MIEC

The Exchange

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INSIDE

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From the Chairman of the Board

Post MICRA Challenge

James O. Gemmer, MD, Chairman MIEC Board of Governors

We had a resounding victory over Prop 46 on November 4, 2014. The final results revealed a more than 2-to-1 victory for the "No on 46" campaign. Why did we win?

First of all, the message was in our favor. Ultimately, voters did not want to see more lawsuits and have medical care costs rise. We spent a great deal of time, money and energy in determining the best messages and we stayed with them. It was tempting at times to respond to some of the ads and charges made by our opponents, but our professionals knew better. It was extremely helpful that we bought our media ads early, allowing us to capture some of the best airing times.

We had a very well-organized group that was led by Dustin Corcoran, Chief Executive Officer for the California Medical Association (CMA), who did an excellent job of keeping us focused. The Funder's group consisted of the medical professional liability (MPL) companies, CMA, CDA, CHA, CAPP (Coalition to Preserve MICRA), Planned Parenthood, and representatives from the Community Clinics throughout the state. This group contributed generously to allow us to develop the kind of campaign that it would take to win.

We hired a campaign team of two people, one from the Democratic Party and the other from the Republican Party. This balance allowed us to make inroads with the various groups that might give their support. In addition, we hired an outstanding team to do our polling, conduct focus groups, work with media, develop social media messages, and manage all of the aspects that constitute a good campaign.

As a result of all of these efforts, we received support from entities such as the ACLU, California Teachers Association, CNA, various unions, city governments, and the

California Republican Party. It is said that it may have been the largest support group ever developed for the Proposition process. In addition, we had unanimous support from the editorial boards from all of the major California newspapers. That was truly impressive.

Another major factor was the amazing support that we received from the physician community. Physician participation was awesome! CMA and the various medical societies were very active in getting buttons, signs, and informational material out to offices for distribution. Physicians and their practices were very engaged in answering questions and getting the information to the voters. The results showed that our efforts were worth it.

The Prop 46 campaign team included a couple of "sweeteners" that they made part of their "patient safety" initiative to gain more votes. In the end, I believe they created a three-headed monster that voters couldn't support because they didn't understand or couldn't support all of its parts.

The CURES database resource for physicians was not a bad idea, but the program is not ready for implementation and continues to struggle with inefficiencies that need to be corrected. It is my hope that organized medicine and the MPL companies will actually take the lead and develop a system that is efficient and can be very beneficial to physicians and their patients. How about a program that is connected directly to the EHR programs in offices and hospitals?

The drug testing of doctors was not a well-defined component. It proved to be unpopular with nurses and unions in addition to many physicians. However, it did poll well and I suspect we may hear more about this in the not-too-distant future.

In the end it was a great effort with an excellent outcome — namely, the protection of a vital element of MICRA, which is the cap on non-economic damages. Unfortunately, this victory doesn't guarantee long-term continued success. There is nothing to keep the trial attorneys from coming back at us with a better package. Although the recent election would suggest that we have even more support in the Sacramento Legislature, you never know when that will change. My biggest concerns are the continuing court challenges to MICRA.

With the resignation of Associate Justice Marvin Baxter at the end of 2014, we lost one of our best MICRA supporters on the CA State Supreme Court. On January 5, 2015, Governor Brown swore in two of his appointees: Mariano-Florentin Cuellar (nominated in July 2014) and Leondra Kruger (nominated in November 2014). This is a total of three Democrats who have now been nominated and installed by Governor Brown, which could lead to a very different outcome when the next MICRA challenge occurs. One can only speculate when that will happen, but the trial attorneys are constantly looking for new opportunities to expose us to litigation. Remember, it only takes one ruling to take away the protection we have had for the last 40 years.

Take care and remember to let us help you if we can. We are here to serve our policyholders.

Jim Gemmer, MD

How do I say I'm sorry? Let me count the ways

(Revised 2015)

Confused about discussions related to disclosure of unexpected adverse outcomes, apology versus sympathy, early resolution of injury-related complaints, and how to avoid unnecessary liability risks? You're not alone. Here is some advice for handling potentially difficult circumstances with compassion, truthfulness and candor.

What does "I'm sorry" mean?

In the lifetime of a practice, a physician experiences a multitude of opportunities to offer an expression of sympathy, condolence, regret, or apology. Saying "I'm sorry," the most common representation of these sentiments, can convey a variety of messages depending on the context in which it's expressed. Defense attorneys historically counseled physicians to avoid saying "I'm sorry," assuming that a plaintiff's attorney would argue that the words were an admission of guilt. Dr. Lucian Leape, Professor of Health Policy at Harvard Medical School, has this to say about that assumption: "For decades, lawyers and risk managers have claimed that admitting responsibility and apologizing will increase the likelihood of a patient filing a malpractice suit and be used against a doctor in court if they sue. However, this assertion, which seems reasonable, has no basis in fact. There is to my knowledge not a shred of evidence to support it. It is a myth."[1] In fact, according to Norman Tabler, there is good evidence "…that instead of increasing lawsuits and awards to patients, apologies actually reduce both the incidence of lawsuits and the amount of awards. Evidence from multi-year studies at both the Veterans Administration Hospital of Lexington, Kentucky, and University of Michigan Health support this conclusion."[2]

1 Leape, Lucian, MD, "Full Disclosure and Apology—An Idea Whose Time has Come," *The Physician Executive*, March-April 2006, p. 17.
2 Tabler, Norman G., "Dealing with a medical mistake: should physicians apologize to patients?," Medical Economics, November 10, 2013.

Notwithstanding any legal consequences, physicians have an ethical duty to inform their patient about what happened during a treatment or surgery. In 2001, the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission) established a standard that requires hospitals to ensure that unexpected adverse outcomes are fully disclosed to patients (To learn more about **Standard RI.1.2.2** and disclosure of untoward outcomes, see *Special Report: Claims Alert,* No. 33 titled, "Disclosure of Untoward Outcomes"). Until recently, no one championed the cause of physicians who want to apologize to patients—and no one helped them to do so in a way that avoids putting the physician needlessly in legal jeopardy.

SITUATION 1: You appropriately prescribed Tegretol and your patient developed Stevens Johnson syndrome.

SUGGESTION 1: You say, "Mrs. Bee, this is one of those unlikely, but possible, side effects we discussed when I prescribed the medication and I am so sorry that you were one of the people who experienced it! I will do everything possible to take care of your symptoms and look for another solution to your original problem."

Sometimes it is appropriate—even essential—to say "I'm sorry." Even in those instances, some physicians hesitate, fearful that an apology will be held against

them if the patient brings a lawsuit against them. On the other hand, a more damaging situation could unfold: consider the effect it would have on a jury if a physician was on the witness stand and the plaintiff's attorney asked, "Doctor, did you ever tell my injured client that you were sorry this happened?" and the physician replies, "No."

"I'm sorry" legislation

Legislators in many states have passed laws in recent years to protect physicians who express empathy, compassion, and condolence to injured patients. In California, a physician's expression of sympathy for patients' untoward outcomes is protected from being used in a civil action as an admission of liability; however, if the physician orally admits liability, the confession of fault is admissible (**See California Evidence Code §1160**). Idaho legislation makes physicians' expressions of apology, condolence, and sympathy, and their accompanying explanation of what happened, inadmissible as evidence of liability. Statements of fault, however, are admissible, so care must be taken to make certain that an expression of apology or an accompanying explanation do not also contain an admission of fault. Similar laws are in place in Hawaii and most recently in Alaska. (See **Table 1** for apology statute references.)

SITUATION 2: Your patient says that your medical assistant was too rough as she changed his dressing.

