

Telemedicine and Its Liability Implications



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While the concept of telemedicine has emerged well over the last decade, its application has only slowly been interpreted and analyzed by medical boards, national associations and courts across the nation. However, the sluggish evolution of interpreting law has certainly not precluded physician disciplinary action and frustration within the medical community regarding the use of telemedicine.

The benefits of telemedicine include greater patient access and reduced in-office patient load. The concept has been appreciated for its applicability to address issues from radiologic interpretation and pathologic interpretation to patients' minor infections, rashes and colds, after the patient has already seen a physician and established a physician-patient relationship. This article will focus on the issues for a Florida provider concerning telemedicine.

Is Telemedicine defined in Florida?

The Florida Board of Medicine (the "Board") has addressed telemedicine in the past but not as much as one would think given the size and patient population of Florida. The only rule published by the Board that addresses telemedicine is Rule 64B8-9.014, F.A.C. The Rule states that telemedicine includes, but is not limited to, prescribing legend drugs to a patient through the

internet, telephone and/or facsimile. The rule is geared specifically to the Standards for Telemedicine Prescribing Practice and does not address one of the more common uses of telemedicine, and that is teleradiology.

The authors note that the Board has been supportive of the concept of telemedicine but there is not particularly much written guidance or disciplinary action guidance available for providers. The U.S. Government supports the use of telemedicine, which has been adopted and is in use by the Veteran's Administration health care facilities and through the Indian Health Services Administration. Moreover, Medicare reimburses for the use of telemedicine, the largest source of which is through teleradiology.

Prescribing Via the Internet

In 2003, the Board promulgated the Standards for Telemedicine Prescribing Practice, Rule 64B8-9.014, F.A.C. This Rule was written to address the significantly growing issue concerning the prescribing of medications over the internet. In summary, the Rule provides that prescribing medications based solely on an electronic medical questionnaire constitutes the failure to practice medicine within the standard of care, as well as prescribing legend drugs other than in the course of a physician's professional practice. See 64B8-9.014(1), F.A.C. The Board requires through the Rule, that physicians and physician assistants shall not provide treatment recommendations, including issuing a prescription, via electronic or other means, unless the following elements have been met:

1. A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed.

2. Discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment.

3. Maintenance of contemporaneous medical records meeting the requirements of Rule 64B8-9.003, F.A.C.

The Board stated however that the provisions of its rule are not applicable in an emergency situation, i.e., those situations where the prescribing physician or PA determines that the immediate administration of the medication is necessary for the proper treatment of the patient, and it is not reasonably possible for the prescribing physician or PA to comply with the rule prior to providing such prescription. See 64B8-9.014(3), F.A.C.

Additionally, the Board specifically explained that the rule is not intended to prohibit patient care in consultation with another physician who has an ongoing relationship with the patient and who has agreed to supervise the patient's treatment, including the use of any prescribed medications, nor on-call or cross-coverage situations in which the physician has access to patient records. Simply stated, a physician must perform a history and physical/patient evaluation prior to writing any prescription unless either immediate administration is required and it is not reasonably possible to perform a history and physical or if the prescribing physician is in consultation with another physician or is an on-call or cross-coverage relationship with the patient's physician. Similarly, the Florida Board of Osteopathic Medicine has promulgated a telemedicine rule which also proscribes the prescribing of medicine for patients who the physician has not personally examined. However, they too have also indicated that such regulations should not interfere with interstate consultation between physicians. See 64B15-14.008, F.A.C.

Application of Rule 64B8-9.014, F.A.C

In 2006, the Florida Board of Medicine considered the case of DOH v. Mathew Wise, M.D. Dr. Wise, who lived in New Mexico and was licensed in Florida, operated a website known as getthepill.com, which provided prescriptions for contraceptives to those who responded to an internet medical questionnaire and his instructions. Upon considering the facts of the case, the Board determined, by clear and convincing evidence, that Dr. Wise failed to comply with the Florida Telemedicine Rule, as he solely relied upon an internal medical questionnaire and failed to document a patient evaluation, including a history and physical, to establish the diagnosis for which the legend drug was prescribed, discuss patient treatment options and appurtenant risks and benefits and maintain contemporaneous medical records. The Board suspended the physician's Florida license for six (6) months, followed by a two-year probation and \$10,000 fine.

Recently, clinicians in South Carolina, Minnesota and Georgia received 60-days license suspensions from the North Carolina Medical Board after providing internet consultations for an online North Carolina company, and writing prescriptions for its patients without examining the patients or establishing a physician-patient relationship. In so doing, the Board determined that the clinicians' actions substantiated a finding of unauthorized practice of medicine within the state.

