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MLMIC Insurance Company Enters Berkshire Hathaway Family

In July of 2016, MLMIC Insurance Company entered into a definitive agreement to be acquired by National Indemnity Company, a subsidiary of Berkshire Hathaway Inc. That transaction has been finalized, and MLMIC is pleased to announce that we are now MLMIC Insurance Company, a Berkshire Hathaway Company.

As a Berkshire Hathaway company, MLMIC will bring policyholders further peace of mind, knowing we will be able to offer an even higher level of financial security. MLMIC is now a member of a group that includes other insurers that specialize in providing medical professional liability insurance coverage to healthcare providers. This affiliation will afford additional healthcare contacts and insights for MLMIC and allow it to expand its offerings with more customized policy limits, risk-sharing features, and services to individual practitioners, medical groups, and facilities large and small.

In the coming weeks, MLMIC policyholders can anticipate receiving further details on the enhancements to its services that this significant event will bring. To receive the latest information in real time, policyholders and their staff and representatives are urged to visit MLMIC.com to sign up for MLMIC's Blog and Twitter feeds.

Please direct any questions regarding this announcement to (888) 998-7871 or go to MLMIC.com for additional contact information. ❖

In this second installment of Dateline's *series on Electronic Health Records, we look at the three major storage options for medical practices of all types and examine their relative advantages and disadvantages.*

Electronic Health Records – Risks and Benefits of Storage Alternatives

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Since the development of the first electronic medical record system in 1972, electronic health records (EHRs) have become progressively more prevalent throughout the healthcare industry. Today, the clear majority of health records are stored and accessed digitally in the form of EHRs.

Selecting from the various data storage options is a challenging process, one

continued on page 2

that mandates the exercise of due diligence to assess the capabilities of available storage systems. The major difficulty lies in weighing the relative risks and benefits of each alternative prior to reaching a decision that results in ease of authorized access and HIPAA compliance. Performance, services, customer support, data security, cost, and incident and disaster response are some of the variables that must be carefully analyzed for informed decision-making that yields the most suitable choice for a healthcare practice. It is important to understand where generated data will reside and how this can potentially impact operations and patient satisfaction.

There are three basic options to select from for the electronic storage of protected health information (PHI): on-site; cloud based; and hybrid. The primary benefit offered by having PHI storage on the premises of a healthcare provider or facility is the ability to maintain greater control over access to and the physical location of EHRs. A wireless internet connection is not required so that there is less risk of downtime or external cyberattacks. The most significant drawback to hosting a server on site is the sizable initial capital investment required for the purchase of equipment and software, as well as the ongoing costs. System management, maintenance, updates, and backups must be performed on a routine basis by experienced IT staff. The provision of designated physical storage space that offers protection from fire, floods, and other disasters, as well as cooling costs, contribute to overhead. Other factors to consider include: the expense of employing knowledgeable IT support; the potential for physical server HIPAA breaches; the responsibility for performing regular backups; and lack of remote accessibility to data.

Cloud technology involves the internet-based sharing of computing resources, and transmission of data to and from connected devices on demand. A cloud-based system does not involve the burdensome investment in expensive hardware on the premises of a healthcare provider or facility. This option allows for a simplified, flexible, and cost-effective alternative for data storage as leasing fees paid to an off-site service provider are typically based on actual storage needs. Data remains accessible by a healthcare practice from any computer with an internet connection. Frequent data back-ups, as well as encryption and automated recovery capabilities, afford better security protections from the potential consequences of a natural disaster or data breach.