SUGGESTION 2: You say, "Gosh, Mr. Ali, I am so sorry it hurt. Although I know she's usually as gentle as possible, I'll ask her

State	State Apology Laws
Alaska	**House Bill 250, effective October 6, 2014 (ultimately Alaska Statute 09.55.544)** Summary: "An Act making an expression of apology, sympathy, commiseration, compassion, or benevolence by a health care provider inadmissible in a medical malpractice case; requiring a health care provider to advise a patient or the patient's legal representative to seek legal advice before making an agreement with the patient to correct an unanticipated outcome of medical treatment or care; and amending Rules 402, 407, 408, 409, and 801, Alaska Rules of Evidence."
California	**Evidence Code §1160:** (a) The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section. (b) For purposes of this section: (1) "Accident" means an occurrence resulting in injury or death to one or more persons which is not the result of willful action by a party. (2) "Benevolent gestures" means actions which convey a sense of compassion or commiseration emanating from humane impulses. (3) "Family" means the spouse, parent, grandparent, stepmother, stepfather, child, grandchild, brother, sister, half-brother, half-sister, adopted children of parent, or spouse's parents of an injured party.

Table 1

State	State Apology Laws
Hawaii	**Hawaii Rules of Evidence Rule 409.5:** Evidence of statements or gestures that express sympathy, commiseration, or condolence concerning the consequences of an event in which the declarant was a participant is not admissible to prove liability for any claim growing out of the event. This rule does not require the exclusion of an apology or other statement that acknowledges or implies fault even though contained in, or part of, any statement or gesture excludable under this rule.
Idaho	**Idaho Statutes Title 9, Chapter 2, §9-207; Idaho Rules of Evidence Rule 414:** Admissibility of expressions of apology, condolence and sympathy. (1) In any civil action brought by or on behalf of a patient who experiences an unanticipated outcome of medical care, or in any arbitration proceeding related to, or in lieu of, such civil action, all statements and affirmations, whether in writing or oral, and all gestures or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence, including any accompanying explanation, made by a health care professional or an employee of a health care professional to a patient or family member or friend of a patient, which relate to the care provided to the patient, or which relate to the discomfort, pain, suffering, injury, or death of the patient as the result of the unanticipated outcome of medical care shall be inadmissible as evidence for any reason including, but not limited to, as an admission of liability or as evidence of an admission against interest. (2) A statement of fault which is otherwise admissible and is part of or in addition to a statement identified in subsection (1) of this section shall be admissible. (3) For the purposes of this section, unless the context otherwise requires: (a) "Health care professional" means any person licensed, certified, or registered by the state of Idaho to deliver health care and any clinic, hospital, nursing home, ambulatory surgical center or other place in which health care is provided. The term also includes any professional corporation or other professional entity comprised of such health care professionals as permitted by the laws of Idaho. (b) "Unanticipated outcome" means the outcome of a medical treatment or procedure that differs from an expected, hoped for or desired result.

Table 1 cont.

whether something happened that may have made her movements more abrupt this time. I hope she apologized as it happened. She did? Great, but I'm going to remind her, too, how important it is to keep you as comfortable as possible."

What can physicians do?

Defense attorneys, professional liability carriers, risk managers, and physician consultants have long known why patients bring lawsuits against their physicians. First, those patients have been or believe they were injured. Second, they are angry. They are angry—about not having their questions answered, about being given too little information about their condition and treatment, because they were treated coldly or dismissively, and for other real or imagined slights during the course of treatment.

The first step a physician must take to ensure that he or she can successfully communicate about an untoward outcome is to establish a comfortable, solid rapport and trust with all patients from the outset of the doctor-patient relationship. To facilitate the best decision-making about

whether or how to express sympathy, condolence, regret, or apology, the physician must anticipate and prepare for such an event.

It is not possible to offer physicians specific advice for every possible circumstance and related contingency. Inevitably, there will be situations which require rapid judgment yet have far-reaching consequences. Every physician must consider the possibilities, be comfortable with the doctor-patient relationship, and rely on his or her moral compass for decision-making. In many situations, however, a framework of practical recommendations and a common sense application of them will cover most contingencies.

SITUATION 3: Your 93-year-old patient suffered a fatal heart attack the day after her last visit to your office. Her youngest son, also your patient, is beside himself with grief and asks, "Why didn't you save her, Doc?"

SUGGESTION 3: You say, "I am so sorry for your loss, Mr. Chow. You know we were right there with her to the end, trying everything that might have helped her, but your mom's heart was just too fragile and couldn't be fixed. I'm honored that I was able to participate in the care of such a well-loved and long-lived patient as your mother."

SITUATION 4: Despite your utmost care in the examination of your 6-month-old cardi-

Recommendations:

Anticipation and preparation—what to do BEFORE you are confronted with an unexpected adverse outcome:

- Establish and maintain a warm and communicative rapport with patients.
- Introduce new patients to you, your staff and your policies by giving them a "Patient Information Brochure" (*Ask the Loss Prevention Department for sample brochures*).
- Ensure that your staff is well trained to welcome patients to your practice and convey interest in their well-being, both on the phone and in person. Hire staff who will convey warmth and reassurance to patients.
- Ensure that your staff knows how to respond to patient complaints to avoid escalation of perceived problems (See *Managing Your Practice*, Advisory No. 3, "Patient complaints: how to stop them before they start").
- Educate patients about their disease, condition, general health, medication, or other treatments. Give them written information about these topics and your advice. Tell them to read what you've given them and invite them to ask questions if they have any. Document that you've done so.
- Lay the groundwork for future discussions by having a thorough **informed consent** discussion prior to invasive procedures or other risk-inherent treatment. Remember that informed consent is a process, not a form. Obtaining informed consent is an opportunity to educate patients, answer patients' questions, reassure patients, strengthen the doctor-patient relationship, and to realistically establish patients' expectations. (See MIEC Loss Prevention *Claims Alert*, No. 17, "Informed Consent Revisited: What is Expected of Physicians").
- Thoroughly document your care, your justification for medical decisions, your patient education efforts, and your informed consent and informed refusal discussions (see *MIEC's Medical Record Documentation for Patient Safety and Physician Defensibility*).
- Contact Loss Prevention to participate in a **physician-led communication training seminar** to sharpen your skills in the art of disclosing of unanticipated outcomes, expressing compassion and empathy to patients and family members, and communicating in potentially difficult doctor-patient situations.
- Consider in advance, informally (with trusted colleagues) and formally (in appropriate committees or groups for that purpose), what you might do if faced with a situation in which a patient suffers an unexpected adverse outcome in which you played a role. These discussions needn't involve actual cases that might be discoverable, but hypothetical circumstances of the kind physicians are likely to face. Include consideration in advance of what you might do if you were faced with such a situation and lacked the opportunity to call MIEC for advice about how to proceed.

ology patient with osteogenesis imperfecta, you realize you've fractured his arm.

SUGGESTION 4: You say, "Mr. and Mrs. Dillon, I'm so sorry, but I believe that Donnie's arm is broken. It's even possible that my examination contributed, as gentle as I tried to be; his bones are so very fragile, as you know. I'd like to take him right over to the emergency department for evaluation and treatment. I'll stay with all of you until he's been treated and until we know everything that needs to be done has been done." (As soon as possible, you call MIEC's Claims Department to report the situation.) [Note: The parents in this real circumstance did not sue the doctor.]