Another case which made headlines was that involving a 19-year old Stanford University student in California, who committed suicide following treatment by a Colorado physician. It was alleged that the physician, without ever seeing or examining the student, prescribed a generic form of Prozac after receiving the student's request over the internet. The parents of the student subse-

quently dropped their suit against the physician, who surrendered his Colorado medical license, however the criminal case continued. The First District Court of Appeal in San Francisco subsequently determined that a California county can prosecute an individual who writes a prescription in another state for a Californian, if it is known that the medication will be delivered in California.

Physician Assistants

Like physicians, PAs cannot provide treatment recommendations or issue a prescription via telemedicine unless the PA has performed a history and physical for which the drug at issue is prescribed. The purpose of the law is for a practitioner to obtain thorough patient information, facilitate discussion with the patient of treatment options, and related risks and benefits and maintain appropriate contemporaneous documentation in accordance with existing Florida law. However, again, the rule does not apply in emergency situations or to on-call or cross-coverage situations where the physician has access to patient records.

Radiology

While the Board does not have a specific rule addressing the reading of x-rays and other diagnostic imaging studies, it has long taken the position that a provider who sends his or her imaging studies out of state for review by a provider that is not licensed in Florida, shall be deemed to have performed the primary read/interpretation of the films and thus be responsible for any errors or misreads. This position results simply from one of control over the quality of medicine practiced in Florida. The medical quality assurance boards in Florida are charged with protecting the health,



safety and welfare of the citizens of the state of Florida. The various medical quality assurance boards, like the Florida Board of Medicine, do not have jurisdiction over a licensee in another state, unless that individual is licensed in Florida. If a provider in Florida simply states that the interpretation was performed by someone else, then the Board has no way, in that instance, to protect the patient that received care in Florida. It cannot discipline the physician in another state, nor can it make the other state discipline the physician either. While Florida requires that a person have a license to practice medicine in the state of Florida, it is very difficult to pursue a practitioner not licensed in Florida who provided medical services and may be, for example, in Washington state.

With the onset of telemedicine has been the concomitant evolution of domestic and foreign outsourcing. Most of the outsourcing of teleradiology is to capitalize on time differences (a radiologist in India will read images while radiologists in the United States are fast asleep.) As a result, many are urging the Board and legislators to better delineate the practice of telemedicine given Rule 64B8-9.010, F.A.C., which provides:

“Physicians who order, perform, or interpret diagnostic imaging tests or procedures are responsible for the appropriateness and quality of the non-invasive diagnostic procedure, interpretation of the results, diagnosis, and either maintenance of medical records or provision of the results of the test to the referring physician.”

Florida and many other states mandate that any radiologist who provides an official or primary interpretation relied on for treating a patient in their jurisdiction is practicing medicine. Consequently, such radiologists must apply for and receive a license in the state within which the patient is located. These states typically exempt occasional out-of-state interpretations or consultations done

as second opinions. See Teleradiology: An Underdeveloped Legal Frontier (RADLAW: September 2005 ACR *Bulletin*) Tom Hoffman, ACR Associate General Counsel

Consultations

We feel the need to address the difference between a consultation and telemedicine. Rule 64B-2.001(7), F.A.C., states that a consultation encompasses the actions of a physician lawfully licensed in another state, territory or foreign country. Such physician is permitted to examine the patient, take a history and physical, review laboratory tests and x-rays, and make recommendations to a physician duly licensed in this state [Florida] with regard to diagnosis and treatment of the patient. According to the rule, the term consultation does not include such physician's performance of any medical procedure or for the rendering of treatment to the patient.

As you can see, a consultation is something different than providing the primary medical diagnosis or treatment. The rule contemplates that regardless of who a Florida physician consults with, he or she is still responsible for the medical decision making and care and treatment of a Florida patient.

Looking ahead

Recently, a Petition for Declaratory Statement concerning the practice of telemedicine was scheduled to be heard at April 4, 2009, the Florida Board of Medicine. The Petitioner sought the Board's opinion as to whether a pathologist must perform a physical examination before ordering a diagnostic test if the test is directly requested by the patient. More specifically, the Petitioner sought the Board's clarification as to whether 458.331(1)(m), Fla. Stat. requires a pathologist to perform a physical examination on a patient before

ordering a diagnostic test, where there is no referring physician. An additional issue presented in the request for a declaratory statement was whether the act of ordering a test requested by a patient would be considered the practice of telemedicine under Rule 64B8-9.014, F.A.C. The petition was withdrawn and not heard by the Board.