However, cloud storage of PHI can potentially compromise the smooth operation of a healthcare practice because access to data is impossible if the internet connection is lost. Data recovery can be time-consuming, which may negatively impact the delivery of healthcare services. In addition, lack of control over the server can result in security implications and HIPAA violations stemming from third-party access to PHI. HIPAA specifies that a signed Business Associate Agreement that outlines permitted and required uses and disclosures must be obtained from the chosen data storage vendor.[1]

The option of a hybrid system for the storage of PHI consists of a combination of onsite and cloud-based solutions. Maintaining some onsite server hardware is advantageous because there is no need to rely on continuous access to the

1. https://www.hhs.gov/hipaa/for-professionals/special-topics/cloud-computing/index.html.

internet. The cloud component of a hybrid system enables connectivity from any user location. In addition, data security can be enhanced by backing-up PHI to both an on-site server as well as to a cloud system. However, as with any system involving the cloud, reliance must be placed on a service provider for uptime, performance, regulatory compliance, and technical support.

Technological advancements in the collection and storage of PHI have enabled significant improvements in communication among healthcare providers and with patients. The healthcare industry is under increasing pressure to balance these enhancements while maintaining the accessibility and security of PHI. The selection of a dependable data storage solution is essential for the safe and effective handling of PHI, and the avoidance of practice disruptions.

Are you satisfied with an in-house structure, or should you reach for the cloud? The pros and cons of internal servers and cloud-based systems must be weighed very carefully before choosing an approach that is a good fit for a healthcare practice. Thorough research is crucial to determine which solution best suits individual practice needs. Obtaining guidance and expertise from a skilled technology partner will assist healthcare providers in this demanding undertaking. During the complex process of selecting an EHR storage solution, all issues with the potential for an adverse impact on operations should be thoroughly examined. ❖

New York State and New York City Implement Stronger Protections Against Sexual Harassment in the Workplace

New York State and New York City have each enacted legislation aimed at providing stronger protections against sexual harassment in the workplace. Both pieces of legislation require New York employers to revise their policies and procedures, and provide training relative to sexual harassment in the workplace. The New York State legislation applies to all employers throughout the state. The New York City legislation, which contains additional requirements, applies to employers within the city with 15 or more employees. For information about the key components of both pieces of legislation, please visit www.fakslaw.com.

New York State has also released minimum standards for all sexual harassment prevention policies. These standards are available at https://www.ny.gov/combating-sexual-harassment-workplace/employers ❖

Case Study

Poor Documentation and Communication Make Aneurysm Case Indefensible

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This case involves a then 41-year-old female who presented to the ED on 12/2/2006 with complaints of right upper quadrant abdominal pain and was admitted by a general surgeon. She had developed epigastric and abdominal pain after consuming a large meal. A CT scan of the abdomen and pelvis suggested some distention of the gallbladder and perhaps some pericholecystic fluid. At 10:10 a.m. on 12/4/2006, the patient saw the MLMIC-insured physician assistant (PA), whose assessment was that she likely had gallbladder disease. A further abdominal ultrasound revealed cholelithiasis and sludge within the gallbladder with a normal common bile duct.

The patient was then evaluated by the MLMIC-insured surgeon, who performed a laparoscopic cholecystectomy on 12/5/2006, assisted by the PA. The surgery was uneventful and the patient was sent to the recovery room. The post-op orders included Dilaudid and Vicodin, as needed. A call was made at 8:50 p.m. that evening from a member of the nursing staff to the PA. The patient's blood pressure was elevated and she had some complaints of post-operative pain.

At 1:05 a.m. on 12/6/2006, the nursing note indicated complaints of abdominal pain described as 10 out of 10, headache, and nausea. The nurse did not mention headache on the graphic nursing note. It should be noted that neither of the MLMIC insureds were contacted by nursing staff with regard to the complaints of a headache or abdominal pain. The pain management section of the nursing note does not mention a headache. Cold compresses were applied to the patient's forehead. She was then seen by the PA at 12:00 p.m. on 12/6/2006, on routine rounds. The patient complained of generalized soreness, achiness, nausea, and a headache. Medications were continued.

On 12/7/06, at 7:30 a.m., a nurse noted that the patient's pain was 6 out of 10, but the location of the pain was not documented. A further assessment at 8:00 a.m. was unchanged. The patient was given one dose of Motrin 600 mg at 11:30 a.m. pursuant to an order by the PA written earlier that morning. The PA saw the patient again for a final assessment and noted she still had a headache that was consistent with her menstrual cycle. At this time, the patient was discharged home with a prescription for Vicodin.

