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RESOURCES FOR STAFF/ PHYSICIAN EXPOSURE TO COVID-19

Also in this issue:

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Q3
Quarter 3, 2020

RESOURCES FOR STAFF/ PHYSICIAN EXPOSURE TO COVID-19

As the number of COVID-19 cases continues to rise and threatens to overwhelm Texas hospitals and emergency departments, physicians face another stark possibility . . . exposure to SARS-CoV-2 for themselves or their employees.

The TMLT Risk Management Department has been contacted by physicians seeking guidance for positive test results or exposure to SARS-CoV-2 for themselves or their staff members. If this occurs in your practice, please follow the recommendations of the Centers for Disease Control and Prevention (CDC) and your local public health authority.

The Texas Department of State Health Services (DSHS) provides a listing of public health authorities in Texas on its website: https://www.dshs.state.tx.us/regions/2019-nCoV-Local-Health-Entities/. This listing includes contact information and website links for each county. Visitors to this page can also download an Excel spreadsheet of this listing.

The CDC, American Medical Association (AMA), Texas Medical Association (TMA), and the Texas DSHS have also published guidance, found on the next page. These resources provide information about appropriate quarantine, infection control measures, and safe return-to-work protocols.

For example, the TMA offers a "COVID-19 Guide for When Someone Tests Positive" [1] that contains "basic steps that physicians can follow should a staff member or a patient test positive for COVID-19 in their outpatient clinic." A sample of details from these steps include:

- **Follow routine cleaning and disinfection procedures.** This step includes links to the CDC and recommendations for environmental infection control, cleaning of rooms, and personal protection equipment (PPE) to be worn by environmental services personnel.

- **Notify your staff of the potential exposure and implement appropriate work restrictions as necessary.** This step includes a link to the CDC's health care personnel assessment guide that details appropriate work restrictions based on the level of exposure and PPE being used at the time of potential exposure. For example, if 1.) a health care worker who had close contact (<6 feet) for >15 minutes with the person confirmed with COVID-19 or unprotected direct contact with infectious secretion or excretions of the infected person, and 2.) was not wearing a respirator or face mask or not wearing eye protection if the infected person was not wearing a mask, then this worker should be excluded from work for 14 days after last exposure, monitor themselves for symptoms of COVID-19, and immediately arrange for medical evaluation and testing if symptoms appear.

  This step also includes complying with confidentiality requirements for infected or exposed staff members.

- **Notify any patients who may have been exposed and recommend appropriate public health guidance.** For example, if a patient had close contact (<6 feet) for >15 minutes with an infected person, recommended precautions include:
  - "Stay home until 14 days after last exposure and maintain social distance (at least 6 feet) from others at all times.
  - Check temperature twice a day and watch for fever, cough, or shortness of breath, or other symptoms of COVID-19.
  - Instruct patients to seek appropriate diagnostic viral testing and follow CDC guidance if symptoms appear. If patients want a test but are asymptomatic, wait at least five to eight days post exposure to test to avoid false negatives (CDC, 06/25/20).
  - Avoid contact with people at higher risk for severe illness from COVID-19." This includes older adults or individuals with underlying medical conditions.[1]

  Again, with this step, be mindful of privacy laws and regulations.

The TMA's guide, listed fifth in the next column, includes other considerations and guidance, with links to related federal and state laws and regulations; contact tracing information; and guidance for staff exposures related to travel.

A listing of helpful resources and guidance is found here:

- The AMA's "A Physician's Guide to COVID-19." This webpage includes information curated from the CDC, World Health Organization and *Journal for the American Medical Association (JAMA)*, including how to protect yourself and your employees from the effects of COVID-19 and how to minimize exposure and implement standard and transmission-based precautions. This is found at https://www.ama-assn.org/delivering-care/public-health/physicians-guide-covid-19
- CDC: "Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19": https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
- CDC: "Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)": https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
- Texas DSHS: "Information for Hospitals & Healthcare Professionals" webpage: https://dshs.texas.gov/coronavirus/healthprof.aspx?terms=Healthcare%20Personnel%20Return%20to%20Work%20Strategies#prep
- TMA: "COVID-19 Guide for When Someone Tests Positive": https://www.texmed.org/uploadedFiles/Current/2016_Public_Health/Infectious_Diseases/309207%20when%20someone%20tests%20positive.pdf
- TMA: "COVID-19 Infection Prevention and Control for Outpatient Clinics: Frequently Asked Questions (FAQs)": https://www.texmed.org/uploadedFiles/Current/2016_Public_Health/Infectious_Diseases/308911%20COVID-19%20Whitepaper(1).pdf
- TMA: "COVID-19: Human Resource FAQs": https://www.texmed.org/uploadedFiles/Current/2016_Public_Health/Infectious_Diseases/308947%20Human%20Resources%20COVID-19.pdf

SOURCE

1. COVID-19 Guide for When Someone Tests Positive. TMA COVID-19 Task Force. July 7, 2020. Texas Medical Association. Available at https://www.texmed.org/uploadedFiles/Current/2016_Public_Health/Infectious_Diseases/309207%20when%20someone%20tests%20positive.pdf.
Accessed July 23, 2020.

CME - SEXUAL HARASSMENT AND MISCONDUCT IN HEALTH CARE: A PRACTICAL GUIDE FOR PHYSICIANS

by Karin Zaner, JD

OBJECTIVES

Upon conclusion of this course, the physician will be able to:

1. recognize how the conditions of a health care setting may create an environment conducive to sexual harassment;
2. discuss the AMA definitions and guidelines for dealing with workplace sexual harassment; and
3. describe how employers or supervisors can prevent and correct harassment in the workplace.

COURSE AUTHOR

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DISCLOSURE

Karin Zaner has no commercial affiliations/interests to disclose related to this activity. TMLT staff, planners, and reviewers have no commercial affiliations/interests to disclose related to this activity.

TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for medical liability.

CME CREDIT STATEMENT

The Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Texas Medical Liability Trust designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

PRICING

A fee of $75 will be charged when accessing this CME course online at http://lonestara.inreachce.com.

ETHICS CREDIT STATEMENT

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

TEST

To receive CME credit, physicians should complete the test questions that follow the activity. A passing score of 70% or better earns the physician 1 CME credit.

INSTRUCTIONS

the Reporter CME test and evaluation forms must be completed online. After reading the article, go to https://lonestara.inreachce.com. Follow the online instructions to complete the forms and download your certificate. Questions about the CME course? Please call TMLT Risk Management at 800-580-8658.

ESTIMATED TIME TO COMPLETE ACTIVITY

It should take approximately 1 hour to read this article and complete the questions and evaluation form.

RELEASE/REVIEW DATE

August 17, 2020 and will expire on August 17, 2023.

Please note that this CME activity does not meet LSA's discount criteria. Physicians completing this CME activity will not receive a premium discount.

INTRODUCTION

In the fall of 2018, the #MeToo movement took various industries — entertainment, politics, business, education — by storm, with unprecedented public disclosures; condemnations of improper sexual behavior; and several criminal convictions.

In under two years, a full-blown campaign of awareness and demand for culture change has matured and greatly affected societal norms. The health care industry is not immune and has experienced its own #MeToo movement, with considerations and ramifications unique to physicians.

This article discusses sexual assault and harassment in the health care setting on a general basis (prevalence, reasons, and legal accountability). It also explores the various physician relationships that may be affected if and when sexual harassment occurs, as a physician's duties differ depending on whether such allegations involve a patient, a colleague, hospital staff member, or employee. Relevant legal and ethical guidelines are discussed, and various perspectives of both the harassed and the harasser examined.

