

the Reporter

Crossing professional

boundaries



By Anna Tauzin

In the physician-patient relationship, the line defining right, wrong, and in between can easily become blurred. Physicians are in a position of knowledge and power while patients are in a position of trust, believing their interests will be protected by their physicians. Clearly, the physician-patient relationship is not equal. Maintaining professional boundaries is an important aspect of patient care.

Boundary violations can range from having a sexual relationship with a patient to a patient's misinterpretation of a physical exam. They can

also include entering into an inappropriate financial relationship with a patient, accepting gifts from patients, and treating family members, friends, and staff members. While these types of allegations may seem trivial, such accusations can result in civil litigation, disciplinary action by the Texas Medical Board (TMB), or possibly criminal misdemeanor or felony charges. In short — allegations of boundary violations can pose a serious threat to a physician's medical license and career.

"Physicians should always remember that they hold a position of power over a patient, and the law recognizes this unequal relationship," says Peter Anderson, an attorney with Chamblee & Ryan, PC, in Dallas. "No matter how 'appropriate' a relationship may seem to a physician, he/she should always remember the particular relationships which raise boundary issues and proceed with an abundance of caution."

The Texas Medical Board

In addition to disciplinary actions for quality of care violations, non-therapeutic prescribing, inadequate medical records, or unprofessional conduct, the TMB can and does discipline physicians for "inappropriate conduct involving the physician-patient relationship."

Jane Holeman, vice president of Risk Management at TMLT, defined such conduct as "Any words said to a patient or touching a patient in a way that might be construed as improper. Blatantly flirting or asking a patient out on a date would also be inappropriate."

Holeman recalled a case where a physician was sued over inappropriate comments written

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about a patient in the medical record. It is also not unusual for a physician to be accused by a patient who misunderstood a justifiable examination. “For instance, a family practitioner sees a teenage girl with suspected glandular fever. Without explaining his actions, he begins to feel the lymph glands in her armpits. The patient subsequently complains that he fondled her breasts.”¹

Out of 329 physicians disciplined by the Texas Medical Board in 2005, six were disciplined for “inappropriate conduct involving the physician-patient relationship.” One physician’s license was suspended.²

The TMB disciplines physicians under the Texas Occupations Code 164.052(a)(5) which states, “A physician or an applicant for a license to practice medicine commits a prohibited practice if that person commits unprofessional or dishonorable conduct that is likely to deceive or defraud the public, as provided by Section 164.053, or injure the public.”³ Title 22, Part 9 of the Texas Administrative Code defines “unprofessional and dishonorable conduct” to include:

- “ . . . (e) engaging in sexual contact with a patient;
- (f) engaging in sexually inappropriate behavior or comments directed towards a patient, and;
- (g) becoming financially or personally involved with a patient in an inappropriate manner.”⁴

Clearly there are several types of relationships that the TMB considers inappropriate. Regarding sexual relationships, the TMB released a policy statement in 2002 that further defines improper conduct. The definition includes:

- “• any physical contact or body movement intended to express or arouse erotic interest;
- any relationship between a physician and patient where sexual behavior occurs that is either heterosexual or homosexual;
- any sexual behavior between a physician and patient with the context either proximate or distant;
- any gestures or expressions sexually demeaning to a patient or such actions or words lacking respect for the patient’s privacy that are not clinically necessary;
- any inappropriate touching; and
- any sex with patients, including consensual relationships.”⁵

According to Jill Wiggins, public information officer with the TMB, physicians who are disciplined for boundary issues are usually required to complete a continuing education course and may be required to speak at local county medical society meetings about maintaining proper boundaries. However, more serious allegations — such as sexual assault — can lead to the immediate suspension of a physician’s license.

AMA guidelines

Guidelines published by the American Medical Association’s Council on Ethical and Judicial affairs prohibit any sexual contact between physicians and their patients. “Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician’s objective judgment concerning the patient’s health care, and ultimately may be detrimental to the patient’s well-being . . . At a minimum, a physician’s ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.”⁶

Former patients and “key third parties”

AMA ethical guidelines also discourage personal relationships with former patients where the physician exploits the previous professional relationship. “Sexual contact between a physician and a patient with whom professional relations have been terminated would be unethical if the sexual contact occurred as a result of the use or exploitation of trust, knowledge, influence or emotions derived from the former professional relationship . . . the extent of

the physician’s general knowledge about the patient, i.e., the patient’s past, the patient’s family situation, and the patient’s current emotional state are all factors which may render a sexual or romantic relationship with a former patient unethical.”⁶

For example, due to the intense nature of a relationship between a psychiatrist and patient, it is unwise to ever pursue a relationship beyond the bonds of the profession. However, a personal relationship between an emergency department physician and patient who had only met each other once may be considered permissible.

Most experts agree that time needs to pass before entering into a relationship with a former patient, but there is no strict rule on how long a physician should wait. “The physician should examine the level and type of medical care provided and the psychological concerns cited above to make a prudent decision.”⁵ Just because the professional obligation has ended does not mean that the playing field is completely even.

Additionally, it has been suggested that the amount of time passing between termination of the professional relationship and the beginning of a personal one may be key to the appropriateness of such relationships. The AMA policy suggests that, “. . . a sexual or romantic relationship which immediately follows the termination of the physician-patient relationship may be more suspect than one which occurs after considerable time has passed . . .”⁶

Another consideration involves relationships between physicians and key third parties who accompany the patient — such as spouses, parents or caregivers. Ethical guidelines also discourage these relationships. “Physicians should refrain from sexual or romantic interactions with key third parties when it is based on the use of exploitation of trust, knowledge, influence, or emotions derived from a professional relationship. Key third parties are just as susceptible as patients to the influence a physician can hold in this relationship. For this reason, as well as for the sake of the patient, boundaries must be set and respected in the relationship between a physician and a key third party.”

