



THE SCOPE

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Managing Your Social
Media Presence

The Joint Commission
Issues Telehealth Strategies

CASE STUDY:
Improper Medication
Management in
Psychiatric Treatment

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EXECUTIVE MESSAGE

To Our MLMIC Insurance Company Policyholders:

As I write this, it's Thanksgiving eve. Normally, families would be traveling to convene at a parent's or sibling's home, kids in tow, for our traditional national feast and holiday. But obviously, this year is different. And while the holidays (and occasionally our extended families) can be sources of stress, I suspect most of us would welcome a return to norms and traditions. In other words, next year... I'm having two slices of pie..

It is with optimism that we anticipate the implementation of three newly developed COVID-19 vaccines. We trust that these treatments will help to minimize or eliminate both the fear and reality of future "waves" of this pandemic and help us get back to celebrating the traditions we cherish with those we love.

Throughout it all, *MLMIC continues to work for you.*

The [MLMIC.com](https://www.mlmic.com) portal is being updated with useful features for the administration of policies by both our policyholders and their staff. Our Risk Management department is hard at work developing our next CME program, which will provide a 5-12% premium credit, eligibility for the NYS excess insurance program, and practical insights into "Diagnostic Error, Near Misses, and High Exposure Cases." And a new coverage option for employed physicians, SILO, is being developed for healthcare practices, facilities, and systems.

Stay tuned!

My sincere wishes for a happy and healthy holiday season,

A handwritten signature in black ink that reads "John W. Lombardo MD". The signature is fluid and cursive, with a long, sweeping underline that extends to the left.

John W. Lombardo, MD, FACS
Chief Medical Officer, MLMIC Insurance Company
jlombardo@mlmic.com

To: Joyce Siska
MLMIC Insurance Company Underwriter

“Thanks for your assistance, Joyce, and for MLMIC’s coverage of my medical practice over the decades and into the future through its ‘tail.’ Thankfully, I never had to endure a malpractice claim, trial, or settlement over the course of my 45-year career as a family physician providing continuous outpatient, in-hospital, and obstetrical care.”

William Morehouse, MD
Family Practitioner
Rochester, New York



Managing Your Social Media Presence

PART ONE: AVOIDING SOCIAL MEDIA PITFALLS



Social media's use in society has continued its rapid expansion. In fact, statistics demonstrate that roughly 80% of adults are using some form of social media – a figure nearly double the amount just ten years ago.¹ Social media applications like Twitter, Facebook, and Instagram have become part of daily life for individuals and businesses alike. These include healthcare professionals, practices, groups, hospitals, and large health systems.

Healthcare professionals and organizations must take appropriate steps to manage their online presence, address negative patient commentary, and develop policies to prevent the inappropriate use of social media by employees and staff.

This installment is the first in a series that will explore how healthcare professionals can effectively manage their social media presence while minimizing the risks that using these platforms can present.

Media sharing applications are cost-effective tools that allow healthcare professionals and organizations to promote their services, educate the public, and even communicate with current and prospective patients. However, unlike many other industries, the use of social media presents unique risks to healthcare professionals and organizations that can have a devastating effect on a career or practice.

Social Media Pitfall No. 1:

Breaches of Patient Confidentiality

Without question, the biggest risk associated with the use of social media in healthcare is the potential for a breach of patient confidentiality. Studies have

demonstrated that more than half of the compromised data records worldwide stem from social media incidents.² Included in this statistic are breaches of patient confidentiality resulting from the inappropriate use of social media applications by healthcare professionals and organizations.

State and federal privacy regulations, including the Health Insurance Portability and Accountability Act (HIPAA), require healthcare professionals to safeguard the protected health information (PHI) of their patients. Known as its “Privacy Rule,” HIPAA regulations have mandated a national standard that healthcare professionals must ensure the protection of individually identifiable health information held or transmitted in any form or media.³

While most, if not all, healthcare professionals are familiar with these requirements, many likely have not considered the application of the Privacy Rule to social media and the ramifications a breach of protected information in that forum could have on a practice.

SOCIAL MEDIA AND HIPAA ENFORCEMENT

A recent settlement by the Department of Health and Human Services, Office of Civil Rights (OCR), highlights how the inappropriate use of social media can lead to possible HIPAA violations and negatively impact a practice.

