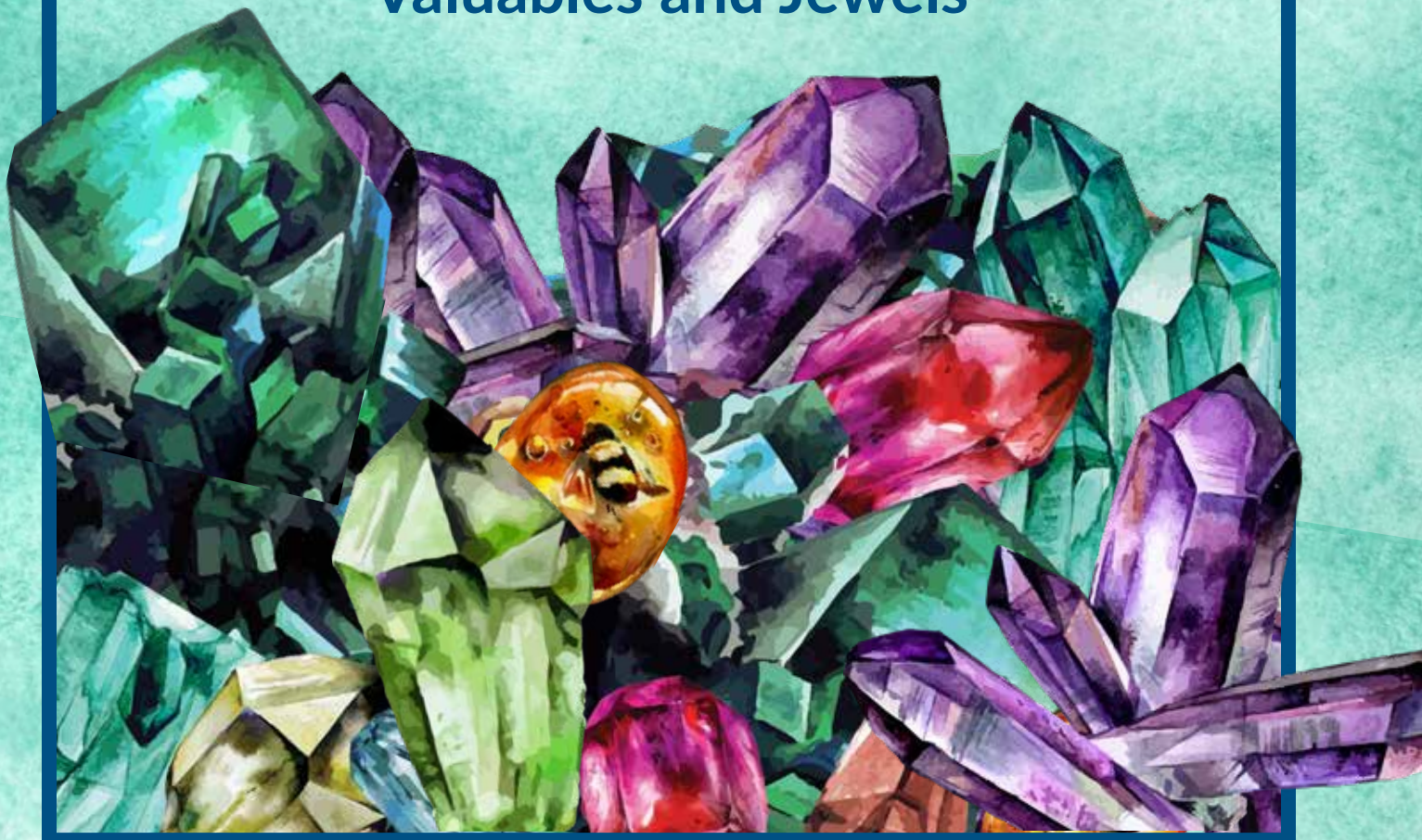
RISK MANAGER

Fall 2018

TREASURE TROVE

of Risk Management

Valuables and Jewels



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MACM®

Dear MACM Insured:

Welcome to the latest copy of the *Risk Manager!* We hope this issue finds you well and that your practice is productive and growing.

Earlier this year, MACM hosted our biennial education program targeted to your clinic staff. From February through July, over 400 physicians and clinic staff gathered in 11 locations across Mississippi to learn about the liability involved for those managing and working in a medical practice. This year's program featured a collection of topics and discussions from the Risk Management files – from prescribing controlled medications to violence in the workplace to technology.

In this issue of the *Risk Manager*, we have transposed into the written word the topics from the office staff program that generated the most questions and the most interest. While we hope you keep and refer to every publication that MACM sends your way, I ask you to definitely keep this issue of the *Risk Manager* as a reference. The topics discussed are ones that generate phone calls and emails to our department every day. File this publication away in a drawer, and when you face one of these situations in the future, pull it out and give us a call. Together we can work through a difficult or uneasy situation.

In addition to the articles written by each of your Risk Management Consultants, MACM General Counsel Stephanie Edgar offers some advice on responding to negative reviews and comments on social media – definitely a hot topic these days. While your first instinct may be to respond immediately, you may be in violation of privacy laws in doing so. Please read Stephanie's article to get a better idea of how to handle these situations. And, again, call us when a social media situation arises.

As always, if there is anything that anyone in Risk Management can do for you, do not hesitate to let us know.

