

# Preventive Action

The Quarterly Risk Management Newsletter for Policyholders of FPIC Fourth Quarter 2002

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## Risk & Liability Issues Associated with Electronic Physician/Patient Communication

By Cliff Rapp, LHRM, Vice President, Risk Management

Although written and verbal communications have traditionally been the primary method of communicating healthcare information, the Internet opens new avenues for providing such information and communicating with patients. In tandem with the potential benefits of electronic communications are sobering legal concerns and emerging increased liability exposure to the public through website capacity. To date, legal waters are largely untested. Consequently, it is important for those

who communicate electronically to address the key risk management issues in developing office policies and procedures for Internet-based communication entailing patient privacy, confidentiality of patient information, security and encryption, informed consent, use of disclaimers, opportunities for patient education, and the implications of website linkage.

Recent data reveals that there is a growing demand by patients for specific healthcare information and directives. Along with that demand is an increasing expectation for online interactivity.

### ELECTRONIC COMMUNICATION SYSTEMS

Electronic communication systems encountered in the healthcare delivery system include:

- Practice-based Internet web pages
- Electronic prescribing systems
- Wireless personal data
- Drug formularies, allergies, and potential conflicts
- Electronic/hard copy e-mail transmission
- Internal, intranet web pages

### ONLINE ADVANTAGES

There are numerous advantages in communicating electronically with patients. Inherently, electronic transmission of information is faster than traditional modalities, and in some cases, instantaneous. Along with meeting growing expectations for quick



and precise information exchange, electronic communications have these advantages:

- Informs and educates patients
- Confirms delivery of communication/information exchange
- Provides automated follow-up
- Enhances informed consent and compliance
- Documents sequence of communication

### INHERENT RISKS

There are, however, inherent risks in communicating electronically. Such risks include:

- Online malpractice exposure
- Extension of the physician/patient relationship beyond the scope intended
- Inadvertent creation of the physician/patient relationship
- Inappropriate disclosure of confidential patient information
- Violation of HIPAA regulations.

### HIPAA

Federal requirements pertaining to electronic transactions and communication set forth by HIPAA (The Health Insurance Portability and

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## FLORIDA

*Requirements for those who supervise prescribing physician assistants*

Florida Administrative Code 64B8-30.007 sets forth requirements and limitations of prescribing privileges for physician assistants. Each supervising physician and prescribing physician assistant shall enter into and keep on file a written agreement outlining which of the medical drugs in the formulary the supervising physician has specifically authorized the physician to prescribe. Furthermore, pursuant to the Code, each agreement must be signed and dated by all parties and maintained for at least a five year period.

## GEORGIA

*Retention of medical records*

Pursuant to the Official Code of Georgia 31-33-2(a)(1)(A) providers having custody and control of any evaluation, diagnosis, prognosis, laboratory report, or biopsy slide in a patient's record shall retain such item for a period of not less than 10 years from the date such item was created.

**Q. Is it against the law to refer to a medical assistant as a "Nurse" in the office practice setting in the State of Florida?**

Yes. The Florida Statute Chapter 464.016, paragraph (2)(a) Each of the following acts constitutes a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083:

(a). Using the name or title "Nurse," "Registered Nurse," "Licensed Practical Nurse," "Advanced Registered Nurse Practitioner," or any other name or title which implies that a person was licensed or

certified as same, unless such person is duly licensed or certified

**Q. What is the effective date for new HIPAA privacy rules?**

Although the HIPAA Privacy Rule became effective April 14, 2001, final revisions continue to be made and physicians and dentists covered by the new rule must comply by April 14, 2003. Continue to watch for final revisions.

**Q. Do state or federal laws set forth a specific manner in which obsolete patient records must be destroyed?**

No. However, the manner selected must protect patient confidentiality. Under new HIPAA confidentiality provisions, it is recommended that obsolete patient records be shredded for disposal. If a service is contracted for this purpose, it is not only wise to verify in writing that the contractor or entity agrees to maintain patient confidentiality but requires that a written business associates contract be executed pursuant to HIPAA requirements. It is suggested that providers require that such entities include indemnification and hold harmless language in the contract and/or written agreement.