What to do if you are involved in, believe you have contributed to, or are implicated in an unexpected adverse outcome:

- Call MIEC's Claims Department as soon as possible! The Claims Representative will discuss with you the relevant facts of the circumstances and your role in them, and will advise you of the most prudent and appropriate course of action. Together you will discuss how to manage this situation. The Claims Representative may discuss the elements of a successful disclosure and provide guidance in how to start a conversation with your patient. Of course, a more traditional resolution route may be indicated. The Claims Representative may obtain the services of an attorney to participate in the discussion and subsequent decisions on your behalf. As the Claims staff is not available "24/7," in some instances it will be necessary to express sincere sympathy (but not liability), and call MIEC after the fact to determine how to proceed. Attorneys caution against making statements of liability because some physicians may be so overwhelmed by an outcome that they are prematurely self critical, when in fact they did not contribute to an injury and their care turns out to be entirely defensible.
- Be aware that when patients are injured (or believe they've been injured) they want three things: (1) sincere sympathy and/or an apology (2) a show of concern; and (3) if they were injured by an untoward event, a commitment that no one else will be injured in the same way in the future. Many patients also want an explanation for what happened and why; physicians should advise the patient or family member that every effort will be made to understand the circumstances of the event. It is important to then follow through with that promise, with the assistance or advice of the Claims Department.
- Know your hospital's disclosure policies, especially the specific steps to take in the face of an unanticipated adverse outcome in the hospital.
- With the help of a Claims Representative, determine what events and details will be disclosed, if any. Determine when disclosure will take place, who should be present, who will conduct the discussion, what should be said and to whom, who will say it, and where the meeting will be held (in a private setting, for instance).
- With the help of a Claims Representative, determine whether you will offer an apology, an expression of sympathy, an accurate and objective explanation, a promise of an investigation, or some other demonstration of your sincere concern about the situation. [In some instances, if the situation is hospital based, it may be appropriate to work

cooperatively with the hospital risk manager—again, with the advice of a Claims Representative.]

- If you offer an apology or an expression of sympathy and an accompanying explanation, you may want to have a colleague, nurse, or other person present to observe and listen. In the event you are accused of admitting liability and not "just" apologizing and explaining, a witness to the conversation will be helpful.

SITUATION 5: When your patient called at 3:00 a.m., you suggested he go to the emergency room to be evaluated and after initially agreeing, he said he wasn't that ill. You urged him to go because you wanted to make certain that nothing serious was missed. You make a note to that effect. The next day his wife calls to tell you that the patient collapsed and died at home at 11:00 a.m.

SUGGESTION 5: You say, "Oh, Mrs. Eddy, I am so very sorry to hear that! Is there anything I can do to be of assistance to you?" [As soon as possible, you call MIEC's Claims Department to report the situation. DO NOT make changes to the patient's chart.]

SITUATION 6: The results of the PSA you ordered was filed in a patient's chart without your review, and you didn't see it until 18 months later. It is acutely elevated, and given the patient's general health, you know that this result indicates a further compromise of his health.

SUGGESTION 6: First, you call MIEC's Claims Department to discuss how to proceed. You and the Claims Representative review the patient's chart and the pertinent details and decide when and how you will contact the patient, and what you will say. You will discuss possible ways to take care of the patient's immediate and long-term needs related to this obvious lapse in care.

SITUATION 7: Your 15-year-old appendectomy patient developed post surgical peritonitis; you supervised and assisted the surgical resident who did the surgery. Upon returning her to the OR, you discover that you nicked her bowel. You're aware that her recovery is likely to be slow and complicated.

SUGGESTION 7: You spoke briefly to the Claims Representative prior to taking the patient to surgery the second time because you suspected the cause of the patient's distress. Upon meeting with the parents after successful surgery to repair the tear, you say, "Mr. and Mrs. Goodman, it appears that a slight problem arose from the original surgery and that somehow we may have nicked Jessica's bowel, causing the contents to contaminate her belly. As you recall from our discussion prior to her appendectomy, this is one of the common surgical risks, and we're so sorry that it happened. Dr. Berry and I will go back over the original surgery to determine exactly when and how this might have happened, and we'll tell you what our conclusion is. In the meantime, we are taking good care of her, and we'll keep you informed of her progress every step of the way. Her recovery will take longer than we initially discussed, but please let us know if we can answer any of your questions, or assist you as Jessica recovers."

- If you will be involved in lengthy discussions about sensitive issues with the patient or family, respect the patient's cultural frame of reference, ability or disability, cognitive skill level, education, language, religion, or any other factor that may influence how you communicate.

- If an investigation will be forthcoming, determine what will be done and by whom (policyholder, hospital, internal review committee, MIEC, other professional liability carrier), and what will be done with the investigative results. If the patient or patient's family is to be informed of the findings, determine who will be responsible for conveying the information, and whether it will include details about accountability, personal responsibility, and/or resultant policy changes.
- DO NOT change anything in the patient's chart. If you believe that something is in error or requires an amendment, call the Claims Department to discuss how to proceed.
- Avoid casually placing blame or finding fault. (These actions are distinct from assigning or taking personal responsibility when it is appropriate to do so.)
- Focus on the patient's experience, which may prevent the conversation from becoming adversarial and help you avoid becoming defensive.
- Do not discuss offering assistance or compensation with anyone without first consulting and obtaining the approval of MIEC's Claims Representative. If you have questions about such matters, ask the Claims Representative what should be offered to the patients and/or family, if anything, and if so, of what nature and how much.
- Document accurately, specifically and objectively all discussions you have with the patient and/or the patient's family about the subject event, including what you said and the patient's response, and contributions by others present—in the patient's chart. DO NOT document in the patient's chart any discussions with the Claims Representative or your defense attorney, if you have one.
- If it is possible, recommend, organize or participate in a program designed to provide emotional support to physicians who have had to admit to a patient or patient's family an error that caused a patient injury. Although the process of making an apology to a patient is frequently a healing experience for patient and physician alike, it is not without consequence to either. Many physicians, following closure with the patient or patient's family, benefit from a "debriefing" process in which they experience closure with their internal critic as well. Prior to establishing such a group, consult the Claims or Loss Prevention Departments, local or state medical society, or defense attorney to ensure that the group does not discuss discoverable events, but focuses on the emotional impact of having experienced a sensitive patient interaction that involved saying "I'm sorry."

Part of your MIEC premium goes towards having our Claims, Underwriting, and Loss Prevention Departments' experts available to answer your questions and provide advice when you are faced with challenging liability-related issues in your practice of medicine. Our policyholders own MIEC. We're here to help you. Call us.

Our thanks to former MIEC Loss Prevention Manager Judy Huerta for her contribution to this article.

From the Claims Department

Part II insurance coverage:

Q **I am in receipt of an inquiry from my state's medical board regarding my care and treatment of a patient. Do I have coverage for this under my MIEC policy — and, if so, what should I do?**

A Yes, you have coverage. First**, contact** MIEC immediately. **Avoid** communicating with the medical board without engaging MIEC first. An attorney will be assigned to you to counsel you and represent your interests in this matter.

Second, be advised that coverage under your MIEC policy is limited to *defense costs only*, up to an aggregate limit of $25,000.00 for all such claims during the policy year. Part II. B, Section 1 (a) of your policy reads:

1. Subject to the exclusions, limitations, and other terms and conditions of this **policy**, MIEC will pay reasonable expenses and costs to a maximum of $25,000 for combined expenses and costs to defend you against investigations, civil lawsuits, or administrative proceedings in a matter arising from your professional practice first initiated after the effective date:

   a. By a state agency licensing **you** to engage in professional practice as a physician.

The $25,000 coverage limit applies to an investigation and any resulting administrative proceedings or civil lawsuits and all related or consequential proceedings, regardless of when concluded.

This means that the maximum fees and expenses (to defend only) paid by MIEC are $25,000.00 total for all matters (under Part II.B) combined and reported in the same policy year. As this matter progresses, we will monitor legal expenses and be sure to advise you should defense costs approach the limit. If the limit is consumed, all future invoices will be your responsibility. Any fines assessed by the medical board will be your responsibility as well.

To best protect your interests in this matter, do not discuss any aspect of this patient's care and treatment with anyone other than a representative of MIEC or someone from the assigned law firm. Do not make any alterations or additions to the medical record, as any changes to the chart could jeopardize your defense.

More on Indemnification Agreements:

In the July 2013 issue of The Exchange, we discussed the very significant, and uninsured, liability that may arise from indemnification clauses in professional service agreements (PSAs). Such clauses are frequently included in PSAs, and until recently they often have been overlooked by both the physicians signing the agreements and the attorneys enforcing them. However, this is beginning to change as damage claims increase and parties look for ways to shift the burden of liability onto other parties.