Finally, the article provides suggested best practices and policies for handling and avoiding these types of circumstances. Whether the physician is the harassed or the alleged harasser, the reporting duties and consequences can be uniquely damaging to a physician's record and reputation. Thus, it is vital for physicians to understand the dynamic and complicated issues that may arise in a #MeToo situation.

PREVALENCE OF SEXUAL ASSAULT AND HARASSMENT IN HEALTH CARE

Studies show that sexual assault and harassment are widespread throughout the United States. The National Sexual Violence Resource Center cites the following U.S. statistics.[1]

- One in three women and one in six men experienced some form of contact sexual violence in their lifetime, including rape.
- One in five women and one in 71 men will be raped at some point in their lives.
- 51.1 percent of female victims of rape reported being raped by an intimate partner and 40.8 percent by an acquaintance.
- 52.4 percent of male victims report being raped by an acquaintance and 15.1 percent by a stranger.
- 91 percent of victims of rape and sexual assault are female, and nine percent are male.
- In eight out of 10 cases of rape, the victim knew the perpetrator.
- Eight percent of rapes occur while the victim is at work.

Arguably, the health care environment is even more conducive to sexual assault or harassment than a typical work environment. For example, in contrast to a rigidly-scheduled, buttoned-up business office, law practice, or banking institution, the health care setting is made up of a range of physical work environments — hospitals, private practices, health care facilities, urgent care facilities, and emergency rooms—operating at all hours of the day and night, seven days a week. Physicians often work long hours or multiple shifts, where access to call rooms and other private quarters may exist. These conditions encourage a "blurring" of work life and personal life, and professional behavior can become relaxed.

Patient care often has a physical nature to it; treatment often involves human touch and deeply personal interactions. The health care environment may also raise intense emotions, especially those that surface when issues of physical pain, emotional distress, and sometimes life and death are at hand.

While noble intentions may initially drive health care providers to their profession, the reality of the day-to-day health care environment also sets the stage for perceived or real sexual harassment that may involve patients, colleagues, employees, or hospital staff members.

Since the #MeToo movement has swept the country, media articles have told of various ordeals by physicians, nurses, and other health care professionals subjected to sexual harassment, including the harmful effects on patients and health care outcomes as a result.[2]

LEGAL DEFINITIONS OF SEXUAL ASSAULT IN TEXAS AND BEYOND

Each state has specific legal definitions of sexual harassment that must be reviewed and taken into consideration. In Texas, for example, physical sexual assault is the most serious form of sexual harassment and is defined as a serious criminal violation that occurs when a defendant, intentionally and knowingly, commits any number of prohibited sexual activities without the victim's consent, such as rape, penetration, or other physical battery.[3, 4]

If physical violence was threatened or used in order to get the victim to submit or participate in these activities, the act is considered to have been nonconsensual or without the victim's consent. Also, if the victim is physically unable to resist or appreciate the nature of the act being performed, for any reason, there is a lack of consent.

Consent is further lacking in any situation where the defendant is in a place of power or charged with the care of the victim, which explicitly includes being a health care services provider (e.g., a physician).[5]

Other states may differ in specific definitions of, and defenses to, sexual assault charges. For physicians practicing outside of Texas, please consult with counsel licensed in your state for criminal and civil statutes as well as other legal guidance. Also consider consulting with your state medical board.

As with legal definitions of sexual assault, each state also has specific charges, fines, and jail sentence ranges for sexual assault. Again, for example, in Texas, sexual assault is a second-degree felony, which can result in a sentence of two to 20 years in prison and a fine of up to $10,000. Aggravated sexual assault is a first-degree felony in Texas which can result in a sentence of five to 99 years (or life in prison) and a fine of up to $10,000.

Even if the assault is not technically charged as sexual, it is still a misdemeanor criminal charge in Texas. Punishment depends on the severity of the incident. For example, making physical contact such as rubbing shoulders or touching buttocks with intent to offend can be charged as a Class C misdemeanor, resulting in a relatively small fine of $500 and no jail time. However, a more serious incident, such as causing pain or injury by actual physical touching, may be considered a Class A misdemeanor assault, which can be punished by up to one year in a Texas county jail and a fine of as much as $4,000.[6]

The civil tort of assault in Texas has the same elements as in the Texas criminal code and may allow for actual and punitive damages against the assailant.[7] Again, other states may vary, so please consult with legal counsel in your state. Generally, any common law liability for assault can

be preempted by Title VII of the Civil Rights Act of 1964 (a federal law) as well as any corresponding state law counterpart.[8]

When an assault is committed by an employee, a lawsuit may include accusations of vicarious liability against the employer. The plaintiff may accuse the employer of negligence, if the employer facilitated the assault due to negligent hiring, supervision, or training of an employee and the assault was foreseeable by the employer.[9]

ACCOUNTABILITY FOR SEXUAL HARASSMENT

Even when offensive behavior does not lead to an actual assault, criminal harassment charges may still generally be brought. Again, using Texas as an example, such charges may be brought against a person acting with the intent to "harass, annoy, alarm, abuse, torment, or embarrass" another person.[10] These actions may include various sexually harassing behaviors, such as persistent phone calls, text messages, or explicit sexual advances.

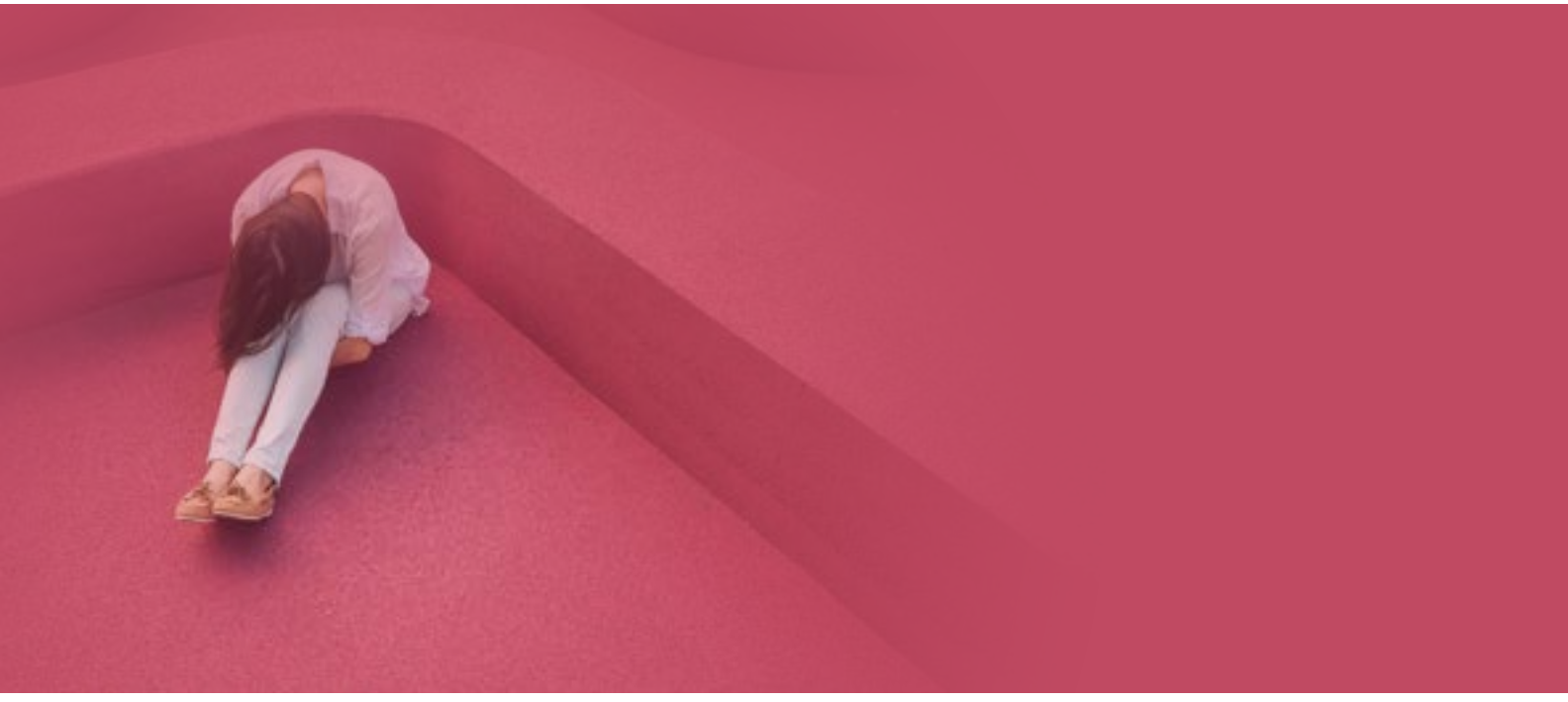
In Texas, this is a Class B misdemeanor that can be punished by a sentence of 6 months in jail and as much as a $2,000 fine.[10] As with the crime of sexual assault, criminal laws regarding sexual harassment may vary in other states. Again, if practicing outside of Texas, please consult with legal counsel in your state.

