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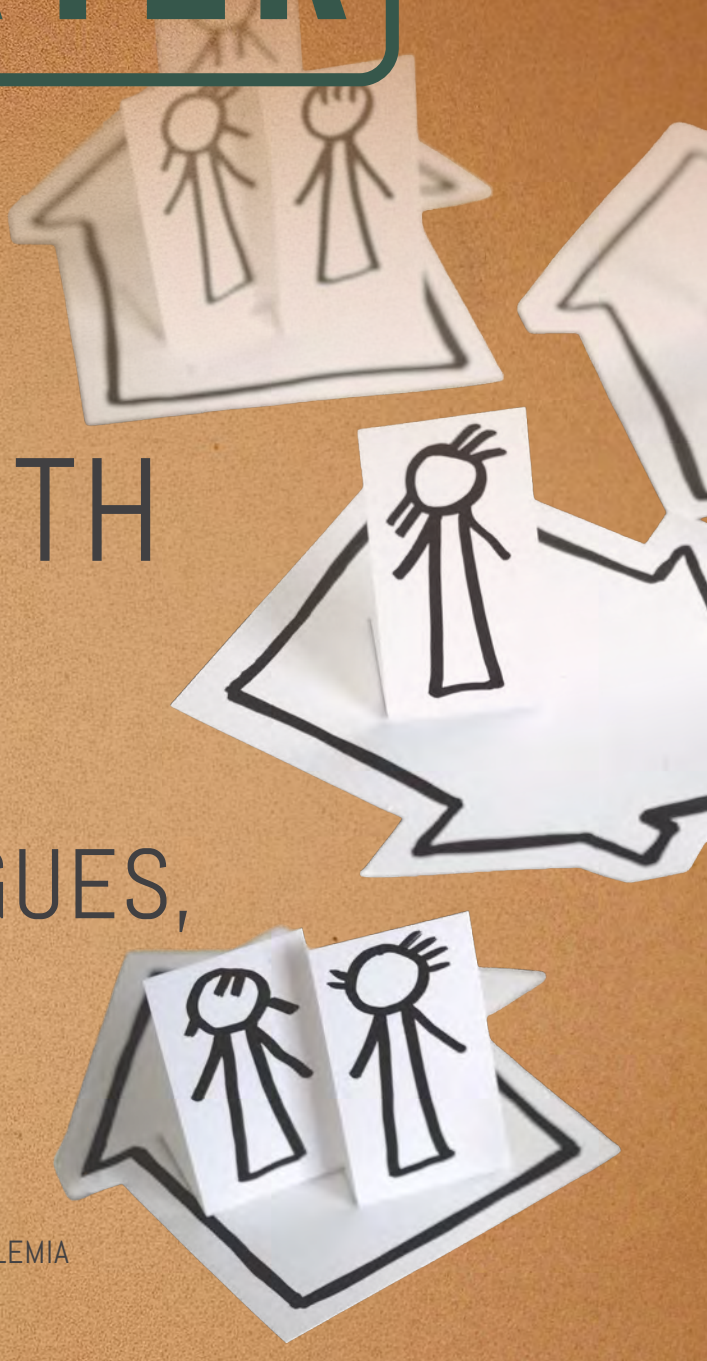

CME

PROCEED WITH CAUTION:

TREATING FAMILY, FRIENDS, COLLEAGUES, AND STAFF

HHS EXTENDS DEADLINE TO MAKE PATIENT-FACING TECHNOLOGY ADA COMPLIANT

CLOSED CLAIM STUDY: FAILURE TO RESPOND TO HYPOKALEMIA

CLOSED CLAIM STUDY: FAILURE TO HONOR A PATIENT'S REQUEST FOR A SPECIALIST CONSULT

LONE STAR ALLIANCE
A RISK RETENTION GROUP

Quarter 3, 2026

CME:
PROCEED WITH CAUTION:
TREATING FAMILY, FRIENDS, COLLEAGUES, AND STAFF

by Brian S. Sayers, MD
with additional material by Cathy Bryant, Manager, Cyber Consulting Services, TMLT

OBJECTIVES

Upon completion of this educational activity, the learner should be able to:

1. describe the rules and statutes related to treating or prescribing for family members or oneself;
2. list the risks that come with treating family members, friends, colleagues, or employees;
3. discuss the legal and ethical implications of providing care when there is an "immediate need"; and
4. examine the difficulties for physicians who act as a caregivers for family members or loved ones.

COURSE AUTHOR

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DISCLOSURE

Brian S. Sayers MD and Cathy Bryant have no relevant financial relationship(s) with ineligible companies to disclose. TMLT staff, planners, and reviewers have no relevant financial relationship(s) with ineligible companies to disclose.

TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in learning more about the rules and potential risks of treating patients with whom they have a special relationship, such as a family member, friend, colleague, or co-worker.

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CLOSED CLAIM

The closed claim study included in this article illustrates how action or inaction on the part of the physician during treatment of a family member led to allegations of professional liability. This study is based on an actual closed claim from TMLT and has been modified to protect the privacy of the physician and the patient.

RELEASE DATE

This activity is released on September 1, 2026, and will expire on September 1, 2029. 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

Physicians are drawn to medicine to help people, to relieve suffering, to care for those around us. As physicians, we are often asked to provide medical care for the people in our lives who are not our traditional patients — family, friends, neighbors, employees, colleagues, or even ourselves.

These requests often occur outside of settings where care is usually provided — in hospital corridors, our own front yards, at social events, or through phone calls or text messages.

These "informal" requests can sometimes be out of the scope of a physician's practice and involve people we care about. It can be difficult to maintain objectivity or be thorough when treating people from our personal lives. This can put everyone in jeopardy.