In this issue, we will examine a medical malpractice case (from one of the states where MIEC insures) in which the plaintiff attorney's attempt to hold the hospital solely responsible for a physician's alleged negligence resulted in just the opposite, as the physician ultimately was found to be contractually responsible for the hospital's liability under a PSA containing an indemnification clause.

This case involves a 41 year-old male who presented to the ER with complaints of radiating back and bilateral leg pain. He reported a history of chronic back pain, but a recent MRI was negative.

The patient also complained of vomiting and diarrhea on the previous day. Upon further discussion, the ER physician learned that the patient had a sick child at home, and his symptoms were attributed to a viral illness.

The examination was unremarkable and the lower extremities were noted to be neurologically intact. The ER physician diagnosed the patient as having exacerbation of chronic back pain and viral gastroenteritis. She administered IV fluids, morphine, and Phenergan, and the patient was discharged home.

Three days later, the patient returned to the ER with a fever and change in mental status. Upon admission, he was hypotensive and labs revealed renal failure, abnormal liver functions, and abnormal electrolytes.

The patient was admitted to the hospital with the diagnosis of acute bacterial endocarditis with septic emboli. Despite aggressive treatment, the patient developed worsening sepsis and renal failure, and he ultimately died on the day after admission.

The patient's family filed a wrongful death lawsuit against the ER physician and the hospital. Their allegation was failure to diagnose and treat acute bacterial endocarditis, resulting in the patient's death. Due to the patient's young age and high earnings at the time of his death, the total initial claimed damages were in excess of $3,000,000.

While the lawsuit began in 2007, the case did not go to trial until 2013. As the trial date approached, plaintiffs offered to dismiss the ER physician with prejudice and pursue their case against the hospital which they held responsible for the physician's actions.

Due to the hospital's decision not to require minimum physician insurance and post specific signage in the ER, both of which would have specifically allowed them statutory protection from liability for the physician's care, the hospital remained liable.

During the course of discovery, the physician's defense attorney obtained a

copy of the ER group's contract with the hospital, which included the following indemnification and defense provision:

> *"Indemnification. Medical Group agrees to defend, indemnify and hold the Hospital harmless from all liability, claims, losses, damages, expenses, costs and attorney's fees arising out of or related to all acts or omissions of Medical Group including the specific medical directions and standing orders given by Medical Group physicians to Hospital-furnished non-physician personnel."*

The existence of this contract was not immediately raised by the hospital, and there was no tender of defense to the ER group, which was not a named defendant in the case. However, the physician's attorney later discovered that the physician's PSA with the ER group contained similar language outlining an indemnification and defense provision, meaning that the physician was contractually obligated to indemnify, and possibly even defend, the hospital in the case.

The MIEC policy, similar to other professional liability policies, contains an exclusion pertaining to liability arising from any written or oral agreement to indemnify a third party, if that liability is greater than that which would have existed in the absence of such an agreement. Therefore, the physician's liability under the contract was uninsured.

After learning of the physician's potential dismissal, the hospital asserted its right to indemnification under the ER group's contract and tendered the claim to them. As a result, liability flowed to the physician through both the hospital and medical group contracts, but this extra-contractual liability was excluded under the insurance policy.

After a lengthy discussion with her attorney, the physician declined dismissal and instead chose to remain in the case as a defendant, in order to avoid personal exposure for extra-contractual liability in the event that the jury found her negligent and awarded damages against the hospital for liability arising from her care and treatment.

By the time the case went to trial, plaintiff's total damages claim had increased to $10,000,000. Fortunately for the physician, the case resulted in a defense verdict; however, the trial lasted for over one month and the experience was both exhausting and financially burdensome for the physician.

While the liability imposed by the indemnification provisions in the physician and group contracts was not initially a focus of the case, and may never have been had plaintiff's counsel not offered to dismiss the physician, it certainly was a focus of the ensuing trial. Thus, any verdict imposed by the jury against the hospital arising from the physician's treatment would have resulted in uninsured exposure for her.

Recently, and particularly in high damage cases, plaintiff attorneys have increasingly focused on theories of vicarious liability and ostensible agency in order to maximize available insurance coverage by placing liability on hospitals and medical groups for the actions of defendant physicians. In response, attorneys representing hospitals and medical groups are increasingly looking at ways to protect their clients from such liability and are examining PSAs more closely. In this setting, physicians who sign such agreements containing indemnification/defense clauses are placing themselves at significant risk of uninsured exposure in a medical malpractice case.

MIEC recommends that you carefully review your PSA(s) for indemnification clauses. If such language is included in a contract that you are being asked to sign, we recommend that you ask to have the language removed entirely, or replaced with a clause requiring each party to maintain professional liability insurance.

CRICO Strategies Corner

In 2014, MIEC and CRICO/RMF Strategies (the Risk Management Foundation for the Harvard system) conducted a comparative benchmarking analysis of MIEC's cardiology medical events reported between 2008 – 2012 in which cardiology was named as the primary responsible service and with indemnity or expense reserves or payments of $25,000 or higher. The purpose of such an analysis is not only to provide our policyholders with critical benchmarking data in the cardiology specialty, but also to dig deeper and to uncover opportunities where MIEC can help policyholders mitigate risk, increase patient safety, and have a more robust understanding of what drives cardiology claims. CRICO Strategies' analysts deep coded 98 medical events and determined that the distribution of cardiology cases across the care continuum is similar between MIEC and peer organizations in the Comparative Benchmarking System (CBS) database.[3] Peer organizations included all CBS insurers and excluded academic institutions.

The analysis revealed three primary allegations: (1) negligent medical treatment; (2) failure to diagnose; and (3) negligent medication management. Negligent medical treatment was alleged in 57 cases (58% MIEC cardiology claims vs. 43% of peer cases), with total losses incurred of $4,020,464. Twenty-two cases alleged the failure to diagnose cases with total incurred losses of $3,442,610. Medication mismanagement cases were the fewest in number (12 total) but cost the most to resolve: $4,277,166.

CRICO Strategies Cardiology Analysis in a Nutshell

Key Findings:

- 58% of cases had an allegation of *negligent medical treatment* resulting in $4M of incurred losses
  - ✓ 28 cases involved *improper performance of treatment/procedure, particularly cardiac catheterizations* — 6 deaths. As with peer organizations, *technical skills* were usually cited as the primary contributing factor.
  - ✓ 18 cases involved *improper management of treatment course* — 14 deaths; behavior-related issues were among the top contributing factors.
- Medication-related cases had the highest total dollars incurred for the smallest number of claims
  - ✓ Anticoagulation therapy — both outpatient management and pre/post procedures were the driver of medication-related cases and were more prevalent than for peers (83% MIEC vs. 46% peers)
  - ✓ Issues involving *clinical judgment*, *communication,* and *clinical systems* were the dominant contributing factors.

3 CRICO's Comparative Benchmarking System (CBS) is an extensive database of medical malpractice cases (claims and suits) from Academic and Community hospitals, and Physician Practice Groups within the Harvard system and across the country.

Negligent medical treatment claims were primarily divided into two categories: improper *performance* of a treatment/procedure and improper *management* of a treatment course. The analysis demonstrated that MIEC has a slightly higher percentage of claims relating to improper *performance* (49% for MIEC vs. 42% for peers), while peers' claims more often related to improper *management* of care (32% MIEC vs. 43% peers). Poor technical skills (particularly with cardiac catheterizations) were the major contributing factor in MIEC's 28 improper *performance* cases, resulting in just over $3M total in losses, high-severity injuries in 43% of the cases, and six deaths. Clinical judgment issues and communication factors impacted these cases as well.