Finally, the issue of telemedicine was recently considered by the Florida Legislature in Senate Bill 456. Known as the "Deputy Anthony Forigione Act," the bill was recently signed into law by Governor Crist in May 2009 and is scheduled to take effect on July 1, 2009. The law concerns involuntary inpatient and outpatient placement and notes that a second opinion authorized within the context of that law may be conducted through a face-to-face examination, in person or by electronic means. Under the Act, electronic means is defined as "a form of telecommunication that requires all parties to maintain visual as well as audio communication." See 394.455(38), Fla. Stat.

It will be interesting to see what direction the Board moves in the coming years as telemedicine is certainly going to become more and more prevalent. It does provide a critical role in the delivery of health care services.



Sovereign Immunity – A Primer For The UF Health Care Provider

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This article published in the April-June 2006 edition is being reprinted for the benefit of new faculty and residents.

The Concept of Sovereign Immunity

The doctrine of sovereign immunity, also referred to as “Crown immunity,” is grounded in the English common law concept that “the king can do no wrong,” and was not, therefore, subject to claims and suits by his countrymen. In the United States, the doctrine takes on a more practical perspective, recognizing the reality that there is no legal right to sue the sovereign authority for rights and obligations that are conferred by laws made by the same sovereign authority. Accordingly, unless the sovereign agrees, it cannot be sued. In American jurisprudence, the doctrine of sovereign immunity applies not only to the United States government (federal sovereignty), but also to each of the individual states. The immunity enjoyed by the United States and the individual states may be waived, in whole or in part, by federal and state lawmakers, thereby permitting these sovereign entities to be sued. Any waiver of sovereign immunity, however, will be limited to the expressed parameters in the waiver statutes and will be strictly construed by the courts that interpret these statutes.

Limited Waiver of Sovereign Immunity in Florida

The State of Florida enjoys sovereign immunity to the extent that the Florida law permits. Section 13 of Article X of the Florida Constitution authorizes the state legislature to enact laws permitting claims and lawsuits to be brought against the state. The provisions of Section 768.28 of Florida Statutes set forth the specific conditions limiting the extent to which the state waives sovereign immunity in tort actions, including medical negligence claims and litigation. This statute permits the state to waive sovereign immunity, to a limited extent, when personal injury or death was caused by the “negligent act or wrongful omission” of any employee of the state, state agency, or state subdivision, while the employee or agent was “acting within the scope of the employee’s office or employment.” The statute

provides that the state, for itself and for its “agencies and subdivisions,” waives sovereign immunity for liability for torts but only to the extent specified in this statute. The statutory reference to “agencies and subdivisions” includes independent establishments of the state, such as state university boards of trustees. Accordingly, when an employee of the University of Florida (UF) negligently causes personal injury, sovereign immunity is waived, subject to limitations, and the injured party may assert a claim or file a lawsuit against the University of Florida Board of Trustees.

The Basic Application of the Waiver of Sovereign Immunity to UF Health Care Providers

Within the ambit of sovereign immunity, Florida law affords immunity from personal liability for UF health care providers, when their care and treatment of patients becomes the subject of a claim or lawsuit, provided certain criteria are met. Specifically, UF health care providers will not be held personally liable for medical negligence if the negligent act or omission occurred while the health care provider was acting within the scope of the health care provider’s UF employment and the provider was not acting in bad faith, or with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. In practical terms, this means that, when a UF health care provider is performing duties within the scope of the provider’s employment with UF and the provider’s care is alleged in a claim or lawsuit to have been negligent, the provider will not be held responsible personally for any money damages that might result from the claim or lawsuit. This presumes, however, that the provider was acting in good faith and was not wanton and reckless, *i.e.*, grossly negligent. Section 768.28 of Florida Statutes provides further that a state employee or agent may not be named as a “party defendant” in any claim or lawsuit. The University of Florida Board of Trustees is, as a mat-

ter of law, the proper defendant in any claim or lawsuit alleging medical negligence on the part of a UF health care provider. The practical application of these statutory provisions is illustrated in the [Question-and-Answer](#) section of this article.