While we are all aware of the risks, heartfelt concern and a desire to help may draw a physician incrementally into a compromised physician-patient relationship that is not in anyone's best interest.

The scope of care rendered can range from answering a question about symptoms to providing comprehensive care for a serious condition. Each scenario is unique, but all share something in common: the people with whom we have a pre-existing personal or professional relationship are not ordinary patients.

CLOSED CLAIM STUDY: IMPROPER PERFORMANCE

The following closed claim illustrates how treating a staff member can lead to a medical malpractice lawsuit.

Presentation

An ob-gyn obtained additional training to perform gynecological cosmetic and reconstructive procedures, including breast augmentation. The physician's long-time employee — a 49-year-old woman — told the ob-gyn that she wanted to be his first breast augmentation patient. The ob-gyn examined her, took her breast measurements, and provided her with information about breast implants.

The ob-gyn and his family were close to the employee and her family before this incident. In addition to the employment relationship, the families socialized together.

Physician action

Nine days later, the ob-gyn examined the patient again and completed the informed consent discussion with her for bilateral breast implants to be performed by the infra-mammary approach. The ob-gyn obtained a history and physical, documenting that the patient was healthy, but had an eating disorder and a history of mood dysfunction. The patient requested "total secrecy" for the procedure from the other employees in the office.

The breast augmentation was completed, as requested, on a Sunday in the ob-gyn's office. Before the procedure the patient was given promethazine, clonidine, diazepam, and acetaminophen. Only the ob-gyn and nursing staff had knowledge of the procedure. The procedure went well, and the patient was sent home with her husband. She was prescribed diazepam to assist with postoperative discomfort.

Twenty-four hours after the surgery, the patient's husband called to report that his wife was experiencing shortness of breath. The ob-gyn sent his nurse to the patient's home to assess her. The patient reported chest wall pain and had minimal dyspnea. The nurse examined the incisions and helped the patient take a bath. There was no documentation of this home visit or of the nurse's assessment.

Over the next several days there were frequent phone calls between the patient and the ob-gyn's nurse. The patient's shortness of breath was attributed to "panic attacks" by the ob-gyn and the patient's family.

On the fifth postoperative day, the patient was seen by the ob-gyn in the office. She continued to report shortness of breath and coughing. Her 0_2 saturation was recorded as 98 percent. On the ninth postoperative day, the patient continued reporting shortness of breath. A chest X-ray revealed a small pleural effusion with no pneumothorax or other lung problem. The patient returned to work 17 days after the procedure.

One day after returning to work, the patient was seen by a plastic surgeon in a neighboring town. The patient was dissatisfied with the appearance of her breasts and reported dyspnea on exertion. The plastic surgeon examined the patient and found no evidence of wound problems or infection. He ordered a chest X-ray that showed a 10 percent pneumothorax and fluid at the base of her lung.

The patient was referred to a pulmonologist. His diagnosis was a hemopneumothorax or a resolving pneumothorax with pleural effusion associated with atelectasis. The pulmonologist placed the patient on amoxicillin clavulanate for one week. When the patient returned, a chest X-ray showed reinflation of the pneumothorax, resolution of the pleural effusion, and resolution of the infiltrate.

The patient returned to the plastic surgeon and stated that she was unhappy with the appearance of her right breast. She also reported pain in the inferior crease of the right breast. The plastic surgeon described the right implant as having “tethering of the pectoralis muscle with the superior pole of the implant appearing to be under the pectoral muscle and the inferior pole to be pinched within the pectoral muscle.”

He told the patient that the implant could stay or he could perform a revision of both implants to the pectoral plane. The patient elected to have the revision surgery. During the procedure, the plastic surgeon released muscle tissue attached to the capsule holding the implant of the right breast.

Allegations

A lawsuit was filed against the ob-gyn, alleging that he caused the patient's pneumothorax and failed to recognize, diagnose, and properly treat the pneumothorax. The patient also alleged that he improperly placed the right implant and that he did not possess adequate knowledge, skill, training, and experience to perform breast augmentations.

Legal implications

The plaintiff's plastic surgery expert was critical of the surgical and post-surgical care of the patient. He stated that the ob-gyn caused the pneumothorax during the procedure and failed to recognize it, which was below the standard of care. This expert was also critical of the ob-gyn's lack of training to perform breast augmentations.

The defense argued that a pneumothorax was a recognized complication that can and does occur without negligence. Shortness of breath is not an unusual symptom following breast augmentation surgery. When the patient's symptoms continued, the ob-gyn appropriately ordered a chest X-ray that did not identify a pneumothorax.

The defense expert — an ob-gyn who performs breast augmentation procedures in his office using the same anesthesia and procedures as the defendant — testified that the defendant was properly trained and qualified to perform breast augmentations. This was the ob-gyn's first breast augmentation procedure and it was performed on a Sunday in his office procedure room.

Disposition
This case was dismissed by the court before trial.

Risk management considerations
When initiating new procedures, those procedures should occur when and where adequate support is available even when attempting to honor a patient's request.

All patient-related contacts, including phone calls with patients or family members, home visits, and office visits should be documented in the medical record in a timely manner. Complete and accurate documentation ensures continuity of care, facilitates communication among the care team, and provides a record of clinical assessments.

Documentation and communication also creates opportunities to identify and address abnormal findings promptly. The results of the findings could then be used to determine next steps in the patient's care, such as a physician examination or referral for diagnostic testing as clinically indicated.

This case demonstrates that anyone — even long-time employees and friends — will seek legal counsel when they believe they have been injured during treatment or surgery. Though this employee was eager to have the procedure and was well informed when she consented, she was dissatisfied with the result and filed suit against the ob-gyn.