The patient called the surgeon's office on the morning of 12/8/2006, complaining of a severe persistent headache, despite having taken Tylenol and Motrin, and was told by the PA to contact her primary care physician. She returned to the ED on 12/8/2006. A CT of the head revealed an intracranial hemorrhage with a Sylvian fissure clot. She was transferred and evaluated by a neurosurgeon, who noted that she had a Hunt-Hess Grade 2 hemorrhage, indicating focal motor deficit. A diagnostic angiogram revealed a wide neck fusiform-type aneurysm or a dissecting aneurysm located on the carotid artery just proximal to the carotid bifurcation.

The neurosurgeon later testified that the width of the neck of the aneurysm was very important in terms of determining what type of endovascular procedure could be performed. Ideally, he wanted to put coils in this aneurysm, but the neck was very wide and the coils would not stay in. He attempted to use a balloon during the procedure, but the neck was so wide that once the balloon was removed, the coils

failed to stay in place. He noted that, given the fact that the patient had gallbladder surgery three days prior and had an active subarachnoid hemorrhage, stenting would be too high a risk given the need for anticoagulation and anti-platelet therapy. He explained to the patient that clip reconstruction was the next option in an effort to rebuild the artery.

A craniotomy was performed on 12/8/06. A drain was placed as the patient's pressure was greater than 25. Mannitol was administered and her ICP decreased. The dura was opened and microdissection down to the aneurysm located on the internal carotid artery was performed. The neurosurgeon dissected down to the optic nerve and opened the cistern to relieve more fluid, which was through brain tissue that was red and "hot" in appearance. A large clot was removed. The aneurysm ruptured again and the entire field filled up instantly with aggressive arterial bleeding. The neurosurgeon did not have control of the artery above and below before the rupture. He was able to suction the blood out of the field and put a clip proximally to control the bleeding.

The neurosurgeon also testified that, at this point, he had to make a decision on whether to sacrifice the artery because it was entirely diseased circumferentially. He obtained a second opinion, who agreed that the safest and best option for the patient was to take the artery where a branch vessel came off the choroidal artery. A clip reconstruction was performed to sacrifice the artery while trying to maximize the amount of branches that were kept open, including the middle and anterior cerebral arteries.

After the surgery, an intraoperative angiogram was performed, which indicated that the carotid was completely occluded, ensuring no more filling of the aneurysm. A follow-up angiogram performed on 12/10/2006 revealed a right cerebral hemisphere infarction. The patient was then taken back for further emergent exploratory craniotomy to remove the dead brain tissue. The patient returned to surgery on 12/11/2006 for tissue removal and was discharged on 1/7/2007.

The patient was admitted to a traumatic brain injury rehabilitation unit from 1/25/2007-3/9/2007, and underwent occupational and physical therapy. She could not go from sit to stand position without help and could not stand in parallel bars without supervision. She continues physical therapy with limited function.

The patient was treated by a psychologist for depression, a urologist for bladder spasticity, and a neurologist for issues of bowel and bladder incontinence. She continues to have headaches, for which she takes Naprosyn and Botox injections every 3 months. She is monitored for her intrathecal Baclofen pump, which is used to control spasticity and muscle tone.

The plaintiff commenced a lawsuit in which she claimed the MLMIC insureds were negligent and committed medical malpractice by failing to evaluate the cause of her headache and failing to timely diagnose her cerebral aneurysm and subarachnoid hemorrhage, resulting in permanent deficits.

The plaintiff alleged that, as of 2016, she could only do minimal activities. An aide is constantly present to help her get out of bed and provide personal hygiene activities, and she goes to physical therapy three days a week. The plaintiff suffered total permanent disability and will not be able to return to work. She will also require 24-hour care for the remainder of her life.