After receiving a complaint from a patient, OCR determined that a Dallas-based dental practice had wrongfully disclosed the names, treatment plans, and insurance information of multiple individuals in response to comments made on an internet review site. During its investigation, OCR also determined that the practice did not have policies and procedures in place with respect to PHI, including its release on social media platforms.

In the resolution, the practice paid a \$10,000 fine and was required to develop, maintain, and revise as necessary written HIPAA-compliant policies and procedures with respect to the privacy and security of patient information.⁴ In his commentary about the resolution, OCR Director Roger Severino stressed “social media is not the place for providers to discuss a patient’s care.”⁵

INADVERTENT BREACH OF CONFIDENTIALITY

The Dallas dental practice case is

an example of direct disclosure made on social media that caused a breach of patient confidentiality. Healthcare professionals must also be mindful that inadvertent violations of patient confidentiality can occur, especially when using platforms such as Facebook or Twitter that allow for two-way communication between users.

Consider this hypothetical example: A dermatologist posts on Facebook about an exciting new treatment being offered at the practice. An existing patient with a skin condition asks if she would be a candidate for the treatment. The physician responds that she would be a candidate and specifically identifies the patient’s skin condition, noting

Due in part to her unsafe practices, the physician ultimately agreed to a two-and-a-half-year suspension of her medical license.⁶

that treating it would not be a problem. In answering the question, the physician inadvertently disseminated the patient’s PHI to all the practice’s Facebook followers.

Just over a decade ago, such a breach was not possible. Today, with the reach of social media, the unintended breach of privacy could be broadcast to hundreds, if not thousands, of individuals

Simply stated, social media should never be used to discuss patient care. As the use of social media in society becomes more and more routine, the potential is there for healthcare professionals to let their guard down and forget this simple

rule. Healthcare professionals and organizations must ensure that information disseminated through social media does not include any PHI that identifies or could identify a patient. For this reason, practitioners should avoid engaging in two-way communication with patients on social media.

Social Media Pitfall No. 2: Posts in Violation of Professional Conduct, Policies, and Good Taste

Aside from a breach of patient confidentiality, the biggest risk presented by social media is the potential for its misuse by professionals or staff, which can have a severe impact on the professional image of a practitioner or organization. Perceptions based on information generated on social media can make a lasting impression.

The most prevalent example of misuse is the physician who posted videos to her public YouTube channel of herself dancing and singing in the operating room holding surgical instruments without wearing a surgical mask or gloves while patients lay unconscious on the operating table. Despite claiming to have had the patients’ consent to make these videos, which were posted for promotional purposes, it ultimately had the undesired effect of gaining national notoriety for unprofessional and unsafe behavior. Due in part to her unsafe practices, the physician ultimately agreed to a two-and-a-half-year suspension of her medical license.⁶

Healthcare professionals should also be mindful that even inadvertent comments or imagery that seems harmless could be misconstrued

or taken out of context. In fact, just recently, a large health system that services multiple Southern states posted a photograph of a physician performing surgery in a racing helmet as part of a #WearYourHelmetToWork movement. Despite removing the post, it drew media attention and

...the surgeon claimed that the anesthesiologist failed to notice dangerously low blood-oxygen levels for nearly 20 minutes...

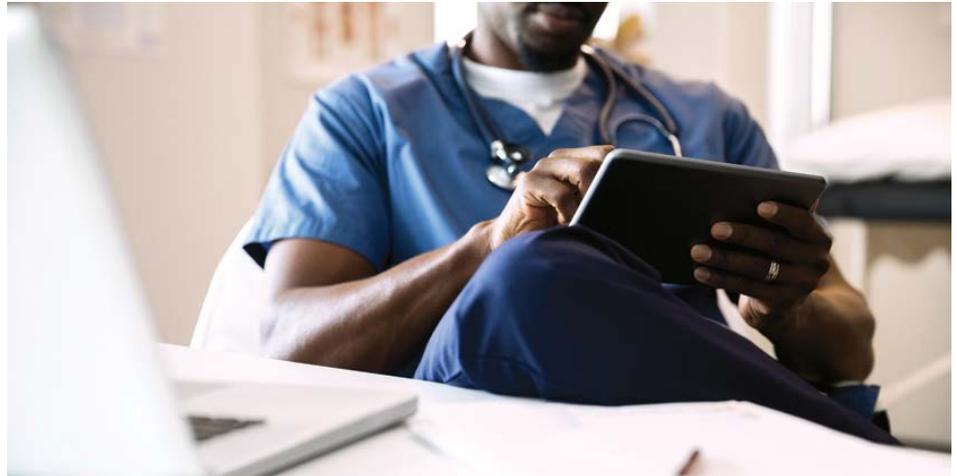
required the system to comment that the action was unacceptable and in violation of its policies.⁷