RULES, REGULATIONS, AND ETHICAL GUIDELINES
For physicians in Texas, **Texas Medical Board (TMB)** rules apply when providing medical care — including prescribing — for family, friends, employees, and colleagues.

Among the most commonly cited is Chapter 180, Subchapter A, Rule 180.1(L), Violation Guidelines:

> "Inappropriate prescription of dangerous drugs or controlled substances to oneself, family members, or others in which there is a close personal relationship that would include the following:
>
> 1. prescribing or administering dangerous drugs or controlled substances without taking an adequate history, performing a proper physical examination, and creating and maintaining adequate records; or
> 2. prescribing controlled substances in the absence of immediate need. "Immediate need" shall be considered no more than 72 hours." [1]

Of note, the TMB defines "dangerous drugs" throughout their rules as any drug requiring a prescription.

TMB rules describing violations of the Medical Practice Act also apply.

> "(A) failure to treat a patient according to the generally accepted standard of care;…
> (G) failure to disclose reasonably foreseeable side effects of a procedure or treatment;
> (H) failure to disclose reasonable alternative treatments to a proposed procedure or treatment;
> (I) failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, procedures…;
> (J) termination of patient care without providing reasonable notice to the patient." [2]

TMB rules remain the same for all patients — including your loved ones, employees, or yourself — with or without prescribing. The formal establishment of a physician-patient relationship — which includes obtaining a medical history and performing a physical exam — is part of the "generally accepted standard of care." Additionally, complete, contemporaneous documentation is expected with all patient encounters.

While these elements are no less important when treating family members, they may be deficient or even absent when treating loved ones or other "informal" patients.

Of special note, resident physicians — whether working under a Physician in Training permit or a TMB license — are specifically forbidden from writing prescriptions for themselves or family members.

TMB disciplinary actions for physicians who violate these rules may depend on the severity of the violation and whether the physician has been subject to previous board actions. (If you practice outside of Texas, please refer to your state medical board for more details and rules for practicing in your state.)

Rules from the **U.S. Drug Enforcement Administration (DEA)** state that, "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." [3]

The key clause in this general rule requires that the prescribing physician is "acting in the usual course of his professional practice." There are many implications within this phrase, but it indicates that a physician-patient relationship has been established including full documentation of an appropriate history and physical exam and working within the usual framework and scope of the physician's usual day-to-day practice. [3]

DEA actions against violators may be administrative, civil, or criminal depending on the nature and severity of the violation.

The American Medical Association (AMA) Code of Medical Ethics states that: "In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

a. In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.
b. For short-term, minor problems." [4]

This section of the AMA Code of Medical Ethics further states that physicians in this setting should properly document treatment, recognize the adverse effect that a professional relationship might have on a personal, family relationship, and avoid providing sensitive or intimate care (especially for minors who might be uncomfortable being treated by a family member). It further warns that family members may be reluctant to state their preference to be seen by another practitioner. [4]

Medicare rules (42 CFR § 411.12) prohibit payment for services usually covered under Medicare to physicians for services provided to immediate family or household members. [5]

Some professional and specialty organizations also offer guidance.

A **Texas Medical Association (TMA)** House of Delegates Resolution states:

> ". . . treatment of self and family members for minor medical problems, including prescriptions for medications is not, in the absence of substantive and specific evidence to the contrary, a de facto deviation from the standard of care expected of a physician licensed to practice in the State of Texas."[6]

Similarly, the *TMA Board of Counselors Current Opinion: Treatment of Family Members and Friends*, states:

> "One of the physician's primary duties is to alleviate suffering. Thus, it is ethical to treat family and friends in immediate need. In those circumstances medical records may not be relevant. The Board of Councilors cautions a physician treating his or her family or friends because of the potentially hazardous medical consequences. (Modified February 2007)."[6]

The **American College of Physicians** has also issued a position statement. In part, it states:

> "Physicians may want to provide care for themselves, or from time to time be asked to provide medical care to a family member or others with whom the physician has a close nonprofessional relationship or an employee or supervisor with whom there is a reporting relationship. Each of these situations raises clinical and professionalism concerns that should be considered.
>
> Except in emergent circumstances when no other option exists, physicians ought not care for themselves. A physician cannot adequately interview, examine, or counsel herself or himself, without which ordering diagnostic tests, medications, or other treatments is ill-advised.
>
> Regarding people with whom the physician has a significant preexisting, nonprofessional relationship, such as family members and close friends, and regarding employees or supervisors, the relationship necessarily adds another layer that may complicate what would become the professional patient–physician relationship."[7]

PROCEED WITH CAUTION

When individuals with whom you share special relationships are asking for care, carefully consider these consequences and potential hazards:

- loss of objectivity for both the physician and patient;
- absence of a comprehensive patient history and inability to perform an appropriate physical exam;
- inability to thoroughly document all aspects of care, as required;
- confidentiality issues;
- "patient" reluctance to fully disclose sensitive information or discomfort with intimate or sensitive physical exam;
- potentially compromising an important relationship;
- unintentionally creating an atmosphere that makes it difficult or awkward for the "patient" to change providers, get a second opinion, or advocate for themselves when they disagree with the diagnosis or treatment;
- potentially providing care that is beyond your scope of practice;
- the care may be unnecessary, potentially adding stress to an already strained professional and personal life;
- lack of or inability to follow-up;

- incomplete or absent patient education or informed consent;
- a tendency to over- or under- treat; and
- regulatory and medical liability issues.

Research indicates that treating and prescribing for self and others in a physician's personal life is a common occurrence.