Sincerely,

Kathy Stone, BSN, RN
Vice President of Risk Management

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TREATMENT OF FAMILY, CLOSE FRIENDS, AND YOURSELF:

What are the rules?

By Kathy Stone, BSN, RN, Vice President of Risk Management

Have you ever been asked to look at a rash in the checkout line of the grocery store? What about writing a "quick" prescription for a family member to avoid a visit to the emergency room? Do you realize that treatment of this nature may not be acceptable according to the American Medical Association and the Mississippi State Board of Medical Licensure and may be frowned upon by MACM?

At MACM, we do recognize that physicians practicing in small towns and communities may find it necessary to treat close friends and family. It is part of life in a small town. But, recently, the Mississippi State Board of Medical Licensure (MSBML) has shown great interest in physicians who treat themselves, family members, and even their practice partners. There are ways to meet these needs if necessary, and at the same time, protect your practice from any malpractice issues and ethical violations.

The American Medical Association (AMA)'s Code of Ethics Opinion 1.2.1 states, *"In general, physicians should not treat themselves or members of their own families." The AMA goes on to say, "Treating oneself or a member of one's family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent."*

The personal feelings of a physician can influence his clinical approach, as well as his ability to consider the facts objectively and arrive at the appropriate diagnosis. It is not difficult to see that a physician might curtail his usual detailed history questions with his sister-in-law or opt to not examine intimate body areas on his aunt. These scenarios can be uncomfortable for both the physician and the patient. Also, despite a physician's best efforts, cognitive bias may arise based on the physician's personal background and knowledge of the family member's or close friend's history. Will the physician evaluate the pain complaints of his cousin, who has a long history of malingering and shirking responsibility, in the same manner as a patient with whom he has no personal history?

Physicians who have established a pattern of caring for family and friends may find themselves feeling pressured to practice outside of their comfort zone, even outside of their specialty entirely. For example, an orthopedic surgeon may feel he is obligated to provide an antibiotic to his sister's young son to treat a possible

AMA CODE OF ETHICS

The American Medical Association (AMA)'s Code of Ethics Opinion 1.2.1 states, "In general, physicians should not treat themselves or members of their own families." The AMA goes on to say, "Treating oneself or a member of one's family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent."

EXCEPTIONS

Despite the AMA's strong stance against the treatment of family, close friends, and even themselves, they did provide a couple of exceptions in limited circumstances, which include

1. Emergency situations or isolated settings where there is no other physician available; and
2. For short-term, minor problems.

CAUTIONS

If a physician does decide to treat himself, family, or close friends, the AMA cautioned the physician to

1. Document the care provided, just as for any other patient,
2. Share any relevant information with the patient's primary care provider, and
3. Avoid providing "sensitive or intimate care," especially to a minor.

strep throat (the child's third in three months) so his sister can avoid a trip to the pediatrician, or even the emergency room, over a weekend.

Both the physician and the family member can have a sense of obligation to allow treatment by the physician, while in truth, neither is comfortable with the idea. The AMA notes this may be the case when parents treat their own children. Certainly, as the child matures, he may find it difficult to discuss sensitive issues with his physician-parent.

In addition to the above issues, the physician's relationship with the friend or family member can be irreparably damaged should the patient have a negative experience for which the patient holds the physician responsible. Along the same lines, a patient who is a family member or close friend may very well find it difficult to request a second opinion or referral for fear of offending or angering the physician.

The MSBML has taken actions against physicians for prescribing medications (not just scheduled drugs) without performing a proper history and physical and documenting that care is appropriate.

At MACM, we have had claims from clinic staff members and even other physicians who allege their physician friend or employer did not follow the standard of care while providing prescriptions for them – at the patient's request!

But, what about treating yourself? The Mississippi Board of Medical Licensure has a dim view of physicians prescribing medications for themselves, especially scheduled drugs. Moreover, the old adage attributed to Sir William Osler, "A physician who treats himself has a fool for a patient," reflects the myriad of problems associated with trying to objectively diagnose and treat yourself. For your sake, we encourage you to seek out a physician with whom you are comfortable and follow his recommended treatment plan. As a patient, do not circumvent the normal doctor-patient relationship (thereby putting your colleague on the spot) by requesting prescriptions or orders without a proper examination.

In Risk Management, we often say to "Treat every patient in the same way." Physicians sometimes find themselves in a difficult situation when they take shortcuts or alter their usual practice, for whatever reason.

In summary, we recognize the contribution that you, our physician insureds, make to your communities and understand it can be difficult to draw clear boundaries when you have known virtually every one in your town all of your life. But, MACM's concern is the well-being of our physicians and their patients. With that in mind, our best recommendation regarding the treatment of yourself, family, or close friends is "just don't do it." If it is necessary, please heed our advice on the next page. Remember, we are always here to discuss your concerns and assist you in any way we possibly can.

For those of you who have tried to be helpful to friends and family and have found yourself treating outside of your comfort zone or providing prescriptions because of someone else's expectations, here are suggestions on how to transition that relationship to a more appropriate one.

When someone approaches you for medical advice or intervention outside of a clinic visit

- Express sympathy and explain it would not be the best medical practice to try to diagnose and treat without getting a proper history and performing a thorough exam. In fact, doing so could do more harm than good.
- Give only very general medical advice.
- Remember to not joust another physician should the discussion include care previously provided.