Social Media Pitfall No. 3: Digital Distraction

Whether it is a call from another physician, a question from a staff member, or even responding to an equipment alarm in a hospital setting, healthcare professionals are adept at dealing with distractions while remaining focused on patient care. That said, digital distractions caused by social media applications present an entirely new vulnerability that could have a detrimental effect on the quality of patient care.

By design, social media applications are incredibly addictive and geared to keep users engaged for extended periods of time. The habitual use of personal devices containing social media applications for nonclinical purposes can cause distraction, leading to errors in care and potential medical professional liability claims.

The impact digital distraction could potentially have on patient care was a central issue in a wrongful



death case venued in Texas that stemmed from a node ablation surgery.⁸ During a deposition, the defendant surgeon claimed that the codefendant anesthesiologist failed to notice dangerously low blood-oxygen levels for nearly 20 minutes after the patient developed cyanosis. The surgeon testified that during that time, the anesthesiologist was using a personal handheld electronic device. Surprisingly, the surgeon went on to volunteer:

“You know, we see this sort of thing with these procedures. I mean, they’re long procedures. We see this kind of thing and usually – it’s not – doesn’t seem to be a problem especially with relatively short procedures. What can I say? I mean it happens.”

During his deposition, the defendant anesthesiologist denied surfing the web or posting on Facebook while managing the decedent’s anesthesia. He went on to testify that posting on social media while managing a case would not be recommended “because you’re supposed to be monitoring the patient.”

Having set the trap, the plaintiff’s attorney produced a post from the

anesthesiologist’s Facebook page that depicted a photograph of an anesthesia monitor that showed the vital signs of an anonymous patient accompanied by the comment: “just sitting here – sitting here watching the tube on Christmas morning. Ho, ho, ho.” The anesthesiologist tried to rehabilitate his testimony by explaining that the post could have been made after he had completed the anesthesia management. But the damage was done, not only to his credibility, but also to the

The anesthesiologist tried to rehabilitate his testimony...but the damage was done...

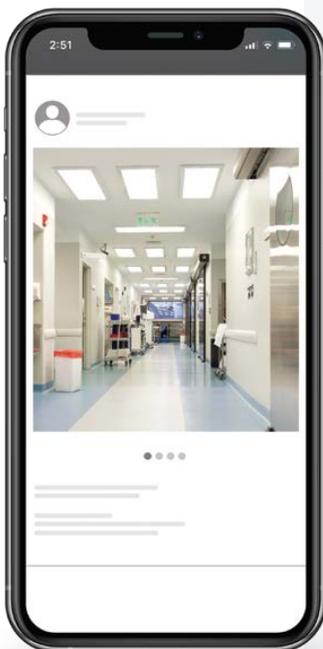
strength of his argument that he was not digitally distracted during his management of the deceased patient’s anesthesia.

This is just one example of how digital distraction could stem from the use of social media. As use of these applications becomes more entrenched in our day-to-day personal and professional activities, we should anticipate seeing more medical professional liability claims involving similar fact patterns. Similarly, plaintiffs’ attorneys will likely increase their probe of

social media usage by healthcare professionals during the discovery process to determine whether digital distraction played a role in any alleged negligence.

New York state's highest court, the Court of Appeals, has determined that well-established rules that permit the discovery of any information that is material and necessary apply equally to social media, even if the information was posted on a nonpublic portion of the application.⁹ In fact, the Court has noted that there is not a "heightened threshold for production of social media records that depends on what the account holder has chosen to share on the public portion of the account."¹⁰

Like a medical record, private materials on social media may be subject to discovery if they are relevant. "For purposes of disclosure, the threshold inquiry is not whether the materials sought are private, but whether they are reasonably calculated to contain relevant information."¹¹



Avoiding Social Media Pitfalls – What to Consider

Solo practitioners and large health systems alike must take steps to minimize the unique risks associated with using social media applications in healthcare by developing an appropriate plan for their use that is multifactorial and includes privacy policies, staff education, and professional ethics. Here are some examples of issues healthcare professionals and organizations should consider with respect to the use of social media.