- A survey conducted in Ireland of more than 4,000 physicians found that two-thirds had prescribed for themselves; more than 70 percent had prescribed for family members; and almost 60 percent had prescribed for friends or colleagues. [8]

- An analysis of 29 databases — including PubMed, PsychInfo, EBSCO, Medline, BioMed central and Science Direct — found 27 research studies had been conducted between 1990 and 2009 that demonstrated self-prescribing rates exceeded 50 percent in more than three quarters of the studies. [9]

"IMMEDIATE NEED"

Medical board rules and ethical guidelines permit providing care and prescribing for oneself or family members under the following specific circumstances:

- medical care is not otherwise easily accessible; and
- a delay in treatment may worsen the condition or cause avoidable harm or suffering.

This is commonly referred to as providing care under "immediate need."

As stated, the AMA Code of Medical Ethics notes that treatment of self or family members is acceptable "in emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available." [4]

TMB rules specifically restrict "prescribing controlled substances in the absence of immediate need. 'Immediate need' shall be considered no more than 72 hours." [10]

Regardless of the urgency of the circumstances, TMB rules apply regarding the establishment of a physician-patient relationship and documentation of care.

TREATING "MINOR" AILMENTS

Most ethical guidelines include an exception for treating a "minor" symptom or problem. Yet, the definition of that word deserves scrutiny. Applying an over-the-counter antimicrobial ointment to a child's skinned knee, prescribing mupirocin for a friend's superficially infected mosquito bite, or recommending acetaminophen, rest, and fluids for a common cold may reasonably fall within this category.

What may not fall within this category — recommending an acid blocker for an in-law with atypical chest pain or suggesting a nutritional supplement for a neighbor with unexplained weight loss (particularly without ensuring they follow up with a specialist). These symptoms may point to something more serious, and your informal (and trusted) advice could delay treatment and follow up.

While common sense should prevail, it is good practice to pause briefly and consider whether a situation would be perceived as "minor" by a third party. When in doubt — especially with anyone outside of your immediate household — take extra care to document in real time and plan for follow up.

TREATING FAMILY MEMBERS AND CLOSE FRIENDS

Perhaps the most common source of requests for medical care from special relationships comes from family members. A *New England Journal of Medicine* study revealed that:

- 99 percent of physicians surveyed reported receiving requests from family members for medical care, treatment, or advice;
- 83 percent had prescribed for a family member;
- 80 percent had diagnosed medical illnesses;
- 72 percent had performed physical exams;
- 15 percent had acted as primary attending physician during a hospitalization; and
- 9 percent had operated on a family member. [11]

Interestingly, 22 percent said that they had "acceded to a specific request about which they felt uncomfortable." [11]

The treatment of close friends and romantic partners deserves equal consideration. Whether it is a friend or family member who approaches you for advice or care, the intimacy of the relationship is what matters and may drive treatment decisions. [12]

The ethical lines are perhaps most easily blurred when the physician is also the parent of the "patient." Parental responsibility includes closely monitoring the physical and emotional health of one's children. Parents, whether

physicians or not, assess, diagnose, treat, or refer their children for medical conditions on a daily basis. These instincts, judgement calls, informal assessments, and decisions to seek professional care are no less appropriate when the parent is a physician.

However, the ethical line may be crossed when a physician parent moves beyond what any parent is able to do, such as applying their own clinical knowledge and training to decision making. This is especially obvious when medication is prescribed, as personal involvement may compromise objectivity.

In non-emergent situations, physicians should avoid adopting the role of treating physician for loved ones. Many adopt an "all or nothing" approach which sets a clear boundary between their role as loved one and their role as physician, a boundary that is maintained and understood by everyone involved.

This boundary does not mean becoming detached or aloof with loved ones. A physician can still pay close attention to a loved one's health, show concern, help them get the care they need, or provide appropriate assistance in situations of immediate need. What the boundary does emphasize is that your primary role in their lives is a personal one. Trying to be both physician and loved one is ultimately in no one's best interest.

PHYSICIAN-CAREGIVER FOR A FAMILY MEMBER

Physicians who serve as a personal caregiver for a spouse or close family member must examine the boundary issues that exist between being a loving family member, a caregiver, and a physician. The temptation to act as a physician — formally taking over medical care for their loved one with the loved one's informed consent — can be strong. But keep in mind, the roles of caregiver and loving family member are equally important and necessary.

For example, caregiver functions or responsibilities typically include:

- offering emotional support, listening, and encouragement;
- providing for physical needs, focusing on activities of daily living (ADLs), such as bathing, dressing, and feeding;
- encouraging contact with appropriate members of the health care team when needed;
- helping to maintain medication compliance and prescriptions;
- supporting and encouraging the completion of physical activities;
- honoring the loved one's independence and ultimate authority over their health care and daily activities;
- maintaining a loved one's confidentiality regarding medical information, finances, physical privacy, and more; and
- assisting their loved one with carrying out recommendations found in their physicians' care plan.

None of these caregiver duties include prescribing medication, making medical decisions, or advising deviation from the prescribed treatment plan. A good caregiver facilitates the independence and agency of their loved one and provides appropriate emotional and physical support.

If a physician has assumed any part of a loved one's medical care, that care must be carefully and fully documented. This means complete and contemporaneous records — not informal notes or memory. It also means that the physician must fully discuss with the loved one the benefits and risks that come with this dual role.

If it becomes necessary to prescribe controlled substances, carefully consider obtaining and documenting input from other members of the care team. As mentioned above, physicians in Texas may not prescribe controlled

substances to themselves, family members, or others in which there is a close personal relationship, for more than 72 hours.

Caregiving is difficult and can be emotionally and physically draining over extended periods of time. Physicians acting as caregivers often feel helpless or responsible when their loved one is suffering. Feelings of guilt, self-doubt, and compassion fatigue can become overwhelming.