Offer to help them in other ways

- Ask them to call your office the next business day, and you will ask your receptionist to work them in as soon as possible.
- Suggest the type of specialist that would be best for the problem.
- Consider offering to call another physician or the recommended specialist on that person's behalf to get the patient worked in quickly.

If treatment of close family and friends is necessary, remember to make it a rare occurrence

- Treat them just as you would any other patient. In other words, do not make assumptions about the patient's wishes regarding his care, ability to pay, willingness to allow discussion with other family members, etc.
- Use the same diagnostic approach and management as you would with any other patient. Do not deviate from your usual practice.
- Stay within your training and practice area. If you do not treat pediatric patients, do not try to treat your friend's child, your brother's child, or even your child.

In EVERY instance, keep the same medical records on these patients as you would any other

- Do not skip any of the usual steps. If your patients complete a history form, be sure your family member does so as well.
- Do not assume you know the patient's history.
- Do not fail to document your progress notes, phone calls, or any other aspect of the chart to the same degree as you would any other patient.

The HIPAA/PUBLIC RELATIONS TIGHTROPE: Online Reviews

By Stephanie Edgar, JD
General Counsel

There's no question that patient satisfaction has become an important part of medical care and that the internet has given patients a large forum to publicize their satisfaction or dissatisfaction. According to surveys performed by Softwareadvice.com in 2013 and 2017, the percentage of patients using online reviews to find a physician increased from 25 percent to 72 percent. So, putting aside your (and my) feelings about the myriad issues with online patient reviews, they've become a necessary evil.

Acknowledging Your Assets

In reality, even confirming that you've treated a patient is a violation of HIPAA. For example, if a patient posts a favorable review, you can't respond and thank them for coming to the clinic. You can, however, post a generic acknowledgment such as, "Thank you. We work hard every day to care for our patients." Likewise, you can't hijack a patient's positive online review and "share" it or use it as advertising for yourself or your clinic without first getting the patient's consent. In 2016, a physical therapy clinic was fined $25,000 by the Office for Civil Rights (OCR) for doing just that.

Rolling With The Punches

While negative reviews are often uninformed and may even be patently incorrect, a healthcare provider's hands are tied in responding in a way that doesn't violate HIPAA. Just because a patient has spilled his medical beans all over Facebook, Twitter, or Yelp doesn't give you permission to set the online record straight about his medical care. There aren't many absolutes in life, but this is one of them. You can't do this under any circumstance. A good rule of thumb is that you must be as professional online as you are in the office or the hospital. If you wouldn't walk out to your crowded waiting room and say the things you want to post online, step away from the computer or put away your smartphone.

It's ok not to respond at all. A survey conducted by Softwareadvice.com revealed that patients focus on positive reviews more than negative ones. One school of thought is that if you respond to a negative review, you bring more attention to it and effectively keep it alive. That said, if you're consistently getting negative online reviews, you might consider whether there's any truth to the criticisms because studies have shown that most patients post only positive or neutral reviews.

If you decide that you absolutely must respond to a negative review in an online forum, proceed with extreme caution. According to the OCR's former deputy director of health information privacy, this is what your response should say, "We work hard every day to care for our patients and have been reviewed favorably in other contexts." That's it—nothing more.

If you can determine the patient's identity from the statements made in the review or, in the case of Facebook, by looking at the post's author, you might consider reaching out to the patient by telephone or in person at the patient's next appointment and talking about the merits of the review. The purpose of this conversation is NOT to coerce the patient to remove the review but to sincerely get to the bottom of the complaint. A by-product of this discussion may very well be removal of the review but, again, that shouldn't be your intended goal.

Some anonymous review sites have a direct message feature that enables you to contact the reviewer. You may think you know who the anonymous reviewer is and think that because this is a "private" direct message, you can communicate confidentially with this patient. The problem with this is that you may divulge PHI to a person that's either not really your patient or not the patient you think wrote the review. The only foreseeable way to use direct message would be an invitation to the reviewer to please contact your office.

Just because a patient has spilled his medical beans all over Facebook, Twitter, or Yelp doesn't give you permission to set the online record straight about his medical care.

With responding to online patient reviews, less is always best. You don't have to respond online to either a negative or positive review, but if you feel led to do so, a short response that doesn't divulge any PHI or that you've treated the patient is the only way to go. If you encounter this situation in your practice, please call MACM.

TEST RESULTS:

Do you manage them or do they manage you?

By Judy Cleveland, BSN, RN
Senior Risk Management Consultant

If you practice medicine, then you order tests.

We are often asked why it is necessary to track test results. Well, if a test is ordered and results are not received, reviewed, and the patient notified, then the provider's order has not been completed. And how would you explain that a test was important enough to order, but not important enough for you to follow up, review results, and notify the patient? To successfully accomplish this, a process is necessary.

So why is a process necessary? There are so many scenarios where something can go wrong if a step-by-step process is not followed. For example, a provider might order a test/lab, but the patient never gets it done, and the ordering provider does not realize it was never done. Or if the test is done, the provider might not get the results back, and because a process is not in use, no one notices and no one does any follow-up. What if the test reveals a significant problem, but no one finds out until the patient comes back to the clinic months later or ends up in the Emergency Department? What if the test/lab results are returned to the clinic, but the clinic does nothing with the results?

So how do you develop a process for this, or how can you evaluate your current process to ensure it is adequate? To start, address these three questions: Was the test actually done? What were the results? What follow-up was done? Let's break these down.