Physicians often find themselves interacting with key third parties as much — if not more so — than with the patients themselves, especially when it comes to critical health decisions. Therefore, “the more deeply involved the individual is in the medical decision-making and the clinical encounter, the more troubling sexual contact with a physician would appear to be.”⁷

Finally, it has been said many times that the physician must act in the best interest of the patient. “In addition to the risk of exploitation, a sexual or romantic relationship between a physician and a key third party can detract from the goal of furthering the patient’s best interests. It has the potential of becoming a preoccupation that affects the clarity of both the physician and the third party’s decision-making powers.”⁸

Treating family, friends, and staff

Another boundary issue that may alert the TMB involves prescribing medication for family members and friends. In these situations professional objectivity can be compromised, putting the patient at risk. According to an AMA ethics opinion, “Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.”⁸

“Only in an emergency on the short term is it okay, and even then it must be documented,” says Wiggins. “For example, if a child has an ear infection on a Saturday and the parent, a physician, wants to write a prescription for an antibiotic.”

“The chief ethical concern a physician faces when treating friends or family members is the potential for loss of professional objectivity, which could directly interfere with the care and expose the patient to undue and unnecessary risks.”⁵

A family member may be embarrassed and hesitant to speak about sensitive medical issues if the physician is also a family member. Conversely, a physician’s sense of obligation to a friend

or family member may cause reluctance to refer to another physician or specialist. Also, the physician may not ask the questions necessary to make a proper diagnosis since they are already familiar with the patient.

“Speaking generally, it is okay to treat family members, so long as they are treated like any patient. Often the importance of keeping records is cast aside,” says Holeman. “In a situation like that, it is even more important to keep accurate medical records.”

The same applies when treating members of your staff. “It’s the same as treating family members; you have to treat them just like any other patient,” says Holeman. Both medical and billing records should be flawlessly kept to help avoid the appearance of impropriety or preferential treatment.

Other boundary issues

Not all boundary violations are sexual in nature. Recall that the Texas Occupations Code’s definition of “unprofessional and dishonorable conduct” includes “becoming financially or personally involved with a patient in an inappropriate manner.”³

A report published by the National Ethics Committee of the Veterans Health Administration examines several types of physician-patient boundary violations. In one case: “Mr. D, an independent contractor, has been Dr. H’s patient for three years. During a visit, he overhears Dr. H talking to a colleague about some remodeling for Dr. H’s home. Later in the visit he hands Dr. H his business card and tells Dr. H that he will do the remodeling for a great price because he appreciates the care he has received from Dr. H.”⁹

By hiring his patient to complete the remodeling project, Dr. H may violate TMB rules and put himself in a very compromising position. Mr. D may expect a reduced fee or special services from Dr. H.

“Obviously, Dr. H’s argument would be that their financial relationship for the remodeling project was ‘appropriate.’ An ‘appropriate’ financial relationship with a patient would not violate the rule. Unfortunately, the determination of an ‘appropriate’ financial relationship is necessarily determined on a case by case basis by the Board,” says Anderson.

Gift giving

Gifts to physicians may be an important way for some patients or their caregivers to express gratitude for the care provided. However, it is important to thoughtfully consider the motive behind the gift giving.

According to the AMA’s Council on Ethical and Judicial Affairs, “Acceptance or rejection of a gift could strengthen or weaken a patient-physician relationship. If the gift is a measure of the giver’s gratitude, a refusal could be offensive. If a gift is an attempt to secure preferential treatment, then a refusal may be required to maintain the mutual respect and independent judgment that are essential to the patient-physician relationship.”¹⁰

A report published by the AMA on gift giving and the physician-patient relationship urges physicians to consider several issues when accepting or declining a gift. These include:

- Motives for the gift giving — “When motives for a gift fall within the realm of goodwill or cultural traditions, as discussed above, there may be little concern in accepting a gift.”
- The relative monetary value of the gift — “For example, nominal gifts that are hand-made by the patient, such as baked goods or crafts, are common and probably do not present any concern.”
- Timing of the gifts — “For example, if a gift is offered before or after the patient has made a special request, it is possible that there is expectation that the gift will influence the physician’s decision or conduct.”¹⁰

Risk management considerations

The following risk management considerations may assist physicians in managing boundary issues.

- “Certainly, physicians should not engage in any flirtatious

behavior toward patients. In reality, however, the majority of complaints don’t arise from outright flirting or inappropriate actions, but from misunderstandings regarding ‘boundaries’ and miscommunication between physicians and patients.”¹

- Help avoid such misunderstandings by describing what an examination will involve and allow the patient to ask questions. This is particularly important if you need to examine one part of the body when the symptoms occur in another.

- Use of chaperones can help protect physicians against complaints.
- If the patient initiates an inappropriate relationship, the physician should speak with the patient and explain why this behavior is inappropriate. Holeman advises physicians to have a witness present when doing so, and to document the discussion.

- In extreme cases, it may be necessary to terminate the physician-patient relationship. However, this should occur in a manner that reduces liability for patient abandonment and facilitates patient care. The patient should be notified in writing via first class U.S. mail and certified mail, return receipt requested. Keep a copy of the letter and return receipt in the patient’s chart. You are not required to state a reason for termination. Agree to treat the patient in an emergency and only for 30 days. Clearly state the effective date of the termination. Provide resources to help the patient find a new physician, (health insurance plan, county medical society) but do not make a specific referral. Offer to send a copy of the medical record to the new physician upon receipt of signed authorization.

- When providing medical care for family members, friends or staff members, treat these individuals as you would any patient. Thoroughly document the care given.