CONTROL OF CONTENT

Who is in charge? One person, such as the Director of Media Relations/ Communications, should be the voice on behalf of the organization and have final approval on all information disseminated to the public via social media, ensuring that these applications are being used responsibly and correctly. Smaller practices should designate a physician or practice manager to oversee social media communications.

STAFF EDUCATION

How are you educating your staff about the use of personal social media in the workplace? The appropriate use and separation of personal and professional social media platforms should be addressed on an ongoing basis in staff education programs. Social media use must be integrated with HIPAA education and compliance programs and vice versa.

ORGANIZATION POLICY

Does your employee handbook or code of ethics address the use of social media? Employees and staff must be made aware of the organization's policies concerning social media, and how indiscretions on personal accounts could have a detrimental effect to them professionally.

KEEP IT SEPARATE

Are you friends with your patients on your personal social media accounts? To maintain professional boundaries, healthcare professionals should avoid accepting friend requests from patients on their personal social media. In fact, healthcare professionals should ensure that their personal social media applications maintain maximum privacy protections. Commentary about work-related experiences on personal social media platforms should be tempered and should never include imagery or commentary that could violate patient privacy.

MAINTENANCE OF PLATFORMS

Who monitors your social media platforms to ensure commentary is appropriate? Many times, comments left in response to a social media post can be inappropriate. Each practice or group should designate an individual to ensure that any such remarks are removed from the organization's social media platforms.

TWO-WAY COMMUNICATION

Is your practice engaging with comments left by the public posts? If the social media policy of the organization allows for responses to commentary, there should be one voice with final say as to what is posted. The organization should also be mindful of the slippery slope associated with responsive posts that can lead to patient privacy violations.

HIPAA POLICY REVIEW

Are your social media platforms compliant with HIPAA, and do your HIPAA policies and procedures address the use of social media? Organizations must make sure that all social media posts are compliant with HIPAA regulations and do not contain any protected health information, including the inadvertent depiction of patients in photographs. As social media applications are constantly evolving – think about social media ten years ago compared with today – policies must be reviewed and revised annually to stay current and protect the organization, staff, and patients from inappropriate use.

SOCIAL MEDIA CRISIS

Do you have a planned response to a social media incident? All healthcare practices/organizations should have a plan in place to respond should a breach of patient privacy via social media occur. Depending on the size of their social media footprint, larger healthcare organizations should have a multidepartmental response team incorporating communications, information technology, human resources, and risk management that is prepared to develop and implement an appropriate response on behalf of the organization.

Should you have any questions on the use of social media, please do not hesitate to contact the attorneys of Fager Amsler Keller & Schoppmann, LLP, for assistance and guidance.

*The next installment of **Managing Your Social Media Presence** will focus on the liability issues associated with managing negative online reviews.*



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¹ <https://www.pewresearch.org/internet/fact-sheet/social-media/>

² <https://www.itweb.co.za/content/G98YdqLxZZNqX2PD>

³ See 45 CFR parts 160, 164

⁴ <https://www.hhs.gov/sites/default/files/elite-dental-ra-cap.pdf>

⁵ <https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/elite/index.html>

⁶ "Dancing Doctor' agrees to two-and-a-half-year suspension of medical license, records show." Ralph Ellis and Jamiel Lynch. <https://www.cnn.com/2018/06/29/us/dancing-doctor-medical-license/index.html>

⁷ "Ballad Health responds to surgery photo posted to Social Media". <https://www.wjhl.com/news/local/ballad-health-responds-to-surgery-photo-posted-to-social-media/>

⁸ "Dallas Anesthesiologist Being Sued Over Deadly Surgery Admits to Texting, Reading iPad During Procedures", Eric Nicholson. April 1, 2014. <https://www.dallasobserver.com/news/dallas-anesthesiologist-being-sued-over-deadly-surgery-admits-to-texting-reading-ipad-during-procedures-7134970>

⁹ Forman v. Henkin, 30 N.Y.3d 656, 93 N.E.3d 882, 70 N.Y.S.3d 157 (2018); See also, N.Y. C.P.L.R. §3101(a) providing "Generally. There shall be full disclosure of all matter material and necessary in the prosecution or defense of an action, regardless of the burden of proof...."

¹⁰ Id.