Was the test actually done? If a provider orders a test, then that provider is responsible for ensuring the test was performed and the results are returned to the clinic in a timely manner. Your clinic process should prompt follow up to ensure that results are returned to you, or if not, remind staff to contact the testing facility to see if the test was done. If the test was not done, the patient needs to be con-

tacted to find out why it was not done. Once this is determined, staff can confer with the provider so appropriate steps can be taken. This discussion, the patient's reason for not having the test done, and all follow-up efforts should be noted in the chart.

What were the results? You have to take into account all the different ways in which results are returned to you and be sure you have a system in place to ensure you know what tests are pending and when you receive the results. The provider should document a review and awareness of the results. This can be done by the provider initialing or e-signing the results.

What follow-up was done? All results should be reviewed by an appropriately trained medical person, *i.e.*, a clinical person. A clinical person can review results or 'triage' them before the provider sees them. Why? Providers have to process a lot of data every day from multiple sources. They can suffer information overload and miss important information. Once the clinical staff member's review is complete, any atypical findings can be brought to the attention of the provider and be discussed. The provider can then give direction as to what follow-up should be done. This discussion, orders from the provider, and all follow-up efforts should be clearly noted in the medical record.

Patients should be notified of every test result including normal results, not just abnormal results. Patient notification can be done in whatever process works best in the clinic: using phone calls, letters, or the clinic portal are all acceptable methods for notifying of normal results. However, if a result is abnormal or unexpected, the patient should be called or a follow-up appointment should be scheduled so the results can be explained to the patient along with any changes in treatment. This

will also allow the patient to ask questions. And of course, these patient contacts should be fully documented in the patient record, along with clear documentation of any discussion or direction from the provider. It is best to avoid notifying patients by email unless it is sent via the portal.

A quick thought about portals. If you utilize portals to notify patients of results, is there a mechanism set up to alert you that the patient actually viewed the test results? Is this captured so it can be reproduced if needed to document the patient was notified? You may want to investigate this.

Be sure your staff is aware of your process and that they truly understand it. And you should educate your patients about your process too. While it is not the patient's responsibility to do any follow-up by contacting you, they can act as another "fail safe" if they know to call the clinic if they have not been notified of their results in a specified time frame. Be sure your patients understand that the "No news is good news" tradition is no longer in play. They should hear from you even if their results are ok.

No matter what kind of clinic you are – primary care, specialty, urgent care/walk-in – you are responsible for obtaining results of any tests ordered in your clinic, of making sure the patient is notified, and of being sure any abnormal results are addressed.

In addition to this, the ordering provider should 1.) discuss with the patient why it is important for the patient to complete the testing, 2.) explain why the patient needs the test, and 3.) inform the patient of how the test result will help the provider in treating the patient. It is a proven fact that compliance increases when the patient understands why something needs to be done. This is where patient compliance starts, and this is where you can show in the medical record that the patient was informed of and knew the reason for the testing.

As always, there are some special situations you need to consider. If a test needs to be done ASAP or STAT, then you need to contact, by phone, the facility that will do the test. The facility needs to be told you need the test right away. In the case of scans or procedures, you should communicate the specifics of what is going on with the patient. Don't depend on the orders alone to convey this adequately.

Sometimes a provider is out on vacation, medical leave, etc. So what happens then? Are results routed to another provider so they are reviewed in a timely manner? Everyone needs time off sometimes, but your patients shouldn't have to wait for results because the provider is out of the clinic.

What if you are notified of a critical value? There should be an established procedure in your clinic as to how these notifications will be handled. Designate specific individuals to receive critical results and outline how that information is to be conveyed to the ordering provider. If a laboratory calls with a critical value, ideally the call should be transferred to either the provider or nursing personnel who will understand the implications of the results and be able to take action.

No matter what kind of clinic you are – primary care, specialty, urgent care/walk-in – you are responsible for obtaining results of any tests ordered in your clinic, of making sure the patient is notified, and of being sure any abnormal results are addressed.

VACCINES:

A common treatment with an uncommon requirement

By Lisa Smith, BSN, RN, Risk Management Consultant

Many physicians and healthcare providers administer vaccinations on almost a daily basis. During certain seasons, it is done numerous times each day. The ubiquitous nature of vaccinations may obscure the risks and requirements associated with them. Healthcare providers must use diligence to thwart liability claims related to the administration, or the withholding, of vaccines. Provider liability protection is best afforded by practicing the following immunization guidelines.