**Q. What is a deposition?**

A deposition is testimony given under oath before a court reporter. Depositions are important in the preparation of a case

for trial and a part of the legal discovery process. Depositions freeze testimony and can be used to impeach your credibility if you later deviate from the testimony provided. Failing to appear for a deposition subjects you to the potential to be held in contempt of court. Always seek guidance from your personal attorney or FPIC's Risk Management Department before providing a deposition. Even if you are being deposed merely as a fact witness, the potential exists that the testimony you provide can later be used to facilitate a claim against you.

**Q. Does the physician/patient relationship end at the time insurance coverage expires or managed care plan terminates?**

No. Once established, the physician/patient relationship does not end merely because insurance is no longer available or a change in managed care coverage occurs. A physician's responsibility to the patient continues unless and until the patient severs the relationship or the physician provides proper notification to the patient of the intent to withdraw from providing further care and treatment. Seek legal or risk management guidance before terminating the physician/patient relationship.

admission consent form indicated that students would be involved in the patient's care and appropriately supervised.

*In light of this recent Supreme Court opinion, supervising physicians are cautioned to:*

- Become familiar with the medical condition of supervised patients.
- Review the medical record, test results and patient management plans for supervised patients.
- Maintain contact with supervised students and provide appropriate supervision.

## ALABAMA

*Investigative records remain privileged*

Section, §34-24-60 of the Code of Alabama provides that investigative records of the Board of Medical Examiners remain privileged and confidential and shall not be public records nor be available for court subpoena or for discovery proceedings. This section pertains to all reports of investigations, documents subpoenaed by the board, reports of any investigative committee appointed by the board, memoranda of the board's counsel relating to investigations, statements of persons interviewed by the board or any committee of the board, all information, interviews, reports, statements or memoranda of any kind furnished to the board, and any findings, conclusions, or recommendations resulting from proceedings of the board or any committee of the board, unless presented as evidence at a public hearing.

## STATE AFFAIRS

## OHIO

*Liability exposure as a supervising physician*

The Ohio Supreme Court recently issued an opinion that may have consequences for supervising physicians. The case involved a prenatal patient who was referred to a teaching hospital for induction of labor. An obstetrics resident performed a stress test that revealed fetal distress. The resident misread the results and discharged the patient. Four days later the patient delivered and the baby was profoundly brain damaged. Medical experts claimed that had the infant been delivered just one day earlier, she would not have suffered permanent neurological damage. A malpractice suit was filed naming several defendants, including the resident's supervising physician.

The trial court dismissed the supervising physician from the case on grounds that a physician/patient relationship had not been established. However, the Ohio Supreme Court concluded that a physician/patient relationship may exist between a physician who assumes the duty to supervise residents in a teaching hospital, and a hospital patient with whom the supervising physician had no direct or indirect contact. The teaching hospital's



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Accountability Act) is an important consideration affecting virtually all practices. HIPAA mandates compliance with a standardized format for electronic transactions by October 2002 unless a one-year extension for compliance has been granted. HIPAA requirements also pertain to electronic dissemination of patient information, although most requirements are pre-empted by state confidentiality laws. It is important to remain vigilant to and compliant with the final revisions once made to a number of the requirements originally set forth by HIPAA.

#### RECORDS BECOME EVIDENCE

It is also important to remember that seemingly intangible electronic communication becomes part of the patient's medical records, and as such could become evidence in a malpractice claim. Consider all forms of communication as potential evidence. In this context, will the communication support a defense or facilitate a claim? Such evidence could include:

- Notes you author
- Records made by others
- Correspondence
- Insurance and billing statements
- Staff notations and messages
- E-mail transmissions
- Answering service records

#### ADDITIONAL (WEBSITE) INFORMATION

Additional information pertaining to electronic communication is available at:

[www.an-da.org/pubs/fpubl.html](http://www.an-da.org/pubs/fpubl.html) • [www.ahima.org/journal/pb/00.0i.html](http://www.ahima.org/journal/pb/00.0i.html)  
[www.medrecinst.com](http://www.medrecinst.com)

## PREVENT ALLEGATIONS OF SEXUAL MISCONDUCT

Of all the allegations that can be raised against a physician, sexual misconduct is the most devastating. Professional as well as personal integrity is attacked. Moreover, the stigma of such allegations lingers long after vindication. Careers get ruined and private practices destroyed. Personal relationships with family, friends, and colleagues often become strained and irreparably harmed. In terms of loss prevention, understanding the definition of sexual misconduct is essential.

