Supplementary Pre-Course Materials

for

Medical Ethics and Professionalism

Presented by

The *Western Institute of Legal Medicine*

and

The *American College of Legal Medicine*

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ABOUT THESE ENDURING MATERIALS

The Supplementary Pre-Course Materials for Medical Ethics and Professionalism include Practical Medical Ethics and Professionalism.

The topics listed under the Table of Contents depict medically ethical, medical-legal, and risk management principles that can protect patients and clinicians.

The materials are based in part on California law, and because laws vary from state to state, some specific information and statutes may differ. The general principles will still apply, but if you are not located in California, you should consult legal counsel practicing in your state to identify any variations in your state laws.

Successful completion of this program earning six (6) continuing medical education hours requires the following:

1. Study of these written materials.
2. Successful completion of a test on these written materials during attendance at the Western Institute of Legal Medicine *Practical Ethics* course.
3. Completion of the Enduring Materials page in the *Accreditation Manual* during attendance at the Western Institute of Legal Medicine *Practical Ethics* course.

A written objective test will be given on this material at the time of attending the Western Institute of Legal Medicine *Practical Ethics* course. A 70% passing grade is required for the award of six continuing medical education credit hours for your study of these written materials.

Successful completion of the test is required to satisfy state licensing board mandates.

Any California statutes and administrative code regulations quoted in these materials are for reference only. The test will **not** require detailed knowledge of the text of these statutes and regulations.

I. INTRODUCTION

Medical Ethics, Morality and Conscience

Medical ethics uses values, facts, and logic to decide what the best course of action should be. It is a thought process which involves people skills, such as gathering the facts needed to make a decision and presenting one's decision in a way that wins over the confidence of all parties.

Medical ethics utilizes persuasion to get its message across. Its solutions are flexible, and they are based on facts and logic, and not religious doctrine. Its decisions should respect the values and attitudes of patients. For example, if patients oppose vaccinations or blood transfusions for their child, their beliefs have to be taken into account.

In contrast, morality relies on personal, political or religious views an authority to justify its message. It involves adhering to a specific belief system or code of conduct. It may be grounded on tradition or belief rather than facts or arguments.

Conscience and the religious faith of the physician should not overrule the patient's need to get the best treatment possible. For example, a physician refuses to give a patient a morning-after pill, on the basis of the physician's own values, even though the pill has been clinically proven to work. The patient's needs should come before the doctors' principles. Caregivers are expected to set their beliefs aside and focus on the best interests of the patient. If the doctor cannot bring treat a patient because of conscience, he or she must find or refer the patient to another doctor who will.

Medical Ethics History

In the 1930s, medicine was a paternalistic profession. Doctors gave advice, and patients were expected to follow along.

During World War II, German doctors, working in the concentration camps, conducted deadly scientific experiments in which the subjects had no say. The Nuremberg Code signaled the beginning of modern medical ethics.

Beginning in 1946, American researchers conducted an observational study of syphilis at the US Public Health Service on African Americans who were infected with syphilis under the guise of offering them free healthcare. In 1947, the standard treatment for syphilis was penicillin, which was withheld from the Tuskegee subjects. They were deliberately misinformed and were given placebos. Consequently, many of them died of syphilis, and their wives and children became infected with syphilis. In 1972, word of the Tuskegee syphilis experiment in Alabama appeared in the media. That and other exploitative experiments in the United States lead in the 1980s to

the development of strict limits on how research subjects are treated and heightened peer-based oversight.

In the 1960s and 1970s, medical values changed and gave way to new ethical standard involving forthright honesty toward patients. Physicians recognized that patients generally determine what is in their best interest. Patients began to exercise their right to know what was being done to them and have a say in the clinical process.

Also in the 1960s and 1970s, hospitals began to routinely use ventilators, feeding tubes, and other technology to keep patients alive, which rarely helped dying patients. Consequently, doctors were placed in the uncomfortable position of deciding who should live and who should die and when to remove life support.

In the 1960s, kidney dialysis was introduced, but it was a scarce and expensive resource at the time. Doctors selected which patients would be dialyzed. Ethical principles were used to determine allocation. In 1972, Medicare began covering dialysis for patients of all ages; the need to allocate dialysis slowly faded away.

The Concept of Futility

The ***concept of futility*** emerged which described medical interventions that have little prospect of altering a patient's ultimate clinical outcome. That resulted in confrontations between doctors and family members, for example in the cases of Karen Ann Quinlan (1976), Nancy Cruzan (1990), and Terri Schiavo (2005).

Medical Ethicists and Private Practitioners

Medical ethicists are healthcare providers who are trained and experienced in bioethics. They serve as consultants providing a second opinion to help doctors resolve mostly inpatients' problems.

Private practice doctors routinely confront time constraints when dealing with sundry ethical issues, including professional boundaries and responsibility, time constraints on appointments, cultural and personality issues, pressure to make more money, allocation and distribution of resources.

Hospital Ethics Committees

The majority of ***hospitals*** provide medical ethicists for doctors to consult, but relatively few practices have ethicists on staff. Large hospitals have advisory ***ethics committees***, comprised of professionals from a variety of disciplines, including doctors, nurses, chaplains, social workers, ethicists, and lawyers.

Clinical Research Ethics

Obtaining informed consent from the patient is the greatest ethical issue in medical research. The potential research participant will be taking a risk, either to get a new cure or to benefit others who suffer from the same disorder. Thus, enhanced informed consent documents are required that easily describe the risks and benefits, using terms, and supplemental visual and electronic aids, that the participants understand.