A more common remedy pursued by a victim of sexual harassment (especially in the employment context) is for violation of Title VII of the Civil Rights Act of 1964 as well as any state law counterpart. To prove sexual harassment under Title VII, a plaintiff must show that:

- he or she belongs to a protected group;
- he or she has been subjected to unwelcome sexual advances;
- the harassment was sufficiently severe or pervasive to alter the terms and conditions of employment and create a discriminatorily abusive working environment, and
- a basis for holding the employer accountable exists.[11, 12]

In this context, "protected group" refers to the seven categories protected against discrimination by the U.S. Equal Employment Opportunity Commission (EEOC): race, color, religion, national origin, age (40 or older), disability, genetic information (including family medical history), and sex (including pregnancy and sexual orientation).[13] The EEOC describes sexual harassment as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature."[14] Further definition includes:

- "Harassment does not have to be of a sexual nature, however, and can include offensive remarks about a person's sex. For example, it is illegal to harass a woman by making offensive comments about women in general.
- Both victim and the harasser can be either a woman or a man, and the victim and harasser can be the same sex.
- Although the law does not prohibit simple teasing, offhand comments, or isolated incidents that are not very serious, harassment is illegal when it is so frequent or severe that it creates a hostile or offensive work environment or when it results in an



adverse employment decision (such as the victim being fired or demoted).
- The harasser can be the victim's supervisor, a supervisor in another area, a co-worker, or someone who is not an employee of the employer, such as a client or customer." [14]

In 2015, these protections were extended by the EEOC to discrimination based on gender identity (including transgender status) and sexual orientation.[14]

Generally, sexual harassment is categorized by the EEOC as one of two categories.

- "Quid pro quo" harassment in which job benefits are made contingent upon provision of sexual favors or submission to unwanted sexual advances. Refusal to submit may result in a tangible employment action. This can occur between a manager and employee, or even between co-employees of equal professional footing.
- "Hostile work environment" harassment is created when an employee is subjected to conduct that interferes with work performance or creates an intimidating or offensive work environment that is sexual in nature or directed to the employee because of the employee's sex.[15]

In either category, an employer's liability may stem from whether he or she knew or should have known the harassment was happening but did not take remedial action.[16, 17]

THE EEOC COMPLAINT PROCESS

Each state has its own specific procedures for filing claims of employment discrimination that must be reviewed and strictly followed. Generally, before filing any lawsuit, any harassment claims must first be filed with the EEOC as well as the state workforce commission in the applicable state.

For example, in Texas, these claims are filed with the Texas Workforce Commission (TWC). The TWC's website provides a detailed explanation of the grounds and process for submitting a sexual harassment claim under both TWC and EEOC guidelines, which allow for such claims to be jointly processed after a review of all of the surrounding circumstances.[18]

In order for an employee to file a complaint of discrimination in Texas:
- the employee must have been physically working within the state when the alleged discrimination occurred;
- the company where it took place must have 15 or more employees;
- the date of discrimination must have occurred within the last 180 days from the complaint submission;
- discrimination due to sex must be alleged; and
- employment harm (such as demotion, denial of promotion, or termination) must be identified.[19]

Upon submission, the TWC will either dismiss the claim, which allows the employee to sue in a court of law, or file a "charge of discrimination," which allows for a mediation process followed by a formal TWC investigation to determine whether or not there is sufficient evidence of discrimination.[19]

Outside of Texas, please contact your state workforce commission for guidance on filing a discrimination complaint.

AMA'S CODE OF ETHICS POLICY ON SEXUAL HARASSMENT

The American Medical Association (AMA) Code of Ethics Opinion 9.1.3 defines sexual harassment as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature." The opinion plainly finds that "sexual harassment in the practice of medicine is unethical." [20]

The opinion emphasizes that "sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance, harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care." [20]

The opinion strongly encourages that physicians "promote and adhere to strict sexual harassment policies in medical workplaces." The opinion further recommends that physician participation in grievance committees "be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve." [20]

While these ethical principles are meant to help guide physicians regarding appropriate behavior, the practical realities in the day-to-day practice of medicine make defining sexual harassment much more complicated. As with any industry or social setting, determining what behavior needs to be reported or confronted will pose a challenge.

When does a line get crossed from improper behavior of a sexual nature to sexual assault or threat? When does a line get crossed from poor judgment (such as a tasteless joke of a sexual nature, or comments that are too personal

or familiar) to a hostile work environment? Are there generational, religious, or cultural differences that should be considered?

For example, members of various generations, religions, and/or cultures may have different and stricter standards of modesty than others. Do "normal" (i.e., less formal) interactions among younger generations somehow offend older ones? Or will comments that may have been acceptable in previous generations, such as "honey," "little lady," or "darling," be taken with offense when made today? Aside from disparities in generations, religions, or cultures, will differences in personalities make the actor more likely to make misjudgments, or the recipient more sensitive to certain types of comments?

Eventually, these inquiries lead to the bottom-line question, what is the physician's responsibility? Should the behavior be called out to the attention of the actor? Should the behavior be reported to an outside party? Does the physician immediately decide to confront the actor at the time of the event or raise the issue later? Confront the first time it happens or wait until the second, third, or fourth time?

Obviously, these specific judgments will depend on a myriad of facts, such as how serious the events were and the context in which the behavior occurred. Such as, did the event involve patients, physician colleagues, hospital staff, or a physician's own employees?

PATIENT-PHYSICIAN RELATIONSHIP

A standard in medicine is that a physician places patient welfare above his or her own self-interest. To that end, a physician who has sexual or intimate relations with a patient currently under the medical care of that physician could be considered in breach of that standard. Accusations may arise about whether the physician is exploiting the trust, knowledge, emotions, or influence derived from the patient-physician relationship.

AMA Ethics Opinion 8.14 (Sexual Misconduct in the Practice of Medicine)[21] states that "sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct." This opinion also states that such conduct may obscure a physician's objective judgment concerning the patient's health care and therefore be potentially detrimental to the patient's well-being. This would materially detract from the goals of the patient-physician relationship.