Limits on Recovery by Claimants and Plaintiffs

Section 768.28 of Florida Statutes not only relieves UF health care providers of personal liability for negligent acts or omissions occurring within the scope of their duties, the statute also limits the amount of money payable by the state to those injured as a result of such negligence. The amount of monetary damages payable by the University of Florida Board of Trustees to a successful claimant is limited to \$100,000 per claimant, and the aggregate that may be paid on any claim, regardless of the number of claimants, is limited to \$200,000. If, for example, a husband and wife sue the University of Florida Board of Trustees in a medical negligence action and the jury awards the plaintiffs \$1,000,000, Florida law limits the payment to each claimant to no more than \$100,000 and limits the total payment to both plaintiffs to \$200,000. In order for the claimants to recover damages in excess of these statutory limits, they would need to pursue a claims bill in the Florida legislature. The Florida legislature can award recompense, without monetary limits, which must be paid by the University of Florida Board of Trustees. It is rare, however, that claims bills based upon medical negligence incidents are successful.

The Practical Impact of Sovereign Immunity Upon the UF Health Care Provider – Some Common Questions and Answers

Question: A UF faculty physician is named as a defendant in a Notice of Intent to Initiate Litigation for Medical Negligence. How can this happen if Florida law prohibits state employees from being named defendants in claims and suits?

Answer: The most common reason for this occurrence is simple ignorance on the part of the claimant's attorney concerning the employment status of the UF physician. Florida law requires that, before a claimant may legally file a medical negligence lawsuit, the claimant (normally through the claimant's attorney) must conduct a good faith investigation of the facts giving rise to the claim. After investigation, notice of the claim must be sent to the health care provider alleged to be negligent. At the time the notice is sent, it is not uncommon for a claimant's attorney to have insufficient information to confirm the actual employer of the health care provider. The claim package sent to the provider is called a "Notice of Intent to Initiate Litigation for Medical Negligence" (NOI). When UF health care providers receive NOIs, they forward them to the Self-Insurance Program (SIP) for action. SIP will investigate the claim, respond to the matters alleged in the NOI, and advise the claimant's attorney of the UF health care provider's immune status. The claimant's attorney will also be advised that Florida law prohibits the naming of the UF provider as a defendant in any lawsuit that may be pursued and that SIP will pursue legal sanctions against the claimant if the UF provider is specifically named as a defendant in future proceedings. If the claimant's attorney ignores this admonition and files suit naming a UF provider as a defendant, motions will be filed with the court to remove the name of the UF provider as a defendant and to substitute the University of Florida Board of Trustees as the proper defendant.

Question: Are UF resident physicians and physician extenders covered by the Florida sovereign immunity statute?

Answer: As is the case with all other state employees or agents, all UF residents and physician extenders, acting within the scope of their university function, are afforded immunity and are not sub-

ject to personal liability for their negligent acts or omissions that cause injury to a patient.

Question: Are there any circumstances in which the conduct of a UF health care provider might result in the loss of immunity from personal liability?

Answer: Yes. The more common occasions where immunity is lost include: (a) committing an intentionally tortuous or criminal act; (b) committing medical negligence during a time when the provider is not performing duties within the scope of employment with UF; and (c) performing an act or omission that is considered grossly negligent, *i.e.*, an act or omission exhibiting wanton and willful disregard for safety and well-being of the patient. Providers who commit intentional acts of misconduct, such as sexual assault, battery, and defamation of character, are not immune from personal liability. Some providers engage in patient care outside of their duties with UF. Although all UF providers are required to seek permission from UF prior to accepting employment outside of the scope of their UF employment, they are not immune from personal liability for any negligence on their part that occurs during the course and scope of outside employment. The mere fact that UF has granted permission to the provider to engage in outside employment does not afford the provider immunity for negligent acts when engaging in those activities. Examples of actions rising to the level of gross negligence that would result in a loss of immunity include acts such as being intoxicated while performing a procedure or, while on call, intentionally ignoring repeated pages by the nursing staff to attend to the needs of a critical patient, solely because the provider was preoccupied with personal business.

Question: A physician is appointed to the UF faculty as an attending physician and clinical professor. Prior to her appointment she was a member of

a private practice professional association. While serving in her position at UF, she receives an NOI alleging that she was medically negligent in treating a patient while she was in private practice. Does the fact that the physician was a UF employee at the time that she received the NOI render her immune from personal liability for any medical negligence that occurred in her former private practice?

Answer: No. The physician is provided immunity only for those acts or omissions occurring during the course and scope of her employment with UF. There is no immunity from personal liability for acts or omissions occurring at times and under circumstances when the physician was not acting within the scope of her employment with UF, even though she received the NOI when she was employed by UF.