Sexual misconduct between a physician and patient may include sexual behavior or involvement with a patient, including verbal or physical behavior that may reasonably be interpreted as romantic involvement, regardless of whether such involvement occurs in the professional setting or not. Courts have interpreted sexual misconduct to include behavior or actions reasonably interpreted by the patient as being sexual. This could include a patient not actively receiving treatment from the physician, which results from the use or exploitation of trust, knowledge, influence, or emotions derived from the professional relationship. Generally, sexual behavior or involvement with a patient excludes verbal or physical behavior that is required for medically recognized diagnostic or treatment purposes when such behavior is performed in a manner that meets the standard of care appropriate for the diagnostic or treatment situation.

The fact that a person is not actively receiving treatment or professional services from a physician may not be determinative, and depending on local statutes, may extend even after the physician-patient relationship has ended. Sexual misconduct in the practice of medicine means violation of the physician-patient relationship through which the physician uses the relationship to induce or attempt to induce the patient to engage in sexual activity outside the scope of the practice or scope of generally accepted examination or treatment.

Although allegations of sexual misconduct are among the most difficult to defend, they are the easiest to avoid. To prevent allegations of sexual misconduct, utilize a chaperone whenever possible and document the record to that effect. Avoid statements or behavior that could be misinterpreted by the patient. Consider terminating the physician-patient relationship should inappropriate signals be sent by the patient. Exercise the same, if not heightened caution, when examining or treating employees.

## The Medical Assistant Asset or Liability?

By Linda Blythe, RN, LHRM, Risk Management Consultant

Most medical practices experience the challenge of providing quality patient care in a safe and cost effective manner. The medical assistant plays a valuable part in the efficient delivery of patient care. However, when the medical assistant's performance negatively impacts the vicarious liability of the physician, it becomes a liability instead of an asset. This, of course, encompasses those situations where the physician may have acted appropriately but is found responsible for the negligence of another. Once a physician has taken on the obligation and duty of rendering medical care, one cannot escape that duty by delegating the responsibility to others. An example of this is the medical assistant who passes along medical advice by telephone. Due to the limitations in the medical assistant's education and ability to exercise clinical judgment, the decisions regarding the clinical care of the patient can be jeopardized through misunderstanding or lack of recognition of critical issues.

Another frequently seen problem occurs when the medical assistant is perceived to be a licensed nurse. This can result when the office practice commonly refers to the medical assistant as "the nurse," and when the patients regard them as such. Each of the following acts constitutes a felony of the third degree, as described by **Florida Statute 464.016 Violations and penalties: Paragraphs**

- (1) Knowingly employing unlicensed persons in the practice of nursing.**  
**(2)(a) Using the name of title "Nurse," "Registered Nurse," "Licensed Practical Nurse," "Advanced Registered Nurse Practitioner," or any other name or title which implies that a person was licensed or certified as same, unless such person is duly licensed or certified.**

This can also lead the medical assistant to feel authorized to perform beyond their educational or legal scope of duties. A patient could assume that the medical assistant performing nursing functions, judgment, and patient care decisions is also a nurse, and hold them to that level of skill. Refer to **Florida Statute 458.3485** for a complete description of the duties of the Medical Assistant in Florida. If your practice is in a state other than Florida, refer to your state statutes.

There are actions that the employing physician should initiate in order to determine that medical assistants are not performing services beyond their capabilities or those allowed by law.

- Check credentials carefully before hiring and verify with original sources of education and certification.
- Obtain permission to conduct background checks and check both personal and professional references.
- Provide a written job description which aligns the duties of the MA with the educational preparation and which specifically lists all clinical accountabilities.
- Limit duties to avoid performance at a higher level, such as that of a licensed LPN, RN, or even as an allied health professional.
- Utilize a skills checklist to evaluate the clinical competencies for all patient care duties expected for this position, to mirror the formal job description.
- Complete this checklist, along with a medication test (pharmacology and administration), before formal completion of the orientation period and during annual performance evaluations.
- Maintain these reviews in the personnel files.
- Develop clinical policies and procedures for each clinical care activity to be performed by the clinical care staff.
- Provide and document appropriate continuing education and CPR certifications to ensure appropriate skill to provide emergency care to the entire patient population within your scope of practice; to include PALS or NALS for pediatric and newborn patients.
- Ensure that all other members of your healthcare team understand the role and limitations of the medical assistant.
- Refer to the medical assistant as such and provide a nametag with the appropriate designation, to be sure that patients are not misled into thinking the MA is a nurse.