Physicians who combine caregiving with the usual stressors of practicing medicine run the risk of compromising their own mental and physical well-being, their judgment in both roles, and their relationships with the people they love.

TREATING YOURSELF

We have all known colleagues who act as their own primary care physician. These physicians self-diagnose and treat their own acute and chronic conditions. Sometimes this self-care seems appropriate, other times it seems haphazard and ill conceived.

The reasons to avoid treating family members also apply to self-treatment. Within the setting of self-care, a physical exam may be difficult to perform. Documentation may be incomplete. As such, the basic medical-legal requirements of a physician-patient relationship are likely not achieved.

Except in cases of "immediate need," regulatory agencies and professional organizations unanimously discourage self treatment. Self-prescribing controlled substances is specifically mentioned in DEA and TMB regulations as something to be avoided or limited to a 72-hour period or less with contemporaneous documentation.

In these situations, it is good practice to promptly report the incident and your self-care to another physician. This can help you assess the appropriateness of the care, determine the need for any longitudinal care, and serves to document and support your self-prescribing.

TREATING EMPLOYEES

As the closed claim study illustrates, treating employees is especially complex. These requests — within the context of an employee-employer relationship — can represent a potential legal minefield. Consider the following tips when faced with an employee who requests medical care.

- Whenever possible, avoid becoming your employee's physician. Be prepared to offer referrals to other trusted physicians.
- Consider adding a formal policy against physicians providing care to employees in your practice's policy and procedure manual.
- If you are considering becoming your employee's physician, carefully determine whether you can maintain the same objectivity and confidentiality that you would for any other patient.
- Carefully consider the effect that providing medical care for your employees will have on your important employee-employer relationship. This relationship will be irrevocably changed, and the change may not be for the better.
- When you agree to treat an employee, establish a tangible and fully documented physician-patient relationship that is identical to any other patient that you see within your practice.

- Make sure you are working within the scope of your daily practice. Again, be prepared to offer referrals to more appropriate specialists.
- Patient confidentiality is especially important in this setting. To the extent possible, keep your employee-patient's medical record inaccessible to other practice employees.
- Encourage your employee-patients to transfer their long-term care to a different physician outside of the practice. Document these conversations/referrals.

TREATING COLLEAGUES

As with employees, most of us will be asked to provide care for a physician colleague. Yet as physicians, we are not always the best patients. In a survey of physicians who treated other physicians, 52 percent reported that their physician-patient tried to dictate their own care, and 81 percent reported that their physician-patients tried to obtain special privileges in their care. This temptation for physician-patients to care for themselves or to drive their own care can complicate treatment. [13]

In these scenarios, the following issues should be recognized and addressed from the outset.

1. Maintain proper boundaries between personal and professional relationships.
2. Do not make assumptions about the physician-patient's medical knowledge or past health behavior.
3. Recognize that treating colleagues can provoke anxiety and may cause the treating physician to provide care differently than is their routine. [14, 15]

Consider the following recommendations when treating colleagues.

- Carefully consider your ability to provide objective, confident care for a close colleague.
- Avoid "corridor consultations" or "curbside consults" (informal clinical conversations with colleagues asking for quick advice or an opinion).
- Engage in an honest conversation — at your first appointment — with a physician-patient about the importance of maintaining a typical physician-patient relationship.
- Follow all confidentiality guidelines.
- Allow for shared decision making, but once a treatment plan is established make your expectation clear that the physician-patient will not self-treat and will adhere to the mutually agreed upon plan.
- Avoid ordering tests that you would not normally order for patients with the same health issues.
- Obtain a complete history and perform a thorough physical exam. Take a full social history, including alcohol or substance use, high risk behavior, and any history of self-treatment.
- Recognize that treating a colleague or other physician can be stress-provoking. [16]

While caring for another physician or colleague can be challenging, it can also be extremely rewarding. As physicians, we too deserve excellent medical care from the physicians of our choice.

RISK MANAGEMENT STRATEGIES

At some time during their careers, most physicians will face decisions about whether to treat a family member, friend, or employee. Thinking through the issues described below and establishing your own personal guidelines can help make these situations easier to manage.

- Will I be working within the same scope of practice as my usual daily practice?
- Will I be treating this person in my usual practice setting (office, ED, etc.)?
- Can I be as objective as I would be with any other patient?
- Will I fully document the care, including having them fill out usual new patient forms, documenting history and physical, shared decision making, and fully documenting treatment undertaken?
- Will I be providing longitudinal care or making concrete arrangements for it?
- Will I be able to take a complete history and perform all necessary components of a physical exam?
- Can I guarantee confidentiality? This includes not discussing care with other family members without obtaining consent from the patient.
- Will I obtain legitimate and specific informed consent?
- Will treating this patient adversely affect our personal or professional relationship?
- Would I feel confident if the details of the care provided to a patient with a special relationship were reviewed by a colleague, medical board, or peer review panel?
- Have I explored and offered other care options with my loved one/colleague before and during ongoing care?
- If prescribing controlled substances, have I carefully considered DEA and medical board rules, ethical issues, and potential ramifications?
- Requests for informal or curbside medical advice about a health condition, even when responded to with a very basic answer or advice but no actual treatment, should prompt dated, contemporaneous documentation of the encounter.

