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DATELINE

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The near-universal adaptation of electronic medical records by the healthcare industry, and the speed with which this dramatic change has occurred, has brought new challenges and pitfalls to healthcare practitioners in all specialties. In this third installment of Dateline*'s series on Electronic Health Records, a prominent defense attorney examines the risks involved when a practice or facility upgrades or changes their EHR software, and offers practical guidance to MLMIC policyholders on how to safely and effectively mitigate them.*

The Risks of EHR Software Changes and Upgrades

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Electronic Health Records (EHRs) have been implemented since Dr. Lawrence Weed first wrote on them in a 1968 New England Journal of Medicine article. Since that time, there have been many new innovations and upgrades to EHRs. While these advances have produced great enhancements to EHR capabilities and improved patient care, they have also introduced new challenges when litigating medical malpractice actions. While taking advantage of these

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Don't Let Treatment Refusal Result in Legal Liability

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Informed consent is a well-established ethical and legal requirement in healthcare. This common law right of patients was recognized by Justice Cardozo over 100 years ago:

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable

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advances in development to better care for their patients, physicians must be careful not to make litigation against them more complex with as little as a keystroke, or wrongly upgrading or implementing a new EHR system that exposes them to greater liability.

Paper charts were static and, while they were updated with newer progress notes or various studies, the chart always remained the same and did not change over time. EHRs are dynamic and many things can cause the EHR to change. They are based on a binary code of 1's and 0's. To be readable, the software has to convert the binary code into a form that can be read by humans. With a paper chart, the physician could simply flip through it to get the data they need. Physicians now review the data on a computer screen. Many physicians find navigating the EHR system to be difficult, particularly with new or upgraded systems, and important facts can be missed, or information can be erroneously entered into the EHR, creating liability. To keep up with the Stages of Meaningful Use to receive Medicare and Medicaid incentives, and now avoid disincentives, physicians are required to make multiple upgrades to their EHR systems every few years, further exacerbating these problems.

Template Revisions

When a patient's attorney requests a medical record to determine if they will commence a medical malpractice action, the data is printed out in templates. If they decide to commence an action, then we as defense counsel request a complete copy of the physician's records to represent them. By the time we get to the physician's deposition, the EHR system is often upgraded and the certified printout of the medical record will look different than the copy obtained by plaintiff's counsel, often two years earlier. One example is the section for Review of Systems that when the plaintiff's attorney received a copy of the records, it did not include a check box for carotid bruit. However, the software was upgraded, and a carotid bruit check box was added to the Review of Systems and the copy printed out for the deposition had that and other changes. Of course, the plaintiff's counsel argued that the record had been altered. We were able to show that the update created the differences, but keep in mind there is a fundamental principle in litigation: if you are the one doing the explaining, you are usually losing.

Data Migrations

Many physicians are becoming employed by hospital systems or joining large group practices that have a different EHR system and must switch to the new practice's or system's EHR system. Often, the data in a physician's former EHR cannot be migrated over to the new EHR system or, if it is, not all of the data transfers over. When the data is not compatible with the new EHR system, the physician must keep the old EHR system operating and pay for the vendor maintenance agreements to service the old system, including the maintenance of older equipment that may not be compatible with the new EHR.

More Information to Process

When a physician joins a hospital or large group practice, where the EHR contains the records of hospitals and other physicians, a physician often ends up inundated with far more information than would have been contained in their own replaced EHR. While more information is often beneficial to the practitioner when caring for a patient, it can be argued that there is liability if the physician did not follow up on a study ordered by another physician or a finding when the EHRs of multiple physicians and facilities are now combined and available for review. However, the physician was focused on the medical issue the patient came to them for. Thus, the data overload from moving to a new system now connected to multiple physicians and hospitals can create liability. Many newer or upgraded EHR systems have problem checklists that the treating physicians and hospitals can add to or mark as resolved. Physicians should always view a problem checklist, or have a policy that a responsible assistant such as a physician assistant or nurse practitioner review a problem checklist and advise the physician on action to be taken and documented. A problem checklist that goes unreviewed can lead to a claim of liability.

Obsolescence

Many practitioners adopted EHR systems years ago and many of those software companies have gone out of business or have stopped supporting the EHR software that the physician is using daily as their legal record of the patient's care. This obsolescence is one of the biggest issues with EHR software. Contracts signed years ago

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The Risks of EHR Software Changes and Upgrades **continued from page 2**

with the EHR companies often provided that they could discontinue support for the software after a certain period of time. Physicians must be mindful that New York State law requires a physician to maintain an accurate record for each patient. For an adult patient it is six years from the last date of treatment. Medicare look back is ten years. For an infant, the time period is even longer. If your EHR becomes non-functional due to being outdated or the software is no longer supported, the onus is on the physician, who will be in violation of the New York law requiring maintaining an accurate record for each patient encounter(s). In addition, if the records are not available, the plaintiff's counsel may argue for spoliation of evidence, which, if granted, can result in a trial solely on damages with no chance to defend on the merits of the care rendered.