Clinical research is a closely monitored activity. Federal law requires researchers to submit their proposals for review and approval by an ***institutional review board (IRB).*** The IRB consists of a group of peers who have no conflict of interest with the research and do not benefit financially from a successful study. The IRB sets criteria for the study's deliberations and decisions to ascertain that potential participants know their options, and overseeing the informed consent process.

Public Health Ethics

Public health issues involve ethics. They are controlled by the government, but partly arise at the practice level. They involve ethical resource allocation to problems such as preventing disease, prolonging life, flu epidemics, vaccination, drug abuse (e.g. opioid epidemic), mental health services, birth issues, safe use of guns, urging the use of bike helmets, and promoting health through organized efforts.

For example:

1. The purpose of requiring vaccinations is "protecting the herd." The overriding concern is a societal problem. But some parents exercise their individual rights and refuse the measles vaccine for their children, for fear of causing autism. Unvaccinated children can spread the disease to others.
2. Doctors are permitted, based on First Amendment right, to talk to patients about gun safety and focus on the risks of suicide prevention, and the importance of keeping guns in a locked and secure place at home or other storage places.
3. The emergence of Accountable Care Organizations and other modes of value-based payments have pressured physicians to keep costs controlled and maintain quality care. Some physicians control cost by resorting to Choosing Wisely, a list of over utilized services selected by medical associations and others.

Ethical problems include:

1. Withholding treatment to meet an organization's budget, or because of insurance policies;
2. Accepting money from pharmaceutical or device manufacturers;

3. Upcoding to get treatment covered;
4. Getting romantically involved with a patient or family member;
5. Covering up a mistake;
6. Reporting an impaired colleague;
7. Cherry-picking patients;
8. Prescribing a placebo;
9. Practicing defensive medicine to avoid malpractice lawsuits;
10. Dropping insurers; and
11. Breaching patient confidentiality owing to a health risk.

The principles of medical ethics include:

1. Autonomy: Patients basically have the right to determine their own healthcare.
2. Justice: Distributing the benefits and burdens of care across society.
3. Beneficence: Doing good for the patient.
4. Nonmalfeasance: Making sure you are not harming the patient.
5. Truth-telling, transparency, listening, showing respect for patients and families, and showing respect for patients' own values.

At times, these values conflict with each other. For example, when patients refuse a treatment that could help them, the physician confronts a conflict between respecting patient autonomy and doing what is in the patient's best interest.

Ethical decisions cannot be avoided. Ethical decisions can change over time. The ultimate arbiter of clinical medical ethics is the individual caregiver, working in concert with the patient. Caregivers' ethical decisions go hand-in-hand with their clinical and technical decisions. Getting the ethics right depends on the integrity of the caregiver.

Judging Colleagues' Behavior

The AMA Code of Medical Ethics states that physicians should report colleagues' behavior "in the first instance so that the possible impact on patient welfare can be assessed and remedial action taken."

Administrative doctors have, as part of their job title, to supervise the behavior of doctors. And non-administrative doctors are implicitly responsible to uphold the well-being of patients in general, in addition to their own patients.

Medical Ethics and the Law

Medical ethics may have different standards from the law. The law is created by judges or legislators and may not share the values and reasoning of ethical physicians. With most

malpractice cases, courts examine clinical standards of care and determine whether the defendant doctor has met them. In many cases, unethical conduct does not rise to the level of medical malpractice.

Failure to obtain a patient's informed consent for a procedure is unethical and illegal; it is an important element in a malpractice complaint,even if the procedure meets all the standards of clinical care.

Baby Doe laws require doctors to treat premature babies even when they are severely disabled. Some doctors believe that preemies, too sick to survive, should not be treated. Physicians who disobey the Baby Doe laws are rarely prosecuted.

Unethical Behavior and Medical Boards

The definition of unprofessional conduct promulgated by the Federation of State Medical Boards includes "patient abuse" and "dishonesty." Medical malpractice cases require some evidence of harm, but this is not the standard for reporting physicians' conduct to medical licensing boards. Medical boards can and do take action against many behaviors that are widely considered unethical even when no harm takes place.

1. MEDICALLY ETHICAL CONDUCT DEFINED AND EXPLAINED

To understand these written materials in proper context requires an introduction to medically ethical conduct. Our medical ethics teaching is designed to enhance clinical practice.

We believe it is more useful to clinicians than traditional teachings that are based heavily on philosophy and on absolute but indefinable concepts. Our definition is as follows:

Medically ethical conduct is:

(1) Avoiding ***dishonesty*** *that is detrimental to a patient; and*
(2) recognizing and minimizing ***conflicts of interest*** *that could influence clinical judgment or behavior that is detrimental to a patient.*

Conduct that is not detrimental to the patient but may be detrimental to others can be **professionally** unethical even if it is not **medically** unethical.

The first principle of medically unethical conduct is ***dishonesty***. Dishonesty requires intentional misstatement, or use of misleading language that is in some way detrimental to the patient.

Deliberately withholding information from a patient is not necessarily an ethical violation if it has no detrimental effect. Nor is it possible to disclose everything. Examples of withholding information for the patient's benefit are:

1. Misleading a patient to maximize placebo effect;
2. Giving hope where there is none;
3. Overstating dangers of non-compliance;
4. In certain situations, reassuring a patient that you will not take an action that you fully intend to take because such action is required by law.