Even if a sexual relationship is not present, a physician should avoid any patient relationship of a personally intimate nature. Guidelines suggest that under specific circumstances a physician may terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.[22] However, it is not recommended to enter into such a relationship, as the former clinical relationship could factor into any future allegations of sexual misconduct.

Former patients "may be unduly influenced by the previous patient-physician relationship,"[21] and the physician may become vulnerable to accusations of exploitation years after terminating the professional relationship. While some sources may allow a physician a "cooling off period" of one-to-two years before starting a personal relationship with a former (relationship-terminated) patient, other sources encourage a "no tolerance" policy given the difficulty in judging the impact of the previous professional relationship on the patient's ability to freely consent to a sexual relationship.

This same standard should also be applied to a patient's family members, including spouse, child, or parent, especially if the family member has decision-making authority for the patient. AMA Ethics Opinion 8.145 — Sexual or Romantic Relations between Physicians and Key Third Parties indicates that key third parties "include, but are not limited to, spouses or partners, parents, guardians, and proxies."[21]

This opinion indicates that a physician in this context should consider certain factors, including "the nature of patient's medical problem, the length of the professional relationship, the degree of the third party's emotional dependence on the physician, and the importance of the clinical encounter to the third party and the patient."[21]

While the AMA Ethics Opinions ideally guide physicians in making prudent decisions going forward, state medical board rules typically govern the minimum standard that must be followed. For example, the Texas Medical Board (TMB) rules set forth what effects such improper sexual behavior can have on a physician licensed in Texas and his or her practice—and they are severe.

TMB Rule 190.8(2) (E) defines "Unprofessional and Dishonorable Conduct" as "engaging in sexual contact with a patient."[23] The Texas Disciplinary Guidelines, set forth in the TMB Rules, consider sexual contact with a patient to be unprofessional conduct likely to "injure the public," and categorized as a boundary violation under Texas Occ. Code §164.052(a)(5).[24]

A boundary violation such as this deprives a physician from being able to receive a non-disciplinary remedial plan in a licensing investigation. Instead, only an Agreed Order would be available to the physician. An Agreed Order is disciplinary and has harsher reporting effects. In addition, such a boundary violation statutorily disqualifies the physician from participating in the Texas Physician's Health Program (Texas PHP), an organization allied to the TMB for impairment issues.

Even if the improper behavior does not include sexual contact with the patient, the TMB can still impose sanctions against a physician's license. TMB Rule 190.8(2)(F) defines "Unprofessional and Dishonorable Conduct" as "engaging in sexually inappropriate behavior or comments directed toward a patient." In determining any such sanctions, the TMB will consider whether the behavior was a single isolated event or multiple events that form a pattern.[25]

Verbal remarks and/or inappropriate behavior without physical contact might cause the TMB to order the physician to take:

- the jurisprudence exam (JP Exam);
- certain CME courses of an appropriate topic, or
- a more in-depth physician evaluation/assessment course.

The TMB may even impose a chaperone requirement.[26]

A physician who is found to have engaged in physical contact will likely receive more serious sanctions, such as a prohibition against seeing the affected gender as patients, or even possible suspension or revocation of his or her license.

Even minor infringements may cause concern, especially if they have no diagnostic or therapeutic purpose.

TMB Rule 190.8(2)(K) prohibits "behaving in an abusive or assaultive manner towards a patient or the patient's family or representatives that interferes with patient care or could be reasonably expected to adversely impact the quality of care rendered to a patient." [27]

Given the breadth of this prohibition (for example, how is "abusive" defined, and to what extent must that "interfere" with patient care?), a physician should use good judgment at all times, and always refrain from inappropriate comments such as adult humor or jokes, flirtatious banter, and texting while using a personal or "familiar" tone. Even when a physician does not initiate these types of actions or statements, his or her response to an improper comment could still create an issue.

In most circumstances, a TMB complaint made by a patient, former patient, or a patient's key decision maker or family member can be easily submitted without consequence and will remain anonymous. Patient feedback and/or complaints at hospitals and health care entities are encouraged and typically remain anonymous as well.

But the TMB's mission is to protect patients in the State of Texas and, once a physician is on the radar of the TMB, the consequences can be very serious. This is also true for a physician accused of improper conduct by a hospital or health care entity in the peer review process.

Outside of Texas, appropriate legal counsel should be consulted to determine applicable state law and medical board rules.

PATIENT AS HARASSER

What if the patient is the one who is sexually harassing the physician? Or acting improperly in a manner that cannot be ignored? The physician should reasonably and carefully analyze the patient's behavior to determine whether the patient-physician relationship can be salvaged.

The physician may first attempt to counsel the patient to change his or her behavior, or even warn the patient that if the behavior continues, the relationship may be terminated. Document any incidents of harassment, improper behavior, and counseling of the patient in the patient's record.

A physician may also try having a chaperone present during encounters with the patient to minimize the risk of alleged inappropriate behavior.[26] If the patient declines the presence of a chaperone, document this fact in the chart. If a physician remains uncomfortable, a decision to terminate the patient-physician relationship may be the reasonable choice.

In this event, a physician should proceed cautiously and use the correct protocols, as determined by your state medical board, to terminate the relationship. Otherwise, the physician may be held accountable for harm caused by the termination. This is especially true if the patient can prove that the physician unilaterally severed the relationship without reasonable notice or without providing alternative medical care when continued medical attention was necessary (i.e., patient abandonment).[28]

Therefore, when termination is required, the physician should send a formal dismissal letter to the patient. Before doing so, review state medical board guidelines to determine any state-specific requirements for the letter.

Generally, it is recommended that the letter be printed on office letterhead and sent by first-class mail and by certified mail with a return receipt requested. "The dismissal letter should include the following elements, along with any state-required language.[29]

- It should include a statement that the patient-physician relationship will terminate in a specified time period and a recommendation that the patient find another physician… The patient should be given a reasonable amount of time to find a new physician. In many states, 30 days is recommended. The current physician should remain available for care until the specified time period elapses.

- While the AMA suggests providing the patient with a brief explanation for terminating the relationship, physicians may wish to consider whether they would be comfortable with the wording of the termination letter if it were later reviewed by a state board, an attorney, or a jury. Potentially inflammatory remarks should be left out of termination letters.

- Describe in general terms how the patient can locate a new physician. It is not advisable to name a specific physician, clinic, or group. Refer the patient to their insurance company's list of providers, county medical society, or a physician-referral service.

- Include an authorization for the release of the medical record and advise the patient to designate the new physician as soon as determined, sign the form, and send it to your office promptly. Indicate in the letter that the record will be copied and forwarded to the physician as soon as possible. Since you are ending the relationship with the patient, you may choose to forego copying charges for the medical record to avoid engendering additional bad feelings.

- Additionally, physicians may not withhold a copy of the patient's medical record because of an outstanding account balance.