EHRs were supposed to be the panacea for all the ills of the paper chart. They have improved medical care and the sharing of information for better patient care. They have also frustrated physicians who now have to make hundreds if not thousands of clicks a day and navigate in an ever-changing digital environment. They have frustrated lawyers having to learn the technology and explain changes in the printed charts that are still being used in depositions and trials even though the printout of the EHR record often differs with every change or update made to the system. However, EHRs are here to stay and we have to work together to minimize potential legal exposure. Although working a busy schedule is always taxing on the physician, it is recommended that they or another physician in their practice be involved with any upgrades to an EHR system, or any implementation of a new system, rather than leaving it to an administrator or someone who is not going to be an active user of the system. Being knowledgeable of new features and user interface changes, as well as how the system will fit into the physician's or group's practice, will help better tailor the system's implementation to the needs of the practice, better educate the system's users, and reduce the disruption that upgrading or moving to a new EHR system often causes.

Questions? Email Joshua Cohen at Cohen@dcsf.com

Important Facts to know about the Americans with Disabilities Act

The Americans with Disabilities Act (ADA) is a federal law prohibiting discrimination based upon disability. Though the disability may not be obvious, this law offers protection to anyone who has a physical or mental/cognitive disorder or certain diseases. The disability must substantially limit the individual's major life activities.

Private medical offices are considered to be places of public accommodation and must comply with both state and federal discrimination laws. We recommend that all physicians carefully assess their offices to determine whether they meet safety and disability requirements (see Spring 2016 *Dateline*). Additionally, how one documents or releases records may be affected if the patient has a protected condition under the ADA.

Hearing-Impaired Patients

A frequent telephone call received by Fager Amsler Keller & Schoppmann, LLP involves the need to provide interpreters for the hearing-impaired. Interpreters or communication devices for deaf patients must be provided at the expense of the physician. The modality for interpretation must be acceptable to the patient, and the choice of the patient takes precedence. Physicians must retain translators who provide "effective communication." However, "certified" interpreters are not required. Proper interpretation is particularly important when informed consent is being obtained. If the patient files a complaint with the Equal Employment Opportunity Commission (EEOC) or the New York State Division of Human Rights, malpractice policies cannot and do not provide a defense or pay damages for such claims by governmental agencies, as this is against public policy. However, if other allegations against the physician are made, MLMIC should be notified to determine whether they fall within the policy coverage.

Physicians must retain translators who provide "effective communication." However, "certified" interpreters are not required.

Service Animals

Another frequent question is whether a practice or hospital must allow service animals on the premises for blind and otherwise disabled individuals. The use of service animals has now been extended to persons with post-traumatic stress disorder (PTSD), which is considered a mental disability. When patients come to the office with service animals (service dogs or horses only), these animals are permitted to be in public areas of the office. However, they can

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CASE STUDY

Double Amputation and Finger Pointing at Trial Result in Large Settlement

Brianna Mulazzi
Claims Examiner
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Initial Hospital Visit

A 75-year-old woman presented to the emergency department (ED) at 8:45 am on 1/21/07 with complaints of abdominal pain and urinary frequency. The ED physician saw the patient at 9:15 am and felt that she was dehydrated. He ordered the patient be given fluids and also ordered an abdominal and pelvic CT scan to rule out appendicitis, renal colic, or an ovarian cyst. The woman's urine was tested and came back abnormal. The ED physician increased her fluids at 10:45 am and was suspicious of a urinary tract infection (UTI).

When the CT scans became available at 2:30 p.m., the radiologist noted that there was significant hydronephrosis and a right hydroureter. The ED physician admitted the patient to the hospitalist's service with a diagnosis of ureterolithiasis and renal colic on the right large hydronephrosis, and a UTI. The ED physician never saw the woman after 2:30 p.m. The ED physician claimed that, based on his diagnosis, he called the MLMIC-insured urologist. There was no documentation in the medical record of a conversation between the ED physician and the urologist. The urologist later testified that he was unaware of the patient at this time.

The hospitalist didn't see the patient until 4 p.m. She ordered a CBC panel and urine cultures and placed her on normal saline, Tylenol and morphine. The hospitalist testified that she was unable to examine the woman because she was sleeping due to the morphine. The hospitalist then called for a urology consult. However, when she put the order through, she noted it was elective. According to hospital procedure, an elective consult means that the consulting specialists have 12 hours to respond. It was understood that if a consult is elective it is not an emergency.