- Regarding gifts from patients, “There are no definitive rules to determine when a physician should or should not accept a gift . . . One criterion is whether the physician would be comfortable if acceptance of the gift were known to colleagues or the public.”¹⁰

- Allegations of boundary violations should be taken seriously. Document them thoroughly and contact the TMLT risk management or claim department at 800-580-8658 if you have any questions.

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Managing the medical record part 2

Course author

Mary Angela Meyer, JD, is a Houston-based attorney who has specialized in the defense of physicians and hospitals in malpractice lawsuits for nine years.

Disclosure

Mary Angela Meyer has no commercial affiliations/interests to disclose related to this activity.

Target audience

This one-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

CME credit statement

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Ethics statement

This course has been designated by TMLT for 1 hour of education in medical ethics and/or professional responsibility.

Directions

Please read the entire article and answer the CME test questions. In order to receive credit, submit the completed test and evaluation form to TMLT. All test questions must be completed. Please print your name and address clearly. Allow four to six weeks from receipt of test and evaluation form for delivery of certificate.

Estimated time to complete activity

It should take approximately one hour to read this article and complete the questions.

Release/review date

This activity is released on May 27, 2006, and expires on May 27, 2008. Please note this



CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

This CME activity is the second of a two-part series. Part 1 was published in the March-April 2006 issue of the Reporter. This CME activity does not constitute legal or professional advice. If a situation arises in a physician's practice requiring legal or professional advice, the physician should consult with a lawyer or professional of his/her choosing.

Minors and health information

HIPAA clarifies that state or other applicable law governs in the area of parents and minors. Although the Privacy Rule provides parents with new rights to control the health information about their minor children, there are limited exceptions based on state or other applicable law and professional practice. For example, if a state has explicitly addressed disclosure of a minor's health information to a parent, or access to a child's medical record by a parent, the Privacy Rule clarifies that state law governs. In addition, the Privacy

Rule clarifies that, in the special cases in which the minor controls his or her own health information and the law does not define the parents' ability to access the child's health information, a licensed health care provider may exercise discretion in allowing

Objectives

At the conclusion of this educational activity, the reader will be able to:

1. Identify situations in which a minor may consent to medical care;
2. Describe exceptions to the release of health information;
3. Understand the types of subpoenas that may be sent to a physician's office; and
4. Explain the fees for copying medical records allowed by statute and the Texas Medical Board.

access, as long as that decision is consistent with the state or other applicable law.

In Texas, a child's parent's rights and duties include:

1. the duty to support the child, including providing medical and dental care; and
2. the right to consent to medical and dental care, and psychiatric, psychological, and surgical treatment.

In the case of divorce, a parent appointed as a conservator of a child has at all times the right of access to medical, dental, psychological, and educational records of the child. Further, a parent appointed as conservator has the right to consult with the child's physician, dentist, and to consent to medical, dental, and surgical treatment during an emergency involving an immediate danger to the health and safety of the child.

A child may have the disabilities of minority removed pursuant to Chapter 31 of the Texas Family Code. If a minor represents that this court procedure has taken place, a physician should request a copy of the court order removing the disabilities of minority. Under the Texas Family Code, the order must state the limited or general purposes for which disabilities are removed.

Further situations in which a minor may consent to medical treatment include:

1. if the minor is on active duty with the armed services of the U.S.;
2. if the minor is:
 - a. age 16 or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and
 - b. managing the child's own financial affairs, regardless of the source of the income;
3. if the minor consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of State Health Services;
4. if the minor is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;
5. if the minor consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use; or
6. if the minor is unmarried, is the parent of a child, and has actual custody of his or her child and consents to medical, dental,

psychological, or surgical treatment for the child.

However, a licensed physician may — with or without the consent of the minor patient — advise the parents, managing conservator, or guardian of the treatment given to child if it is provided under one of these exceptions. Although not stated, it is implied that the records of treatment may be released to parents at the physician's discretion.

Further, a physician may counsel a child without parental consent for the following: suicide prevention; chemical addiction or dependency; or sexual, physical, or emotional abuse. (Texas Health and Safety Code Section 32.004) A physician having reasonable grounds to believe that a child has been sexually, physically, or emotionally abused, is contemplating suicide, or is suffering from a chemical or drug addiction or dependency may:

1. counsel the child without the consent of the child's parents, managing conservator, or guardian;
2. with or without the consent of the child who is a patient, advise the child's parents, managing conservator, or guardian of the treatment given to the child; and
3. rely on the written statement of the child containing the grounds on which the child has capacity to consent to his or her treatment under this section.

Again, although not stated, it is implied that records of treatment may be released to parents at the physician's discretion.

Exceptions to the release of health information

Judicial and administrative proceedings

Health care providers may disclose protected health information in the course of any judicial or administrative proceeding:

- 1) in response to a court or administrative order; or
- 2) in response to a subpoena, discovery request, or other lawful process that is not accompanied by an administrative or court order, if the health care provider receives satisfactory assurances that reasonable efforts have been made to give notice to the patient to whom the protected health information belongs, or that reasonable efforts have been made to secure a qualified protective order.

A qualified protective order is an order from the court tailored towards protecting certain information that has been requested

in discovery. The "satisfactory assurance of notice to the patient" must be in writing and must state that:

1. a good faith attempt has been made to provide written notice to the patient;
2. the notice provided enough information to the patient about the request to enable the patient to raise an objection; and
3. either no objections were filed, or the court has resolved all objections filed.

The Texas Civil Practice and Remedies Code requires that every medical malpractice plaintiff provide a HIPAA-compliant authorization for the release of medical records when notice of a health care liability claim is filed. If the proper authorization is not provided, the lawsuit is abated. Therefore, a physician should be provided the proper authorization before releasing medical records in a medical malpractice action. If this signed authorization is not provided with a records request/subpoena in a malpractice action, a physician should request it before releasing protected health information.