Question: A physician leaves his employment with UF. One year later, he receives an NOI alleging medical negligence for delay in diagnosis and treatment of a patient he examined and treated while he was acting within the scope of his duties at UF. Is the former UF physician immune from personal liability for the claim of medical negligence involving this patient?

Answer: Yes. The former UF physician is immune from personal liability with respect to any medical negligence claim based upon incidents that occurred at any time that the UF physician was acting within the scope of his employment with UF, even if he received notice of the claim subsequent to terminating his relationship with UF.

Question: Is it true that if a UF health care provider is afforded sovereign immunity, he or she will not be subject to any consequences if a claim or lawsuit alleging medical negligence on the part of the provider is resolved in favor of the claimant?

Answer: Although it is true that the UF health care provider will be immune from personal liability, *i.e.*, personally paying money damages as a result of a claim or lawsuit, the provider is not shielded from the administrative consequences of medical negligence. Under current Florida law, for example, a copy of a complaint in a medical negligence lawsuit must be sent to the Florida Department of Health (DOH). Even though the University of Florida Board of Trustees will be the named defendant in a lawsuit involving alleged negligence on the part of a UF health care provider, the “body” of the complaint will most likely contain allegations asserting negligence attributable to particular UF providers for whom the University of Florida Board of Trustees assumes responsibility if any monetary damages are awarded as a result of the suit. Upon receipt of a copy of the complaint, the DOH will review the allegations and may, based upon the review, open an investigation into the licensure of a provider alleged to have been negligent. The ensuing investigation may lead to the provider losing his or her license or may result in lesser sanctions, such as community service, mandatory education, and fines. Additionally, when UF healthcare providers are medically negligent, they may be subject to possible administrative sanctions by UF and by the facility where the negligence occurred.

Question: Are there any unique situations that are not covered in this article that might affect the immune status of a UF health care provider?

Answer: Florida and other states have “Good Samaritan” statutes that provide limited immunity to physicians and other healthcare providers who respond to medical emergencies that occur at accident scenes and during disasters. There are also some unique immunity issues that arise when a UF provider, acting within the scope of his or her UF employment, performs activities for UF outside of the state of Florida. Analysis of these special cir-

cumstances is beyond the scope of this current article but will be addressed in a future edition of Risk Rx. However, as you will learn in greater detail, UF health care providers are provided liability protection under these circumstances.

Question: Where may a UF health care provider seek additional information and advice concerning the impact of sovereign immunity upon his or her practice?

Answer: The staffs of the Gainesville and Jacksonville SIP offices are always available to answer questions and address concerns that a UF provider may have concerning sovereign immunity.

Of all the common questions posed, the last may be the most helpful to UF health care professionals. The two SIP offices are staffed with professionals that are ready, willing, and able to assist you and are available on a 24/7 basis. The offices may be reached as follows:

Gainesville: (352) 273-7006
Jacksonville: (904) 244-9070

Patient Non-Compliance— A Powerful Legal Defense

By: Becky Summey-Lowman, LD, CPHRM

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There is little doubt to any practicing physician that patient non-compliance is a significant and contributory factor to poor outcomes. There is also little doubt that patient non-compliance can often lead to more aggressive and costly treatments. What you may not know is the extent that to which

a patient's noncompliance can increase your risk for a medical malpractice claim and how much good documentation can protect you.

While it is reasonable for you to expect a patient to share in the responsibility for their own care, juries nationwide have placed a significant amount of responsibility for follow-up on the provider. When patients fail to follow treatment advice, it is prudent to document this in the medical record. There are compelling reasons for providers to document patient noncompliance.

If such non-compliance contributes to an injury that results in a malpractice suit, it can usually be introduced as evidence in the doctor's defense.

Documentation of patient noncompliance can may provide a powerful defense to any lawsuit.

Depending upon the comparative fault laws in your state, a plaintiff's recovery is reduced or prohibited based on the percentage fault attributed to the plaintiff. A recent case involved the death, while hospitalized, of a 39 year old 6'4, 225 white male 11 days post bilateral laminectomy and lumbar decompression at the L3-4 and L4-5 from a pulmonary embolism. The MAG Mutual insured neurosurgeon ordered TED and SCD devices for the patient upon his presentation in the emergency department. This order was never discontinued, but the patient was non-compliant throughout his hospitalization, despite repeated education by the medical team of the risk associated with a deep vein thrombosis (DVT).

The plaintiff contended that because our physician never documented his conversation with the patient regarding the possible risk of DVT and because he failed to implement heparin therapy these actions rose to the level of malpractice.