The second principle of medically unethical conduct is acting on a ***conflict of interest*** that in some way may benefit you, but may be detrimental to the patient. Examples of conflicts of interest are the following:

1. Receiving financial benefit beyond reasonable compensation for care provided;
2. Receiving unreasonable benefit to your reputation or credentials;
3. Spending inadequate time providing necessary care;
4. Failing to exercise impulse control (acting out);
5. Agreeing to the patient's or family's inappropriate demands in order to save time or avoid confrontation;
6. Refusing to change an opinion out of pride or arrogance;
7. Failing to devote adequate time to staying current in the clinician's specialty; and
8. Failing to devote adequate time to learning applicable law governing medical practice.

Medically unethical conduct must be intentional.
Medical negligence (malpractice) may be unintentionally detrimental to the patient, but is not in itself unethical.

II. ACTIONS REQUIRING SPECIAL CARE

The Process of Making Ethical Decisions

The following are helpful principles in making appropriate ethical decisions:

1. Eliminate misunderstandings. "Good facts make good ethics."
2. Listen, even when you strongly disagree.
3. Be aware of your own biases.
4. Be somewhat flexible.
5. Be transparent.
6. Provide a recommendation.
7. Don't use value-laden language.

When dealing with a disagreement between doctor and patient, or team member, in a clinical situation, consider the following step-by-step approach:

1. Establish the clinical facts, emotional state, and capacity to make informed consent or refusal decisions about the medical care. Share the facts with patients, family, and team caregivers. Determine if they agree.
2. Establish the goal for your patient. For example, control, prevention or cure of disease, prolonging life, or alleviating suffering, restoring function and/or relieving pain. Consider the ethical justification and reasonable ways to accomplish the goal.
3. Decide after weighing the different values involved, such as morals, religious beliefs, attitudes toward different types of care patient, autonomy, privacy, truthfulness, and transparency. There may be a conflict between these values. And some patients may be concealing the real values that are motivating them.
4. Step back and evaluate the information. If needed, collect more information about a patient's goals, search the medical literature for treatment alternatives, engage administrators and insurers, or take steps to address misunderstandings or restore trust.
5. Be a unifier. Avoid vague language. Choose words carefully. Work to bring both sides together in a safe, secure and comfortable environment. Discuss emotional and contentious issues. And offer agreements that allow both sides to move forward.
6. Prepare for inability to resolve the situation. For example, consulting a medical ethicist or others doctors, transferring the patient care to another physician, obtaining recommendations from the ethics committee or medical director, contracting with an outside mediator or bringing in a chaplain.
7. Follow up on the situation to determine what happened.

Examples

A. Parents Don't Want to Tell Teenager About HIV Diagnosis

A patient who is younger than 18 years is diagnosed with HIV. His parents tell the doctor that they don't want her to tell the son. They will handle it. They basically have a good motive—to protect the child against feeling ashamed about having HIV—but it is misplaced.

Parents have a more powerful role in pediatric cases than in adult cases. Adult patients should be told what's going on with their health, but parents of minors have the right to withhold information from their children if they think that is in their best interests.

Parents' minds can be changed, but this requires good negotiating skills on your part. You may fail to persuade the parents. In that case, you may decide to walk away from the situation, but this creates another ethical issue: possible abandonment of the patient.

B. Patient With Terminal Cancer Wants Cataracts Removed

A patient in the final stages of multiple myeloma is in a lot of pain and also has cataracts that have made him almost blind. His request: Before I die, could I get the cataracts removed so I could see my family?

Cataract surgery costs $3500 per eye, and the patient won't live much longer. Many procedures at the end of life seem wasteful, but this one seems to have real value to the patient. In this situation, the patient's doctors recommended the surgery.

This is an example of how ethical decisions often involve conflicting goals that are not easy to compare, but it has to be done. For example, you can put an exact value of the cost of an intervention, but it's harder to put an exact value on what brings joy to the patient.

Common Ethical Issues

1. Delivering Bad News

Most physicians would neither withhold information from a patient about a terminal diagnosis in an effort to bolster their spirit or attitude nor withhold information from a competent patient at the family's request. But there is such a thing as being too frank with the patient or family. It is best to tell the truth without hurting peoples' feelings with blunt statements.

2. Issues Surrounding Medical Futility

Doctors often take a stand against the family when treatment is futile, or express their reservations and point of view. But a family may insist on life support for the dying patient. In some states, futility laws authorize doctors to overrule the patient's family. The doctors are required in those states to go through a lengthy process before life support can be removed.

Avoid stand-offs with the patient's family about futility. Instead, offer some modest hopes. And when discussing a major medical procedure with the patient and family, include a discussion on when life support should be stopped.

3. Disagreements With the Patient's Family

Avoid them. Disagreements with the patient's family are destructive. Doctors should maintain good relations with family members and treat them with respect and cordiality. When visiting a patient's family, consider the following:

- Sit down when you talk to them.
- Ask the family to talk about the patient.
- Admire the family members' interest in the patient.
- Discuss what's happening at each step of the care process.
- If a disagreement arises, determine what it's all about. If it's hard for the family to relate to the doctor, it is best to find another physician who is more acceptable to the family.

4. Revealing Mistakes to Patients

Most doctors believe that it is never acceptable to avoid revealing a mistake to the patient. Each revelation of a medical error has the potential of reducing the patient's trust in the doctor. Some errors are minor and are not worth bringing up, such as mistakes that caused no harm. However, all mistakes should be discussed with clinical colleagues for learning purposes.