Law enforcement

There are numerous permitted disclosures for law enforcement purposes, including: victims of crimes; reporting crimes in an emergency; crimes on the premises of the health care provider; and decedents. Covered entities may disclose protected health information as required by law for the reporting of certain wounds or other physical injuries. Protected health information may also be disclosed if there is a court order, warrant, or subpoena issued by a judicial officer, a grand jury subpoena, or if there is an administrative request. The request must seek relevant information and must be limited in scope and purpose for which the information is sought. This exception applies only if de-identified information cannot be reasonably used.

Protected health information may also be disclosed if requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. However, the disclosure must be limited to:

- name and address;
- date and place of birth;
- social security number;
- blood type and Rh factor;
- date and time of treatment;
- date and time of death; and
- a description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair, scars, and tattoos.

Information regarding DNA or DNA analysis, dental records, or blood typing, samples or analysis of body fluids or tissues is usually not permitted for identifying or locating a suspect, fugitive, material witness or missing person.

Covered entities may disclose protected health information about victims of a crime to a law enforcement official if the individual agrees to the disclosure, or the covered entity is unable to obtain consent because of incapacity or other emergency circumstance. In the case of incapacity or emergency, the law enforcement official must represent that the information is needed to determine whether a violation of the law has been committed by a person other than the victim, and that the information is not intended to be used against the victim. The law enforcement official must also represent that immediate law enforcement activity which depends upon disclosure would be materially and adversely affected by waiting until the individual is able to consent. The covered entity must also determine that the disclosure is in the best interest of the individual.

A covered entity may also disclose protected health information about an individual who has died to a law enforcement official if the covered entity believes that the death occurred as a result of criminal activity. Protected health information may be disclosed to law enforcement officials if the covered entity believes in good faith that the information constitutes evidence of a crime that has been committed on the premises of the covered entity.

A covered entity providing emergency health care in response to a medical emergency may disclose protected health information to a law enforcement official, if necessary, to alert the official to the commission and nature of a crime, the location of the crime and/or its victim(s), and the identity and location of the perpetrator of the crime. However, if the medical emergency results from suspected abuse, neglect or domestic violence, a different standard applies.

Protected health information may be disclosed to a health authority or other agency authorized by law to receive reports of child abuse, neglect, or domestic violence. These disclosures are permissible if 1) disclosure is required by law; 2) the individual agrees to the disclosure; or 3) if the disclosure is authorized by law and the covered entity believes that disclosure is necessary to prevent serious harm to the individual or other victims.

Disclosures under this exception are also permissible if the individual is unable to agree due to incapacity, a law enforcement official represents that the information will not be used against the individual, and that

an immediate enforcement activity that depends on the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

If a disclosure is made regarding abuse, neglect or domestic violence, the individual must be promptly informed unless the covered entity believes that informing the individual(s) would place them at risk of serious harm. Further, the covered entity may not inform a personal representative if this is the person whom the covered entity believes is responsible for the abuse, neglect or domestic violence and informing the person would not be in the patient's best interest.

Although there are many law enforcement situations in which protected health information may be disclosed, physicians must carefully protect confidential information. Physicians involved with a criminal or law enforcement situation should review the disclosure guidelines contained in Section 164.512 of HIPAA.

Medical record subpoenas

Physicians may receive record subpoenas frequently, but most are not tied to any potential lawsuit against the physician. However, it is important to treat each subpoena with equal care and prompt attention. If the subpoena is related to malpractice claims against the physician and it is not properly responded to, the plaintiff's attorney will attempt to equate sloppy record keeping with sloppy care. It is frustrating for a defense attorney to find out after suit has been filed that an incomplete or disorganized record has been produced in response to a subpoena or a request from a patient. If records have been inadvertently omitted from the copy, allegations of record destruction/falsification will be made. These types of allegations divert attention from good medical care.

It is the physician's responsibility to ensure that the staff member who prepares medical records for reproduction verifies that the record is complete. Further, staff should notify a physician before reproducing a medical chart. Physicians must read the request to determine if the response is complete. Does the request simply ask for the office chart or does it request all medical records in the physician's possession? If the subpoena requests "all" medical records, all records should be produced, including those records obtained from other physicians and hospitals. If the physician believes some records cannot be produced, whether it be due to confidentiality concerns or a belief that production is not in the best interests of the patient (i.e. certain psychotherapy notes), it must be noted that records have been withheld.

If the subpoena is accompanied by depo-

sition on written questions, the physician should make sure that the person who responds to the written questions is qualified and makes a good witness. A deposition on written question is sworn testimony and may be used in court. The person responding to the questions may be asked to testify at trial, and therefore should be well spoken and knowledgeable. Employees who are called to testify create an impression with the jury, and reflect the office in which they work. If the employee is disheveled, disorganized and ill informed, the jury may assume the physician's office operates in a similar manner.

When presented with an authorization for the release of medical records or a court subpoena, physicians may also be presented with an affidavit attesting to the reasonableness and necessity of the medical charges. This affidavit, once executed, is sworn testimony. A physician should not sign an affidavit stating that his or her medical treatment was necessary as the result of another physician's treatment/negligence unless the physician executing the affidavit knows that to be a fact. In most cases, this kind of testimony is pure speculation on the part of the subsequent treating physician since he or she may not know all the facts surrounding the previous care.