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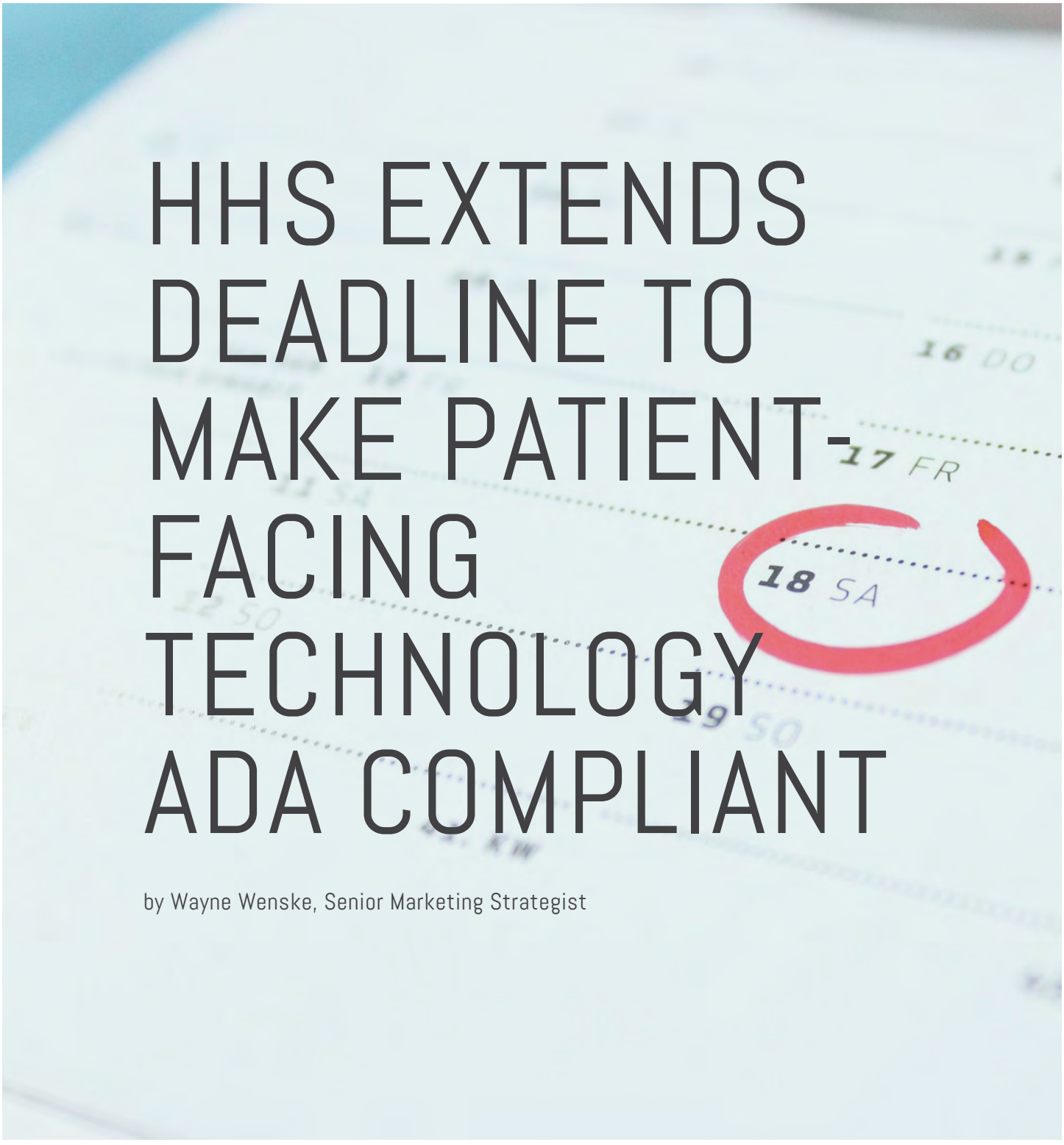

HHS EXTENDS DEADLINE TO MAKE PATIENT-FACING TECHNOLOGY ADA COMPLIANT

by Wayne Wenske, Senior Marketing Strategist

Under a recent update to U.S. Department of Health and Human Services (HHS) rules, health care professionals and facilities that receive HHS funding must ensure that all their patient-facing technology — websites, web content, kiosks, and mobile apps — is compliant with the Americans with Disabilities Act. [1]

After recognizing that many HHS funding recipients were unlikely to meet an original May 11, 2026 deadline, HHS extended the deadline to May 16, 2027 for health care organizations with more than 15 employees. Organizations with fewer than 15 employees have until May 10, 2028 to comply. [2]

The rule requires that recommendations found in the Web Content Accessibility Guidelines (WCAG) 2.1 become standard practice. [3] These compliance measures can include:

- providing alt text or descriptions for website images and graphics;
- adding accurate captions to videos for individuals who are deaf or hard of hearing;
- incorporating multiple navigation options, clear visual layouts, and sufficient color contrast between text and backgrounds;
- all website functions — scheduling, portal login, payment interfaces — must also be operable by keyboard and not rely on the use of a mouse;
- offering non-visual digital maps for blind patients using screen readers; and
- using a telehealth platform that can offer a sign-language interpreter on a video call. [2]

HHS states that these compliance measures are "necessary" to help disabled patients "avoid discrimination, health disparities, and poor outcomes. [HHS funding] recipients are increasingly using technology as part of their programs and activities, and unless that technology is accessible, people with disabilities will be left behind … Web content, mobile apps, and kiosks already play a large role in the health and human services programs and activities offered by recipients, and that role will likely continue to grow in the future. This rulemaking is necessary given these realities." [4]

These requirements were put into place after an HHS review found "severe consequences" exist when patient-facing technologies are not designed with accessibility in mind, including "barriers to necessary health care, poor health outcomes, and even death for people with disability." [4]

The rule's accessibility requirements extend beyond a provider's main website and mobile apps to include applications operated by third parties on a provider's behalf (such as an EHR vendor), as well as patient portals, appointment schedulers, bill pay portals, and telehealth platforms. "Widgets and iframes that pull in third-party functionality inherit the accessibility limitations of that third-party system. If those tools are used to access program services, they are in scope." [5, 6]

