PRF NEWS

Covering Practice and Risk Management Issues for Physicians

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Stephen Scheifele, MD, Executive Editor
Robert D. Nachtigall, MD, Editor

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Physicians Reimbursement Fund, Inc.
1409 Sutter Street
San Francisco, CA 94109
(415) 921-0498 - voice
(415) 921-7862 - fax
June@PRFrrg.com

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Soad Kader
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Privacy Pertains to the Patient's Body as Well as Information

Given the impending enforcement of HIPAA's privacy rule, physicians should carefully monitor new developments and obtain sound advice to be sure that their practices comply with the new regulations. While the HIPAA legislation pertains largely to privacy of medical information, a recent Southern California case underscores the importance of protecting the privacy of a patient's body in a clinical setting.

Following successful treatment for breast cancer, a 46-year-old woman returned to her oncologist's office for a routine follow-up visit in 1998. The patient was led into an exam room, where she was to wait for her doctor, who soon entered the room with a man who was dressed as a professional. According to the patient, the physician said the man was "a person . . . who was looking at his work." The oncologist asked the patient to remove her blouse and bra and he then examined her breasts, axillae, and abdomen. With the other man observing the examination, the patient "felt hot and flushed" according to David W. Shapiro, MD, JD, who described the case in the January/February 2002 issue of *Professional Liability Newsletter*.

At the end of the visit the patient dressed and, as she was leaving, asked the receptionist who the other man was. The receptionist said he was a drug salesman, and that it "wasn't right" for him to have observed the examination. After leaving the office the patient "cried from shame and anger." She called the oncologist the next day to complain, and he allegedly apologized for not explaining who the drug salesman was, although the salesman later said that the physician did adequately explain the salesman's presence before the exam.

The patient sued the oncologist and his medical group for invasion of privacy and lack of informed consent, in addition to suing the pharmaceutical company for invasion of privacy. While the trial judge dismissed the privacy claims in 1999, an appellate court in 2001 reinstated the privacy claims and allowed the case to proceed to trial. Just before the start of the trial, however, the defendants settled for an undisclosed amount.

Shapiro writes that the appellate court based its decision on an 1881 Michigan ruling in which "a physician took a nonprofessional man with him to deliver a baby at a patient's home." The man held the patient's hand during a particularly painful moment during delivery, although the physician "did not disclose to the patient the man's 'true character.'" The court "held that the patient had the right to presume that a practicing physician would not enlist a nonmedical person to assist in a delivery. Further, the mother was not precluded from recovering damages because she had consented to the man's presence under the mistaken assumption that he was a physician."

Shapiro notes that:

- Only clinically necessary personnel should be present during medical visits, procedures, or operations.
- The identity and purpose of anyone else should be disclosed and consent should be obtained, preferably in writing.
- Violations of the confidentiality of medical information can have serious consequences and have precipitated numerous lawsuits.

PRF–RRG – BOARD OF DIRECTORS 2002

The election of the PRF–RRG Board of Directors took place at the Annual General Membership Meeting. The following Board of Directors will continue to serve the Company in the same capacities as each served in 2001:

President – George F. Lee, MD
Treasurer – Damian H. Augustyn, MD
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Vice President – Michael E. Abel, MD
Vice President – W. Gordon Peacock, MD

We thank our Insureds who took the time to attend the Annual General Meeting of PRF–RRG. If you did not attend the meeting this year, please consider attending next year's meeting. It is an opportunity for you to meet with some friends and colleagues and learn more about your professional liability insurance provider. ■

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Newsletter of the Physicians Reimbursement Fund, Inc.

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Risk Factors and Interventions for Mood (Affective) Disorders in the Postpartum

BY ANNA SPIELVOGEL, MD

It is important that physicians recognize that in the first three postpartum months, new mothers are at a seven-fold increased risk for psychiatric hospitalization compared to non-pregnant women. Approximately 90% of these hospitalizations are for major mood disorders, predominantly depression.

Postpartum depression, occurring in 10-15% of women, has identifiable risk factors, which include previous episodes of depression or a strong family history of depression. Depressive episodes often occur when a person with a genetic predisposition experiences psychosocial stress. A newborn represents a major challenge for a woman, while she is still recovering from the pregnancy and delivery. These stresses may be further compounded by sleep deprivation and hormonal adjustments. While depressed women often can manage their pregnancy, caring for an infant frequently exceeds their coping capacities and their difficulties in functioning becomes apparent.