Unless the records custodian is a physician, record custodians are usually not qualified to testify regarding causation. Plaintiff's attorneys often try to use an unwitting subsequent treating physician to prove damages, even though it was not the physician's intent to do so. At times, a subsequent physician will be asked by deposition on written question whether the subsequent treating physician's bills were incurred due to the negligence of another physician. Again, unless the subsequent treating physician has made a thorough review of the medical records, and is familiar with the facts surrounding the previous medical care, the subsequent physician should not speculate as to the cause of the alleged injury. It is the record custodian's responsibility to read medical records affidavits carefully and mark through any statement that cannot be attested to under oath.

***Risk management tip:** Legal correspondence or other legal information not directly related to the care of the patient should not be incorporated into the patient's medical record. Legal correspondence, information from the liability insurance company or other agencies should be kept in a separate, secure file.*

Subpoenas for appearance at trial or deposition

A deposition is a means by which sworn testimony is obtained in question and answer

format. Although depositions are not usually taken at the courthouse, the testimony is sworn and may be read to the jury at trial. The Texas Rules of Civil Procedure provide for pre-suit depositions and state that a pre-suit deposition may be taken for the purposes of perpetuating the person's testimony for use in an anticipated suit, or to investigate a potential claim or suit.

A deposition to perpetuate testimony is usually taken when it is anticipated that a witness may die or move out of subpoena range. For example, in an alleged failure to diagnose cancer case, the plaintiff's deposition may be taken before a suit is filed if the attorney thinks his client may not be able to provide testimony at a future date. Although the rule provides for investigatory depositions when additional information is needed for an attorney to decide whether to file suit, some plaintiff's lawyers use this procedural rule to obtain a deposition when the physician is unsuspecting and unprepared. In many cases, the attorney has already decided to sue the physician. If this is the situation, nothing the physician may say in a pre-suit deposition will change the mind of the plaintiff's attorney. It is unwise for a physician to appear for a pre-suit deposition without counsel. Additionally, the physician should not call the plaintiff's attorney to discuss the case once a subpoena for a pre-suit deposition has been issued.

Pre-suit deposition notices must be taken seriously. A physician should notify his professional liability insurance carrier immediately after service with a notice of claim or deposition. Insurance companies usually provide the physician with a lawyer for the deposition. Additionally, a judge must grant the request for the pre-suit deposition before it can take place. The hearing regarding whether the deposition will go forward usually occurs 15 days after the deponent has been served with the notice. Time is of the essence, so a pre-suit deposition notice should not be placed in the drawer to be dealt with on another day. Depending on the circumstances, a defense attorney may be able to limit or cancel the deposition completely.

If served with a subpoena for appearance at trial, a physician should call his insurance carrier. Although a request to testify at trial does not usually lead to a lawsuit against the witness, it is best to discuss the situation before providing testimony.

Risk management tip: *Do not agree to meet with attorneys to discuss individual cases or patient care rendered until you have contacted your medical liability insurance carrier.*

Charging for copies of medical records

HIPAA Guidelines

HIPAA provides that a reasonable cost-based fee may be imposed for providing copies of medical records, provided the fee only includes the costs of:

1. copying, including the cost of supplies for and labor of copying the protected health information;
2. postage, when the individual has requested the information be mailed; and
3. preparing an explanation or summary of the protected health information, if agreed to by the individual.

The fee may not include costs associated with searching for and retrieving the requested information. "Reasonable" is not further defined by HIPAA, but is defined by Texas law.

The Texas Administrative Code

The Texas Administrative Code provides that a reasonable fee may be charged for copies of medical and billing records. "Reasonable fee" is defined as no more than \$25 for the first 20 pages and 50 cents for each additional page. In addition, a physician may charge actual cost for mailing, shipping or delivery. A physician may also charge a reasonable fee of up to \$15 if an affidavit is requested certifying that the information is a true and correct copy of the medical records. A physician may charge separate fees for medical and billing records requested. These charges are maximums. Physicians may charge less, or may choose to charge nothing at all.

When charging a fee for records, a physician is entitled to payment before releasing the records, unless the records have been requested by a licensed Texas health care provider or a physician licensed to practice medicine in the United States or Canada if requested for purposes of acute or emergency medical care. A physician may charge no more than \$8 per copy of films and studies. However, a physician may not charge for records requested by a patient, former patient, or authorized representative of the patient if the records request is related to a benefits or assistance claim based on the patient's disability.

The Texas Medical Board guidelines

The TMB guidelines for charges to copy medical records mirror those of the Texas Administrative Code. If the physician receives a proper request for copies of medical and/or billing records or a summary or narrative of the records for purposes other than for emergency or acute medical care, the physician may retain the requested information until

payment is received. In the event payment is not routed with such a request, within 10 calendar days from receiving a request for the release of such records for reasons other than emergency or acute medical care, the physician shall notify the requesting party in writing of the need for payment and may withhold the information until payment of a reasonable fee is received. A copy of the letter regarding the need for payment shall be made part of the patient's medical and/or billing record as appropriate. Medical and/or billing records requested pursuant to a proper request for release may not be withheld from the patient, the patient's authorized agent, or the patient's designated recipient for such records based on a past due account for medical care or treatment previously rendered to the patient.

A subpoena is not required for the release of medical and/or billing records requested pursuant to a proper release for records made by a patient or by the patient's guardian or other representative duly authorized to obtain such records. In response to a proper request for release of medical records, a physician is not required to provide copies of billing records pertaining to medical treatment unless specifically requested pursuant to the request for release of medical records.

The allowable charges are maximum amounts. There are certain circumstances in which a fee may not be charged. Under Section 161.202 of the Texas Health and Safety Code, a physician may not charge a fee for a medical or mental health record requested by a patient, former patient or authorized representative of the patient if the request is related to a benefits or assistance claim based on the patient's disability.