¹¹ Id.



CASE STUDY:

Improper Medication Management in Psychiatric Treatment

Initial Treatment

The patient in this case was first seen by the MLMIC-insured psychiatrist in June of 1997, when he was then 48 years old. He was referred for evaluation by his primary care provider for what was described as “being in crisis.” The patient was unemployed and was exhibiting grandiose paranoia behavior and poor judgment and insight.

According to the history given, the patient had been seen by multiple psychiatrists and had experienced many involuntary psychiatric hospitalizations over the years due to his potential to inflict harm upon himself and others. He had been seeing another psychiatrist from July 1992 to April 1997. These notes also indicated that the patient had been started on lithium in October 1993.

The physician notes listed his medications as lithium 300 mg, 5 capsules daily, Thorazine 50 mg,

2 tablets at night, and Xanax 0.5 mg, 1 tablet twice daily. After admitting to recently decreasing his medications, the patient was advised against this and agreed to continue taking them as prescribed. There was no documentation that lab work was ordered at this visit.

...the patient had been seen by multiple psychiatrists and had experienced many involuntary psychiatric hospitalizations over the years due to his potential to inflict harm upon himself and others.

Over the subsequent months, the patient was seen by the insured psychiatrist every three to four weeks without significant change. He remained unemployed. When the patient was seen in November 1997, his lithium level was tested to be 0.4 mEq/L. The lithium dosage

was increased to 600 mg, twice a day, while other medications remained the same.

The patient missed his December appointment and was next seen on January 20, 1998. He did not appear manic or depressed. It was noted that the patient was taking only his prescribed lithium and had stopped the other medications. The psychiatrist would later testify that a lithium level test would have customarily been ordered at this time, but there were no indications of this order and no test results were entered in the patient’s record.

The patient was next seen on April 7, 1998, after missing his scheduled February appointment. He was not very verbal and demonstrated aimless actions. He had difficulty focusing, displayed poor hygiene, and was verbally aggressive. The patient was now on lithium 900 mg, twice a day. The psychiatrist would later testify again that a lithium level test would have customarily been ordered at this

time, but there were no indications of this order and no test results entered in the patient's record.

On June 1, 1998, the psychiatrist wrote a disability determination to the New York State Department of Social Services for the patient. The treating diagnosis was bipolar disorder and paranoid personality disorder. Schizoaffective disorder was ruled out.

For the next several years, the patient was treated by the insured psychiatrist based on the concerns he expressed. There were periodic

It was noted that the patient was taking only his prescribed lithium and had stopped the other medications.

changes to his medications, but the prescribing of lithium remained relatively consistent. The patient was occasionally noncompliant with keeping appointments and regularly taking his medications. Labs were drawn infrequently.

In addition to psychiatry, the patient was also being seen by a general practitioner from 2004 to 2016. The general practitioner did not treat the patient for manic depression and, therefore, did not order any blood work to test for lithium levels.

Toxic Lithium Level Detected

On October 15, 2012, the patient's lithium level was 1.95 mEq/L, a potentially toxic level. He was directed by the insured psychiatrist to stop the lithium and to return for follow-up on October 18. At this time, the patient's lithium level had decreased to 0.45 mEq/L. The

patient was directed to remain off lithium.

On November 7, 2012, the patient advised that he was unable to sleep, was waking up early, and felt drowsy. His medications were now lithium and Thorazine at bedtime. Again, the psychiatrist would later testify that a lithium level test would have customarily been ordered at this time, but there were no indications of this order and no test results entered in the patient's record.

Over the subsequent years, the patient was seen routinely without significant changes to his medical regimen. When he returned on June 10, 2014, the psychiatrist noted that the patient's mood was good, his speech was normal, and that he was pleasant and healthy. He continued to smoke. The patient was directed to continue with his medications and have his lithium levels checked. Once again, the psychiatrist would later testify that a lithium level test would have customarily been ordered at this time, but there were no indications of this order and no test results entered in the patient's record.

During the August 1, 2014, appointment, the psychiatrist noted the patient appeared disheveled. The patient reported that he was in a recent motor vehicle accident in which his car was totaled. He also stated that he had stopped taking lithium about three weeks prior to this visit.

The patient was last seen by the psychiatrist on November 18, 2014. He was now 65 years old and reported that he had been started on kidney dialysis. Testing indicated his red blood counts were decreased. Thorazine 200 mg at

bedtime was his only prescribed medication. The patient failed to make his next office visit.