Hospitalist Leaves, Urologist Arrives

The hospitalist found the patient's vitals to be stable, and at 6 p.m. her shift ended and she left the hospital. She never spoke with a urologist, though she did leave the consult request with an answering service. Once she left the hospital, a different hospitalist came on duty. The new hospitalist called the MLMIC-insured urologist at his home sometime between 6 and 6:30 p.m. and made him aware of the woman's condition. The urologist was then able to remotely access the patient's hospital chart from home and log into the system to review the CT scan. He determined that the woman was suffering from right hydronephrosis and a right hydroureter due to an obstruction. Further, his assessment of the CT scan was that the radiologist also missed a tumor at the right ureterovesical junction. The urologist later testified that his conservative approach was because of the diagnosis of a tumor obstructing the ureter.

The urologist arrived at the hospital at 7 p.m. and found the patient on a stretcher in the hallway of the ED. Presumably, she was placed there to have her vitals constantly monitored. During his deposition, the urologist expressed his displeasure with the woman's overall treatment up to that point. He testified that the first hospitalist had not ordered sufficient hydration. The hospitalist had placed her on 75ml per hour and the urologist increased it to 125ml per hour. Further, the urologist testified that his impression was that the staff was not taking the woman's condition seriously.

The urologist reviewed his consultation request, which was noted to be a level 3 elective consultation, and also reviewed the patient's vitals. The patient's maximum temperature had reached 104.5, with a pulse of 75, and a BP of 180/65. The urologist's impression was that this woman was experiencing urosepsis with a right hydroureter secondary to a questionable stone. His plan was to place a J stent in the morning. The urologist had been prepped to testify that the reason the woman was to receive the stent in the morning was because there was no emergent reason to do it that night. However, the urologist testified "in a perfect world, the patient would have been taken to the OR right away." The chart showed that the woman was seen on a Sunday. Supporting OR staff would have had to be called to the hospital, making it easier to place the stent the following morning.

The urologist noted the woman was not tachycardic, not in septic shock, and had a fever that was responding to Tylenol. The urologist then left the hospital. Unfortunately, he never authored a note about asking the nursing staff to keep him up to date on the patient's vital signs. He later testified that he had asked the nursing staff to apprise him of any changes to her vital signs.

Patient Condition Worsens

At 7:30 p.m., an ED nurse contacted the hospitalist on call because the woman's BP had precipitously dropped

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to 72/40. The hospitalist issued a telephone order to have the patient sent to telemetry. The order was not signed off on and carried through until 10 p.m. The hospitalist then ordered the patient brought to the ICU at 10:30 p.m. due to septic shock, an obstruction and neuropathy. The hospitalist ordered Dopamine. However, he never called the urologist. Instead the hospitalist requested an infectious disease consult.

The MLIMC-insured urologist testified that he called into the hospital sometime around 10 p.m. looking for an update and was advised that the patient was hypotensive. The urologist made the decision that the patient was to be taken to the OR to have the J stent inserted with the hope that it would relieve the obstruction. The patient was in the OR at 11 p.m. and the stent was placed. It was a difficult surgery due to the ureter being tortuous.

The urologist later testified that while the patient's condition was emergent, her degree of emergency was such that at the time of the initial consultation, she did not need to undergo immediate stent placement. The urologist also testified that there were other factors that contributed to when the patient would need to be taken into the OR. They included the fact that it was a Sunday evening, none of the ORs would have been in operation, and staff would have to have been called to come into the hospital. While the doctor's testimony may have seemed reasonable, it did not come across as logical because when it did become an emergency, the OR was prepped and staffed within an hour.

Ultimately, the patient had an uphill battle following surgery. She was on a ventilatator and, due to prolonged sepsis, it was noted that her hands and feet were cool and cyanotic. Her limbs eventually became gangrenous. She was then transferred to a different hospital and another surgeon performed a bilateral below the elbow amputation on 2/22/07.

As the MLMIC urologist noted, he had seen a potential tumor on the CT scan that was taken in the ER. A diagnosis was made in March 2008 of bladder cancer, and the woman ultimately passed away in December of that year.

Lawsuit Filed

A lawsuit was commenced against the ED physician, the urologist, the admitting hospitalist, and the hospital. MLMIC in-house experts indicated that the MLMIC-insured urologist met the standard of care. The impression was that when the woman was first seen in the hospital, she had a very high fever and the presence of an infection. The patient had appropriately responded to Tylenol, and a conservative treatment of the infection with antibiotics was an appropriate course of action before any type of surgery would be performed. Experts opined that the main reason to wait until Monday would be to administer antibiotics and draw blood levels to see if there was a therapeutic amount of antibiotics in the blood that would help overcome any possibility of sepsis that could result from manipulation of the area which undoubtedly contained infected urine.