5. Caring for Uninsured or Underinsured Patients

Physicians should be advocates for their patients. They should not cherry-pick—meaning, selecting only patients who have good insurance. Cherry-picking can be particularly harmful to patients with chronic diseases, such as a child who has asthma. Additionally, physicians should advocate strongly for their patients on getting prior authorization from insurance companies and dealing with the escalating costs of drugs.

6. Practicing Defensive Medicine

Defensive medicine involves ordering a procedure that some consider warrantless, with the sole purpose of protecting the physician from a possible malpractice lawsuit. It means that the patient or insurer will pay more money in return for a questionable increase in quality of care. An extra test outside the standard of care may be hard to justify to the patient or in court.

7. Taking Away an Impaired Patient's Driver's License

Six states, including California, require doctors to report impaired drivers, mostly elderly and those with dementia, partial blindness or seizure disorders, to the Department of Motor Vehicles (DMV). And 25 states encourage physicians to report impaired drivers. If these patients are allowed to drive, they could be a danger not only to other people but also to themselves. But taking away the driver's license may lead to anger, depression, isolation and loneliness.

Doctors may ethically and directly discuss the impaired driver's situation, get their response, work towards an agreement, and get sign-off from family members. The agreement might include the use of other transportation, such as Uber, Lyft, a community van, or a taxi.

8. Reporting Impaired Colleagues

Many state laws and ethics codes of professional societies mandate reporting practicing colleagues who are incompetent, physically impaired, addicted to drugs, drink alcohol heavily, or exhibit significant loss of memory, stamina, or motor coordination. But doctors have reservations about reporting colleagues, because of concerns about what might happen to reported doctors, worry that licensing boards would be too harsh, and fears of retribution by them. Licensing board have a duty to shield the public from harm which outweighs the need to shield a physician's reputation. However, many licensing boards allow the impaired doctors to keep their licenses if they agree to go into treatment or practice under observation.

9. Relationships With Patients

There are many strong ethical arguments against dating your patients, even though more doctors now think it is okay to date ***former (and <u>not</u> active)*** patients.

Having intimate relations with patients, even when consensual, can exploit the patient's vulnerability and compromise a doctor's ability to make objective judgments about the patient's care. And don't expect much loyalty from a patient-turned-lover if the relationship ends.

Physicians also have to be cognizant of how they approach patients. Obviously, unwanted advances toward patients are never okay, and this injunction has only intensified with the

#MeToo movement. To address any confusion, let patients tell you what they want the boundaries to be. Ask them if it's okay to touch them on the arm, and whether they want to be called by their first name or not.

10. High-tech ethical issues

These include:

1. ***Infertility treatments***, involving frozen embryos, could create three-parent embryos, which might potentially prevent or lead to certain diseases.
2. ***Gene therapy*** could potentially treat hereditary disorders and create "designer babies" with specific chosen attributes.
3. ***Precision medicine*** involves using genetic and molecular information to create more exact dosages and more precise and less toxic drugs.

11. Dealing With the Opioid Epidemic

Opioids account for the worst drug epidemic in US history, with a death rate of 115 Americans a day. In 2017, drug overdose caused more fatalities than motor-vehicle related deaths or gun-related deaths. Pain control is one of the metrics patients are asked to assess in the Hospital Consumer Assessment of Healthcare Providers and Systems, and results are tied to Medicare reimbursements.

The opioid epidemic can be traced back to the 1990s, when medical authorities decided that patients' pain wasn't being treated well enough, and that doctors needed to treat pain like a disease. The pharmaceutical industry marketed a new generation of pain medications, which for many were addictive. The result: Sales of prescription opioids have steadily increased since 1999. In many ways, the cure turned out to be worse than the disease. Many patients treated for pain became addicted to their prescriptions. Prescription opioids became a gateway drug for street opioids, such as heroin and fentanyl.

The ethical answer to the opioid crisis is that physicians must prescribe opioids with great care and be prepared to help patients to wean themselves from these drugs. The ethical problem is that opioids are an unreliable and dangerous tool. Pain is a subjective measure, and there is no accurate test to figure out how much medication a patient really needs. Some patients seem to have a built-in propensity to become addicted, and it's not easy to tell who they are. Between 21% and 29% of patients who are prescribed opioids for chronic pain will misuse them.

Managing patients' expectations and working with them to manage stopping opioid use, however, can be a step in addressing this problem.

12. Physicians' Role in the Healthcare Cost Crisis

Physicians should concentrate on preserving their own practices, and work to preserve the whole healthcare system. Health insurance is undergoing double-digit rate increases; the number of uninsured Americans is rising again; and almost one half of commercial insurance policies now have high deductibles, which force patients to pay for care out-of-pocket at levels that many can't afford. Patients also have rapidly escalating drug prices to deal with. Doctors can play a role in lessening the effect for patients.

13. Big Data Takes Over Healthcare

Vast amounts of healthcare data are accumulating, called Big Data. They flow out of electronic medical records, payer information, telehealth devices, genetic testing data banks, and research studies. There are fitness tracking devices (e.g., the Fitbit®) and home health equipment that measure all kinds of bodily functions, and transmit the results into the doctor's office or hospital. IBM Watson mines oncology patient data compiled by Memorial Sloan Kettering Cancer Center to come up with insights about patients' disease. The Centers for Medicare & Medicaid Services is building a computer system that will look for Medicare fraud and anticipate beneficiaries' medical disorders.

Doctors might not be able to ethically or legally ignore Big Data when caring for their patients, but they should proceed with caution. They will need to find a way to sort through it efficiently, and decide what needs to be shared with patients and what data can be ignored.