Lawsuit Commenced

The patient went on to develop end-stage renal disease, and a lawsuit was commenced by the patient against the psychiatrist and the general practitioner, alleging failure to properly monitor prescribed medications, which resulted in kidney damage. A lack of informed consent was also alleged.

One expert reviewer found the case indefensible. There were gross lapses in the care and treatment of this patient, specifically with respect to the management of his lithium levels.

Another expert opined that testing is crucial when placing a patient on lithium. An annual blood test, including a complete blood count and a complete chemical profile, should have been performed. This expert further noted that the patient, in fact, was not bipolar and never should have been on lithium. He felt that the

This expert further noted that the patient...was not bipolar and never should have been on lithium.

patient was a classic schizophrenic, which was first identified back in the 1980s. When seen at age 32 years, the patient clearly fit within the clinical diagnosis period when schizophrenia develops. The expert believed that the patient's psychiatric problems started as early as 1980.

In addition to the lack of testing results for lithium levels, the records

also showed that the insured psychiatrist failed to document the numerous times he advised the patient to go for blood testing. This was problematic for the defense.

The codefendant general practitioner was granted summary judgment and dismissed from the case. The case was settled on behalf of the insured psychiatrist prior to trial for \$480,000.

A Legal and Risk Management Analysis

Dealing with a psychiatric patient can pose significant challenges for a medical professional.

While documentation and proper monitoring are important aspects of care for all patients, they are essential with psychiatric patients who are being treated with lithium or any other medications. The failure to do so could put a patient's life at risk.

In this instance, the patient had a long history of psychiatric disorder and treatment with lithium. At the onset of treatment, the psychiatrist should have contacted

...the psychiatrist should have contacted the patient's prior treating providers to identify the indication for the lithium therapy...

the patient's prior treating providers to identify the indication for the lithium therapy and to obtain the patient's medical chart, which would have provided the patient's full prior medical history including his prescription history, dosages, indications, therapeutic effect, and all relevant blood and lab test results.

While the patient did have a general practitioner, that physician was not treating the patient's manic depression and, therefore, it was the psychiatrist's responsibility to treat, manage, and monitor the patient's psychiatric conditions. Regular tests should have been conducted to assess serum lithium levels and electrolyte levels, and all relevant monitoring/testing should have been ordered as he continued

Office practices should keep clear, consistent records of missed appointments and follow-ups.

the lithium treatment. Proper monitoring and testing could have resulted in earlier treatment for the patient and potentially prevented the end-stage renal disease.

This patient had a history of noncompliance and there was a failure to document the noncompliance in the patient's chart. While the psychiatrist did order lithium levels, they were infrequent and without regularity, and did not demonstrate a proper therapeutic range. It was the psychiatrist's responsibility to follow up with the patient after the missed appointments and failure to follow medical advice. This required the psychiatrist to discuss the importance for compliance with the recommended course of treatment, the benefits of the recommended treatment, and the risks involved in not adhering to the proposed treatment. Office practices should keep clear, consistent records of missed appointments and follow-ups. The office should document their attempts at contacting the patient, what was

communicated to the patient, and the patient's response.

Lastly, the psychiatrist failed to document that an informed consent discussion had occurred. Patients must be counseled about the use of lithium and monitoring requirements so they can make an informed decision about proceeding with the treatment. The prescription of lithium, even with due care by a physician, may lead to unwanted and harmful side effects. These possible side effects, along with any other risks/benefits/alternatives, including no treatment, must be discussed with the patient, and documented in the patient's chart.