MIEC improper *management* cases (e.g., improper management of treatment course, delay in treatment/procedure, failure to treat, or premature end of treatment) more often resulted in high-severity injuries than they did for peers (83% vs. 76% respectively) — 14 of the 18 cases involved patient death, leading to $4M total of incurred losses. As would be expected, mismanagement cases primarily occurred in the outpatient setting. Clinical judgment, such as failure/delay in obtaining a consult, narrow diagnostic focus, and improper patient assessment, was a contributing factor in 83% of the improper management cases. Patient behavior — including noncompliance with a treatment regimen, seeking other providers due to dissatisfaction with care, and failure to return in follow-up as recommended — contributed to the outcome in 50% of the mismanagement cases.

The 22 failure of or delay in diagnosis medical events involved issues of miscommunication regarding a cardiac catheterization; an incidental lung nodule not followed up on; delay in diagnosing endocarditis or myocardial infarction; and three anticoagulation therapy cases.

Moreover, MIEC's medication-related issues (shown below) had the highest total dollars incurred in its peer group for mismanagement of anticoagulation therapy (83% for MIEC vs. 46% for its peers). This included both outpatient management and pre/post procedures. Issues with clinical judgment were the number one contributing factor in medication-related cases (e.g., failure to order the proper medication, failure to monitor the medication appropriately, inadequate patient assessment, reliance upon patients to monitor their medication regimen). Communication factors — such as poor follow-up instructions, lack of communication among providers regarding a patient's condition, and failure to discuss the risks of prescribed medications contributed to the outcome in 67% of medication-related claims. Clinical systems factors likewise affected the cases.

After evaluating the 98 cardiology medical events, CRICO Strategies' analytical team offered the following recommendations to help our policyholders reduce their risk while enhancing patient safety:

Develop structure around anticoagulation management and consider the use of anticoagulation clinics.

- Investigate Anticoagulation Forum — a multidisciplinary organization of healthcare professionals whose mission is to improve the quality of care for patients taking antithrombotic medications.
- Implement practice protocols for office-based management, including clinical oversight by RN, PA or NP.

MEDICATION	MIEC # CASES	MIEC % CASES	PEERS % CASES
Anticoagulants	10	83%	46%
Cardiovascular Drugs	3	25%	30%

- Investigate and drive EMR alerts for providers in electronic medication reconciliation and order entry systems to remind ordering clinicians to fully assess the risk of anticoagulation discontinuation both pre and post procedures.
- Ensure that patients are both educated and involved in their medication management.
- Improve pre-procedural assessment by investigating best practices such as those that have proven successful (e.g., Society for Cardiovascular Angiography and Interventions; Blue Cross Blue Shield of Michigan Cardiovascular consortium model; Michigan Anticoagulation Quality Improvement Initiative's "anticoagulation toolkit" at http://anticoagulationtoolkit.org).

Improve communication and management of the ongoing care process, including reviewing your processes for:

- Routine testing/result management
- Monitoring/adapting
- Case review with respect to communication breakdowns
- Apology and disclosure

We Get Letters
Q&A with Loss Prevention

(Focus: Psychiatry Records)

Throughout the year MIEC's Loss Prevention staff receives a variety of questions from policyholders. The questions for this edition of *The Exchange* focus on psychiatry as a specialty and address concerns about medical records, confidentiality, and telepsychiatry. Although psychiatry is the emphasis, the information crosses many specialties and we hope you will find it beneficial.

Q **I'm a psychiatrist and often discuss sensitive mental health information with patients, data that could be damaging to the patient if privacy were breached. As a result, I've decided not to document any of my patient encounters. Am I required to produce a medical record memorializing patient visits?**

A According to statutes and administrative rules of Alaska, California, Hawaii, and Idaho (states where MIEC insures physicians), **yes**, healthcare providers are required to produce and maintain medical records. It is considered either below the standard of care or unprofessional conduct if you fail to do so. **(See Table 2 for state-specific laws.)**

Medical records serve important functions for healthcare providers. As stated by Thomas G. Gutheil, MD (Professor of Psychiatry and co-founder of the Program in Psychiatry and the Law, Department of Psychiatry, Beth-Israel-Deaconess Medical Center at Harvard Medical School), "The patient's record provides the only enduring version of the care as it evolves over time."[4]

4 Gutheil, Thomas G., "Fundamentals of Medical Record Documentation," *Psychiatry*, November 2004, pp. 26-28.

Careful medical documentation is a primary factor in patient care, risk management, and liability prevention. Such documentation represents a contemporary record of the flow of patient care; thus, it can be extremely helpful to the practicing clinician and can be an important factor in error prevention.[5]

Comprehensive records serve an important role in the defense of physicians who are sued in a medical malpractice claim. Expert witnesses and defense counsel rely upon the documented information to determine and effectively argue that the defendant physician met the standard of care.

I understand that I must produce and maintain a medical record; however, I am concerned about confidentiality of the information and protecting my patients' privacy. What should I do?

State confidentiality and privacy laws distinguish between psychiatry records and psychotherapy notes, as do the HIPAA regulations. Become familiar with the laws in your state to understand what is required to release mental health records and psychotherapy notes. (See the enclosed article outlining state and federal regulations for mental health records.)

Electronic health records maintained by health information exchanges, or by healthcare systems within which multiple healthcare providers have access to any and all information, create additional challenges for the confidential retention of mental health records. HIPAA requires full protection of *psychotherapy notes,* which must be kept separate from the rest of the official medical record. These cannot be entered into an electronic system where anyone can access the data without specific and limited patient authorization.[6] However, mental health records do not have the same protections. According to Norman Clemens, MD, Emeritus Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine and Training and Supervising Analyst at the Cleveland Psychoanalytic Center, patients have the right to know (1) that there is significant risk to privacy and confidentiality when mental health records are maintained in electronic networks and (2) that consent is theirs to give or refuse (i.e., to opt in or to opt out).[7]

I recently began using an electronic health record to memorialize patient visits. To help me save time when documenting these lengthy patient encounters, I am using a template-driven system. I find that my documentation often is less detailed than my past records. What risk am I incurring by using this abbreviated system?

While preparing this Q&A piece for our policyholders, we came across an excellent article published by Thomas G. Gutheil, MD, and Robert I. Simon, MD at www.psychiatrictimes.com on December 16, 2011, titled, "Empty Words in Psychiatric Records: Where Has Clinical Narrative Gone?" (referenced above). We encourage you to obtain a copy. In the article, Dr. Gutheil and Dr. Simon warn against some common short cuts that have the potential of increasing physician liability. One common documentation short cut: "no SI/HI/CFS." As Dr. Gutheil explains:

"This, of course, stands for no suicidal ideation, no homicidal ideation, contract for safety. Although these abbreviations suggest that at least some questions were asked, this handful of letters does not represent an adequate suicide or homicide risk assessment of the patient, especially in an evaluation in which these particular concerns arise."[8]

Other concerns voiced by the authors include:

"Psychiatric records depend on narratives to provide a living and comprehensive picture of the patient. This goal is thwarted by the increasing use of checklists and simplistic templates that leave record notes stripped of personal meaning and context."[9]

Also computer-generated templates have a definite tendency toward redundancy and " fail to allow the clinician to obtain an evolutionary picture of the patient as a person undergoing changes." Stock entries, unaccompanied by narrative, suggest that the assessment or intervention was *not* completed. Drs. Gutheil and Simon further observe that " judgment cannot be captured through a host of checkboxes, especially when the checkboxes are designed primarily for recording individual symptoms rather

5 Gutheil, Thomas G. and Simon, Robert I, "Empty Words in Psychiatric Records: Where Has Clinical Narrative Gone?", *Psychiatric Times*, December 16, 2011. Published on www.psychiatrictimes.com.
6 Clemens, Norman A., "Privacy, Consent, and the Electronic Mental Health Record: The Person vs. the System," Journal of Psychiatric Practice, Vol. 18, No. 1, January 2012, pp. 46-50.
7 Ibid.
8 Ibid.
9 Ibid.

than complex mental processes."[10]

Physicians should ensure that their documentation clearly demonstrates their clinical decision-making and judgment, as well as their management of a patient's condition. Care should be taken, in spite of templates and the potential for EHR redundancy, to create complete and meaningful records.