14. Organ Donation

Owing to new trends in organ donation, doctors have more opportunities to ask patients to consider it. Discussing organ donations with patients presents an ethical issue. Concerns about your individual patients (the potential donors) may be pitted against the doctor’s commitment to patients in general (the recipients).

You may even have conversations about donations with patients older than 60 years, who previously were not considered for donating organs. Kidneys from older donors, for example, are used more often now. Older kidneys have only slightly worse outcomes, and they offset growing demand for organs, often from older patients. Overall, 1 in 3 organ donors and 60% of organ recipients are older than 50 years.

Transplants now include the face, hands, uterus, and penis. These transplants are expensive and still extremely rare, but they raise some interesting ethical challenges.

14. Physician-Assisted Dying

Physician-assisted dying (PAD), sometimes also called "physician-assisted suicide" (and some still call it that), has been gaining a lot of traction lately. PAD is legal in Oregon, Vermont, Montana, Washington, Colorado, and the District of Columbia. Hawaii has made it legal beginning in 2019. In California, the End of Life Option Act, passed in 2016, made assisted dying legal, but in May 2018, that law was overturned.

Most of the public now accepts PAD in certain circumstances. A 2017 Gallup poll found that 73% of the American public supports PAD in some cases. Although opponents say PAD violates the physician's duty to "do no harm," there is a strong ethical argument that it's permissible as long as patients ask for it, are terminally ill, and have a low quality of life.

15. Rationing May Be in Our Future

Americans detest the very idea of overtly rationing healthcare, but we have been indirectly rationing for decades. Eventually, we may have to accept overt rationing, owing to a variety of unstoppable trends.

16. Healthcare Costs and Aging U.S. Population

Several forms of rationing already exist in the U.S. Payers already decide what care to cover, and people who can't afford good coverage—have their care rationed and get sicker in the process. Because of growing doctor shortages, it can also be difficult to get an appointment in many parts of the country. It's been said that these are all makeshift forms of rationing, and they clash with such ethical principles as justice and fairness.

We can create an ethical system of overt rationing. In fact, we have already done so for allocation of scarce resources, such as organs for transplant and vaccines in epidemics. Ethical rationing can mean deciding who would benefit the most, who is the neediest, who will be able to return to work, or who has waited the longest, or a combination of these factors.

2. UTILIZING PLACEBO EFFECT

Placebo effect is beneficial to the patient but may require that the patient be misled about the true effects of the “treatment.”

Medical research studies have established the benefits of placebo. Functional MRI has shown changes in brain chemistry due to placebos. There is evidence that placebos given for pain promote release of endorphins that reduce pain and promote feelings of well-being.

Vitamins, mild non-prescription pain relievers or other non-prescription drugs are recommended to patients, telling them that the drug is beneficial, but not typically used for the disorder. This allows patients to look the drug up on the Internet and not be alarmed if the drug is not noted as indicated for their disorder.

Many clinicians believe that the positive effects of alternative medicine may result entirely from the placebo effect. Many herbal remedies have been tested and failed to show any significant difference in benefit between test groups and control groups who were taking placebos.

It is a common error to believe that placebos should only be used when the symptoms are entirely psychological. Placebos can be effective adjuncts in treatment for physical disorders.

The degree of placebo effect tends to increase when the placebo drugs are:

1. Given by injection rather than orally;
2. Capsules rather than tablets;
3. Bright-colored capsules or tablets rather than dull colors;
4. Larger capsules or tablets, rather than smaller ones;
5. Two capsules or tablets, rather than one;
6. Given when the patient trusts the clinician.

Informed consent disclosures are required only for interventions that are potentially dangerous. Placebos, by definition, pose no risk to the patient and therefore do not require the patient's informed consent. Since placebos in clinical practice are used for reduction of symptoms and not for treatment of an underlying disease, there is no harm likely to result. One exception to this general rule is the use of a placebo in place of an indicated prescription medication or procedure, thereby allowing the possibility of the condition getting worse.

Most importantly, use of placebos is not unethical. While using placebos may require deliberately misleading the patient, it is not to the patient's detriment. In fact, proper placebo use is often beneficial. Furthermore, it can be argued that placebos are medically indicated due to the benefits they can confer without adverse effects.

How should placebo use be documented? Many clinicians do not document them, or do not describe them as being used for placebo effect, for fear that the patient may access the record. Not only would this

destroy the placebo effect, but could undermine the patient's trust in the clinician. However, other clinicians who need the record for patient care may not recognize that the purpose of administering the drug is for placebo effect, and inform the patient that the drug has no pharmacologic benefit.

In California and many other states, clinicians can choose to provide patients who request access to their records with summaries, and not provide the actual records. Nevertheless, when documenting the use of a placebo it is not necessary to use the word “placebo.” The record could say; “Will try multivitamins as adjunctive treatment for patient's anxiety.” This shows other clinicians the intended purpose for the multivitamins, and protects the benefit of the placebo. If there is no benefit reported by the patient from use of the placebo, the clinician should later change or discontinue the placebo.

Improvement in symptoms following use of a placebo has been used to suggest that the symptoms were without physical basis and/or the patient was exaggerating them. It has also been used to suggest that the treating clinician did not believe the patient's symptoms were genuine. This is another reason to document the purpose for using a placebo as that such negative or inaccurate inferences can be avoided.