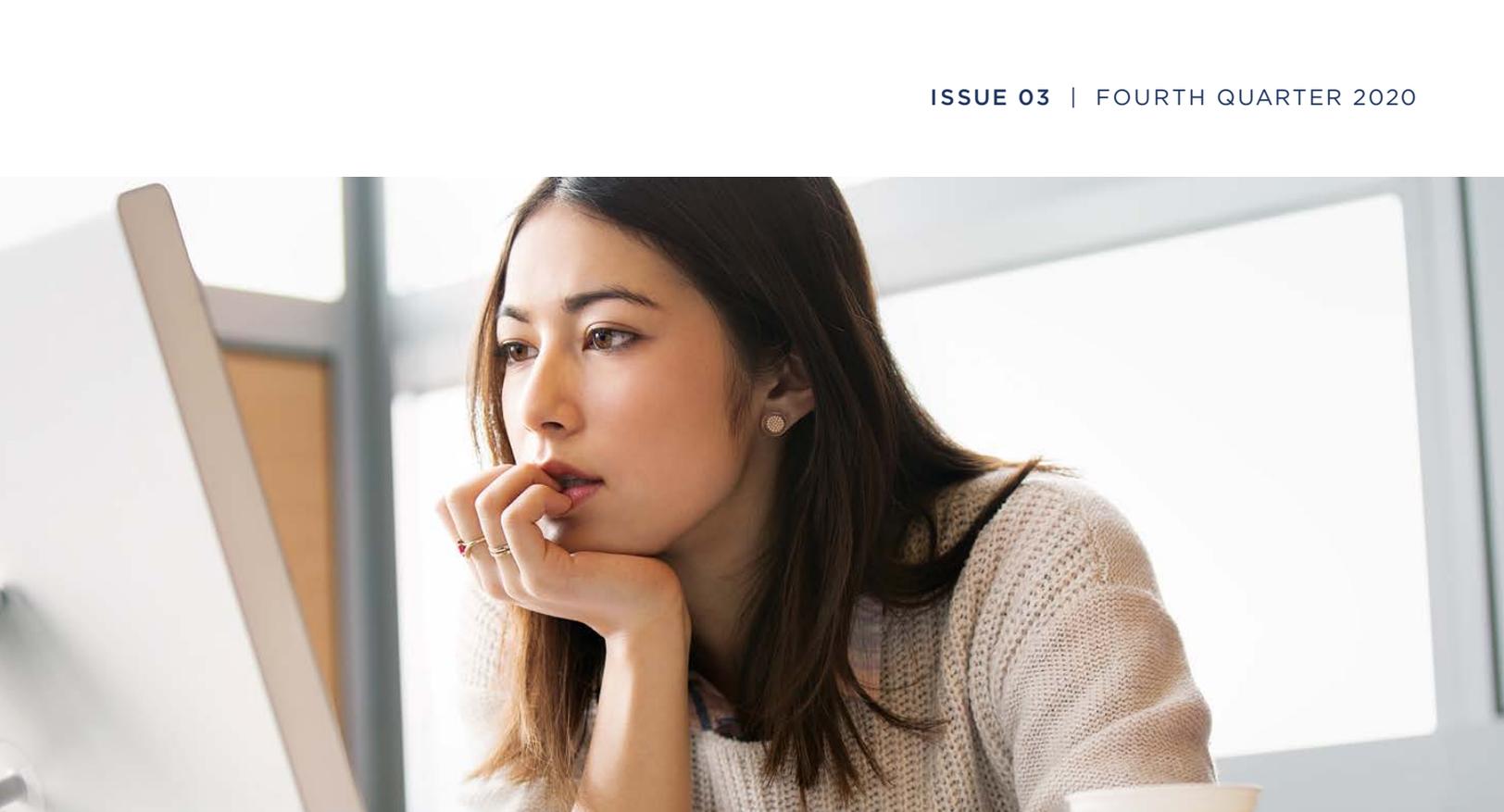
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MLMIC's Online Portal Access for Policyholders and Their Authorized Representatives

With full appreciation in mind for today's healthcare practitioners' and their staff members' busy schedules, MLMIC Insurance Company is pleased to have created an online portal at [MLMIC.com](https://www.mlmic.com) that provides policyholders and their representatives with significant functionality to manage their professional liability insurance coverage.

Accessible 24 hours a day are individualized policy documents, renewal application updates, invoicing and online premium payment options, as well as access to MLMIC's risk management CME coursework and historical publication archives.