This matter was also reviewed by an outside expert in urology. The expert was willing to testify on behalf of the MLMIC-insured urologist as he felt the urolgist's treatment was within the standard of care. However, his opinion was not without its criticisms.

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physician litigation stress resource center

The Physician Litigation Stress Resource Center is a not-for-profit website that provides physicians and other healthcare professionals with the resources they need to understand and cope with the personal and professional stress created by involvement in a medical malpractice case or an adverse outcome that may result in litigation. This site directs practitioners to articles, books, and websites addressing the process of litigation; suggests strategies for coping with the stress of litigation; and lists resources that may provide support for physicians and other healthcare practitioners throughout the ordeal of litigation.

CASE STUDY **continued from page 5**

It was this expert's view that, had the urologist appreciated that the patient's obstruction was a stone and not a tumor, the surgery would have been emergent because it is a departure to not emergently stent a patient that has a stone obstruction in addition to a fever. However, if the obstruction is caused by a tumor, then it is within the standard of care to wait 12 hours.

Fortunately, while the tumor versus a stone aspect was a hinderance to the outside expert, he was willing to testify in favor of the urologist since the urologist never noted what he suspected the obstruction was, only that there was one. Another stroke of luck was that the plaintiff's attorney never questioned the urologist regarding what caused the obstruction, therefore eliminating any concern the expert would have had as it was not addressed.

When the time for trial came, there was a video that the plaintiff's attorney tried to admit into evidence. The plaintiff's husband had preserved her post-operative course in video. Specifically, he had taken multiple home videos of his wife trying to adapt to life after having both her hands amputated.

The Trial

The trial went forward on 9/25/14. The plaintiff's daughter testified that her mother was more affected by the loss of her hands than by her cancer diagnosis. The husband testified in detail how he became her caretaker in everything, including all of her grooming, eating, drinking and bathing. Defense counsel described the video as having shock value.

Initially, the plaintiff's pretrial demand was $1.5 million. Throughout the course of the trial, the hospitalists directly testified against the MLMIC-insured urologist. It was the internal assessment by the claims department at MLMIC that correctly assessed that the trial was not going favorably for the defendants. In large part, the trial was becoming a blame shifting contest with very high sympathy value.

Eventually, the decision was made that it would be better to protect the interests of the urologist in the face of a trial that was going poorly. The plaintiff agreed to accept a $1.2 million settlement on behalf of the urologist, and the involved hospital also decided to settle out at that time for $75,000. The case continued all the way to summations against the co-defendant hospitalist, at which point he also settled out for $225,000. The only defendant released in the matter was the ED physician.

CASE STUDY

A Legal & Risk Management Analysis

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Counsel to MLMIC Insurance Company

The facts of this case present several risk and quality issues, from the level of the consultation ordered by the hospitalist to the 2.5 hour delay in transferring the patient to the telemetry unit. To the defense counsel, this case study highlights the less apparent consequences resulting from failing to document communication in a patient's records. Of course, lack of documentation always adversely affects medical providers in the later lawsuit. Not only has an accurate chronology of medical care been lost, but it opens the door for medical providers to dispute factual events such as undocumented phone calls or undocumented orders. Contemporaneous documentation of communications is the best evidence of the most accurate facts, and this documentation prevents the collapse of defensible cases due to blame-shifting.

The players in this case that were ultimately named in a medical malpractice action were the emergency room physician, the urologist, the admitting hospitalist, and the hospital for the actions of its nursing staff. Based upon the expert reviews, this was a defensible action on the medicine, and the case proceeded to trial. However, the action concluded with a collective settlement of $1.5 million before the jury rendered a verdict. These circumstances require

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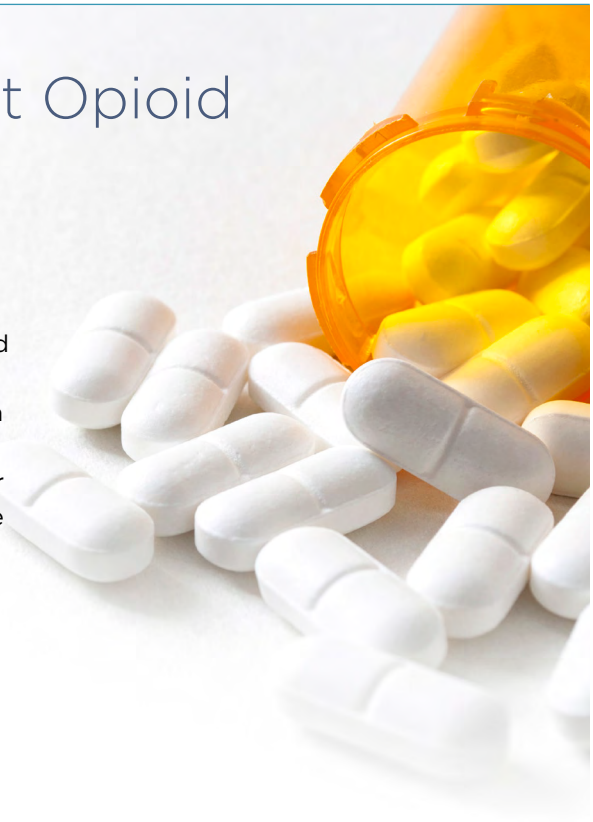
Underwriting Update

Pay your Premium Online!