Self-service kiosks — used by patients to check in to appointments, record vital signs, or access other services — must also be fully accessible. Where kiosk accessibility cannot be achieved, providers must offer an alternative service that affords patients with disabilities the same level of access, confidentiality, and convenience. For example, if a patient is unable to interact with a self-service kiosk, they should be able to go directly to staff at the main desk for help or service. [5, 7]

Notably, these rules may be waived for entities that can demonstrate the changes would fundamentally alter their operations or impose significant hardship. Failure to comply may result in investigation by the Office for Civil Rights (OCR), potential loss of HHS funding, and increased legal risk. [5]

Five types of content are exempt from these requirements, including:

- archived web content retained exclusively for reference or recordkeeping, stored in a clearly identified archive;
- pre-existing conventional electronic documents such as PDFs or Word docs, not currently being used;
- content posted by a third party (unless posted on behalf of the provider under a contractual or licensing arrangement);
- individualized password-protected documents; and
- pre-existing social media posts; all social media content published after the deadline must be accessible.[5, 7]

RISK MANAGEMENT CONSIDERATIONS

Consider the following best practice to help your organization meet these new accessibility requirements.[5, 7]

- Develop a detailed, step-by-step plan to meet full compliance by the appropriate deadline.
- Budget for appropriate resources to help you meet compliance standards.
- Assign staff members or appoint an individual to oversee compliance efforts, respond to accommodation requests, and serve as a liaison with the OCR, if needed.
- Conduct a baseline accessibility audit of your website, web content, patient portals, mobile apps, and kiosks to help you identify any issues.
- Regularly test your website functionality using online accessibility scanners, such as accessiBE or PowerMapper. These tools can quickly scan your website to look for accessibility gaps, such as missing alt text for images or unlabeled navigation buttons.
- Combine scanning tools with manual testing focused on the most common "touch points" for patients: portal login, appointment scheduling, telehealth access, billing, and benefit applications. Test against real assistive technologies such as screen readers, keyboard-only navigation, and voice control.[6]
- Solicit feedback from patients with disabilities to understand any difficulties they may have when making appointments or accessing your patient portal. Find and incorporate solutions to correct any issues.
- Collaborate with internal and/or external technical teams to add accessibility features and make required changes, as needed.
- Ensure that contracts using clear, appropriate language and direction are in place with vendors; confirm that they are aware and acknowledge your accessibility standards.
- Include accessibility standards in your practice's policies and procedures. "Although Section 504 does not require policies, OCR will review policies and procedures in its investigation of alleged noncompliance."[8]
- Make compliance an active, ongoing component of your practice, as new tools, technologies, and online content create new risks.
- Document all compliance efforts, including regular audits, solutions adopted, and vendor communications, to help demonstrate "good faith" and defend against any claims of noncompliance.

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CLOSED
CLAIM
STUDY

FAILURE TO RESPOND TO OR MONITOR HYPOKALEMIA

by Wayne Wenske, Senior Marketing Specialist

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.

PRESENTATION

On March 20, a 39-year-old woman came to an oncology office to begin chemotherapy treatments. She had been diagnosed with multiple myeloma in January. Her history included back pain and leg weakness for two years, with minimal relief after several epidural steroid injections. She recently developed "foot drop."

In February, a chemotherapy plan consisting of bortezomib, lenalidomide, and dexamethasone (VRD) was recommended by Oncologist A to treat her multiple myeloma.

PHYSICIAN ACTION

At the first chemo appointment on March 20, lab work revealed low potassium of 2.9 — flagged as a "critical value" representing severe hypokalemia. Oncologist A prescribed oral potassium capsules for the patient at a dose of 10 mEq twice daily.

On March 25, the patient returned for a second round of chemo. She reported that she was experiencing diarrhea and was passing whole, undissolved potassium and acyclovir tablets since her first chemo treatment. This information was documented and relayed to Oncologist A. A nurse practitioner (NP) then prescribed soluble potassium for the patient to take at home.

At this appointment, the comprehensive metabolic panel (CMP) machine was not working, and the patient's potassium level was not checked. She was administered another round of VRD chemo and sent home with a new prescription for dissolvable potassium.

According to the patient record, the NP had ordered CMP for the March 25 and August 1 treatment appointments after the patient's first chemo treatment on March 20. These were noted as "add ons" as they were added late in the day after the lab had already created their schedule for the coming week.

The order for a CMP was not added to the laboratory order for March 25. The NP did not communicate with the lab to verify the order, nor did the lab personnel recheck the orders on March 25 before the patient was administered another round of chemotherapy.

The next morning, March 26, the patient was found unresponsive by her husband. EMS was called and she was pronounced dead at the scene. An autopsy listed the causes of death as undiagnosed dilated cardiomyopathy and multiple myeloma.

ALLEGATIONS

A lawsuit was filed against Oncologist A, the NP, and the oncology practice. Allegations included failure to:

- properly monitor and respond to the patient's hypokalemia;
- ensure that proper lab work was performed for the patient on March 25 before administering another round of chemo to the patient (Oncologist A and the NP);
- communicate to Oncologist A that the CPM machine was inoperable (the NP);
- perform an in-person assessment of the patient on March 25 (Oncologist A);
- resolve the patient's hypokalemia; and
- investigate or rule out any heart health complications from hypokalemia.

LEGAL IMPLICATIONS

Expert consultants who reviewed this case for the defense felt the providers in this case provided appropriate care when it came to the treatment plan for the patient's multiple myeloma. One internal medicine consultant stated that the patient's 2.9 potassium finding was moderate (not severe) in the context of the patient's condition and current treatment.