Utilization of the medical assistant can be a great asset to the medical office practice, extending your ability to offer quality patient care in a cost-effective way. Know whom you are hiring, be sure of their competence, and use them wisely.

## RISK MANAGEMENT GUIDELINES ENTAILING ELECTRONIC COMMUNICATIONS

- Develop a policy and procedure entailing electronic communications
- Adhere to policy and procedure
- Do not overlook patients who do not have electronic access
- Develop a directory to ensure current and correct e-mail and website addresses
- Provide a disclosure statement specifically delineating the confines of the provider/patient relationship
- Publish disclaimers pertaining to emergencies, confidentiality, documentation, and alternative mechanisms for communication
- Ensure that e-mail is encrypted
- Do not use e-mail for emergencies or time-sensitive issues
- Consider initiating an e-mail triage system
- Avoid initiating unsolicited e-mail
- Prohibit "routing" of e-mail communications
- Include mechanism to block e-messages for non-patients
- Develop a component to ensure completion of the patient/provider/patient communication
- Include electronic communications in retention and documentation procedures
- Include the text of originating message in your response
- Develop secure patient identification/digital certification
- Ensure that patients can access their records
- Always obtain appropriate authorization and consent
- Adopt written privacy procedures
- Train employees and designate a privacy officer
- Limit disclosure of information to the request
- Adhere to stronger state laws pertaining to mental health, HIV, and AIDS
- Review informational websites and edit when necessary before posting or a referral is made
- Insulate clinical website content from commercial content
- Obtain confirmation of message delivery
- Never allow electronic communication to usurp human interaction
- Employ a firewall to protect your website and data from unauthorized access
- Utilize encryption technology to protect the transmission of data to and from your website
- Comply with current and revised HIPAA mandates

## HIPAA Update

As most practices are aware, in August 2002 the final Health Insurance Portability and Accountability Act (HIPAA) medical privacy rules were announced. The new rules address the many concerns of practitioners and provides a more practical approach to safeguard patient privacy. Regulations that were issued earlier created unintentional interference with patients' access to care. The final regulations balance privacy protections with patients' access to quality health care.

- Key features of the final privacy rule:
- Eliminate written consent prior to release of information for certain purposes and instead allow patients to acknowledge they have received the required notice of privacy rights.
  - Lessen "minimum necessary" restrictions.
  - Acknowledge "incidental use and disclosure."

The privacy rule will become effective on April 14, 2003. However, the final security and transaction standards rules have not been released. October 16, 2002, marked the deadline for practices involved in electronic transactions to file an extension for compliance (*Preventive Action Vol. 15, No. 3*).

FPIC will provide compliance guidance to insureds, including sample privacy notices and business associates contracts, in upcoming *Preventive Action* Newsletters.

## LOSS PREVENTION

Consider the case of a 48-year-old female with a history of coronary artery disease and diabetes who presented to our insured, an internist, with complaints of pain and numbness in both lower extremities. The patient was seen by our insured's physician assistant who diagnosed sciatic pain and instructed the patient to return for follow up in two days. The patient returned two days later, continuing to complain of pain and numbness in both extremities. On this visit, the patient was examined by our insured who noted trace peripheral edema, cold feet, and decreased peripheral pulses. A bilateral arterial Doppler was ordered "as soon as possible." The following day the patient was admitted to the hospital and treated with TPA. Despite conservative treatment, the patient's legs became gangrenous requiring bilateral amputation. Medical experts were unable to defend our Insured or his physician assistant. Experts felt that the initial examination performed by the physician assistant was inadequate. Completely missing the diagnosis given the patient's medical history and clinical complaints constituted a breach in the standard of care. Experts were unable to support our insured's failure to order the arterial Doppler STAT and immediately admit the patient when she was seen at the time of the second office visit.

Consequently, settlement of the case was necessitated in the amount of \$500,000 on behalf of our insured and his physician assistant, for whom the internist was both directly and vicariously liable.