Keep a copy of the dismissal letter and the return receipt in the patient's medical record." [29]

PHYSICIAN/COLLEAGUE RELATIONSHIP

There may be other incidents when a physician witnesses a colleague exhibiting inappropriate behavior or sexual harassment. AMA Ethics Opinion 9.031 (Reporting Impaired, Incompetent, or Unethical Colleagues) provides: "[u]nethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service. Unethical conduct that violates state licensing provisions should be reported to the state licensing board. It is appropriate to report unethical conduct that potentially violates criminal statutes to law enforcement authorities. All other unethical conduct should be reported to the local or state professional medical organization." [30]

The ethics opinion also indicates that a physician should report to a "higher authority" if the conduct continues unchanged despite initial reporting. When reporting the suspected violation to appropriate authorities, the physician should protect the privacy of any patients to the greatest extent possible.[30]

As for the physician who receives reports, such as a colleague, medical director, department chair, or peer review committee member, the opinion states that these physicians "should notify the reporting physician when appropriate action has been taken" and "have an ethical duty to critically, objectively, and confidentially evaluate the reported information and assure that identified deficiencies are either remedied or further reported to

a higher or additional authority." The opinion also states that "Information regarding reports or investigations of impairment, or of incompetent or unethical behavior should be held in confidence until the matter is resolved." [30]

In addition, AMA Ethics Opinion 9.4.2 (Reporting Incompetent or Unethical Behaviors by Colleagues) [31] indicates that a physician should report to a higher authority if the conduct continues unchanged despite initial reporting. Examples of appropriate clinical authorities include either the hospital peer review committee where the physician has privileges, or the local or state medical society when no privileges exist.

This opinion reminds physicians that reporting is intended to protect patients and ensure that physician colleagues receive appropriate assistance. The opinion clearly states that physicians must report directly to the state licensing board when the conduct poses an immediate threat to the health and safety of patients or violates state licensing provisions.[31]

In Texas, a physician who is the subject of or has witnessed a physician colleague commit sexual harassment may report such behavior to the TMB, the Texas Physician Health Program, the Texas Medical Association, or to a hospital ethics or peer review committee.

Texas statutory law provides immunity to a physician for such good faith, truthful, and non-malicious reporting.[32] If the behavior is offensive enough, a physician may actually have a duty to report the offending physician to the TMB under another Texas statutory provision which provides that a physician "shall report relevant information to the [TMB] relating to the acts of a physician in this state if, in the opinion of the person or committee, that physician poses a continuing threat to the public welfare through the practice of medicine." [33]

Importantly for the reporting physician, there is civil immunity for failure to report unless the failure was "knowingly and willfully" committed.[34] However, the TMB may take disciplinary action against a physician who fails to report, given that failure to report dangerous behavior to a governmental body is considered to be "unprofessional and dishonorable conduct" that would require disciplinary action.[35]

The reporting physician must keep in mind that serious consequences may result from a formal report against a colleague physician. AMA Ethics Opinion 9.4.2. stresses that physicians must not submit false or malicious reports.[31] This is especially important given the negative ramifications a formal report will likely have on the colleague physician's record in such areas as credentialing, peer review, National Practitioner Data Bank and TMB reporting, self-reporting, and possible contractual difficulties.

For example, peer review investigations must be reported in initial and re-credentialing applications such as the Texas Standardized Credentialing Application. Also, the medical staff bylaws from other facilities may require disclosure of a peer review event or investigation, with immediate or quick deadlines. The health care entity receiving the disclosure may open its own investigation and take independent action against the physician.

A physician's failure to disclose in an application or to another facility may trigger another adverse action, this time for possible dishonesty. Re-licensure, provider status, contracts, and other relationships may also have disclosure duties and serious consequences for any failures.

PHYSICIAN/STAFF RELATIONSHIPS

As with patients, there exists an imbalance of power between physicians and hospital staff members. A TMB Rule also exists for hospital staff similar to the one mentioned for patients.

TMB Rule 190.8(2)(P) prohibits physicians from "behaving in a disruptive manner towards licensees, hospital personnel, other medical personnel, patients, family members or others that interferes with patient care or could be reasonably expected to adversely impact the quality of care rendered to a patient." [36]

The same direction given to physicians when dealing with patients should also be followed when interacting with hospital staff members. For example, a physician should use good judgment at all times and always refrain from inappropriate comments or jokes, flirtatious banter, and email or text messaging that is too personal or "familiar" in tone.

The Joint Commission requires all hospitals and health care organizations to have sexual harassment policies in place to maintain accreditation. Depending on the policy, the complaint process may shield the identity of the accuser (such as an anonymous hotline) to minimize the potential of retribution.

It is recommended that physicians understand the sexual harassment policies of the hospital, practice, or organization where they work, whether or not formal sexual harassment training is conducted or required by the administration.

SUPERVISING PHYSICIAN RESPONSIBILITIES TO PREVENT AND CORRECT HARASSMENT

A physician may also be an employer or supervisor of staff at a for-profit or non-profit hospital, in an academic setting, or in private practice. On its website, the EEOC provides strong, practical guidance regarding the duty of physicians as employers or supervisors to prevent and correct harassment. The website also offers guidance for

employees on how to avoid harassment by using their employers' complaint procedures.[37]

Practical tips for employers from the EEOC's website include the following.

- An employer should "establish, distribute to all employees, and enforce a policy prohibiting harassment and setting out a procedure for making complaints."
- The policy and procedure should be in writing.
- An employer should conduct a prompt, thorough, and impartial investigation of any complaint that arises and undertake swift and appropriate corrective action.
- An employer's anti-harassment policy should make clear that "the employer will not tolerate harassment based on race, sex, religion, national origin, age, disability, or genetic information, or harassment based on opposition to discrimination or participation in complaint proceedings."
- "The policy should also state that the employer will not tolerate retaliation against anyone who complains of harassment or who participates in an investigation."
- "The employer should encourage employees to report harassment to management before it becomes severe or pervasive."
- "The employer should designate more than one individual to take complaints, and should ensure that these individuals are in accessible locations."
- "The employer also should instruct all of its supervisors to report complaints of harassment to appropriate officials."
- "The employer should assure employees that it will protect the confidentiality of harassment complaints to the extent possible."
- "The alleged harasser should not have any direct or indirect control over the investigation."
- "The investigator should interview the employee who complained of harassment, the alleged harasser, and others who could reasonably be expected to have relevant information." [37]

If an employer determines that harassment occurred, immediate measures should be taken to stop the harassment and ensure that it does not recur. Any disciplinary measures should be proportionate to the seriousness of the offense.[37]

The employer also should correct the effects of the harassment where possible. For example, the employer could restore leave taken by the employee because of harassment and expunge negative evaluations in the employee's personnel file that arose from the harassment.[37]

As for the harassed employee's responsibilities, the EEOC's website indicates the following.

- He or she must take reasonable steps to avoid harm from the harassment. "Usually, the employee will exercise this responsibility by using the employer's complaint procedure." [37]
- If a harassed employee fails to use the employer's complaint procedure, an employer is not legally responsible for the behaviors of its managers or employees "unless the harassment resulted in a tangible employment action or unless it was reasonable for the employee not to complain to management. An employee's failure to complain would be reasonable, for example, if he or she had a legitimate fear of retaliation. The employer must prove that the employee acted unreasonably." [37]

CONCLUSION

As in all industries and areas of society, sexual harassment and sexual assault also happen within the health care setting. A physician may decide to tell his or her individual story of sexual harassment, for his or her own personal sake, for the sake of the profession, or for the sake of society in general.

Just like those who have mobilized the #MeToo movement in other industries, a physician who directly experiences or is witness to harassment must determine the professional responsibilities he or she holds to report it. Otherwise, how is he or she ever going to expect accountability or help generate tangible and sustained change for the better?

But in a health care setting, a physician must have a specific and realistic understanding of the context in which the improper behavior occurs (depending on whether it is with patients, physician colleagues, hospital staff members, or employees) and the duties that may arise in each context. The physician must also have self-protection strategies in place, given that his or her professional record may also come into play.