MLMIC in-house experts in vascular surgery, general surgery, neurology and neurosurgery indicated the lawsuit should be settled. The complaint of suffering menstrual headaches was only documented by the PA in the discharge summary. The vascular surgeon signed the discharge late. The complaints of headache and dizziness were never investigated, and a neurologic evaluation was not performed. A neurology consult was not requested, and a CT of the head was not performed. The neurosurgeon's testimony was damaging to the defendant's case, as he testified that an earlier diagnosis before there was clot retraction, scarring, swelling, and increased ICP may have made the craniotomy easier.

Outside experts in these same specialties were willing to testify on behalf of the vascular surgeon and PA. With respect to the plaintiff's symptom of headache, there was no evidence that the plaintiff had a headache prior to surgery. With regards to causation, it was felt that, while it was malpractice for the PA to discharge the plaintiff from the hospital on 12/7/06 without further work-up for the head-

continued on page 6

Case Study

continued from page 5

ache, the cause of the plaintiff's eventual stroke was the surgery performed subsequently by the neurosurgeon.

Ultimately, the plaintiff had a very wide-necked or fusiform aneurysm that was not amenable to coiling. Once the vessel was exposed during the open craniotomy, the wall of the vessel ruptured and dissected. The vessel had to be clamped to control bleeding, which resulted in an infarction of all tissue perfused by the right middle cerebral artery distal to the point of occlusion. The intraoperative rupture is what gave rise to the need to clamp off the middle cerebral artery, and that was the cause of all the plaintiff's deficits. Had there been earlier intervention and a neurosurgical consult immediately after the plaintiff first complained of a headache on 12/6/06, the experts opined that the outcome would have been the same.

The plaintiff's original demand to settle her lawsuit was $9 million. The co-defendant hospital settled out of this case for a non-disclosed amount. The plaintiff's counsel then lowered his demand to $3.3 million, which was the full coverage for the vascular surgeon and PA. Settlement negotiations commenced but were unsuccessful, and the case proceeded to trial on 5/12/2016. During trial, the case was settled for $2.2 million on behalf of both the MLMIC-insured vascular surgeon and the PA.

A Legal and Risk Management Perspective

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Approximately 31,000 people in the United States suffer from an aneurysmal subarachnoid hemorrhage ("aSAH") each year, resulting in significant rates of morbidity and mortality.[1] It is reported that 32%-40% of those cases end in patient death.[2] It is believed that the incidence of aSAH and related death are underestimated by as much as 12-15%.[3] Accordingly, a ruptured brain aneurysm is a rare but fatal event.[4] Four out of 7 people who survive aSAH will have disabilities.[5] However, the American Heart Association/ American Stroke Association, the American Academy of Neurology, the American Association of Neurological Surgeons, Congress of Neurological Surgeons, and the Society of NeuroInterventional Surgery report that the fatality rates appear to be decreasing as a result of "early aneurysm repair, together with aggressive management of complications."[6]

"The clinical presentation of aSAH is one of the most distinctive in medicine.[7] The hallmark of aSAH in a patient who is awake is the complaint of 'the worse headache of my life,' which is described by ~80% of patients who can give a history."[8] This headache is frequently accompanied by nausea and/or vomiting, stiff neck, or photophobia.[9] The diagnosis of aSAH is a medical emergency, and accurate diagnosis is critical.[10] Of course, headache is a common complaint, and aSAH makes up about 1% of those complaints in the emergency department, but the American Heart Association/ American Stroke Association recommends a high index of suspicion "because the diagnosis of a warning leak or sentinel hemorrhage before a catastrophic rupture may be lifesaving."[11]

It is estimated that misdiagnosis occurs in about 12% of patients with subarachnoid hemorrhage when