Postpartum psychosis is the most serious, but rare, disorder, occurring in 1 in 1,000 deliveries. However women with a diagnosis of bipolar disorder have a 30% chance of developing a postpartum psychosis. Once a woman has had an episode of postpartum psychosis, her risk increases to more than 50% after a subsequent delivery. The onset of psychotic symptoms is rapid and most frequently occurs within two weeks of delivery. However, the risk of an episode requiring hospitalization remains elevated for up to two years. Infanticide (1:50,000 deliveries) and suicide are rare but devastating risks of the psychosis.

Since psychiatric disorders during pregnancy and the postpartum are frequent, can affect infant development and attachment, and pose dangers to the mother and baby, obstetricians should routinely screen women when they enter prenatal care. The following items should be routinely assessed:

1. Current mood, anxiety or psychotic symptoms.
2. Major stresses such as a recent loss, exposure to trauma or violence.
3. Past history of seeking psychiatric help, psychiatric hospitalizations, suicide attempts and past or current use of psychiatric medication.
4. Postpartum adjustments during previous pregnancies that made it difficult to care for the baby.
5. Family history of psychiatric disorders (mood disorders have a significant genetic component).
6. Denial of pregnancy, lack of bonding and preparation for infant.

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Women with current psychiatric symptoms, past history of an affective illness or suicide attempts and strong family histories of mood disorders, particularly bipolar disorders, should be referred for a psychiatric consultation. Women with significant symptoms or risks should be started on psychotropic medication. Women already under treatment should not be advised to stop their medication:

- **Medication used for treatment of bipolar disorder** - (Lithium, Carbamazepine, Valproic Acid) *are teratogenic when taken during the first 10 weeks of pregnancy.*

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Women who require these medications when not pregnant may have no choice but to continue them during pregnancy to prevent decompensation and hospitalization. They should be informed about the potential for birth defects and offered screening for their detection.

- **Antidepressants** - Growing data has failed to find adverse obstetrical or long-term behavioral outcomes to *in utero* exposure with selective serotonin uptake inhibitors (Fluoxetine, Paroxetine, Sertraline Citalopram) or tricyclic antidepressants.

- **Antipsychotics** - Relatively few patients have been studied and a small increase in non-specific teratogenicity cannot be ruled out for the frequently used medications such as haloperidol and fluphenazine or the newer antipsychotics olanzapine and risperidol.

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Obstetricians should be familiar with symptoms that require immediate or long-term treatment.

Psychosis. Women who are psychotic often present confused and poorly groomed. They often convey little information or are incoherent and describe delusional or paranoid ideas making it difficult to establish rapport.

Mania is characterized by elated or irritable mood, grandiosity, talkativeness, flight of ideas and an increase in activity. The manifestation of mania changes rapidly every few days. At the height of mania, psychosis can erupt and involve the newborn.

Depression can present with sad mood, somatic complaints, fatigue, recurrent thoughts of death, guilt and worthlessness. A woman can feel so distraught that she feels she and the baby would be better off dead. There is a 50% recurrence rate if women had prior episodes of postpartum depression.

Obstetricians should be familiar with symptoms that require immediate or long-term treatment.

Psychosis, acute mania and severe depressions are psychiatric emergencies, as women's impulse control is poor and they could act on some of the delusional beliefs, hurting themselves or others. They should be immediately referred to a psychiatric emergency service.

Anxiety disorders present with excessive and pervasive worry and somatic symptoms.

Panic disorders, characterized by sudden onset of intense fear of dying or losing control, palpitation, chest pain or the physical sensation of choking, can often be confused with somatic illness. During pregnancy, panic disorders often occur at night and lead to intolerable insomnia. Women suffering from untreated panic disorder are at risk for suicide.

Obsessive Compulsive Disorder. New onset of obsessions in the postpartum have been reported, characterized by vivid intrusive images or obsessive thoughts of harming their baby or husband.

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In summary, routine screening of pregnant women for psychiatric disorders, identification of high risk women, appropriate psychiatric referral, and coordinated treatment with psychiatrists can greatly enhance the care of pregnant and postpartum women and increase the probability that they will deliver healthy, well-adjusted babies.

Dr. Spielvogel is Clinical Professor of Psychiatry, University of California San Francisco, and the Psychiatric Consultant to the Obstetric Clinic at San Francisco General Hospital.