III. CLINICIAN-ATTORNEY INTERACTIONS

3. ETHICAL CONDUCT EXPECTED OF CLINICIANS REGARDING LEGAL MATTERS INVOLVING PATIENTS

The patient's attorney often needs the assistance of the treating clinician to understand medical issues, including terminology, medical records, treatment, prognosis, etc. Without this assistance, the patient's welfare can be jeopardized.

Clinicians have an obligation to make their knowledge of the patient available to protect the patient's interests. Whether this information is used to assist someone else caring for the patient such as another clinician, a patient advocate, or the patient's attorney, does not matter. Refusing to provide such assistance is unethical because it is considered a type of conflict of interest. The clinician can ethically bill a reasonable or customary fee for the time, however.

If the patient gives authorization, the clinician may provide the patient's attorney copies of the patient's medical record. With few exceptions, neither federal nor state law preclude access by the patient's attorney to copies of these records if authorized by the patient. Furthermore, California and other states have laws that allow imposition of penalties for a clinician's refusal to provide these records pursuant to proper authorization.

For example, *California Evidence Code* §1158 states: "Failure to make the records available, during business hours, within five days after the presentation of the written authorization, may subject the person or entity having custody or control of the records to liability for all reasonable expenses, including attorney's fees, incurred in any proceeding to enforce this section. "Unless there is an exception, unnecessary delay by the clinician or other custodian of records to provide copies of records pursuant to the patient's authorization may be detrimental to the patient is unlawful and unethical.

Clinicians may also be asked for assistance by the patient's attorney to understand the content of the records. In a malpractice suit against the clinician, usually such assistance takes the form of formal discovery proceedings such as interrogatories, requests for admissions, and deposition. In other types of legal actions, there may be an informal office visit with the clinician. If the issue is simple, this assistance may be provided by telephone. When assistance will be given, payment may be demanded prior to the office visit or telephone call.

Issues usually addressed in providing assistance includes:

1. Content and sources of medical records.(e.g., in-patient records, out-patient records, emergency records, consultation reports);
2. Identities of other clinicians documented in the records;
3. Indications for prescribed medications;
4. Interpretation of medical jargon;
5. Explaining abbreviations used;
6. Meaning of technical terms;
7. Pronunciation of technical words;
8. Reading of signatures;
9. Significance of diagnosis;
10. Prognosis and basis; and
11. Explanation of medical procedures.

Realize that effective assistance to the patient's attorney helps the patient and is considered assistance in patient advocacy. Refusal by the clinician to provide assistance is unethical.

4. ETHICAL CONDUCT EXPECTED OF ACLINICIAN AS A LEGAL CONSULTANT AND AS TESTIFYING EXPERT WITNESS.

A *clinician witness* may be:

1. A treating clinician who testifies with regard to the course of care of the patient. Such a witness is generally referred to as "***percipient" or "fact" witness***;
2. A non-treating or treating clinician who testifies about facts in the case and renders opinions based on the witness' education, training, and/or experience. Such a witness is generally called an "***expert witness***." When a treating clinician offers opinions not considered during care of the patient, the witness is both a percipient (or fact) witness and an expert witness.

A *confidential consultant* is a clinician who provides facts and expert opinions to the attorney, but does not testify. The consultant cannot be required to disclose such opinions to the opposing side. These confidential opinions are considered: "***attorney work product***" and are privileged (i.e., not required to be disclosed).

The following conduct is unethical:

1. **Overcharging for expert services;**
2. **Testifying to matters that could help win the case, but that deviate from the facts or accepted medical principles**.
3. **Deliberately misleading the "trier of fact" (judge, jury, or arbitration panel) to help win the case**;
4. **Misrepresenting to the attorney who retains you about the testimony that you will give; and**
5. **Failing to do a thorough review of the facts or an honest evaluation**.

IV. BUSINESS RELATIONS

5. ETHICAL CHALLENGES ARISING FROM COMPETITION WITH OTHER CLINICIANS

Interfering with a competitor's ability to earn a living can be an unfair business practice. Unfair business practices are considered unethical. The unethical acts may result in civil lawsuits with damages, including punitive damages. Unfair business practices include the following:

1. **Defamatory comments to patients or other clinicians about competitors, or about the mistreatment of patients by competitors.**

   Defamation is a derogatory statement made about another person which is false.

   Never rely on a patient's statements about the care they received; do not spread hearsay criticism of the competence of other clinicians.

2. **Misuse of authority on a hospital staff, medical group, or medical society to impugn a competitor.**

   Such misuse of authority can take the force of an unwarranted attack on the benefits of the competitor within the organization, or asserting pressure on other members of the staff or group to act against or harass the competitor.

   Use of your authority as an officer or peer-review committee member to limit or terminate the staff privileges or membership of a competitor may appear to be an unfair business practice. If another person initiates the action against your competitor and you have a role in discussing the decision, you should abstain from voting on the matter. A peer-review committee is always obligated to provide the accused clinician with a fair procedure or due process for both ethical and legal reasons. This means all of the following:

   a. Written notice of charges provided to the accused clinician well in advance of the proceedings;
   b. Opportunity to be heard prior to taking any action detrimental to the accused clinician if no imminent harm to others; This

includes opportunity for the accused to present witnesses and documents;
c. The right to be represented by legal counsel if the accusers are represented by legal counsel;
d. The right to confront (cross examine) adverse witnesses;
e. Written regulations or bylaws strictly followed; and
f. A fair opportunity to appeal.

3. **Threatening to withdraw consultation referred business if the consultant accepts consultation requests from the competitor**

Such conduct is unprofessional, and unethical.