A physician responding to a request for copies of films or other static diagnostic imaging studies is entitled to a reasonable fee for providing the copies. A reasonable fee shall be no more than \$8 per copy. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery. If the original films are released, a signed and dated receipt acknowledging the receipt of the films and responsibility for them should be placed in the patient file. Physicians should remember that films may be pivotal to a future lawsuit. It is important to maintain tracking logs if the original films are released to the patient.

Copies or access to films or other static diagnostic imaging studies must be provided to the patient within 15 days of receipt of the request. If the physician denies the request, the physician shall furnish the patient with a written statement, signed and dated, stating the reason for the denial. A copy of the statement denying the request must be placed in the patient's medical record.

Risk management tip: Physicians may not refuse or delay responding to a valid request for a medical record because of an unpaid bill.

Occupational Safety and Health Act

OSHA provides that whenever an employee or an employee's designated representative requests a copy of a medical or exposure record, the employer shall assure that either:

1. a copy of the record is provided without cost to the employee or representative;
2. the necessary mechanical copying facilities (e.g., photocopying) are made available without cost to the employee or representative for copying the record; or
3. the record is loaned to the employee or representative for a reasonable time to enable a copy to be made.

If a record has been previously provided to an employee at no cost, the employer may charge reasonable, non-discriminatory administrative costs (i.e., search and copying expenses) but not including overhead expenses for additional copies of the record, except that:

1. an employer shall not charge for an ini-

tial request for a copy of new information that has been added to a record which was previously provided; and

2. an employer shall not charge for an initial request by a recognized or certified collective bargaining agent for a copy of an employee exposure record or an analysis using exposure or medical records.

With respect to an original x-ray, the employer may restrict access to on-site examination or make other suitable arrangements for the temporary loan of the x-ray.

Conclusions

Every day, complex situations occur in physician offices regarding the release of confidential information. Physicians should be familiar with the laws governing confidentiality and release of health information on a federal level as well as in the state of Texas.

Disclosure of information is critical in several areas: continuity of care, education, research, and public health. Patients can be harmed by withholding information and by the unauthorized disclosure of information.

Educating patients about the uses of health information and their rights may decrease the liability risk for disseminating confidential health information to third parties.

For further information

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To the editor . . .

I am writing in response to your recent article in the March-April 2006 issue of *the Reporter*.

The tragic case of the 7-year-old who died after a T & A illustrates a common clinical scenario that places patients and professionals at excessively high risk. Several points should be emphasized for your readers.

It appears that children commonly undergo airway surgery for obstructive sleep apnea (OSA) without a full evaluation of the extent of their disease.

Numerous publications have found that children with severe sleep apnea have an increased risk (up to 10-fold) of respiratory distress post-adenotonsillectomy. OSA in children can cause serious and even life-threatening cardiac complications. Right ventricular dysfunction, diastolic dysfunction, systemic hypertension and pulmonary hypertension have long been recognized as sequelae of severe OSA. Physicians must appreciate that OSA is a serious chronic illness that can be life threatening.

The American Academy of Pediatrics consensus statements state that children with suspected OSA should undergo a diagnostic test. The current gold-standard test is polysomnography (PSG). History,

physical or other tests are not sufficiently sensitive or specific for stratifying risk in otherwise healthy-appearing children. The best clinical diagnostician cannot define the severity of OSA in at-risk children.

If found to have severe OSA on PSG, a child should be closely monitored post-operatively, even in intensive care. I routinely identify severe OSA in seemingly low-risk individuals.

I suggest that risk management considerations in this case include:

- 1) All children with suspected OSA should undergo a polysomnogram before undergoing surgery. This is consistent with AAP standards of care.

- 2) Physicians should be aware of the ability of their sleep lab to assess children. Few sleep centers have the technical or professional expertise to perform adequate polysomnograms in children. Optimally, such sleep centers should be supervised by board-certified pediatric sleep specialists or at least those pediatric specialists trained adequately in sleep medicine (an American Thoracic Society standard).

The recent approval of sleep medicine as an ABMS specialty may help ensure quality sleep medicine services and polysomn-

ography at our community laboratories.

Please note that these opinions are my own and do not represent those of the Department of the Air Force or the Department of Defense.

Very Respectfully,
Joshua Rotenberg, MD
LTC (Sel), USAF MC
Chief, Division of Pediatric Sleep Medicine Staff, Pediatric Neurology
San Antonio Military Pediatrics Consortium

Sources

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closed claim studies

Failure to perform appropriate diagnostic procedures

by Barbara Rose and Anna Tauzin

The following closed claim studies are based on actual malpractice claims from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physicians' defensibility. The ultimate goal in presenting these cases is to help physicians practice safe medicine. An attempt has been made to make the material more difficult to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

Presentation

A 36-year-old woman came to an internal medicine physician upon referral of her gynecologist. She complained of severe right ear pain. She also listed other problems such as persistent crying, sleep disturbance, mild weight loss, loss of libido, and fatigue.

Her medical history included lower back pain, a disc problem that resulted in prescriptions for anti-inflammatory medications, and endoscopic sinus surgery where myringotomy tubes were fitted in her ears.

Physician action

The internist's initial diagnosis was probable depression, apparent premature menopause, and possible lumbar disc disease. He prescribed Zoloft and recommended thyroid studies. The doctor also requested prior medical records and stated he wanted to see her back in one month.

Five days later, the patient visited the physician complaining of nasal congestion. The physician assessed allergic rhinitis and prescribed Vancenase and Sudafed.

Two months later the patient came in with complaints of low back pain and right leg pain. The physician could not identify an etiology, but planned on getting copies of the past MRI. He wrote her a prescription for Feldene.