INFANTICIDE

A recent report of 16 cases of neonaticide found that all had intermittent denial of pregnancy for psychological reasons, some of which included a strong familial prohibition of extramarital sex, past removal of an infant by CPS, immaturity, and previous sexual trauma or psychosis. Women who have dissociative episodes or women with psychotic illnesses should be closely followed during pregnancy to assure they remain under care and acknowledge their pregnancy. Women with antisocial personality disorder, severe substance abuse and untreated psychotic disorders are at risk for infanticide and should be referred to CPS for evaluation and monitoring. ■

Prepare Now for HIPAA Enforcement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also known as the Kennedy/Kassebaum Act, was created to improve health insurance accessibility for people changing employers or leaving the workforce. But HIPAA also included "Administrative Simplification" provisions to encourage and protect the electronic transmission of confidential health-related data.

Physicians who use or plan to use electronic means for billing, claim inquiries, payment, or other such transactions are subject to HIPAA regulations. The benefit to physicians will be a reduction in administrative costs. For the first time all health plans and other payors will be required to accept the same single claim form without any variations. There will be uniform code sets for diagnoses and treatments.

HIPAA's privacy rule is the first part of the law to be implemented and will be enforced starting April 14, 2003. To comply with the new rules physicians must adopt specific policies to protect patient privacy and for obtaining a patient's permission to use and disclose confidential information, whether in paper or electronic form.

Pertinent requirements include:

- **The privacy rule creates two levels of consent: patient consent and patient authorization.**
  Consent is necessary to release information used for treatment-related purposes, payment and health care operations (TPO). Examples of healthcare operations include: quality assessment and improvement activities, physician qualifications and competence evaluations, medical reviews, and audits.
  Authorization is required to disclose information for non-treatment purposes (employers, underwriters or researchers) and is limited to "minimum necessary". Authorizations must be written in specific terms and must identify:
  - The information to be disclosed.
  - Persons authorized to make the disclosure.
  - Persons authorized to receive the information.
  - "Expiration date" of authorization.
- Physicians may refuse treatment if they do not receive the patient's consent. Treatment generally cannot be refused for failure to sign an authorization.
- Consent is not required for sharing a patient's medical records with another physician when referring the patient to that physician. The specialist must comply with the consent rules when the referred patient presents for treatment except for billing a patient referred for a specialty consultation.
- In general, under HIPAA, a properly issued records subpoena will generally be valid and a physician who releases records under such a subpoena will be protected.
- Physicians must provide a "Notice of Privacy Practices" to each patient no later than the date of the first service after the compliance date (April 14, 2003). If the notice is revised, it must be provided at the first visit after revision. The CMA is developing sample "Notices".
- Patients have the right to inspect and receive a copy of their medical records and to request amendments to their records. Though providers have the right to deny inclusion of an amendment, the patient has the right to file a "Statement of Disagreement" which becomes part of the record. The provider can also file a rebuttal to the Statement.
- Patients also have the right to receive an accounting of disclosures of protected information not related to treatment, payment or healthcare operations. Individuals may request restrictions on the use and disclosure of information that go beyond those provided in the rule, but providers are not required to comply with those requests.

The California Medical Association has published a Model HIPAA Privacy and Security Audit for Small Practices, which is a useful tool for planning how to prepare for HIPAA. CMA is sending regular alerts to members to prepare them for other aspects of HIPAA.

Additional help may be found at www.hhs. gov/ocr/hipaa. This is the July 2001 Privacy Regulation Guidance, which is written in plain English. ■

BRIEFCASE

ANNUAL GENERAL MEMBERSHIP MEETING – PRF-RRG

On April 17, 2002, PRF–RRG had its Annual General Membership Meeting at 1409 Sutter Street on the main floor of the San Francisco Medical Society. President, George F. Lee, MD, reported on the corporate activities of 2001. Dr. Lee also discussed the history of the company and its transition from an off-shore company to the current state of the Company, i.e., an on-shore risk retention group (RRG) offering policy limits of $1 Million/$3 Million while purchasing reinsurance for losses greater than $500,000. Dr. Reuben A. Clay, Jr., Chairman of the Patient Care and Management Committee, summarized the Company's claims experience for the past 10 years. Finally, Treasurer Damian H. Augustyn, MD, reported on the financial status of the Company and its investments. ■