10 Ibid.

State	Statute language re: record-keeping
Alaska	**12 AAC 40.940.** Standards of practice for record-keeping (a) A physician or physician assistant licensed by the board shall maintain adequate records for each patient for whom the licensee performs a professional service. (b) Each patient record shall meet the following minimum requirements: (1) be legible; (2) contain only those terms and abbreviations that are or should be comprehensible to similar licensees; (3) contain adequate identification of the patient; (4) indicate the dates that professional services were provided to the patient; (5) reflect what examinations, vital signs, and tests were obtained, performed, or ordered concerning the patient and the findings and results of each; (6) indicate the chief complaint of the patient; (7) indicate the licensee's diagnostic impressions of the patient; (8) indicate the medications prescribed for, dispensed to, or administered to the patient and the quantity and strength of each medication; (9) reflect the treatment provided to or recommended for the patient; (10) document the patient's progress during the course of treatment provided by the licensee. (c) Each entry in the patient record shall reflect the identity of the individual making the entry. (d) Each patient record shall include any writing intended to be a final record. This subsection does not require the maintenance of preliminary drafts, notes, other writings, or recordings once this information is converted to final form and placed in the patient record.
California	**Business and Professions Code §2266** The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.
Hawaii	According to Hawaii counsel, there are some statutes and administrative rules that require the creation and maintenance of medical records in certain instances: **Hawaii Revised Statutes ("HRS") §334-2.5** requires the Department of Health to "[K]eep a medical record of each person committed to the director's [Director of Health] custody or hospitalized pursuant to this chapter, chapter 704, or chapter 706." HRS Chapter 334 is the statute dealing with mental health. HRS Chapters 704 and 706 are the criminal statutes dealing with the criminal responsibility and disposition of mentally ill criminals.

Table 2

State	Statute language re: record-keeping
Hawaii	**HRS §353-13** provides that "[t]he medical officer of a correctional facility shall carefully examine any committed person upon admission and shall establish a medical record and enter therein a statement of the committed person's physical condition upon entry and all subsequent medical treatment and examination made while such person is residing at a state correctional facility." **Hawaii Administrative Rules ("HAR") §11-93-10** which applies to hospitals, provides in part as follows: (b) Emergency patient care shall be provided and guided by written policies and shall be directed by a physician staff member. Adequate facilities and equipment shall be provided. A medical record shall be kept for each patient receiving emergency services. The record shall become an official hospital record. **Title 11, Chapter 93 of the HAR** also requires certain information to be placed in a patient's medical records in general and in specific for psychiatric patients and patients at freestanding birthing facilities. **HAR §11-95-20** which applies to freestanding outpatient surgical facilities, provides in part as follows: (c) Patient records shall contain, but not necessarily be limited to, the following information: (1) Prior to surgery, the patient record shall contain the following: (A) Sufficient history, physical examination, x-ray and laboratory data to support the admitting diagnosis and the decision to carry out the proposed procedure; (B) Sufficient history, physical examination, and laboratory data to support the decision as to which anesthetic techniques and medications are to be used during the procedure; (C) Results of all pertinent consultation reports, laboratory and x-ray reports shall be recorded on the chart by the patient's physician. Originals or photocopies of the originals shall be on the chart within forty-eight hours of admission to the facility; (D) Documentation that sufficient attention has been given to: (i) Preventing and preparing for the customary complications of the proposed surgical procedure and the proposed anesthetic procedure; (ii) Preventing and preparing for any special hazards confronting a particular patient; (E) An informed consent form shall be signed by the patient or the patient's guardian, or patient's parents, and be filed in the chart; (2) Within forty-eight hours following surgery, the patient's record shall contain: (A) An operative note which shall clearly indicate what was found and what was done; (B) An anesthetic note which shall specify the anesthetic techniques and medications used, as well as dosages of the medications. It shall also contain the result of appropriate physiological monitoring during the anesthetic induction, maintenance and recovery period. A record of any untoward development during this period shall also be noted; (C) All medications given to or taken by the patient shall be properly recorded in respect to time given, dose, and any response noted; (3) A discharge note including the final diagnosis at the time of discharge; (4) A copy of the discharge document required in section 11-95-25(d).

Table 2 cont.

State	Statute language re: record-keeping
Hawaii cont.	**HAR §11-97-5** which applies to home health agencies (but necessarily to physicians), provides in part as follows: (h) Medical records. (1) A clinical record for each patient shall be maintained on the basis of standards acceptable to the department; (2) Nurses, therapists and/or workers responsible for specific professional aspects of care to a patient shall record in the patient's record information about the services rendered. **HAR §16-72-6** which applies to acupuncture practitioners provides as follows: A licensee shall keep accurate records of each patient the licensee treats. The records shall include the name of the patient, the indication and nature of treatment given, and any other relevant data deemed important by the licensee. Records shall be kept on file for a minimum of seven years and shall be open to inspection at any time by the board or its duly authorized representative.
Idaho	**Idaho Statutes 54-1814**. Grounds for Medical Discipline. (7) The provision of health care which fails to meet the standard of health care provided by other qualified physicians in the same community or similar communities, taking into account his training, experience and the degree of expertise to which he holds himself out to the public. **IDAPA 22.01.01 101.03(h)** Additional grounds for suspension, revocation or disciplinary sanctions (Standard of care) (h) Failing to maintain adequate records. Adequate patient records means legible records that contain, at a minimum, subjective information, an evaluation and report of objective findings, assessment or diagnosis, and the plan of care.

Table 2 cont.

I have a patient for whom I have provided psychiatric care and counseling for a number of years. I would characterize her as stable. She informed me this week that she is moving to the East Coast and has requested that I maintain a physician-patient relationship via telepsychiatry. What should I do?

We understand and appreciate that you value this long-standing physician-patient relationship, but as your professional liability carrier we recommend the following:

- Be familiar with your specialty society's guidelines for telepsychiatry and risk-free patient care when treating patients via telehealth.
- To treat patients located outside of the state in which you are licensed (e.g., California, Alaska, Hawaii, Idaho) via telepsychiatry (e.g., video teleconferencing or telephone counseling), you must obtain a separate state-specific medical license. Without such a license, you would be practicing medicine without a license in the state where your patient permanently resides or is located. If you choose not to obtain a state-specific medical license, advise your patient to seek a new mental health care provider in her new state of residence. She should make the change as soon as possible to ensure continuity of care including medication refills.

Q **Some of my patients are college students who want to communicate with me by phone or secure video conferencing while they are away at school. What do you advise?**

A If your patients attend colleges that are located within the state where you are licensed to practice medicine and the individuals periodically return home to see you face to face, it would be appropriate to retain the relationship via telepsychiatry, communicating with them by phone or secure video conferencing. However, we recommend that you and your patients consider establishing a tandem relationship with mental health care workers providing care through the universities' health care services. This is especially important to help manage mental health emergencies and medication refills while they are at school. Ask your patients to sign authorizations so that you and the university-based mental health care providers can share information.

For your patients attending university out of state, you can see them when they return home. Again, as stated above, in order to manage their care via telepsychiatry you would need to be licensed in the state where they are located. As with the in-state college student, we recommend that you (with patient authorization) establish a tandem relationship with a university mental health care provider who would treat the college students while they are at school.

Q **What about medications for my patients who move out of state?**

A Consider how you will manage your patients' medication. For patients who move out of state and where you do not possess a medical license, a new mental health care provider should assume the duty to manage medications. If the patient has temporarily moved out of state, you can possibly renew her medications for up to three months and then refill them upon her return. However, we suggest that you consider having the out-of-state mental health care provider prescribe and manage the medications and/or be advised about your medication regimen for the patient. This will ensure that a physician will be available to the patient should there be an emergency, a reaction, and need for a change in the medication. Avoid refilling psychotropic medications and allowing parents to send them to their student children. Consider the risk affiliated with this type of prescribing behavior.