Another two months passed and the patient visited again. This time she reported dysuria and frequency. Suspecting a UTI, the physician prescribed Bactrim.

The first complaint of long-term headaches came one month later when the patient was

seen again. She also described nasal congestion and sneezing. She reported no fever. The physician determined the patient's symptoms to be the result of allergic rhinitis.

Two months later she returned for the same issue — two weeks of headaches and pain in the posterior neck with a band-like sensation. The patient reported that the pain was worse in the morning but denied aura. She had no neurological symptoms or hearing problems. The physician diagnosed typical muscle contraction headache. He prescribed Valium.

Within a month she was back again complaining of daily headaches and posterior neck pain. Again she denied aura and neurological symptoms, but reported nausea. The doctor diagnosed combination vascular/muscle contraction headaches, based upon the new complaints of the bifrontal location and nausea. He prescribed Calan.

Five months passed before the physician saw the patient again. She reported that her headaches were "much improved" with the Calan, but she was experiencing pain upon urination and frequency. The physician diagnosed a UTI.

The physician saw the patient for the final time two months later. She reported two weeks of daily headaches with band-like pain and pain in the neck without aura. She denied neurological symptoms and claimed that the bifrontal area pain and nausea were gone. The patient reported that she was taking all of her medications. The physician determined the syndrome was probable muscle contraction headaches. He planned to discontinue the Zoloft and put her on Elavil and Midrin.

Three months later, the patient had moved to Oklahoma where she was being treated by a family physician. Within two months, the patient reported to the Emergency Department of a local hospital after passing out. The patient was diaphoretic and disoriented afterwards. EKG and tilt tests were run; both were interpreted as normal.

Six days later the patient was seen by a neurologist. He ordered an MRI and EEG for evaluation of aneurysm, arteriovenous malformation, seizures, or brain tumor.

Due to a lack of insurance and the inability to make payment arrangements, she did not undergo the testing for three months. In the interim, the neurologist recommended Elavil, Neurontin, and Maxalt.

When the EEG was completed, and the reported finding was "irritative features and what appears to be focal delta activity... consistent with a structural lesion or seizure disorder." After studying the results from the MRI, the neurologist reported to the family physician that the test revealed a brain tumor in the third ventricle, consistent with "a giant cell astrocytoma or subependymal ependymoma."

The patient underwent a right craniotomy for intraventricular mass nine days later. She had an episode of bradycardia, became unresponsive, and then went into ventricular tachycardia and arrest. She was successfully resuscitated and placed on mechanical ventilation. A ventriculostomy returned blood-stained cerebrospinal fluid, and a CT scan showed acute hemorrhage in both ventricles. An echocardiogram showed decrease in both left and right ventricular ejection fraction. At that time the patient was considered brain dead. Life support was withdrawn and the patient died.

Allegations

The patient's family filed a lawsuit against the internal medicine physician. The allegations included:

- failure to recognize that the patient's symptoms indicated a potentially fatal condition;
- failure to perform appropriate diagnostic procedures; and
- failure to ensure the patient's medical information was communicated to her future health care providers to ensure continuity of care.

The lawsuit also alleged that the physician limited necessary medical services as a result of financial incentives from his employer. The physician's employing entity was also sued.

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Failure to admit patient to the hospital

by Barbara Rose and Laura Brockway

Presentation

A 51-year-old man came to the emergency department of a regional medical center at 2:55 p.m. on Thursday. The patient had previously been seen at his employer's health clinic for complaints of mild chest pains, right arm pain, left arm pain, and thigh pain. Before that visit, the patient had played one hour of tennis, which he did each day. His employer's clinic called his family physician who instructed him to go to the ED immediately.

Physician action

The triage nurse at the ED reported that the patient was complaining of chest tightness since 10 a.m. and joint discomfort. The discomfort worsened with activity. His initial vital signs were: blood pressure, 151/101 mm Hg; pulse, 106 bpm; respirations, 22. He was placed on a monitor and pulse oximeter, and was noted to be in no acute distress.

An emergency medicine physician examined the patient at 3:25 p.m. He noted the patient was in mild distress, but was otherwise asymptomatic. When specifically questioned by the physician, the patient refused to use the term "chest tightness" for what he had experienced, but rather called it a "chest sensation." He told the physician his symptoms had started the day before, and that he had a physical by his family physician one month earlier. He reported that he took no medications, had no prior surgeries, and borderline high blood pressure. He played tennis for exercise, did not smoke, but drank beer.

The physician completed a thorough physical exam, and the results were normal. He ordered a monitor, chest x-ray, pulse oximeter, oxygen, a heplock, and lab work including a CBC, UA, Chem7, cardiac enzymes, and PT/PTT. He ordered two baby aspirin to be given during the work-up. The physician's recollection is that the patient's chest sensation was not continuing at the time he saw him.

The patient's lab results and chest x-ray were within normal limits. An EKG revealed a normal sinus rhythm with nonspecific T-wave changes laterally. Because the patient did not have chest pain during his visit to the ED and his symptoms had started (as reported to the physician) more than 24 hours earlier with no enzyme elevation, the physician did not recommend admission. At 5:15 p.m., the emergency physician called the patient's family physician to schedule a follow-up appointment. Though the details of this conversation were not documented, an appointment was scheduled for 11:30 Friday morning.

The patient was given two baby aspirins and discharged at 5:30 p.m. He was instruct-

ed to follow up with his family physician, resume a normal diet and take ibuprofen 3 times a day. He was further advised to rest, and report to the ED if persistent or worsening symptoms arose.

The patient did not keep the Friday follow-up appointment. He died two days after the ED visit (Saturday) while playing basketball with his son. The autopsy report listed the cause of death as "a cardiac arrhythmia due to myocardial ischemia due to severe coronary atherosclerosis (heart attack)."