MLMIC Insurance Company's policyholder portal at MLMIC.com now has automated clearing house (ACH) capability. With direct ACH payments, you can pay your premiums electronically instead of having to cut and mail a check. ACH payments also process faster than traditional payments and are more secure.

When signing in for the first time, policyholders will be asked to update their MLMIC.com login credentials to gain access. Those needing assistance logging in or with any other question should call MLMIC at (888) 234-0752 or contact us electronically.

A Reminder from NYSDOH About Opioid Treatment Plan Requirement



The New York State Department of Health (DOH) recently issued a letter to all practitioners and facilities reminding them of a change to the Public Health Law that became effective April 1, 2018. At that time, the law was amended to require that a written treatment plan be placed in the patient's medical record when a practitioner prescribes opioids for pain management for longer than three months or past the time of normal tissue healing. The exceptions are:

- cancer that is not in remission;
- hospice or other end-of-life care; and
- palliative care.

DOH requires documentation of treatment plans at a minimum annually, and they must include:

- goals for pain management and functional improvement based on a diagnosis and a discussion on how opioid therapy would be tapered to lower dosages or tapered and discontinued if the benefits do not outweigh risks;
- a review with the patient of the risks of alternatives to opioid treatment; and
- an evaluation of the risk factors for opioid-related harms.

MLMIC is always available to support our insureds and has

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Choosing the Right Professional Liability Insurer: Experience and Financial Strength Make the Difference

Al Anthony Mercado, Esq. | Fager Amsler Keller & Schoppmann, LLP | Counsel to MLMIC Insurance Company

A process server has just served you with legal papers. You suddenly feel flush with emotions: angst, worry, confusion. Your next call is to your professional liability insurer to report the claim. Now is the time that the experience and financial strength of your professional liability insurer really matters.

Experience:

The experience that a professional liability insurer has in your state and local jurisdiction can make a difference. The laws and regulations, and settlement/jury verdict values vary greatly from state to state. Similarly, the application of those laws and regulations and settlement/jury verdict values can vary by local jurisdiction within a state.

A professional liability insurer that is domiciled within a state has the most experience with plaintiff counsels, defense counsels, the judiciary, and the application of laws and customs. A professional liability insurer that has multiple locations within a state has similar experience, but on a local level.

This experience can translate into knowing how best to manage a particular plaintiff's counsel and assign the best defense counsel to handle that adversary. Similarly, experience with the judiciary can translate into strategizing and anticipating outcomes.

Clearly, a professional liability insurer with experience on a state and local level can make a difference in the handling of your claim.

Financial Strength and Stability:

After you've had a claim brought against you is not the time to worry that your professional liability insurer is having financial difficulties.

When choosing a professional liability insurer, it is best to consider:

1. How long has the insurer been in business?
2. How long has the insurer been in business in your state?
3. Does the insurer have financial issues that impact its business?
4. Does the insurer have an A or higher rating from AM Best?
5. If the insurer becomes insolvent, will you have the protection of a state guaranty protection?
6. Remember the old saying, "you get what you pay for" also can apply to professional liability coverage.

In choosing professional liability insurance

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The Proper Use of Scribes

As the use of electronic health records (EHRs) has become widespread, documentation practices and workflow patterns have changed significantly and have added to a growing clinical and administrative workload. The use of this technology has increased the amount of time necessary to complete medical record documentation and order entry.

One way that physicians have chosen to address these issues is through the use of scribes. Scribes originated in the fast-paced clinical setting of the emergency department (ED) as a way to reduce the time physicians needed to spend documenting care in an electronic format. The use of scribes has expanded from these roots in the ED to numerous other clinical settings. Scribes perform EHR data entry under the direct supervision of a licensed professional, freeing the physician or other provider to spend more time directly interacting with the patient.

As unlicensed members of the healthcare team, the recruitment, training and supervision of scribes is paramount in managing their use in all clinical settings. Whether you are currently using scribes in your practice, or are considering employing them, the following recommendations may be useful in evaluating your program or determining strategies for implementation.