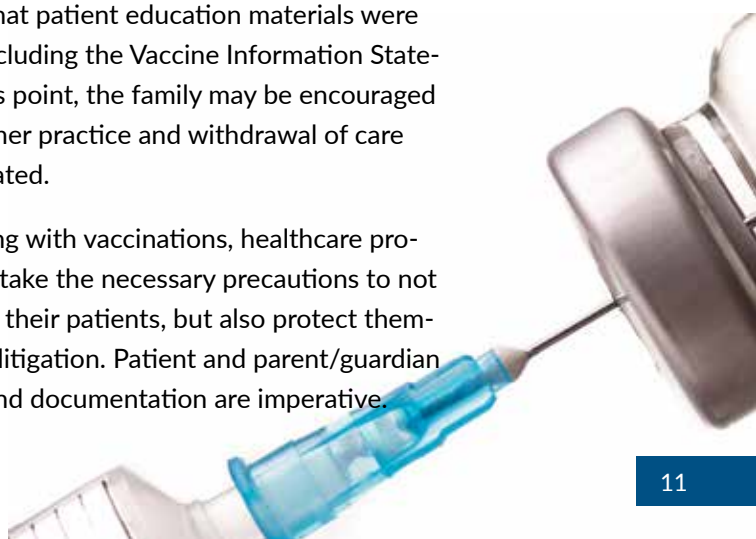
Are you aware that federal law requires that patients or caregivers receive Vaccine Information Statements (VIS) prior to receiving certain vaccinations? Vaccine Information Statements, produced by the Centers for Disease Control, provide essential information to patients and caregivers. The documents not only explain the risks and benefits of a vaccine, they also cover who should get the vaccine and at what age, what to do for a serious reaction, and when not to get the vaccine or reasons to wait. Virtually all commonly used vaccines have VIS forms. For more information, go to the CDC Vaccine Information Statements webpage at https://www.cdc.gov/vaccines/hcp/vis/index.html. In addition to the VIS forms, patients should sign a medication-specific consent form when being administered the influenza and Gardasil vaccines.

Is your staff documenting vaccine administration appropriately? The documentation should not only address the administration of the vaccination, including route, location, and lot number, but also document that the VIS was provided to the patient or caregiver as well. Although a medical record is not necessary on non-patients, the information must be retained and available, if needed.

Providers also need to vaccinate appropriate to their specialty. For example, obstetricians and gynecologists should not vaccinate males; and ophthalmologists should consider not giving vaccines of any kind.

What should you do if a parent or guardian refuses to vaccinate his or her child? Flag charts of unimmunized or partially-immunized children to alert the provider to revisit immunization discussions when evaluating illness in children, especially in young children presenting with a fever of unknown origin. The issue of liability can arise if a parent or guardian refuses to vaccinate and the child later develops a disease. Therefore, documentation of the discussion surrounding the issue, as well as a signed refusal form, are essential. Both the American Academy of Pediatrics' *Refusal to Vaccinate* and the Immunization Action Coalition's *Decision to Not Vaccinate My Child* are good resources to use in framing the parent discussion and documenting the refusal. The clinic note should include that the parent or guardian was informed of why the vaccine is recommended, the risks and benefits of the vaccination, and the possible consequences of not vaccinating. Also, document that patient education materials were provided, including the Vaccine Information Statement. At this point, the family may be encouraged to find another practice and withdrawal of care may be initiated.

When dealing with vaccinations, healthcare providers must take the necessary precautions to not only protect their patients, but also protect themselves from litigation. Patient and parent/guardian education and documentation are imperative.



VIOLENCE AGAINST HEALTHCARE WORKERS:

Prevention and Planning

By Anne Everett, MSN, RN, Senior Risk Management Consultant

Workplace violence is a serious and growing problem that affects all healthcare professionals today. Violence in healthcare may take a variety of forms, ranging from verbal aggression to physical assault, including the use of deadly weapons against physicians, other workers, and patients. According to the U.S. Bureau of Labor Statistics, workers in healthcare and social service settings are nearly five times more likely to be the victim of a nonfatal assault or violent act than the average worker in all industries combined, including law enforcement. Also, violence-related injuries are four times more likely than other kinds of injuries to cause healthcare workers to take time off from work.

The National Institute for Occupational Safety and Health defines workplace violence as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty." Enforcement activities typically focus on physical assaults or threats that result or can result in serious physical harm. However, many people who study this issue and workplace violence prevention programs include verbal violence—threats, verbal abuse, hostility, harassment, and the like—which can cause significant psychological trauma and stress, even if no physical injury takes place. Verbal assaults can also escalate to physical violence.

Healthcare has some unique cultural factors that may contribute to the underreporting or acceptance of workplace violence. For example, caregivers feel a professional and ethical duty to "do no harm" to patients. Some will put their own safety and health at risk to help a patient, and many in healthcare professions consider violence to be part of the job. Healthcare workers also recognize that many injuries caused by patients are unintentional and are, therefore, likely to accept them as routine or unavoidable. Another consideration is unwillingness among healthcare workers to stigmatize the perpetrators due to their illness or impairment.

Patients are the largest source of violence in healthcare settings, but they are not the only source. Many serious violent incidents reported in healthcare settings are caused by interactions with healthcare workers and patients. Patients are not usually in the healthcare setting because everything is ok with them. They may be scared, facing financial concerns, distraught, and/or worried about their future. Other incidents of violence that occur in healthcare are caused by family members of patients, visitors, and co-workers to include nurses, physicians, and other healthcare staff. Many times family members may be angry, fearful, have psychiatric issues, or feel overwhelmed or at a loss of control. Also, healthcare workers may be facing multiple demands/stressors in the day-to-day operations of delivering patient care in the healthcare work setting. Despite being places of healing, healthcare systems contain a unique mix of stressors that can create an environment conducive for violence for the patient, visitor, and healthcare worker.

Workplace violence can start as small incidents involving negative remarks and inappropriate behavior. It may escalate to psychological or physical violence. It is much easier to prevent violence by stopping small incidents than trying to deal with the aftermath of a major crisis.

It is extremely important to understand that the following behaviors do not mean a person will become violent, but they may indicate the person is experiencing high levels of stress. Each situation is unique, and professional judgment or outside assistance may be necessary to determine if intervention is necessary.