1. *See* Connolly, Jr., E. Sanders, The American Heart Association/ American Stroke Association, Guidelines for the Management of Aneurysmal Subarachnoid Hemorrhage, 43(6) Stroke 1712 (May 3, 2012).
2. *See id.*; Brain Aneurysm Foundation, http://www.bafound.org/about-brain-aneursysms/brain-aneursym-basics/ (last visited Aug. 1, 2018).
3. *See id.* at 1712, 1717.
4. *See* Tromp, G., Weinsheimer, S., Ronkainen, A., & Kuivaniemi, H. (2014). Molecular basis and genetic predisposition to intracranial aneurysm. *Annals of Medicine*, 46(8), 597–606. http://doi.org/10.3109/07853890.2014.949299.
5. *See* Brain Aneurysm Foundation, http://www.bafound.org/about-brain-aneursysms/brain-aneursym-basics/ (last visited Aug. 1, 2018).
6. *See* Connolly, 43(6) Stroke 1712.
7. *See id.* at 1718.
8. *Id.* at 1718.
9. *See id.*
10. *See id.* at 1719.
11. *See id.* at 1718.

initially presenting for medical treatment.[12] Alarmingly, "[m]isdiagnosis was associated with a nearly 4-fold higher likelihood of death or disability at 1 year in patients with minimal or no neurological deficit at the initial visit."[13] Noncontrast head CT is the cornerstone of diagnosis of aSAH.[14] During the acute onset of symptoms, CT scan has a nearly 100% sensitivity.[15] However, failure to do a scan results in 73% of the misdiagnoses in ruptured brain aneurysms.[16]

In this case study, the plaintiff was a 41-year-old woman who reported a "Worst Pain Possible" (10 out 10 pain) headache, abdominal pain, nausea, and high blood pressure the day before she was discharged from the hospital. She continued to complain of nausea and headache to the nurses and physician assistant (PA) up through the day of discharge, and then by telephone the following day. On December 6, 2006, at 1:06 a.m., the plaintiff's 10-out-of-10 headache should have sent up red flags because the worst headache of your life requires further evaluation. The record indicates that the nurses recorded the symptoms, but the surgeon and PA were not advised. The surgeon, who performed the cholecystectomy and supervised the PA, is board certified in vascular surgery. Later the same day, the physician assistant examined and assessed the patient, including her complaint of headache, but no further evaluation or workup was ordered and the surgeon was not informed.

This case study provides an opportunity to discuss liability issues that can be addressed and minimized with risk management strategies, including: communication between nursing staff and physicians/physician assistants, and communication between PAs and supervising physicians; documentation of history, evaluations, and assessments; and supervision of mid-level practitioner care. The use of best practices may not have changed the patient's outcome in this case, but, if the care had been more fully documented and better communication had occurred, the medicine could have been the best defense to this medical malpractice action. Instead, the medicine could not overcome the plaintiff's tragic narrative because the medicine's story had gaps and omissions.

This three-tiered lack of communication likely contributed to the delay in diagnosis and treatment of the plaintiff's aSAH. These communication failures also formed the basis of liability for the hospital. The plaintiff had the classic aSAH symptoms of severe headache and nausea, but this information never properly reached the surgeon during the plaintiff's admission. The failure to advise the surgeon, and the surgeon's failure to adequately supervise the PA, are just two sides of the same coin. These subjects are addressed in the Department of Health regulations relative to PAs. The regulations require a licensed PA to be continuously supervised by a physician (physical presence is not required) and documentation of that continuous supervision must be maintained.[17] Further, the PA must have the appropriate education, training, and experience for the medical acts, duties, and responsibilities performed.[18] The physician is always medically responsible for the medical services performed by the PA.[19]

Apparently, the PA did not have the requisite training and experience to recognize the plaintiff's classic symptomology and to act upon it, while the surgeon did not properly supervise the

continued on page 9

12. *See id.* (noting a decrease from 64% in 1985).
13. *Id.*
14. *See id.*
15. *See id.*
16. *See* Brain Aneurysm Foundation, http://www.bafound.org/about-brain-aneursysms/brain-aneursym-basics/ (last visited Aug. 1, 2018).
17. *See* 10 N.Y.C.R.R. § 94.2(a) ("A licensed physician assistant or a registered specialist assistant may perform medical services but only when under the supervision of a physician. Such supervision shall be continuous but shall not necessarily require the physical presence of the supervising physician at the time and place where the services are performed. The licensed physician assistant or registered specialist assistant shall retain records documenting the continuous supervision by the physician who is responsible for such supervision.").
18. *See id.* at §94.2(b)(3) ("Medical acts, duties and responsibilities performed by a licensed physician assistant or registered specialist assistant must . . . be appropriate to the education, training and experience of the licensed physician assistant or registered specialist assistant.").
19. *See id.* at § 94.2(f)("A physician supervising or employing a licensed physician assistant or registered specialist assistant shall remain medically responsible for the medical services performed by the licensed physician assistant or registered specialist assistant whom such physician supervises or employs.").