1. Use documentation policies for your organization that comply with regulatory requirements. In addition, practices should monitor federal, state and regulatory changes to maintain compliance with these guidelines.

2. Develop a written job description for scribes that outlines required qualifications and competencies, including proficiency with your EHR system and medical terminology. Clearly delineate job responsibilities.

3. Provide orientation that includes, but is not limited to, HIPAA, privacy regulations, organizational policies, and patient rights.

4. Scribes should not perform any clinical functions or provide any direct patient care (unless they are otherwise a licensed healthcare provider such as an LPN or RN.) This includes:

    - acting independently;
    - touching patients;
    - handling bodily fluids or specimens;
    - translating for a patient;
    - interpreting any information; and
    - conducting other duties while acting as a scribe.

5. Scribes should be assigned their own unique user ID/password credentials to access the EHR system. All entries to the record made by a scribe must be while logged in with their own password and user ID. In the event a licensed clinical staff member functions as a scribe, they must have two separate user IDs and passwords and use them accordingly.

6. Introduce the scribe to the patient, and give the patient the opportunity to decline having the scribe present during the examination.

7. The primary responsibility of the scribe should be to document the clinical encounter, including the history of present illness, a review of systems, the physical exam, and the assessment and plan, as presented by the provider. Scribes may also create pending orders as dictated by the provider. Providers must review and complete all medical orders.

8. All information entered into a medical record by a scribe must include:

    - the name of the patient and the provider providing care;
    - the date and time; and
    - authentication.

9. Providers must review the scribe's documentation and verify the entry. An attestation statement should include:

    - affirmation of the provider's presence during the time the encounter was entered;
    - confirmation that the provider reviewed the information and verified its accuracy; and
    - authentication, including date, time, name and credentials.

10. Perform regular audits/assessments of the scribe's documentation and provide constructive feedback for performance improvement, as indicated.

References

1. https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=1908&ProgramId=46
2. https://www.acep.org/how-we-serve/sections/quality-improvement—patient-safety/newsletters/october-2016/qips-tips-31-to-scribe-or-not-to-scribe/
3. https://library.ahima.org/doc?oid=106220#.XVwavehKg2w
4. https://www.aafp.org/fpm/2016/0700/p23.html
5. http://psnet.ahrq.gov/perspectives/perspective/277

in damages. This is true except in case of emergency, where the patient is unconscious and where it is necessary to operate before consent can be obtained."[1]

Since that time, this doctrine has been codified in NY public health law § 2805-d.

Obtaining informed consent reflects the modern practices of shared decision-making and patient-centered care. The doctrine recognizes that patients are autonomous and possess the fundamental right to self-determination. The partnership of a provider and a patient should consist of a communication process wherein the physician describes the diagnosis, prognosis, and treatment options, as well as the risks, benefits, and alternatives. The patient must be given an opportunity to ask questions, as well as adequate time to reflect on available approaches to treating their medical condition. Since treatment plans offered to patients should include the risks and benefits of no treatment at all, how should a physician proceed if this is the very option a patient selects? Under these circumstances, it is imperative that the physician obtain an informed refusal.

Physicians should engage in the same process of communication, disclosure and documentation for obtaining informed refusal as they do for informed consent. Both concepts recognize respect for a patient's decisions, which must be balanced with a provider's duty of care to the patient. However, a patient's decisional capacity must continuously be assessed throughout ongoing communications and interactions. These evaluations will assist in the determination of whether the patient has an accurate understanding and appreciation of the nature of the proposed treatment, as well as the implications of available alternatives. If there is any doubt about a patient's mental competency, providers should consider obtaining a psychiatric consultation.

Treatment refusals may create difficult encounters in clinical practice. Parental refusals of vitamin K and newborn screening tests, as well as refusals to adhere to recommended vaccine schedules, have become more prevalent.[2] Complicated ethical dilemmas often develop when a pregnant patient's treatment refusal may have a detrimental effect on the health of an unborn fetus.[3] Some Jehovah's Witnesses may refuse blood transfusions in accordance with religious beliefs, while others may be amenable to autologous blood transfusions.[4]

It is important to recognize that a patient's refusal imposes responsibilities on a physician, who must be able to show that the patient's decision to refuse treatment was based on a full understanding of all facts necessary to make an informed choice. The teach-back method is a beneficial approach to use during these discussions with patients. It enables a physician to assess whether patients have a full grasp of the material facts in order to reach a reasonable and rational decision regarding their choices of treatment. Documentation of this process may provide the very basis for establishing that consent or refusal was truly "informed."