VERBAL / BEHAVIORAL SIGNS

Warning signs of violence may include any of the following:

- Extreme change in behavior/personality
- Temper tantrums/overly emotional
- Overreaction to situation
- Blaming others
- Insistence that they are being mistreated
- Insistence that they are right
- Destruction of property
- Intimidating, harassing, or aggressive behavior
- Numerous conflicts with others
- Threats such as using weapons to harm

NON-VERBAL / PHYSICAL SIGNS

Sometimes it is not what is said, but what a person's body is doing. Use caution if you see someone who shows one or more of the following:

- Flushed or pale face
- Sweating
- Pacing, restless, or repetitive movements
- Signs of extreme fatigue (e.g., dark circles under the eyes)
- Trembling or shaking
- Clenched jaws or fists
- Exaggerated or violent gestures
- Change in voice, loud talking, or chanting
- Shallow, rapid breathing
- Scowling, sneering, or use of abusive language
- Glaring or avoiding eye contact
- Violating your personal space

It is much easier to prevent violence by stopping small incidents than trying to deal with the aftermath of a major crisis.

When signs of violence occur, remember you cannot control the other person or the situation, but you can control yourself. Some options to consider to help with de-escalation are to count to 10, try not to personalize the situation, try controlled deep breathing, empathize with the individual (try to put yourself in the individual's shoes), and listen to the person (hear the person out). Also, be aware of your own body language, and above all, stay calm.

So what can you do to prevent violence in healthcare? Have a zero tolerance policy and post notices in prominent locations that confirm disruptive behavior will not be tolerated in the clinic. Healthcare workers do not have to tolerate abusive, disruptive, or threatening behaviors. Depending on where and why the patient is being seen, withdrawal of care may well be an option. Obviously, a concern with withdrawal of care is to avoid any patient abandonment issues.

Proactive planning is important. Disruptive behavior has a big impact on healthcare workers, and they need to be ready for it. Response plans for workplace violence should be clear and direct on how staff should react or handle the situation. Train staff to recognize the warning signs of violent behavior and react and report proactively. Proactive planning also includes having procedures in place with defined roles, a code word or panic button available in the clinic, and the numbers of whom to call posted near all phones. Encourage all employees and other staff to report incidents of violence or any perceived threats of violence to administration or someone in leadership, security, and/or law enforcement. There are also situations that might warrant the physician being involved to aid in de-escalation.

All healthcare organizations should have specific policies to manage and support the staff in handling such behaviors. Outbursts undermine the culture and safety within an organization. However, policies and plans do not help at all if they are not reasonable and applicable and the staff do not know the policies to follow should disruptive behavior and/or violence occur.

Once a concern develops or after an incident occurs, flag the chart for future employees to have available. Document what occurred objectively making sure to set emotions aside. Documentation should be specific and include the how, when, and where of what happened. Report the tone of the encounter and use specific statements and quotes. Have others that witnessed the incident write up their observations also. Depending on the situation, an incident report may be required as well and an entry in the patient chart, or both. This will support you if you decide to withdraw from care.

When signs of violence occur, remember you cannot control the other person or the situation, but you can control yourself.

Those in healthcare leadership should regularly review and assess the effectiveness of their response strategies to recognize areas of success and weakness and to ensure continuous improvement. Workplace violence is a serious and growing problem that affects all healthcare professionals. While these measures are unlikely to eliminate workplace violence in healthcare, these strategies are needed to minimize the negative consequences experienced by healthcare workers as they go about the business of healing those in need.

WITHDRAWAL OF CARE:

When and how to terminate the physician-patient relationship

By Tabatha Peninger, BSN, RN
Risk Management Consultant

Almost daily, the issue of withdrawal of care comes up in the MACM Risk Management Department, and no two cases are ever the same. Because of this, we want to review the proper process for withdrawal of care, as well as provide you with our recommendations when handling this sometimes unpleasant situation.

The Mississippi State Board of Medical Licensure Policy 3.18 states, "Once a physician-patient relationship has begun, the physician is under both an ethical and legal obligation to provide services as long as the patient needs them." The key point is the physician has a legal and ethical obligation to care for the patient as long as the patient is in need. However, the definition of "in need" is vague and clearly open to interpretation. Therefore, the decision to withdraw from care of a patient should not be made lightly or in the heat of the moment. There are certainly times when it is appropriate to terminate the physician-patient relationship, and there is a proper process to do so.

Patients have the right to limit what a physician can do even though the limitations may bring on disaster. The physician, however, is not required to continue to care for a patient whose restrictions compromise the ability to practice proper medicine. If a patient's

actions hamper management of treatment, consider withdrawing from care. This includes disruptive or threatening behavior by the patient or the patient's caregiver or companion. Either party may terminate the physician-patient relationship. For the patient, this is quite simple. For the physician, this process, including the events leading up to the decision to withdraw from care, requires more thought and effort.

Assess the current problem as it affects the physician-patient relationship. If there is a history of noncompliance with the treatment plan, does the patient fully understand the importance of the physician's instructions? Is there some obstacle the patient faces which prevents compliance? Has the patient been made aware that noncompliance with the treatment plan is hindering the physician's ability to care for the patient? If the problem is nonpayment, is there a way to work with the patient to help meet the financial obligation? Were the clinic's payment policies made clear to the patient from the beginning? Has the patient been warned about the consequences of disruptive behavior? Has it become clear that the physician-patient relationship is no longer in the best interest of the physician and the patient?