However, this same consultant asserted that the providers were negligent in not following up on the low potassium and in continuing the chemo treatment without monitoring the patient's lab work. This lack of follow up likely caused the patient's cardiomyopathy to go undiagnosed and/or to develop. Another defense consultant stated that the patient's sudden cardiac death was likely caused by the failure to diagnose and treat the underlying causes of the patient's cardiomyopathy.

Consultants for the plaintiff pointed out that the standard of care required that a CMP be performed on March 25 before proceeding with a second round of chemo. Had a CMP demonstrated that the patient was hypokalemic, she should have been admitted to a hospital for monitoring and correction of her potassium. Proceeding with a second round of chemo without determining her potassium level was below the standard of care.

DISPOSITION

This case was settled on behalf of Oncologist A, the NP, and the oncology practice.

More on diagnostic errors at https://www.tmlt.org/resource/about-diagnostic-errors.

More on communication errors at https://www.tmlt.org/resource/about-communication-errors.

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CLOSED
CLAIM
STUDY

FAILURE TO HONOR A PATIENT'S REQUEST FOR A SPECIALIST

by Wayne Wenske, Senior Marketing Strategist

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.

PRESENTATION

On September 27, a 61-year-old woman came to an urgent care clinic reporting stomach pain, bloating, and loss of appetite for two days. She had a history of digestive issues, including diverticulitis.

PHYSICIAN ACTION

Upon examination and review of abdominal CT imaging, Physician Assistant A diagnosed the patient with mild to moderate diverticulitis and prescribed antibiotics and pain relievers.

The patient returned the next day reporting new symptoms: more severe pain, very loose stools, feelings of constipation, and elevated blood pressure. Physician Assistant A ordered another CT which showed the patient had developed a micro-perforation and more complicated diverticulitis.

The patient was transferred to Hospital A and admitted under the care of Internal Medicine (IM) Physician A.

During her initial examination with IM Physician A, the patient asked to see a gastroenterologist. IM Physician A told her a consultation was not medically indicated and that she required IV antibiotics, pain control, IV hydration, and monitoring. The patient acquiesced. This conversation was not documented.

Overnight, the nursing staff noted the patient made several requests to see a gastroenterologist. The next day, September 29, the patient's care was transferred to IM Physician B who examined the patient and documented: "Acute diverticulitis. Responding well to metronidazole and ceftriaxone. Ensure adequate pain control with opiates … Anticipate improvement within 48 hours. Will likely be discharged with oral antibiotics with GI follow up."

IM Physician B later noted an addendum: "Patient continues to have discomfort. She insists on not using opiate medication and seeing GI, despite being counseled on the dangers of colonoscopy while having active diverticulitis infection. GI has been consulted."

At 3:50 p.m., IM Physician B examined the patient and noted no rebound tenderness "however, she has already received 50 mcg of fentanyl in addition to PRN morphine." X-ray showed mildly distended bowel loops. A nasogastric tube with intermittent suction was ordered.

On September 30, IM Physician B consulted with a gastroenterologist and a general surgeon and discussed his concerns about potential worsening of the micro-perforation. The consults found that the patient's micro-perforation had grown into a frank perforation and the patient was experiencing fecal peritonitis.

During emergency surgery, the general surgeon diagnosed the patient with sigmoid diverticulitis with perforation. A colectomy was performed and an ostomy required. During surgery, the perforation was located and the perforated section of colon was removed.

ALLEGATIONS

A lawsuit was filed against IM Physicians A and B for failure to consult with a gastroenterologist and/or a general surgeon in a timely manner. This failure resulted in the patient experiencing a perforation of the colon, subsequent surgery, and a colostomy bag for three months.

LEGAL IMPLICATIONS

Expert consultants for the defense and the plaintiffs were mostly critical in their evaluation of the case. One intensivist stated that neither IM Physician A nor B met the standard of care in this case due to their failure to:

- recognize the complications of diverticulitis;
- consider worsening of the micro-perforation;
- consider peritonitis; and
- request a specialist evaluation to more closely monitor the patient's condition.

This physician felt that without closer monitoring, the micro-perforation worsened and led to abscess formation, fecal peritonitis, prolonged hospitalization, and further complications.

An internal medicine physician stated that consultation with a gastroenterologist was not medically indicated until September 30, when the patient developed symptoms of peritonitis and the consult obtained. This consultant also suggested that progress notes seemed to be copied from one day to the next by IM Physician B, suggesting a lack of attention to the patient's worsening symptoms.

A general surgery consultant said the care initially provided to the patient for diverticulitis was appropriate and that time was needed (48 hours) to give the antibiotics a chance to work. He stated that surgical or gastroenterology consults were not indicated or required earlier, as localized perforations have an extremely high cure rate with antibiotics alone, and rarely progress to the point of needing surgery.

This consultant also felt that, even if a surgical consult happened earlier, it was likely the patient would have received the same care — including the surgery and colostomy — and the same outcome.

A hospitalist who reviewed the case stated that the nurses should have communicated the patient's pain, nausea, and requests to see a gastroenterologist to the physicians. There was no documentation that the nurses contacted the physicians about the patient's condition or requests. The hospitalist also felt the patient's request for a specialist (or possible second opinion) should have been honored.

DISPOSITION

This case was settled on behalf of IM Physician A and B.

More on risk management for hospitalists at https://www.tmlt.org/resource/risk-management-for-hospitalists.

More on improper performance at https://www.tmlt.org/resource/about-improper-performance

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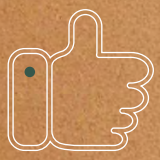

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