For more information on telehealth, please review MIEC's *The Exchange* No. 5.

Q **Will MIEC cover me for telehealth activities?**

A Yes, MIEC will cover you for telehealth services provided in the states where the company covers physicians (i.e., Alaska, California, Hawaii, and Idaho). According to the Claims Department, MIEC would not cover telepsychiatry practiced in a state where you do not possess a license and/or if you practice telehealth in states where MIEC does not insure physicians. Notify your MIEC underwriter of any telehealth services that you provide.

Confidentiality of Mental Health Records: Federal and State Regulations

Few relationships depend as much on an individual's willingness to sacrifice privacy as the relationship between a mental health provider and a patient. The relationship often requires the patient to divulge personal, sensitive information, which requires a great deal of trust. Ensuring the confidentiality of the patient's mental health records is crucial to maintaining that trust.

The United States Supreme Court stressed the importance of confidentiality of mental health records in a case involving a psychotherapist. "Effective psychotherapy… depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals

consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment." Jafffe v. Redmond, 518 U.S. 1, 1996.

The confidentiality of mental health records is governed by both state and federal laws. The applicability of the laws depends on the treatment rendered. This article will discuss the laws which apply to the confidentiality of mental health records, at both the federal and state levels. Being knowledgeable about the confidentiality laws and regulations helps physicians protect the privacy of their patients and reduce liability risks.

Federal Law

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA applies to any health care provider who uses electronic means to submit health payment claims and inquiries into claims status, eligibility, an enrollment.

In general, HIPAA prohibits the use and disclosure of protected health information (PHI) without written authorization from the patient or the patient's representative. There are exceptions to the general rule which allow for use or disclosure without patient authorization for a variety of purposes including disclosure for the purposes of treatment, payment, or health care operations and as required by law. Except for specific requirements pertaining to psychotherapy notes discussed below, mental health records are the same as other medical records under HIPAA. For details of HIPAA requirements, please visit the MIEC website at www.miec.com and review *Special Claims Alert No. 34, HIPAA's Privacy Act: A compliance primer for the solo and small group practices* and *Special Claims Alert No. 43 HITECH Act expands HIPAA requirements.*

Psychotherapy Notes

HIPAA provides for specific requirements for disclosure of psychotherapy notes. Psychotherapy notes are defined as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and **that are separated from the rest of the individual's medical record**" *(emphasis added)*. (45 CFR §164.501)

Specifically excluded from the definition are medication prescription and monitoring; counseling session start and stop times; modalities and frequencies of treatment furnished; results of clinical tests; any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. It is important to note that **if notes are included with the rest of the medical record, then they are not psychotherapy notes under the HIPAA definition and not subject to special HIPAA requirements.**

Separate authorization required

HIPAA requires a separate authorization for disclosure of psychotherapy notes. If a person requests release of all mental health information to a third party, including psychotherapy notes, two authorizations are required, one for mental health information and the other for psychotherapy notes.

Separate authorization is required for any use or disclosure of psychotherapy notes except:

1. To carry out treatment, payment, or health care operations in any of the following cases:
   a. Use by the originator of the psychotherapy notes for treatment;
   b. Use or disclosure by the provider for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;
   c. Use or disclosure by the provider to defend itself in a legal action or other proceeding brought by the individual.
2. Other exceptions, such as disclosure to the Department of Health and Human Services (DHHS), reporting child or elder abuse, disclosure for health oversight activities, disclosure to coroner, disclosure to prevent or lessen serious and imminent threat to health and safety of a person. (45 CFR §164.508)

The Patriot Act

The Patriot Act legislation passed by Congress in 2001, has implications for health care providers, including mental health providers. Specifically, Section 215 of the Act, may compel a health care provider to turn over patient records to federal authorities upon presentation of a valid search warrant.

Section 215 states in part:

- "Access to certain business records for foreign intelligence and international terrorism investigations
- "The Director of the FBI or a designee of the Director may make an application for an order requiring the production of any tangible things (including books, records, papers, documents, and other items) for an investigation to obtain foreign intelligence information not concerning a United States person or to protect against international terrorism or clandestine intelligence activities, provided that such investigation of a United States person is not conducted solely upon the basis of activities protected by the first amendment to the Constitution." (50 United State Code §1861)

If a physician is presented with a duly judge-issued search warrant, we advise you to comply. Contact the MIEC Claims Department immediately upon receipt of a search warrant.

State-Specific Laws

Alaska

Records of Alaska state mental health programs are afforded special protections under Alaska law.

Alaska Statute 47.30.845 states that, "Information and records obtained in the course of a screening investigation, evaluation, examination, or treatment are confidential and are not public records, except as the requirements of a hearing under AS 47.30.660 - 47.30.915 may necessitate a different procedure. Information and records may be copied and disclosed under regulations established by the department only to:

1. A physician or a provider of health, mental health, or social and welfare services involved in caring for, treating, or rehabilitating the patient;
2. The patient or an individual to whom the patient has given written consent to have information disclosed;
3. A person authorized by court order;
4. A person doing research or maintaining

health statistics if the anonymity of the patient is assured and the facility recognizes the project as a bona fide research or statistical undertaking;

5. The Department of Corrections in a case in which a prisoner confined to the state prison is a patient in the state hospital on authorized transfer either by voluntary admission or by court order;

6. A governmental or law enforcement agency when necessary to secure the return of a patient who is on authorized absence from a facility where the patient was undergoing evaluation or treatment;

7. A law enforcement agency when there is substantiated concern over imminent danger to the community by a presumed mentally ill person; or,

8. The department in a case in which services provided under AS 47.30.660 - 47.30.915 are paid for, in whole or in part, by the department or in which a person has applied for or has received assistance from the department for those services."

California

Lanterman-Petris-Short Act

The Lanterman-Petris-Short (LPS) Act gives special protection to records pertaining to certain mental health and developmental disability treatment.

The confidentiality provisions of LPS apply to all information and records obtained in the course of providing services to:

1) Patients who are involuntarily treated or evaluated

2) Patients who are voluntarily treated in a:

   a) State mental hospital

   b) County psychiatric ward, facility or hospital

   c) Psychiatric hospital, unit or clinic owned by the Regents of the University of California

   d) Federal hospital, psychiatric hospital or unit

   e) Private institution, hospital, clinic or sanitarium which is conducted for, or includes, a department or ward conducted for the care and treatment of person who are mentally disordered

   f) Psychiatric health facility is defined to mean a health facility, licensed by the State Department of Mental Health, that provides 24-hour inpatient care for mentally disordered, incompetent, or other persons…

   g) County mental health rehabilitation center for the provision of community care and treatment for persons with mental disorders…

   h) Skilled nursing facility with a special treatment program

   i) Community program funded by the Bronzan-McCorquodale Act

   j) State Department of Mental Health community program specific in the Welfare and Institutions Code §4000-4390.

When applicable, the LPS Act severely limits the disclosure of mental health records. The LPS Act often requires the authorization of both the patient and the patient's treating physician or other health care provider before information may be disclosed to a third party.

There are several circumstances when information may be disclosed without

patient authorization; the most common circumstances are:

a) To other health care providers: In communication between qualified professionals in the provision of services or appropriate referrals;

b) In the course of conservatorship proceedings; and,

c) To third party payers to the extent necessary for the recipient to make a claim.

Information may also be released with a patient authorization including disclosures to professionals not employed by the facility who do not have medical or psychological responsibility for the patient's care; disclosures for life or disability insurance; disclosures to a patient's attorney; disclosures to probation officers; disclosures for genetic counseling. For all other disclosures with patient authorization, the disclosure will also have to be authorized by the physician or other treating health care provider in charge of the patient. [Welfare and Institutions Code §5328(a) and (b)]

Due to the complexity of the LPS Act, physicians should contact MIEC if a question arises about the applicability of the Act.