As mentioned, every question we receive by email and phone call regarding withdrawal of care is different. If and when you are faced with this situation in your own clinic, contact MACM. We are available to guide you through this process.

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1

TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

There are times when termination of the physician-patient relationship is necessary; but, it is important that the appropriate steps be followed. We recommend the following:

- Make a note in the patient's record describing fully the reasons for withdrawal from care. The patient's record should also contain documentation of every instance (at the time it occurs) when the patient was noncompliant or disruptive.
- Inform the patient of the physician's intention to withdraw from care. Whenever possible, the first notice should be given to the patient by the physician during an office or clinic visit.
- Send a written notice to the patient by registered mail, return receipt requested. Keep all documentation of this written notice in the patient's chart.
- Send the same written notice by first class mail. Include on both letters, "Sent by registered letter and first class mail." Know that some patients will not claim registered letters.
- Document any other attempts to contact the patient.
- Be sure the clinic staff is aware of your decision to withdraw from care so the patient will not be given another appointment.
- It is the job of the physician, not the nurse or clinic manager, to talk with and write to the patient.
- A physician assistant or a nurse practitioner may not independently terminate a physician-patient relationship.

2

INFORMATION TO INCLUDE

While no two cases are ever the same, there is basic information to be included in the written notice to the patient. Please include the following:

- Clearly state the physician is terminating the medical obligation to the patient.
- Provide ample time for the patient to find alternative care. We recommend at least thirty (30) days from the date of notification. Advise the patient that the physician will be available during that time for emergencies; but after the date specified, the physician will not be available for further medical care.
- We recommend the patient is made aware of the reason for termination if it has not been discussed previously. The Mississippi State Board of Medical Licensure Policy 3.18 states that you should provide "the patient with a brief and valid reason for terminating the relationship." We do not recommend detailed explanations be outlined in the written notice.
- If in a group practice, consider including a statement that withdrawal from care means withdrawal by the entire group/clinic.
- Call your MACM Risk Management Department and send us your letter. We are available to review the withdrawal of care communication to ensure that everything is included and all bases are covered.

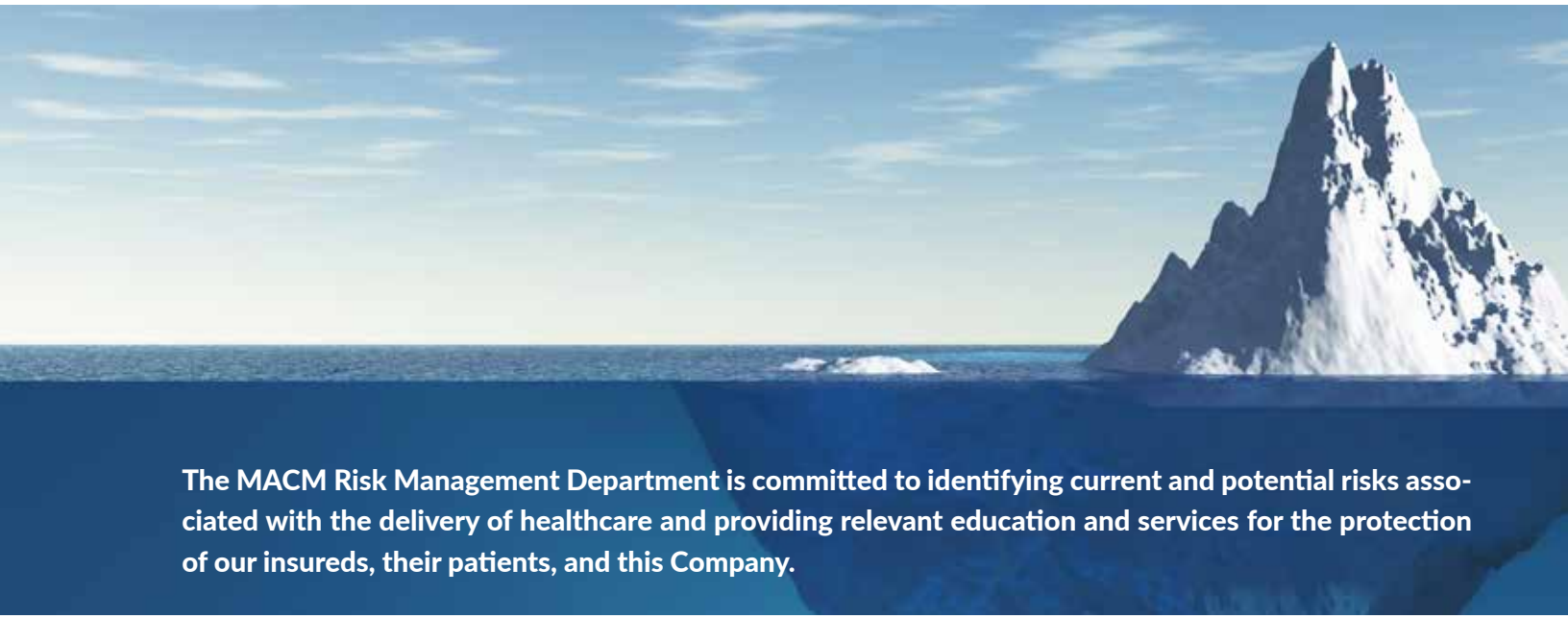
3

SPECIAL CONSIDERATIONS

Every physician-patient relationship is unique, and when terminating that relationship, there are times when special considerations are absolutely critical to prevent future liability issues.