A detailed medical record that clearly reflects the decision-making process can be pivotal to the defense of a lawsuit based on the ramifications of treatment refusal. To avoid liability or to offer evidentiary value to a defense, progress notes should include:

- an assessment of a patient's competence to refuse;
- descriptions of discussions regarding why the recommended treatment is necessary and the risks of this treatment;
- descriptions of discussions regarding the available treatment alternatives and their attendant risks and benefits;
- descriptions of discussions regarding the consequences of refusal;
- documentation of other individuals or healthcare personnel who were involved in the treatment discussions; and
- the patient's reasons for refusal.

Finally, a signed treatment refusal form must be incorporated into the patient's record.[5] Should the patient refuse to sign this form, this fact needs to be documented on the signature line of the form, as well as in the progress notes.

Appropriate management of a competent patient who refuses care should include compromise and negotiations to encourage compliance. Consider and address any factors which may negatively impact on the patient's decision making: depression; fear; finances; family member influences; religion; culture; psychosocial factors; or prior experiences. It may be helpful to explore external influences to assist the patient in diffusing their apprehension. Attempt to allay fears or concerns by asking the patient to involve a close friend or relative in these discussions.

Physicians should recognize that any divergence in treatment approaches could lead to a deterioration in the relationship with a patient. Avoid coercion, intimidation, or threats to discontinue the professional relationship. Engage in further discussions to address concerns and explain your own. Maintain a tactful and sensitive demeanor to reach a suitable decision that is in the patient's best interest. Clarify, negotiate, compromise, document, and, finally, do not take refusals personally.

1. Schloendorff v. Society of New York Hospital, 105 N.E. 92, 93 (N.Y., 1914).
2. http://pediatrics.aappublications.org/content/pediatrics/138/3/e20162146.full.pdf
3. https://www.acog.org/?/media/Committee?Opinions/Committee?on? Ethics/co664.pdf?dmc=1&ts=20190130T1632149463
4. http://bulletin.facs.org/2018/09/statement?on?recommendations?for?surgeons?caring?for-patients?who?are?jehovahs?witnesse/#.XFH3g4G?xok.email
5. A sample refusal form may be obtained by contacting an attorney at Fager, Amsler, Keller & Schoppmann, LLP.

Important Facts to Know about Americans with Disabilities Act **continued from page 3**

be excluded from interior examination and treatment rooms, due to concerns about infection control. If that occurs, the patient must be provided with an alternative reasonable accommodation. Further, service animals can be excluded from the premises when they are disruptive or are a "direct threat" to the health and safety of others that is not eliminated by a reasonable accommodation, i.e. the animal is not housebroken, is out of control, is not restrained by a leash or tether, or has hygiene problems. The fact of the "direct threat" must be documented. Finally, there are only two questions which can be asked of the patient who brings a service animal to the physician's office: 1) Is the animal required due to a disability; and 2) What tasks has the animal been trained to perform?

In summary, treating patients protected under the ADA and New York State Human Rights laws can be costly and difficult at times. However, patients must not be refused service or discharged solely due to a disability. Physicians must fully comply with applicable federal and state laws regarding protection of patients with disabilities in order to prevent claims of discrimination.

For a more detailed examination of the Americans with Disabilities Act, please review the Spring 2016 issue of *Dateline*.

Choosing the Right Professional Liability Provider **continued from page 7**

coverage, it is important to look beyond the mere premium cost and consider the financial stability of the insurance carrier, past, present and future. Often overlooked are the detrimental financial risks and the potential for exposure of personal assets should insolvency occur.

- Insurers are considered insolvent by the New York State Department of Financial Services when liabilities exceed assets, indicating that if the carrier ceased operations today, it would be unable to pay medical malpractice claims.

Generally, in New York, if a domestic insurer is declared insolvent:

- The state would gain control of the carrier and there would be grounds for rehabilitation pursuant to NY Insurance Law § 7402.
- The insurer could be placed into liquidation too, pursuant to NY Insurance Law § 7404, a financial condition that is similar to bankruptcy.

Currently, in New York, admitted medical malpractice insurance carriers are protected from rehabilitation and liquidation even if insolvent:

- Pursuant to NY Insurance Law § 2343, the Department of Financial Services is prohibited from turning an insolvent or undercapitalized medical malpractice carrier over to the state's liquidation bureau to dismantle the carrier or rehabilitate it.
- However, this could leave the medical malpractice insurance carrier unable to pay all its known and anticipated medical malpractice claims.
- Claimants, insureds and the medical malpractice carriers would have to rely on the hope that there will be enough time for the legislature to fix the situation.

continued on page 11

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A Legal & Risk Management Analysis **continued from page 6**

someone to ask, "how did defensible medicine end up costing $1.5 million?" There were many factors, but one of the biggest was the lack of a unified defense. Instead of relying on the defensible chronology of care, the defense broke down over the conflicts of communication and facts in the case.