When allegations rise to a serious level, especially where there is concern that the alleged behavior may re-occur and/or compromise the quality of patient care, a physician may have no other choice but to report it. However, in situations that are less severe (improper behavior that does not rise to the level of a sexual assault or threat or hostile environment; poor judgment in making tasteless jokes or comments), a physician must consider that the possible ramifications on the accused physician may be direct and long-reaching.

Indeed, the #MeToo movement has greatly impacted society and heightened awareness about the seriousness of sexual harassment. Physicians who confront these types of situations must be well-informed, thoughtful, and strategic

as they determine how best to achieve the necessary and meaningful reduction of sexual harassment in the health care setting.

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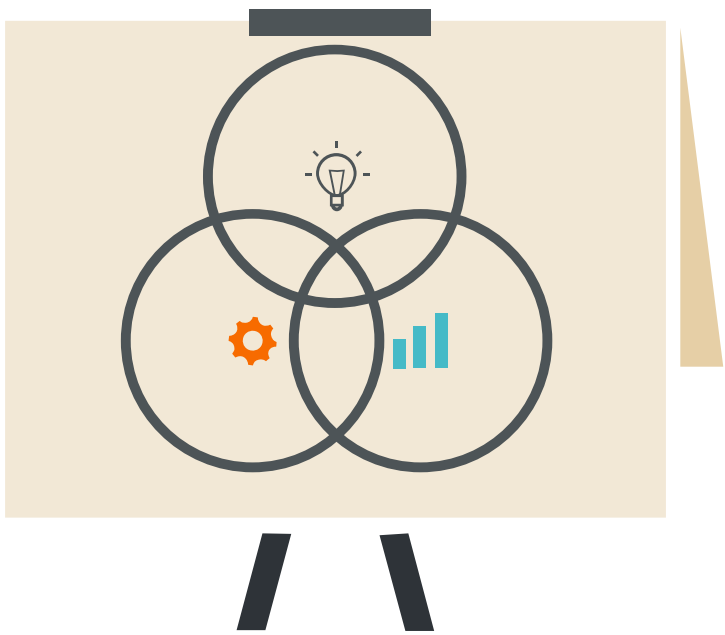
2019 RISK MANAGEMENT TRENDS ANALYSIS

by Lesley Viner, MS, Assistant Vice President, Risk Management Department



To improve services and better understand policyholders' needs and concerns, TMLT's Risk Management Department analyzes trends on an annual basis. Information is collected and examined in the following areas:

1. the most common risk management recommendations made after practice reviews;
2. the most requested seminar topics by physician groups; and
3. the most common phone and e-mail inquiries received from physicians and their staff members throughout the year.

The following is a summary of 2019 results.

PRACTICE REVIEW RECOMMENDATIONS

The 10 most frequent recommendations made by TMLT risk managers after evaluating physician practices include:

1. **Electronic Health Record (EHR) default to normal or negative**
   Update the medical record to reflect the patient's current complaints and check for unintended system defaults to normal or negative. The review of systems or exam should not conflict with the history of present illness (HPI) or chief complaint. Contradictory information in the record can be a challenge in the defense of a claim or medical board complaint.

2. **Practice policies and procedures**
   The practice should have current policies and procedures in place for patient care. Policies and procedures to direct staff should be in place, such as communications with patients, medication refills, order tracking systems, missed appointments, and emergency plans. Policies and procedures should be signed by physicians and staff members and include implementation and revision dates.

3. **EHR policies and procedures**
   The practice should have written policies for EHR security and processes, and policies should be kept current. Federal privacy and security rules require that practices develop protocols to protect the integrity and security of electronic protected health information (PHI). EHR policies may include topics such as documentation of a privacy and security risk analysis; privacy and security training for staff; and other protocols to safeguard PHI. Policies should be signed by the physician(s) and include implementation and revision dates. Staff members should sign and date their acknowledgement of policy review and understanding.

4. **Patient return visit**
   Medical records should include the patient's recommended return visit. For the continuity of patient care, it is important to document when the patient should return for a follow-up visit. This enables office staff to schedule the visit, preventing possible allegations of failure to diagnose or treat.

5. **Documentation of physician review**
   Incoming consultant reports, diagnostic results, or outside tests should include documentation of physician or provider review. Timely review, whether in electronic or paper format, should be documented in the patient's record prior to scanning, filing, or importing. Documentation of the physician's review demonstrates that results were seen promptly. When appropriate, documentation regarding actions or inactions on specific results and decision rationale should be noted in the record.

6. **Timely completion of electronic notes**
   Progress notes in the EHR should be completed in a timely manner. Current and complete medical records are essential to diagnosis and treatment and can assist in the defense of a medical liability claim. Prompt completion of notes promotes accuracy and ensures that patient information is readily available to all members of the health care team.

7. **After-hours calls**
   Documentation of after-hours patient calls should be evident in the medical record. Documenting after-hours calls and any instructions given to patients in their medical records is important. This information can serve the physician and subsequent caregivers in providing patient care and is also evidence of instructions given to the patient in response to specific medical complaints.

8. **Tracking and follow-up**
   The practice should have a consistent process in place to track consultant referrals and lab or diagnostic tests. When patients are referred to consultants or to an outside source for lab or diagnostic tests, a tracking system is recommended to ensure the patient is seen and results are received in a timely manner.

9. **Injections**
   Information regarding injections administered in the office should be documented in the medical record. Include dosage, lot number, expiration date, route and location of injection, and the patient's condition post-injection. Following an injection, patients should be observed for a minimum of 20 to 30 minutes, depending on the type of injection, for any reaction. Documentation of the patient's physical status should

be recorded at the time of discharge, such as "patient alert" or "no respiratory distress noted."

10. Cloned or copied records
Ensure that patient history and other elements of the medical record are appropriately updated at each patient visit. Records which reflect incorrect history; problems that a patient no longer is experiencing; or outdated exam information can compromise the defense of a medical liability claim.

Standard 10 of the Texas Medical Board Rule 165.1 states that "all non-biographical populated fields, contained in a patient's electronic medical record, must contain accurate data and information pertaining to the patient based on actual findings, assessments, evaluations, diagnostics, or assessments, as documented by the physician."[1] While copying text from one visit to the next may save time, caution must be used to ensure that record entries are accurate.

CONTINUING MEDICAL EDUCATION (CME) PROGRAMS

The most requested CME seminar topics by physician groups in 2019 included:

- effective communication;
- medical board rules and complaints;
- termination of the physician-patient relationship;
- the opioid crisis;
- employment practices;
- a review of closed claims;
- anesthesia risk management;
- HIPAA;
- health care reform and reimbursement; and
- telemedicine.

CONSULTATION CATEGORIES

The most common phone and e-mail inquiries received from policyholders involved the following issues:

- termination of the physician-patient relationship;
- general office inquiries (policies and procedures or call coverage);
- selling, closing, or leaving a practice;
- medical records;
- regulatory and medical board concerns;
- HIPAA;
- patient visits;
- prescription issues;
- care of minors; and
- other (cannabidiol (CBD), medical scribes, advance directives).

TMLT urges policyholders to engage in risk management activities including practice reviews, CME programs, phone or e-mail consultations, and the use of sample forms, tools, and resources. The Risk Management team is committed to providing customized, high quality services for physicians.

Contact the Risk Management Department at 800-580-8658 for more information regarding services and scheduling.

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FAILURE TO COMMUNICATE TEST RESULTS

by Laura Hale Brockway, ELS, Assistant Vice President, Marketing

PRESENTATION

A 42-year-old man came to an urgent care clinic for an injury he sustained while playing basketball. He reported pain in his right calf.