Allegations

Lawsuits were filed against the emergency medicine physician and the patient's family physician. The plaintiffs alleged that the emergency medicine physician was negligent for not immediately admitting the patient to the hospital. Allegations against the family physician involve the scheduling of the patient's follow-up appointment.

Legal implications

The plaintiffs were able to locate credible expert testimony that both physicians fell below the standard of care. An emergency medicine expert stated the patient should have been admitted for serial EKGs and cardiac enzymes to rule out acute coronary syndrome. A prompt stress test should also have been scheduled. The plaintiff's emergency medicine expert indicated that had the patient been admitted, he would still be alive. The family physician expert claimed the standard of care was breached when the patient's appointment was rescheduled by the physician's office staff. He further stated that if the patient had been seen as scheduled, it was likely that investigation, treatment, referral or advice could have been rendered that would have prevented his death.

Defense consultants who reviewed this case noted that an appropriate cardiac work-up was completed in the ED. This work-up showed that the patient was not having a myocardial infarction at the time of the ED visit. Further, the patient was appropriately referred to his family physician for follow-up the next day but failed to keep that appointment. To the defense experts who reviewed this case, including two cardiologists and three emergency medicine physicians, the main weakness of the case was that the physician did not admit the patient or order repeat EKGs or cardiac enzyme tests.

The emergency physician stated that there were four pieces of information that he did not receive from the patient: history of playing tennis when the pain started; history of high cholesterol; history of hav-

ing been seen at his employer's health clinic that day; and history of a prior cardiac work up by a cardiologist. If the physician had known that the patient's pain started when he was playing tennis, he would have admitted him as an urgent, but stable patient.

This case was complicated by conflicting testimony from the family physician and the emergency physician about the scheduling of the follow-up appointment. The family physician testified that he told the emergency physician to have the patient call his office the next day to schedule an appointment. The emergency physician testified that the family physician said to have the patient come in the next day at 11:30 a.m., but because the front office was closed, to call the next morning and confirm that time. The conversation between these two physicians was not documented.

The patient's wife and the family physician also gave conflicting accounts regarding the rescheduled appointment. The patient's wife testified that when her husband called on Friday to confirm the appointment, a staff person told him the physician was booked all day and could not see him. An appointment was made for him on Monday.

The family physician's medical assistant testified that when the patient called, he stated he was feeling better and did not want to come in that day. She told him that was fine and to come in on Monday, and in the meantime to follow the doctor's instructions from the hospital. The medical assistant did not check with the physician before telling the patient it was all right to come in on Monday. This conversation is documented in the medical record as "feels better and wants to wait until next week." However, the medical assistant also testified that she made this entry on Monday after the office had learned that the patient died. The entry was dated Friday.

Patient accountability became an issue in this case. In his discharge instructions, the emergency medicine physician told the patient to "rest." The patient's wife acknowledged that the patient knew he should not play sports. The patient did not follow those instructions, and was playing basketball when he collapsed and died. Additionally, the patient failed to follow up with his family physician on Friday as instructed.

Disposition

This case was settled on behalf of the emergency physician and the family physician. Though it was felt that the patient shared a good percentage of responsibility for the outcome, defense experts were con-

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diagnostic procedures . . . continued from page 10

Legal implications

Overall, the expert opinions from the plaintiff claimed that the internist breached the standard of care by not ordering an MRI and neurology consultation earlier. An oncologist for the plaintiff said that identification of the tumor in the months when the patient was under the defendant's care would have resulted in a greater than 50% chance of successful surgical resection. Had this occurred, the patient probably would have had a chance at long-term survival.

However, the defense expert opinions supported the internist's treatment. At no point did the patient have symptoms or historical findings that would raise the index of suspicion of a tumor. A neuro-oncologist for the defense indicated that the patient's tumor could have been present for years, and it would not be unusual for the growth to go undiagnosed for years. She believed the delay in obtaining an MRI did not affect the patient's chance for survival. She pointed out that the patient did not die as a result of the size or spread of the tumor, but from complications that occurred during surgery.

Disposition

The defense of this case was complicated by the volume of material, the number of witnesses, and the plaintiff's attorney's cre-

ative interpretation of what the internist's actions should have been. Additionally, this case involved the death of a young woman who was the mother of three young children. With the consent of the internist, this case was settled before trial.

Risk management considerations

Standards of care are not set in stone. Identifying what a reasonable physician would do under similar circumstances can vary, as reflected in the polarity of opinion from the experts for the plaintiff and defendant. Physicians are expected to exercise consistency with comprehensive documentation of their findings, basis for treatment decisions, and the outcome of those decisions including the patient's choice(s) and compliance. The balance and medical necessity for ordering diagnostic tests needs to be based on symptoms and not economics.

This claim serves as a reminder that some events in life are not equitable. This physician and his care could be defended, but the fear of the unknown regarding the makeup of a jury and the emotional influence of young children in the courtroom led to the choice of a settlement.

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cerned that the patient was not admitted to the hospital and that his appointment was changed at the family physician's office.

Risk management considerations

National statistics regarding lawsuits against physicians indicate that 25% involve actions of staff. Developing guidelines describing staff responsibility and decision-making in regard to patients will serve to prevent staff from exceeding their authority and rendering advice without your knowledge.

Strict protocols for documentation in the medical record apply to physicians and staff. Phone calls function as a key component of health care. In this case, the conversation between the emergency and family physicians was not documented. Secondly, the phone call between the patient and medical assistant was not documented contemporaneously but was written as a late entry that was not identified as such.

It is frustrating that patient accountability was not the sole focus of this claim. In retrospect, if the patient had been admitted from the emergency department, he might be alive today.

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