recommendations:

1. Develop comprehensive patient portal policies which include:
    - patient username and password requirements (minimum number of characters including capitals and non-alphabet characters);
    - a privacy/confidentiality statement on all outgoing messages;
    - encryption updates;
    - account lockout after a specified number of failed login attempts;
    - a mechanism to ensure termination of user access when indicated (e.g., the patient leaves the practice, death, inappropriate use of the portal, etc.);
    - timeframes for responding to patient communication;
    - designated responsibility for replying to patients when the primary provider is not available;
    - utilizing a two patient identifier system for importation of diagnostic studies into the patient portal;
    - monitoring patient access to posted diagnostic results;
    - a follow-up system for patients that do not access the portal; and
    - a mechanism to notify patients if the portal is not functioning properly. A notification should be placed on the practice's website, and also included on any prerecorded telephone message.
2. Advise patients of the reporting mechanism for:
    - email address changes;
    - questions regarding portal use;
    - potential errors in their information; and
    - suspected breaches of privacy.
3. Providers should not use the portal as the means to communicate critical/significant diagnostic results. Diagnostic results should not be posted to the portal until this communication occurs.
4. Instruct patients that the portal is not to be used to evaluate and treat new problems.
5. Utilize a disclaimer on the portal that clearly states it is not to be used for emergencies/urgent problems and include instructions for patients to call 911 or go to the nearest emergency department.
6. Consider the use of a patient portal user agreement that:
    - defines the information patients may access (e.g., appointments, medication refills and referral requests, form downloads, routine appointment reminders, and laboratory reports);
    - prohibits requests for narcotic medication refills;
    - states that the patient portal is the only permissible method of electronic communication with the practice; and
    - includes the disclaimer statement regarding urgent/emergent/new problems.
7. Have staff educate patients regarding the use of the portal and the contents of the portal user agreement upon patient sign-up and as necessary. For additional resources, please contact the attorneys at Fager Amsler Keller & Schoppmann, LLP. ❖

THE MLMIC Library

Fall 2017 Update

The MLMIC Research Library's services are available to all policyholders on a complimentary basis and may be accessed via MLMIC.com by selecting the MLMIC Research Library link at the bottom of the home page under *Services & Resources*. In-depth research services are also available to all policyholders.

The following titles are new additions to the catalog or they pertain to topics featured in this issue of *MLMIC Dateline*®. Please visit the MLMIC Research Library to learn more about these titles and to borrow up to five items from our extensive collection. Or, contact Judi Kroft, Library Administrator at the website's *Ask the Librarian* link, or telephone 800-635-0666 ext. 2786.

- **AMDA 2017–DVDs of Society for Post-Acute and Long-Term Medicine Annual Conference: Phoenix 2017.** American Medical Directors Association; 2017 (LTC 104-136 2017).
- **Clinical collaboration in the post-acute and long-term care setting: LTC Information Series.** American Medical Directors Association; 2016 (LTC 104-150).
- **Drug diversion prevention in healthcare.** Kimberly New. HCPro; 2016 (R M 151-107 2016).
- **Effective peer review: The complete guide to physician performance improvement.** Robert J. Marder. HCPro, Inc.; 2013 (Med Staff 113-079 2013).
- **Emergency care for children - growing pains: Future of emergency care.** Institute of Medicine; 2007 (E R 079-043).
- **The EMTALA answer book 2017.** Jeffrey C. Moffat. Wolters Kluwer; 2017 (Medicolegal 330-023 2017).
- **Guidelines for perioperative practice.** Association of Operating Room Nurses, Inc.; 2017 (Surgery 167-003 2017).
- **HIPAA for managers: Meeting your responsiblities under the law.** Kantola Training Solutions; 2016 (DVD 002-612 2016).
- **I'm here: Compassionate communication in patient care.** Marcus Engel. Phillips Press; 2010 (Pt Rights 131-021).
- **Improving diagnosis in health care: Quality Chasm Series.** ; National Academies Press; 2015 (R M 151-150).
- **Medical malpractice in New York.** Robert Devine. New York State Bar Association; 2017 (Med Mal 112-049 2017).
- **Physician office risk management playbook.** ASHRM; 2016 (R M 151-149 2016).
- **Quality control in the age of risk management: Clinics in laboratory medicine.** James Westgard and Sten Westgard. Elsevier Inc.; 2013 (R M 151-148 2013).
- **Risk management PEARLS on disclosure of adverse events.** American Hospital Association; 2017 (Pt Rights 131-014 2017).
- **Toward precision medicine: Building a knowledge network for biomedical research and a new taxonomy of disease.** National Research Council of the National Academies; 2012 (R M 151-151 2012).
- **The younger adult in the long term care setting: LTC information series.** American Medical Directors Association; 2013 (LTC 104-149).

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

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Case Study

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did not always follow those instructions. The patient's follow up visits should have been scheduled by the office at the time the patient was seen. If the patient is noncompliant or does not return as advised, the patient should be contacted and advised of the importance of keeping time sensitive appointments.

Additionally, there was no evidence to suggest that the PA ever consulted with the dermatologist about the patient's complaints or her condition, although he did document the patient's appearance with photographs. The dermatologist himself stated that he would have preferred to know about the patient's complications early on. Since the patient alleged negligent postoperative treatment of her burns, it would have been prudent to involve the dermatologist in the management of her condition right away, and perhaps her outcome might have been improved.

Finally, this case illustrates the importance of having entity coverage in place for the professional practice itself. This was a case where the dermatologist was vicariously liable for the negligent acts of his employed esthetician. In cases of vicarious liability, the physician may not have committed any negligence. Instead, liability is based upon the relationship between the physician and the person who actually committed the negligent act – in this case, the relationship of employer and employee.

Physicians are legally responsible for the errors of those they employ and those they direct and control. Purchasing separate liability coverage for the physician's entity provides a layer of protection when the entity is named in a suit alleging errors by employees who do not have their own malpractice insurance. Here, there was no entity coverage so the payment was made on behalf of the individual dermatologist. It was therefore reportable to the National Practitioner Data Bank. If the settlement payment had been made by the entity and not on behalf of an individual physician, it would not have been reported to the National Practitioner Data Bank. ❖