The first conflict surrounds communication in the emergency department at the admission of the plaintiff. The emergency room physician claimed that he called the urologist as the plaintiff was being admitted to the hospitalist's care, but he did not make any record of this communication. The urologist claimed that he was unaware of the patient at this time.

Regardless of this conflict, the urologist saw the patient 4.5 hours later in consultation, formed a medical plan, and left the hospital. The urologist claimed to have asked the nursing staff to keep him up-to-date on the plaintiff's vital signs, but he failed to put that order/request anywhere in the medical record. When the plaintiff's vital signs crashed, no one called the urologist.

Years after the events, the medical providers and staff in this case were asked to recall details and defend their medical care where the plaintiff has suffered the amputation of both arms below the elbow. This stressful environment is amplified when communications were not documented, and factual conflicts based upon parties' biased memories develop. A well-documented medical record would minimize these types of conflicts from developing. The defense of this action at trial may have been difficult due to the sympathy value and close calls on the medicine, but the case was lost as soon as the defendants started pointing fingers.

A Reminder from NYSDOH About Opioid Treatment Plan Requirement **continued from page 7**

resources to assist our policyholders with compliance, including Risk Management Tips that can be beneficial in formulating a plan and properly documenting the care and treatment of these complex patients:

- Risk Management Tip #10: Managing Patients with Chronic Pain
- Risk Management Tip #14: Managing Drug Seeking Patients

Additionally, the attorneys at Fager Amsler Keller and Schoppmann LLP are available to provide guidance on the use of pain management contracts and further advice on relevant issues.

Choosing the Right Professional Liability Provider **continued from page 10**

Keep in mind:

- While New York law currently prohibits rehabilitation or liquidation of medical malpractice carriers, this prohibition expires on December 31, 2019. The last time this prohibition was extended was in 2015, when the then senate majority leader was a strong supporter of this law. While the prohibition is likely to be extended again, it is by no means a certainty given changes in the political environment and the addition of another admitted medical malpractice carrier to the New York market since 2015.

If the prohibition expires:

- Upon liquidation, an insured must present proof of any claims to the liquidation bureau by a certain date. If the insured received an additional claim—even one day after the certain date, the additional claim will not be addressed until after ALL timely filed claims are paid in full with interest (something that rarely occurs in a liquidation).
- Delays on payment of claims are much longer in the liquidation process because all claims must be approved by the liquidation court.

The effect of insolvency on an insured creates a series of business, professional and financial uncertainties, distractions and disruptions. Because of this, when selecting a professional liability carrier, one needs to consider financial viability, value, long-term stability and the services offered by the insurance carrier. The appearance of a more cost-effective option at the moment can lead to additional, and even higher, costs and greater financial risks in the long term.

Ultimately, you need to know before you insure: the experience and financial strength of your choice of professional liability insurer can make all the difference in your hour of need.

Event Calendar 2019

In 2019, MLMIC will be participating in the following events throughout New York State. For more information on MLMIC's involvement in these events and others, please contact Pastor Jorge, Manager, Marketing Services, at 212-576-9680.

Westchester Academy of Medicine - 2019 Annual Golf Outing

October 3, 2019 (Westchester County Club in Rye, NY)

Eastern Pain Association (EPA) - 2019 Fall Assembly "Bring It All Together"

October 5, 2019 (New York University - NYC)

HFMA Region 2 Annual Fall Institute - 2019 Annual Meeting

October 9, 2019 - October 11, 2019 (Turning Stone Resort & Casino - Verona, NY)

NYACP - New York American College of Physicians - 2019 Annual Scientific Meeting

October 12, 2019 (Westchester Hilton Hotel, Rye Brook, NY)

ACOG - District II - 2019 Annual District II Meeting

October 18, 2019 - October 20, 2019 (Grand Hyatt Hotel, New York, NY)

NorthStar Network - Cracking the Code on Healthcare
"Doing the Right Things in Healthcare"

October 31, 2019 (Locust Hill Country Club, Pittsford, NY)

New York Metro ASC Symposium - 6th Annual 2019 NY Metro ASC Symposium

November 1, 2019 (Marriott Marquis, New York City)

Onondaga County Medical Society - 2019 Annual Dinner Meeting

November 7, 2019 (Embassy Suites by Hilton Syracuse Destiny, Syracuse, NY)

New York Society of Interventional Pain Physician Symposium - 2019 (NY/NJSIPP)

November 7, 2019 - November 10, 2019 (Hyatt Regency, Jersey City)

NYSSA Post Graduate Assembly in Anesthesiology (PGA 73)

December 13, 2019 - December 17, 2019 (NY Marriott Marquis - NYC)

New York State Neurology Society - 2019 Annual Winter Meeting

December 14, 2019 (Stewart Hotel in Manhattan)

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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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