California Confidentiality of Medical Information Act (Civil Code §56 et seq.)

Any mental health information that is not subject to the LPS Act is subject to the California Confidentiality of Medical Information Act (CMIA). As with HIPAA, CMIA's general rule is that medical information cannot be disclosed without authorization from the patient, unless an exception applies.

Under CMIA, physicians are compelled to disclose information in certain circumstances including: pursuant to a court order, administrative agency, civil or criminal subpoena, investigative subpoena, arbitration panel, lawful search warrant and to the coroner's office when the information is requested,

> "… in the course of an investigation by the coroner's office for the purpose of identifying the decedent or locating next of kin, or when investigating deaths that may involve public health concerns, organ or tissue donation, child abuse, elder abuse, suicides, poisonings, accidents, sudden infant death, suspicious deaths, unknown deaths, or criminal deaths, or when otherwise authorized by the decedent's representative. Medical information requested by the coroner under this paragraph shall be limited to information regarding the patient who is the decedent and who is the subject of the investigation and shall be disclosed to the coroner without delay upon request." Civil Code §56.10(b)(8)

A physician may release information to other health care providers, health care service plans or other health care professionals/facilities for purpose of diagnosis and treatment; to entities responsible for payment of health care services; and to persons or entities that provide billing, claims management, medical data processing or other administrative services.

For a complete listing of mandatory and discretionary disclosures defined in CMIA, please see *Special Report Claims Alert No: 26A, California Confidentiality of Medical Information Act: Rules for Privacy and Release of Medical Information,* located on the MIEC website.

Outpatient psychotherapy treatment notes

CMIA contains special restrictions on

the release of outpatient psychotherapy treatment notes. The law states that a health care provider may not release medical information related to patient's participation in outpatient treatment with a psychotherapist unless the requestor of the information submits a special written request to the holder of the information and also to the patient within 30 days of the release of the information. (Civil Code §56.104)

The special restrictions do not apply to:

1. Disclosures made to providers of health care, health care service plans, contractors, or other professionals or facilities for purposes of diagnosis or treatment of the patient;
2. Disclosure to a social worker, probation officer, or other person who has legal custody of a minor for purposes of coordinating treatment of the minor; or,
3. Disclosure to law enforcement or the target of a threat if disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a reasonably foreseeable victim and the disclosure is made to a person reasonably able to prevent or lessen the threat, including the target of the threat.

MIEC legal counsel suggests that physicians who wish to obtain outpatient psychotherapy records ask the patient to sign an authorization. The signed authorization nullifies the requirement to send a written request to the patient's psychotherapist.

If physician cannot obtain authorization from the patient, but wants to obtain a copy of the patient's outpatient psychotherapy records, the physician's written request must include:

1. The specific information relating to a patient's participation in outpatient treatment with a psychotherapist being requested and its specific intended use or uses;
2. The length of time during which the information will be kept before it is disposed of or destroyed;
3. A statement that the information will not be used for any purpose other than its intended use; and,
4. A statement that the person or entity requesting the information will destroy the information and all copies in its possession or control, will cause them to be destroyed, or will return the information and all copies before or immediately after the stated time frame.

The physician must then send the patient a copy of the written request within 30 days of receipt of the information requested, unless the patient has given the psychotherapist or health plan a signed letter waiving notification.

Hawaii

HRS §334-5 Confidentiality of records. "All certificates, applications, records, and reports made for the purposes of this chapter that are maintained, used, or disclosed by health care providers as defined in this chapter, health plans as defined in title 45 Code of Federal Regulations section 160.103, and health care clearinghouses as defined in title 45 Code of Federal Regulations section 160.103, and directly or indirectly identifying a person subject hereto shall be kept confidential and shall not be disclosed by any person except as allowed by title 45 Code of Federal Regulations part 164, subpart E. Nothing in this section shall preclude the:

(1) Application of more restrictive rules of confidentiality set forth for

records covered by title 42 Code of Federal Regulations part 2, relating to the confidentiality of alcohol and drug abuse patient records;

(2) Disclosure deemed necessary under the federal Protection and Advocacy for Mentally Ill Individuals Act of 1986, P.L. 99-319, to protect and advocate for the rights of persons with mental illness who reside in facilities providing treatment or care; or

(3) Disclosures made by a court or the Hawaii criminal justice data center of orders of involuntary civil commitment issued pursuant to Section 334-60.5 for the purpose of firearms permitting or registration pursuant to chapter 134."

According to the legislative history, the repeal was prompted by the enactment of HIPAA subsequent to the enactment of the original HRS §334-5.

Additional protection of mental health records is found in the Hawaii Administrative Rules §11-175-31 which speaks of the right to confidentiality of the clinical record.

"(a) Information in the clinical record of a consumer of mental health or substance abuse services shall be confidential and shall not be shared outside the mental health division, outside a contract program, or by a private provider, except information shall be disclosed:

1. When there is an emergency which requires immediate sharing of information; however, a consumer of substance abuse services shall not be identified directly or indirectly as a substance abuser;

2. When it is determined that a consumer poses a serious danger or threat of violence toward another. Information shall be released in keeping with the duty to exercise reasonable care to protect foreseeable victims; however, a consumer of substance abuse services shall not be identified directly or indirectly as a substance abuser;

3. When there is suspected abuse or neglect of a minor as provided in chapter 350, HRS and when there is suspected abuse or neglect of an elderly or vulnerable adult as provided in chapter349c, HRS; however, any person named in such a report who is a consumer of substance abuse services shall not be identified directly or indirectly as a substance abuser;

4. When disclosure is deemed necessary by the director or the administrator of a private psychiatric facility to carry out the provisions of chapter 334, HRS, and after justification has been placed in the consumer's clinical record, except for consumers of substance abuse services, for which informed consent to release of information is required;

5. When specific information is ordered to be disclosed by a court, and is deemed by the court to be necessary in connection with the proceedings before it;

6. For management information purposes to the mental health division by the department's direct and contract services;

7. For monitoring purposes to authorized mental health division monitors by the department's direct and contract services;

8. When required by federal or state statutes; or

9. When the holder of the record has obtained informed consent to release of information from the consumer or the consumer's legal guardian.

(b) Information about a consumer requested by a member of the consumer's family shall only be released after informed consent to release information has been obtained from the consumer or the consumer's legal guardian.

(c) Information disclosed shall be only information relevant to the purpose stated in the request for disclosure, and redisclosure shall be prohibited.

(d) Information shared about a consumer among staff members within a program shall be restricted to information needed in order to provide adequate services and shall be conveyed in a manner which maintains its confidentiality.

(e) If information is released without informed consent, the release shall be documented in the consumer's record. Documentation shall include to whom the information was released the purpose for which it was released, who authorized the release, when it was released, what was released, why consent could not be obtained, and the name of the person releasing the information. When information is released with informed consent, the consent form shall be filed in the consumer's clinical record.

(f) Informed consent to release information shall be obtained in order to release information to another service setting when a consumer transfers from one mental health program to another or when a consumer receiving substance abuse services transfers to another program. Informed consent is not required when the consumer transfers between programs having the same direct administrative control over the programs. When consent is required, the referring program shall attempt to obtain consent to release information essential to ensure continuity of treatment and which is germane to the purpose of the new setting.

(g) Any substance abuse program which provides maintenance or detoxification treatment shall provide consumer identifying information to another maintenance or detoxification treatment program upon request for the purpose of determining whether an applicant for maintenance or detoxification services is currently enrolled in the program, provided that:

1. The programs have an agreement to share identifying information; and

2. The consumer has agreed in writing at the time of admission to release identifying information to the other program listed by name and address."

In addition, according to the Hawaii's Health Care Privacy Harmonization Act of 2012 (HRS 323B), physicians who comply with HIPAA regulations are in compliance with Hawaii's confidentiality laws.

Idaho

Idaho law is silent on laws protecting mental health records.

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