- For patients undergoing hospital care, arrangement may be made for other physicians to take over. These substitutes must be acceptable to the patient.
- Do not withdraw from care of a patient in the midst of an acute need, such as the final months of pregnancy.
- Managed care plans usually have special requirements regarding withdrawal from care. Be familiar with all policies in this area.
- The Americans with Disabilities Act prohibits the denial of treatment or service solely on the basis of a disability. Therefore, it is of utmost importance that any denial of treatment or service be documented and be according to the normal operations of the healthcare provider.
- Although you may have terminated the physician-patient relationship, if the patient subsequently presents unreferred to the Emergency Department and you are the physician on call for unreferred care, you must care for that patient as you would for any other unreferred patient. Refusal to respond would be in violation of EMTALA regulations.
- Be sure the patient has enough prescription medication to last until the end of care date specified in the letter. Please be aware that refilling or prescribing after this date will re-establish the physician-patient relationship.

MACM Risk Management



The MACM Risk Management Department is committed to identifying current and potential risks associated with the delivery of healthcare and providing relevant education and services for the protection of our insureds, their patients, and this Company.

At Medical Assurance Company of Mississippi, we believe protecting our insureds from litigation is just as important as the service we provide after a suit is filed. The primary focus of our physician insureds should be the health and well-being of their patients. Our responsibility is to help you keep that focus, while we work to improve the healthcare delivery system.

Consider contacting one of our Risk Management Consultants about any of the following services we offer at no cost to MACM insureds.

- **Onsite Survey.** Through these evaluations, our staff can analyze the risk management systems and documentation within your practice to offer suggestions for improvement.
- **In-Service Education.** With customized presentations and training, our staff can meet the needs of our individual insureds.
- **Consultations by Telephone and Email.** Our consultants are located in Mississippi and available to answer questions from insureds promptly and professionally.
- **Publications.** Our insureds receive information that is timely through *Risk Manager Alert* email blasts, as well as more in-depth information through our *Risk Manager* publication.
- **Reference Materials.** These written bulletins are available to our insureds and designed to help in specific circumstances that come up daily in a medical practice, such as withdrawal from patient care.
- **Educational Opportunities.** In addition to the knowledge of our in-house staff, MACM has contacts across the U.S. and makes this expertise available to our insureds through webinars and conferences.
- **Presentations and Speaking Engagements.** The Risk Management Staff frequently presents at conferences offering suggestions to improve the healthcare delivery system.

Contact us today to learn more about our services.

www. macm.net | rskmgt@macm.net | 601.605.4882

MACM® | Medical Assurance Company of Mississippi

404 West Parkway Place
Ridgeland, Mississippi 39157
Office | 601.605.4882 • 800.325.4172
Fax | 601.605.8849

www.macm.net

Risk Management

Service Request Form

Please Mail, Email, or Fax Request Form to:
Medical Assurance Company of Mississippi / Attn: Risk Management Department
404 W. Parkway Place / Ridgeland, MS 39157
(P) 601-605-4882 / (F) 601-605-8849 / rskmgt@macm.net

Facility Information

Name of Office / Practice: _____ Specialty _____

Mailing Address: _____

_____

Physical Address: _____

_____

Contact Information

Contact Person _____ Title _____

Telephone _____ Cell _____

Email _____ Fax _____

Visit Information

Please mark the type of Service(s) Requested:

- ☐ Office Survey
- ☐ EMR Survey
- ☐ Education Program for Physicians
- ☐ Education Program for Office Staff
- ☐ Risk Management Consultation

Other: _____

Please mark three preferred days you wish for a Risk Manager to visit:

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday

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Rules and Regulations for Medical Assistants by the Mississippi Board of Nursing

Delegation

The Mississippi Board of Nursing has rules and regulations on delegation to medical assistants. This information is clearly displayed in the Administrative Code Title 30, Part 2830, Chapter 1, Rule 1.3, which reads "Supervision and Delegation. The RN shall be held accountable for the quality of nursing care given by self or others being supervised.

The registered nurse:

A: May:

1. Assign specific nursing duties and/or patient treatments to other qualified personnel based on educational preparation, experience, knowledge, credentials, competency, and physical and emotional ability to perform the duties;

2. Assign duties of administration of patient medications to other licensed nurses only (either a RN or LPN), except as set out in Mississippi Board of Nursing Administrative Code, Part 2860."

The Board has made it clear they do not make exceptions to this for nurse practitioners who work with medical assistants. ***Therefore, a nurse practitioner should not request a medical assistant to administer a vaccine, injection, oral medication, or call in medications.***

Referring to Medical Assistants as Nurses

Medical assistants should never be referred to as nurses nor call themselves nurses. This action could be construed as the medical assistant impersonating a licensed nurse and is against the law which states, "It is unlawful for any person, including a corporation or association, to: (d) Use any title, designation or abbreviation by which a person presents to the public that he or she is a registered nurse, a licensed practical nurse or any other type of nurse, unless the person is duly licensed…"

Additional information regarding these topics can be found on the Board of Nursing's website at www.msbn.ms.gov.