Punitive Damages Awarded Against Physician for Destroying and Altering Medical Record

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Over the years, the issue of the alteration or destruction of medical records has been a recurring topic in *Dateline*. Unfortunately, the practice continues amongst health-care providers. The following article highlights a recent court decision that has significantly increased the consequences for practitioners who engage in the destruction or alteration of medical records for the purpose of evading medical malpractice liability.

The consequences of altering or destroying a medical record are serious and can impact a health care practitioner's license, medical malpractice defense, and exposure for monetary sanctions. Recently, a New York State appellate court expanded these consequences, holding that a plaintiff may also ". . . recover punitive damages for a medical professional's act of altering or destroying medical records in an effort to evade potential medical malpractice liability."[1]

In Gomez v. Cabatic, supra, the plaintiff sought compensatory damages (pain and suffering), alleging that the defendant endocrinologist failed to diagnose his six-year-old daughter with Type 1 diabetes, resulting in her death from complications of diabetes. The plaintiff did not claim that the alleged medical malpractice was malicious, reckless, or otherwise met the threshold for punitive damages.[2] Instead, it was not until after the defendant physician was deposed and it was learned that she destroyed and purportedly altered the patient's medical record that the plaintiff first asserted a claim for punitive damages. The plaintiff did not allege that the destruction and/or alteration of the record, which admittedly did not occur until approximately four months after the patient's death, impacted the treatment of the patient. Rather, he alleged that the destruction and/or alteration of the records was undertaken to avoid medical malpractice liability and this conduct supported an award of punitive damages.

The content of the medical records was central to the primary issue in the case: was the patient's mother instructed to return for follow up blood sugar testing in four weeks, as the defendant endocrinologist maintained, or in two months, as the plaintiff maintained? The chart note for the last office visit indicated the patient was "TCB in 4 weeks." In contrast, the plaintiff produced an appointment card indicating that the patient was not scheduled to return until approximately two months later. The timing was critical as the patient died between those two dates, approximately six weeks after her last appointment.

At her deposition, the defendant endocrinologist testified that she prepared and signed handwritten records - "scribble notes"- contemporaneously with each of the three office visits. When she received plaintiff's counsel's request for records approximately four months after the last treatment, she typed up her handwritten records and sent them on to counsel. She retained and provided the handwritten record for the first visit, reasoning that she considered it a registration form, but threw out the handwritten notes for the second and third visits. The plaintiff seized upon the destruction of the handwritten records for the last two visits, and discrepancies between the handwritten and typed notes for the first office visit, as proof that the typewritten notes differed from their original form. The plaintiff contended that the handwritten notes would have reflected a two-month follow-up instruction, not a four-week follow-up instruction, and the typewritten notes were created to avoid medical malpractice liability for the patient's death. Based upon the defendant endocrinologist's destruction of the records and the alleged alteration of the record content, the plaintiff sought punitive damages.

The jury found that the defendant endocrinologist's malpractice was a substantial factor in caus-

1. Gomez v. Cabatic, 159 A.D.3d 62, 64 (2d Dep't 2018)

2. Punitive damages are rarely awarded in medical malpractice actions. See Dupree v. Giugliano, 20 N.Y.3d 921, 924 (2012).

ing the patient's death and awarded $400,000 for pre-death pain and suffering. The jury also found that the defendant endocrinologist maliciously destroyed her handwritten notes after receiving the plaintiff's attorney's request for records and, therefore, awarded punitive damages in the amount of $7,500,000. On the post-trial motion, the trial court allowed the punitive award to stand, but reduced it as excessive to $1,200,000.