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PHYSICIAN ACTION

The urgent care physician documented swelling and a 2+ palpable dorsalis pedis pulse. She diagnosed a muscle tear and possible deep vein thrombosis (DVT). The patient was sent for a venous duplex ultrasound, which was read as showing a right peroneal vein DVT. The patient was directed to a hospital emergency department (ED).

At the ED, the patient was examined and found to have tenderness with passive range of motion and swelling. His right calf circumference was measured at 49 cm and his left calf was measured at 44 cm. The patient was admitted by Hospitalist A, who ordered enoxaparin and requested a consult with an orthopedic surgeon.

Orthopedic Surgeon A saw the patient that day and noted the patient had pain, palpable dorsalis pedis pulse, and intact sensation. He documented that the patient had a muscle tear and no compartment syndrome.

The next day, Orthopedic Surgeon A examined the patient again. He documented pain, swelling, and no compartment syndrome. He ordered an MRI. Later that morning, a physical therapist documented that the patient had decreased sensation with numbness, swelling, and tingling in his right calf.

At noon, a nurse documented that the patient had diminishing posterior tibial signal and had difficulty moving his toes. The patient was unable to feel when his toes were touched, though a palpable pedis pulse was noted. The nurse also noted the patient's need for an increasing amount of pain medication.

Hospitalist A was notified, and she ordered a STAT CT scan and a CT angiogram of the right leg at 6:18 p.m. For an unexplained reason, the STAT order was changed to "Routine."

Radiologist A reviewed the CT images at 10 p.m. He reported the patient had no flow in the right popliteal artery and no flow more distal in the anterior tibial artery. These results were not reported to Hospitalist A or the nursing staff.

The next morning, Hospitalist A saw the patient and documented that he could no longer move his right toes. After reviewing the CT report, Hospitalist A contacted Vascular Surgeon A for a consult. Vascular Surgeon A gave a phone order to hold the patient's enoxaparin. He then performed a fasciotomy due to a presumptive diagnosis of compartment syndrome.

The next day, the patient reported numbness and an inability to move his right leg. Vascular Surgeon A took the patient back to surgery and repaired a bleeding vessel in the right calf. Over the next several days, the patient underwent several procedures due to continued numbness and inability to move his leg.

The patient's condition worsened. Two weeks later, he had a right above-the-knee amputation due to necrosis of the right calf and foot.

ALLEGATIONS

A lawsuit was filed against Radiologist A, alleging failure to timely notify the ordering physician about the critical and urgent results of the CT. Lawsuits were also filed against Hospitalist A, Orthopedic Surgeon A, Vascular Surgeon A, and the hospital.

LEGAL IMPLICATIONS

During the review of this case, there was much discussion among the experts and treating physicians about Radiologist A's duty to directly communicate the results of the CT scan. According to the physicians who were following the patient, the CT results were a critical finding that should have been communicated promptly with a phone call instead of a routine report.

Hospitalist A stated it was her expectation that the CT results would be available within the hour. When her shift ended at 7 p.m., she "checked out the plan, including the pending stat CT, to her night coverage." When Hospitalist A arrived the next morning, she found the CT had been changed to routine and the results were never called in to the night coverage.

A radiologist who reviewed this case was supportive of Radiologist A's action. It was this radiologist's opinion that clinicians have a duty/responsibility to obtain the results of the tests they ordered. However, this viewpoint was seen as difficult to defend in light of the American College of Radiology's *Practice Parameter for Communication of Diagnostic Imaging Findings.* These guidelines state that findings that could lead to death or significant morbidity generally require direct, prompt verbal communication with the ordering clinician.

DISPOSITION

The case against Radiologist A was settled. The cases against Hospitalist A, Orthopedic Surgeon A, and the hospital were also settled. The outcome of the case against Vascular Surgeon A is unknown.

RISK MANAGEMENT CONSIDERATIONS

The American College of Radiology's *Practice Parameter for Communication of Diagnostic Imaging Findings* includes guidance — not rules or requirements — for nonroutine communication of diagnostic imaging findings.

"Routine reporting of imaging findings is communicated through the usual channels established by the hospital or diagnostic imaging facility. However, in emergent or other

nonroutine clinical situations, the interpreting physician should expedite the delivery of a diagnostic imaging report (preliminary or final) in a manner that reasonably ensures timely receipt of the findings. This communication will usually be to the ordering physician/healthcare provider or his/her designee. When the ordering physician/healthcare provider cannot be contacted expeditiously, it may be appropriate to convey results directly to the patient, depending upon the nature of the imaging findings.

a. Situations that may warrant nonroutine communication include the following:

   i. Findings that suggest a need for immediate or urgent intervention:

      Generally, these cases may occur in the emergency and surgical departments or critical care units and may include such findings of pneumothorax, pneumoperitoneum, or a significantly misplaced line or tube. Other urgent conditions typically included in 'critical values' categories in most health care institutions would also be included in this group.

   ii. Findings that are discrepant with a preceding interpretation of the same examination and where failure to act may adversely affect patient health:

      These cases may occur when the final interpretation is discrepant with a preliminary report or when significant discrepancies are encountered upon subsequent review of a study after a final report has been submitted.

   iii. Findings that the interpreting physician reasonably believes may be seriously adverse to the patient's health and may not require immediate attention but, if not acted on, may worsen over time and possibly result in an adverse patient outcome:

      For example, acute infectious processes, possible malignant lesions, or other unexpected findings that may impact patient care if not treated in a timely fashion would fall into this category. This may be particularly applicable when there is a potential break in the continuity of care (such as can occur in emergency department encounters or the outpatient setting) that is unexpected by the treating or referring physician." [1]

It is considered a best practice for interpreting physicians to document all nonroutine communications in the radiology report with the date, time, method of communication, and name of the person receiving the report.[1]

Unfortunately, when a case involves several physicians, poor communication can be an issue. There are several ways to communicate in today's electronic age, but having a conversation with the patient's health care provider and following up by documenting the conversation may provide the radiologist with context for future studies.

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FAILURE TO SUPERVISE ADVANCED PRACTICE PROVIDER AND MODIFY ORDERED MEDICATION

by Wayne Wenske, Senior Marketing Coordinator

PRESENTATION

On October 27, a 40-year-old man with a history of migraine headaches and hypothyroidism for 18 years came to his family physician reporting severe migraine headache with moderate to severe pain and throbbing, nausea, sensitivity to light and noise, sleep disturbances, visual disturbances, and vomiting.

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PHYSICIAN ACTION

The family physician treated him with meperidine 75 mg and promethazine 35 mg.

Two days later, on October 29, the patient returned and reported migraine headaches with increasing pattern for one day, with moderate to severe throbbing, nausea, and sensitivity to light. He was seen by a physician assistant (PA), who again treated the patient with meperidine and promethazine. The PA gave the patient a prescription for prochlorperazine 10 mg (one tablet, four times daily) as needed for nausea.

On October 31, the patient returned and was seen by the PA. The patient again reported migraine headache, nausea, and vomiting with a pain level of 10 out of 10. The PA treated the patient with nalbuphine and promethazine intramuscular injection (IM).

On November 3, at 12:30 p.m., the patient returned and was seen by the PA for an evaluation of migraine headaches. The patient reported continued throbbing headache, nausea, and photosensitivity. He also reported taking one prochlorperazine the night before with minimal relief. The PA ordered meperidine 75 mg (IV), promethazine 25 mg (IV), and a CT scan of the patient's head/brain without contrast.