The MAG Mutual defense team put forth a strong defense that showed the patient's refusal to follow medical instructions and the risks associated with

heparin therapy. Our physician did an excellent job during his testimony educating the jury about the surgical procedure including his normal practice of explaining the risks associated with blood clots. It was also brought out in the testimony by the nurses, physical therapist and nursing assistant regarding their diligence in ambulating the patient and explaining the risk for DVT to both the patient and his wife. After a week of trial the jury returned a defense verdict, following 45 minutes of deliberations.

Non-Compliance versus Patient's Right to Make Decision Regarding Medical Treatments.

It is important to recognize the difference between noncompliance and the patient's right to refuse care. Patients have the right to make informed decisions regarding their care, including being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. Non-compliance may be the result of an educated, rational and reasonable decision on the patient's part to exercise control over their healthcare. The medical record should include documentation that the diagnosis and proposed procedure/treatments were explained to the patient and that the explanation included the patient's prognosis without the procedure, the risks and benefits, and alternative therapies.

Consider the following suggestions to enhance patient compliance:

- Emphasize the seriousness and urgency of any recommended tests.
- Explain the rationale for your treatment advice
- Allow the patient to voice any concerns they have about recommended treatments
- Suggest treatments that are reasonable, taking into account the patient's lifestyle, finances and ability to comply
- Whenever possible, give patients the opportu-

nity to think about proposed treatments prior to making a final decision

- Provide simple written information to patients and others who are involved in their care
- Attempt to gain agreement on the treatment plan
-

Risk Management Strategies

Document Non-Compliance/Informed Refusal

When the patient has failed to comply with your recommendations, document the non-compliance. Among the more common problem areas are:

- Repeated failure to keep appointments;
- Failure to have diagnostic testing or consultation as recommended
- Failure to comply with medication therapy
- Failure to follow medication monitoring recommendations (for example, warfarin monitoring)

Carefully notate episodes of non-compliance, avoiding any documentation that may look judgmental or self-serving. An example of an adequately documented informed refusal discussion is as follows:

“A breast ultrasound has been recommended to evaluate the palpable lesion on the right breast. The patient states that her insurance “will not be effective for ninety days” and elects not to have the test done pending coverage by insurance plan. The risk of delay was discussed with the patient to include the possibility of a malignancy, and the risks of a potentially life threatening delay in diagnosis and treatment. The patient verbalizes understanding of the information provided. I have asked my staff to investigate and advise her of any financial assistance that may be available. She was advised to contact me as soon as possible if she reconsiders this decision or as soon as insurance coverage is

effective.”

A sample informed refusal form can be found on the MAG Mutual website at www.magmutual.com.

Document Screening Recommendations

Advise patients of preventative health screenings and document these discussions. Failure to do so could result in an allegation of a delay in diagnosis if a metastatic or potentially life-threatening condition is not detected in a timely manner.

Inform Patients of Test Results in a Timely Manner

Inform patients of test results in a timely manner. Results that are indicative of a potentially life threatening illness may be best communicated by the physician personally to allow the patient the opportunity for questions and agreement on future treatment plans.

Maintain a Reliable Clinical Tracking System

Without a reliable clinical tracking system, it may be difficult to identify patients who fail to keep scheduled appointments for tests and consultations with specialists. Whenever possible, schedule referrals and follow-up appointments before the patient leave the office. If the patient refuses the test, due to financial or other reasons, this should be well documented. Failure to maintain reliable clinical tracking systems is one of the most frequently cited problems in medical malpractice cases where there is an allegation of delay in diagnosis and/or failure to supervise care.

Coordinate Treatment Plans with Other Providers Involved in the Patient’s Care

Maintain good communication with other providers involved in the patient's care and maintain a clear understanding of the expectations and role in the patient's plan of care. Ask consultants to notify you if the patient fails to keep an appointment and request periodic updates on the care and treatment plan or a summary at the conclusion of care, whichever is appropriate.

Informed Consent

Inform patients regarding any alternatives, benefits, risks and complications associated with the proposed treatments or tests. Document all informed consent and informed refusal discussions. In conclusion, given the extensive research on patient noncompliance, it is reasonable to maintain a high index of suspicion for non-compliance on all patients. The best approach is to maintain effective communications with patients and take proactive measures to enhance treatment goals. However, when patients fail to follow recommended advice and a poor outcomes result in a medical malpractice claim, objective documentation of non-compliance can be your most powerful defense.

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