The defendant endocrinologist appealed the punitive damages award to the Appellate Division, arguing that the alteration or destruction of medical records cannot support an award of punitive damages as a matter of law. The appellate court unanimously rejected this argument, holding that a plaintiff who:

". . . recovers compensatory damages for medical malpractice, may also recover punitive damages for that medical professional's alteration or destruction of medical records in an effort to evade medical malpractice liability."

The court held that the availability of other adverse consequences for alteration or destruction of records, including disciplinary proceedings and spoliation sanctions, did not preclude an award of punitive damages. After reviewing conflicting precedent on whether the imposition of punitive damages requires that the patient's medical care was impacted by the alternation or destruction of the record, the court concluded that this was not required. Finally, the court held that, unlike spoliation sanctions, the imposition of punitive damages does not require the plaintiff to prove the alteration or destruction prevented the plaintiff from proving her case.[3]

Following the Appellate Division decision, all claims against the defendant endocrinologist were settled. Consequently, there will not be an appeal to the highest court in New York, the Court of Appeals. Until the high court addresses the availability of punitive damages for after-the-fact alteration or destruction of medical records for the purpose of evading medical malpractice liability, the Gomez case stands as the law in New York.

The decision provides an important reminder that hindsight-inspired alteration or destruction of a medical record should never be undertaken and will not improve a provider's stance in defending a medical malpractice action. With technological advances, any changes to a record can and will be discovered and used to compromise the provider's credibility. Further, as in Gomez, the provider may face increased personal exposure for punitive damages and other serious legal consequences. Had the destruction and alteration of the record not been an issue in Gomez, the award would have been limited to compensatory damages covered under the defendant endocrinologist's medical malpractice insurance policy. Instead, because of her destruction and alleged alteration of the records, the defendant endocrinologist faced personal liability for the much larger punitive damages award, which, by law, cannot be covered by insurance.[4] ❖

3. The punitive damages award was further reduced to $500,000. Gomez v Cabatic, 159 A.D.3d 81 (2d Dep't 2018).

4. Hartford Acc. And Indemnity Co. v Hempstead, 48 N.Y.2d 218 (1979).

Case Study

continued from page 7

PA prior to the plaintiff's discharge from the hospital. Also, the PA's failure to document his complete assessment and patient history of menstrual headaches within the hospital progress notes contributed to the miscommunication with the surgeon. Finally, if there was appropriate communication and supervision occurring, there was a complete lack of documentation of such. The regulation provides for the surgeon's liability for the PA's negligence, and the omission in communicating the plaintiff's new symptom of headache by the nursing staff was the basis for the vicarious liability of the hospital. Perhaps proper communication occurred in this case, but the defense is unable to tell that story without the evidence a jury would expect to see.

Due to the nature of the medicine, causation in vascular accident cases can be a valid defense, but the words, "I am having the worst headache in my life" – in sum or substance – drive right into the center of any defense counsel. Selling to a jury that the tragic outcome would be the same regardless of the 48-hour delay is nearly untenable, even when it is a valid defense. It is impossible to sell this defense when improper care, communication, and documentation converge. ❖

RISK MANAGEMENT Tip

Tip #24: Security of Patient Information and Health Information Technology

With virtually all medical offices and healthcare facilities connected to the internet and using computer systems for the practice of medicine, maintaining the security of computers and other electronic devices, as well as the privacy of patients' protected health information (PHI), has become critical. The following are tips for staff and providers on securing this technology and information.