The patient returned that day to the office at 4:12 p.m. with reports of intractable severe migraine headache. The patient was administered meperidine 75 mg and promethazine 25 mg (IV) and sent to a local hospital emergency department (ED) for admission.

The PA wrote admission orders for hydromorphone 4mg IV every four to six hours as needed; lorazepam 2mg IV on arrival; ondansetron 4 mg IV every eight hours when required (PRN) for nausea; and diphenhydramine 25 mg IV every four hours for nausea. A head CT scan was also ordered.

The family physician saw the patient on admission. His assessment was acute migraine cephalgia with nausea, vomiting, and dehydration with prolonged headache. His plan was to treat the patient with IV fluids and hydromorphone; treat the patient's nausea; and obtain a CT scan of the patient's head. The results of the CT scan were negative for acute intracranial process.

At 6:30 p.m., the patient was administered lorazepam 2 mg. At 6:33 p.m., the patient was administered ondansetron 4 mg. At 7:35 p.m., the patient was given hydromorphone 4 mg. At 10:25 p.m., he was given topiramate 100 mg, and at 11:30 p.m. he was administered hydromorphone 4 mg and promethazine 25 mg.

On November 4 at 2:50 a.m., the patient was awakened but was drowsy. He said he had a headache but fell back to sleep. He was noted as having shallow breathing.

At 5:40 a.m., an ED nurse found the patient unresponsive and lethargic, and his skin was pale and cool to touch. Cardiopulmonary resuscitation was started, but the nurse was unable to obtain a pulse, blood pressure, or respirations. The bottoms of the patient's feet were noted as mottled and blueish.

An ED physician arrived and found the nurse administering CPR. The patient was connected to a defibrillator, did not have a pulse, and was in asystole. The patient was declared dead at 5:55 a.m.

An autopsy revealed mixed drug toxicity and pulmonary congestion and edema. The medical examiner concluded that the patient died as a result of mixed drug toxicity. The toxicology report revealed elevated levels of hydroxyzine, meperidine, normeperidine (a metabolic by-product of meperidine), and prochlorperazine.

ALLEGATIONS

A lawsuit was filed against the family physician. The allegations included:

- failure to recognize excessive dosing of hydromorphone in an opiate naïve patient;
- failure to properly supervise the PA and modify the PA's medication orders in terms of dosage and monitoring of the patient; and
- failure to recognize lethal effects of concurrent administration of lorazepam, promethazine, and topiramate with hydromorphone.

LEGAL IMPLICATIONS

Consultants who reviewed the case for TMLT were mixed in their assessment of the care provided to the patient. One consultant felt the drug dosages given to the patient were large, but within therapeutic levels and less than toxic or lethal levels. Two other consultants pointed out that the patient's autopsy showed levels of hydromorphone inconsistent with the amounts documented as being given to the patient (two 4 mg doses at 7:35 p.m. and again at 11:30 p.m.).

According to the autopsy report, the patient had 33 ng/mL of hydromorphone in his system. One of the consultants calculated that this level should have been 2.5 ng/mL at 5 a.m. The patient was at 12 times the level of the medication that he should have been, which caused the consultant to theorize that the patient may have been administered a third 4 mg IV dose shortly before his death at 5:55 a.m. If this dose was given, it was not documented in the patient's chart.

There was further conjecture that either the patient was given doses in the hospital that were not documented, or

he took prescription medication that he did not report to his providers. Based on pharmacy records, the patient was filling pain medication prescriptions (hydrocodone) from his dentist, a neurologist, and a surgeon.

Another consultant for TMLT was critical of the hydromorphone dosing. This consultant, an emergency medicine and medical toxicology physician, said he has never ordered such a high dose of the drug nor heard of such a high dose being ordered. He calculated that the patient received eight times the normal dose for this drug.

Consultants for the plaintiff offered further criticism of the family physician. These consultants alleged that the family physician failed to:

- recognize that hydromorphone 4 mg every four hours was excessive;
- modify the PA's order to administer the hydromorphone slowly over several minutes;
- order more frequent monitoring of the patient's vital signs;
- place the patient in a monitored unit;
- order pulse oximetry and cardiac telemetry;
- order that naloxone be administered if the patient developed respiratory or central nervous system depression (the patient was noted as having shallow breathing, approximately three hours before he died); and
- supervise the PA.

One of the plaintiff's consultants surmised that the administration of hydromorphone 8 mg (IV) within four hours (at 7:35 p.m. and 11:30 p.m.) was the proximate cause of death. He further stated that he believed the concurrent administration of lorazepam, promethazine, and topiramate with the hydromorphone accelerated the patient's respiratory depression and death.

DISPOSITION

This case was settled on behalf of the family physician.

RISK MANAGEMENT CONSIDERATIONS

A physician is vicariously liable for the actions of advanced practice providers under his or her supervision. Clear communication and clear documentation will help the physician meet this responsibility. Had the family physician been monitoring the PA's actions, he may have been able to address, modify, or provide reasoning in the patient's record for the administration of the opioids.

It was also questioned whether the patient was receiving prescriptions from other providers that were not being reconciled at appointments with the family physician or PA. It is important to reconcile medications at every patient encounter to avoid risk of over-prescribing and contraindication. Clear, comprehensive, and up-to-date documentation of patient interactions and medication reconciliation can be a critical help to a physician's defense in the event of a claim.

In 2016, the Centers for Disease Control and Prevention (CDC) introduced guidelines for prescribing opioids to chronic pain patients. These guidelines apply to physicians treating patients outside the context of cancer, palliative, and end-of-life care. These guidelines are found online at https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf.[1]

Among the 12 recommendations offered by the CDC for physicians to follow for improving the safety and effectiveness of pain treatment, the following guidelines may apply in this case.[2]

- **"Opioids are not first line therapy.** Nonpharmacologic and non-opioid pharmacologic therapy is preferable when treating chronic pain. Opioids should only be prescribed if the benefits outweigh the risks. If opioids are used, they should be used in conjunction with non-pharmacologic and non-opioid pharmacologic therapy. Other treatment options include nonsteroidal anti-inflammatory drugs (NSAIDs), physical therapy, cognitive behavioral therapy, and interventions."

- **"Establish goals for pain and function.** For patients who are prescribed opioids, realistic treatment goals should be established. Treatment should be discontinued if the risks ever outweigh the benefits."

- **"Consider prescribing the lowest effective dose.** When initiating an opioid prescription, the CDC recommends starting with the lowest effective dose. The CDC also recommends evaluating the risks and benefits if the dosage is greater than 50 MME/day (morphine milligram equivalents/day), and avoiding dosages greater than 90 MME/day without careful justification."

- **"Use strategies to mitigate risk.** Before starting an opioid prescription, evaluate the risks of opioid therapy for your patient. Opioid management should include mitigation of risks and offering naloxone when there is an increased risk of overdose, such as a patient history of overdose, a history of substance abuse, high opioid dosages over 50 MME/day, or concurrent benzodiazepine use. Continue to periodically evaluate your patient's risks going forward." In this case, the patient was prescribed concurrent benzodiazepine medication, but naloxone was not prescribed in the event the patient developed complications.

- **"Review prescription drug monitoring program (PDMP) data.** Physicians should review the patient's PDMP data to determine if he or she is receiving opioids from other health care professionals. The PDMP should be checked when starting opioids and at least every three months while still prescribing opioids to the patient."

- **"Avoid concurrent benzodiazepine use.** Avoid prescribing opioids with benzodiazepines whenever possible." [2]

SOURCES

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