4. **Making complaints with no factual bases against competitors for unprofessional or unlawful conduct.**

If no reasonable supporting evidence, there may be no immunity from liability for making a complaint to a licensing board or other agency and this may be a basis for action against to complaint by the board or agency.

5. **Testifying as expert witness against a competitor with no factual nor legal basis for the rendered opinion.**

This conduct will appear unethical and the opinion is likely to be attacked during cross-examination.

The above forms of ethical misconduct are unfortunately not uncommon, and frequently backfire on the person responsible. It can also lead to distrust and dislike by other clinicians in the community.

6. UNETHICAL CONDUCT IN RELATIONS BETWEEN CLINICIANS AND FORMER PARTNERS AND EMPLOYERS.

Business relationships between clinicians and/or employers may deteriorate resulting in the breakup of partnerships and employment agreements. When this occurs, disputes often arise over who will provide care of the patient. These

disputes commonly involve vengeful actions that can lead to disregard of the safety of the patient.

All the above can be based either on implied, express written contracts.

In partnerships, the medical records of the patients may be considered the business records and property of the partnership; however, the content of the medical records are the property of the patient. Therefore, the patient can provide the clinician access to the content by the clinician requesting copies of the records with the patient's proper written authorization.

The entity holding medical records serves as a trustee and custodian of those records.

Disputes and unethical conduct following dissolution of a partnership or employment contract can be prevented by having a well-written contract prepared by an experienced attorney that is honored by all parties after the partnership or employment terminates. Entering into a partnership or employment contract without taking prevention measures creates a risk for later disputes.

If medical records are needed for ongoing patient care following partnership or employment termination, whichever clinician retains possession must release copies of those records pursuant to a signed authorization from the patient. A dispute over who will provide care for the patient is decided by the patient. Refusing to provide a copy of the records if presented with a legal authorization is unethical and illegal.

Other unethical conduct includes the following:

1. **Refusing to provide a patient with contact information for the clinician the patient chooses to see;**

2. **Unreasonable non-competition clauses in a contract.**

   Contract clauses that prohibit past employees from practicing within an unreasonably large specified geographic area and over an unreasonable length of time following termination of the partnership or employment are illegal. The courts will enforce limited geographic areas and time periods. This is another reason why such contracts should be drafted and negotiated by attorneys representing each clinician;

3. **Abuse of the clinician-patient relationship.**

Disputes may arise between clinicians regarding with whom the patient has the care relationship despite a clear provision in the contract specifying who should possess that relationship. The decision as to who will provide future care is always the patient's.

4. **Defamation of former partners or employees to discourage patients from leaving the practice is unethical and illegal.**

   See the discussion of "Defamatory comments" in the prior section;

5. **Defamation of a former employer to encourage patients to leave the employer's practice;**

6. **Attempts to influence patient's decisions by distorting legal implications of leaving the practice.**

   This improper action may include telling a patient that a lawsuit is planned or filed against a clinician or employer, and that the patient may be a witness if the patient changes clinicians;

7. UNETHICAL CONDUCT BY EMPLOYED CLINCIANS OF EMPLOYERS OF THE PATIENT TO PROTECT THE EMPLOYERS' INTERESTS.

If a clinician is hired to treat employees does not cooperate with inappropriate demands by the employer, the employer may threaten to fire the employed clinician. If the clinician is not hired but receives referrals on a recurrent basis, the employer may threaten to stop referring employees. This can place financial pressure on the clinician to accede to inappropriate demands by the employer, thereby acting unethically.

Employers are required under the *Americans with Disabilities Act* (ADA) to make hiring, firing, and demoting decisions without regard to medical impairments of the individual so long as those impairments do not disable the individual's ability to perform essential job functions. If a disability is present, the employer must provide a reasonable accommodation if such accommodation would enable the employee to perform essential job functions. Employers may be motivated to get around ADA requirements by improperly influencing the clinician who is caring for the individual to find that the employee cannot perform essential job functions and that no reasonable accommodation would remedy this.

Employers are biased against certain employees:

a. Employees who file workers compensation claims;
b. Employees who repeatedly miss work due to medical illness;
c. Employees unable to work due to medical complaints;
d. Employees with substance use disorders; and
e. Employees with psychiatric disorders.

Employers may pressure the clinician:

1. **To fabricate a medical basis for terminating employment or demoting an undesirable employee.**

   Opinions rendered by the clinician must be consistent with clinical findings documented in the employee's medical record; and a good faith evaluation of the employee must be made by the clinician.

2. **To provide protected health information to the employer to make biased decisions about hiring, firing or demoting an employee.**

   Legally, the employer's decisions must be based on factors other than the presence of any medical impairments unless they interfere with essential job functions.

The clinician should disclose only the following to the employer:

1. **Information needed for worker's compensation claim or other type of employee claim;**

2. **Information about functional limitations entitling leave from work or limit the employee's fitness to perform the job.**

   This should not include clinical findings, but should include potential dangers arising from work duties. (Firing or demoting an employee due to inability to perform essential job functions is not a violation of the Americans with Disabilities Act);

3. **Information needed for medical surveillance in the workplace, to evaluate work-related medical issues, or incompliance with OSHA regulations.**

A high risk for liability and sanctions for unethical conduct for a clinician who conspires with an employer to improperly fire or demote an employee. A wrongfully demoted or terminated employee can pursue a lawsuit due to:

a. Intentional interference with economic advantage;
b. Invasion of privacy;
c. Breach of confidentiality;
d. Violations of the ADA; and
e. Libel.