1. Require that staff and providers have strong and unique passwords:
   a. Passwords should have a minimum number of 12 characters and include upper and lower-case letters, numbers and symbols.
   b. Passwords should be changed at set intervals.[1]
   c. Do not keep a written copy of your password where it would be accessible to others.
   d. Set short time frames for the automatic log-off of computers and devices.
2. Do not share passwords:
   a. Do not allow others to document in an electronic health record (EHR) under your password, while you are logged on.
3. Grant staff access to an EHR only on a "need to know" basis:
   a. Individuals should be granted access only to the information necessary to perform his/her job.
   b. If an employee transfers to a different job function, have a process in place to reduce or increase their access based on the new job functions.
4. Educate staff regarding not:
   a. plugging in their personal devices to USB ports on the system's computers;
   b. installing software on their work computers without prior approval;
   c. clicking on suspicious links in emails; and
   d. allowing USB devices to leave the facility unencrypted.
5. Position computers and printers away from patient and visitor traffic:
   a. Consider the use of screen filters to prevent visualization of PHI by others.
6. Encrypt all computer hard drives. At a minimum, all laptops and tablets should be encrypted, especially if they are to leave the facility.
7. Provide frequent and ongoing cybersecurity education and training.
8. Policies and procedures should clearly define the disciplinary actions to be taken for the inappropriate use of the computer system.
9. Develop a cybersecurity incident response process to address a security breach or cyberattack, and test it at least annually to confirm that there is:
   a. a defined procedure for reporting any suspected information security incident;
   b. an obligation for employees to report any suspected incident immediately upon discovery; and
   c. an individual(s) with clearly-assigned responsibilities for managing incidents.
10. Promptly disable an individual's access to the computer system upon their leaving employment:
    a. For involuntary dismissal, disable access prior to the notification of termination.
    b. If access to the employee's emails, voicemail, etc. is necessary, assign another qualified individual to address any information that requires review or action.
11. Maintain inventory control of all computerized devices including laptops, thumb drives, handheld devices, etc.
12. Install appropriate anti-virus software and update devices frequently to protect the computer system from security vulnerabilities.
13. Perform system back-ups of files and data routinely:
    a. Test back-up restoration semi-annually, at a minimum.
14. Perform audits to assure compliance with health information technology policies and any applicable regulations. ❖

1. Current guidelines suggest that if the password length is set to 16 characters, it should be changed annually at a minimum.

THE MLMIC Research Library

Fall 2018 Update

The MLMIC Research Library's services are available to all policyholders on a complimentary basis. Policyholders may submit a research request at the library link on MLMIC.com's homepage. Listed below are some of the customized services available to answer your research request according to your specialty, facility and practice type:

- Literature and Internet Searches
- Medical Textbooks
- Docline Retrieval Service
- LocatorPlus Book Loans
- Standard of Care/Practice Guideline resources

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Recent Additions:

- **2018 hospital accreditation standards.** Joint Commission Resources; 2018 (Hosp Adm 312-032 2018).
- **Clinical documentation quick reference for Long-Term Care.** Barbara Acello. HCPro; 2014 (LTC 104-151).
- **Emergency department compliance manual, 2017.** Rusty McNew. Aspen Publishers, Inc.; 2017 (E R Svcs 079-028 2017).
- **The EMTALA answer book 2018.** Jeffrey C. Moffat. Wolters Kluwer; 2018 (Medicolegal 330-023 2018).
- **Guidelines for perioperative practice.** Association of Operating Room Nurses, Inc.; 2018 (Surgery 167-003 2018).
- **HIPAA compliance handbook 2018.** Patricia I. Carter. Aspen Publishers, Inc.; 2018 (Medicolegal 330-019 2018).
- **Improving nursing documentation and reducing risk.** HCPro; 2016 (Nursing 556-147).
- **Legal manual for New York physicians.** Patrick Formato, Joel M. Greenberg & Donald R. Moy. New York State Bar Association; 2018 (Medicolegal 330-032 2018 v. 1 & 2).
- **The New York State Physician's HIPAA Privacy Manual.** New York State Bar Association; 2016 (Medicolegal 330-048).
- **Obstetrical risk management playbook. ASHRM;** 2017 (R M 151-152).
- **Optimal resources for surgical quality and safety.** David B. Hoyt, et al. American College of Surgeons; 2017 (Surgery 167-038 2017).

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