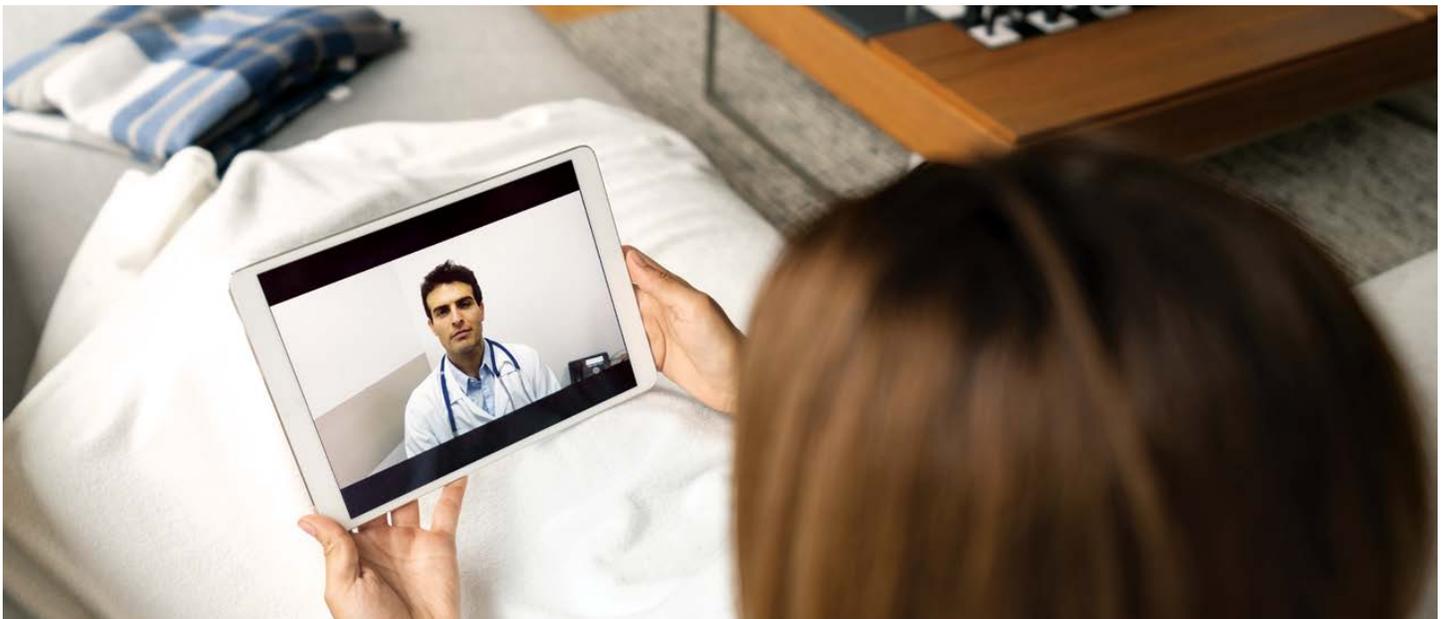
The process to gain access to the portal begins with an active policyholder or their representative establishing their own login credentials. If you have not already done so, be sure to visit [MLMIC.com](https://www.mlmic.com) to take advantage of the added convenience that portal access brings to managing your policy.

UPDATES

The COVID-19 2nd Wave – Are You Ready?

MLMIC has compiled an extensive suite of resources, including the most up-to-date advisories and risk management strategies, to assist its policyholders in the face of this pandemic.

Please be sure to bookmark and visit [MLMIC.com](https://www.mlmic.com) to stay abreast of any updates.



The Joint Commission Issues Telehealth Strategies

From The Joint Commission:

The use of telehealth during the COVID-19 pandemic has skyrocketed, enabling the timely delivery and continuity of safe patient care while preventing exposure to the coronavirus. Continuity of care is especially important for patients with chronic disease, the elderly, and behavioral healthcare patients who require routine check-ins with their providers.

This issue of *Quick Safety* includes strategies that providers and healthcare organizations can employ to optimize the use of telehealth to deliver safe care and effective care to patients during the public health emergency.

Feeling the weight of extra worry and pressure? We Can Help.

As a doctor, you face stress on the best of days. With pandemic conditions fueling widespread depression, anxiety, emotional distress, and worry, you need support more than ever.

MLMIC Insurance Company and the Medical Society of the State of New York (MSSNY) are here for you.

**Call the free Physician Support Hotline
(888) 409-0141**

8 a.m. to 12 a.m. ET, 7 days a week

Supportive therapy from peers to help you manage stress, whether or not it's linked to the pandemic. No appointment necessary.

For additional COVID-19 resources, including hotlines, FAQs, executive orders, blog posts, and more, visit [MLMIC.com/covid-19](https://www.mlmic.com/covid-19).

MLMIC is proud to partner with MSSNY to provide these resources and services for our medical community.

**For more information on MLMIC, call (800) ASK-MLMIC
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