Furthermore, improper information release and collusion with an employer can lead to a licensing board accusation.

It is important for occupational clinicians to have language in their contracts with employers clearly prohibiting demands by employers for inappropriate information to be released.

Clinicians whose employment is terminated for refusing to comply with the employer's demands act unethically may sue the employer for wrongful termination among other bases.

V. ECONOMICALLY MOTIVATED CONDUCT

8. PROTECTING A HOSPITAL AT THE PATIENT'S EXPENSE.

Patient care may be compromised by economic considerations. Examples:

a. An incomplete medication formulary;
b. Inadequate facilities for the number of patients admitted;
c. Poorly maintained or outmoded equipment;
d. Policies that increase risk to patients, such as re-use of supplies designated for one-time use;
e. Understaffing;
f. Under-qualified personnel, a common example is having nursing assistants to carry out duties requiring registered nurses.

Most hospital-based clinicians lack authority to make changes, and if they complain about dangerous practices, the hospital may try to sanction them. It is not unethical for a clinician to practice under conditions that are detrimental to patients if the clinician lacks the authority to improve those

conditions. Where clinicians do have power to effectuate change, failure to use it to protect patients may be an unethical conflict of interest.

Clinicians who participate in discriminating against other clinicians who justifiably complain about hospital conditions may be acting unethically. Examples of such discrimination include: defamatory comments, mislabeling someone as a disruptive clinician, sham corrective actions by the medical staff, interference with referral of patients to or from the clinician, etc. However, clinicians who repeatedly complain about hospital conditions without adequate bases may in fact be disruptive. To the extent they may undermine patient confidence in the hospital or health care team, and harm cooperative and productive behaviors among members of the hospital and medical staff, they reduce the quality of patient care. Failure of disruptive clinicians to regulate their impulse control is unethical.

Other examples of economic protection ofthe hospital to the patients' detriment include the following:

a. Clinicians who prematurely discharge, or refuse to admit patients because they are not fully covered by insurance;
b. Clinicians who order excessive tests, consultations or procedures; and
c. Use of a hospitalist for patient care beyond the hospitalist's expertise. (e.g., assigning an internal medicine hospitalist to attend a complicated cardiac patient, rather than calling in a cardiologist.)

9. MANAGED CARE ISSUES

Managed care entities can bring many new patients into a practice. However, these entities carefully track the costs incurred by the clinician. The risk of being delisted can cause conflicts of interest for clinicians. This is greatly magnified if a large percentage of the clinician's practice relies on managed care participation.

In addition to the threat of being delisted, some managed care entities may offer clinicians a bonus or other economic benefit at the end of the year for saving them money. Pressure to maintain a cost-effective appearance ("low economic profile") can cause clinicians to take some of the following actions:

1. Avoiding referrals to specialists.

The cost of specialty care is higher than the cost of primary care, significantly increasing the clinician's economic profile.

2. **Premature discharge from the hospital.**

3. **Not diagnosing certain disorders that will be expensive to treat.**

4. **Recommending inexpensive treatment options that are less effective than more expensive treatments.**

5. **Omitting preventive medicine screening procedures.**

6. **Ordering fewer imaging studies than are needed.**

7. **Ordering fewer laboratory tests than are indicated.**

8. **Ordering only drugs that are found on the drug formulary when other drugs are indicated and more effective.**

9. **Less frequent follow-up visits to monitor the patient than are needed.**

10. **Undertaking medical/surgical procedures rather than referring to more qualified clinicians.**

    Minor surgery, endoscopy and other invasive procedures are done in office settings, despite inadequate equipment and/or inadequately trained staff.

    Reducing the quality of patient care to assure continued managed care participation is an unethical conflict of interest. If, however, some of the above listed actions do not increase the risk to the patient, they are not unethical.

10. ETHICAL RISKS OF LECTURING FOR PHARMACEUTICAL COMPANIES AND DEVICE MANUFACTURERS

Pharmaceutical companies frequently ask clinicians to lecture on topics related to their products. These services are usually well compensated. The companies attempt to influence the lecturers to make favorable claims for their products, sometimes even scripting the lecture.

These lecture services can involve the following bases for unethical conduct:

1. **Making dishonest claims for the product by overstating the benefits or understating the risks;**
2. **Implying that the product is superior to others when there is no evidence-based research showing such superiority;**
3. **Giving inaccurate descriptions of a theory, research, or experience that presents the product in a more favorable light;**
4. **Defending the merits of the product with untrue statements; and**
5. **Relying on and endorsing biased research, sponsored by the pharmaceutical company or device manufacturer.**

The clinician presenting the lectures must evaluate the research offered by the sponsoring company to determine if it is reliable.

VI. CULTURE & RACIAL SENSITIVITY

11. SENSITIVITY TO CULTURAL/ETHNIC BACKGROUND, RACE, LANGUAGE, RELIGION, AND SOCIO-ECONOMIC STATUS OF PATIENTS

If a clinician ignores cultural/ethnic background, race, language, religion, or socio-economic status of patients when providing care, this may be a basis for unethical conduct based on conflicts of interest. The conflict arises from the clinician's failure to take the time to be knowledgeable of the medical implications and take the time to address them.

I. Cultural/ethnic and racial differences

Culture: *the beliefs, customs, arts, etc., of a particular society, group, place, or time* - Merriam-Webster dictionary.

Ethnic: *of or relating to races or large groups of people who have the same customs, religion, origin, etc*. - Merriam-Webster dictionary.

Ethical conduct requires that a clinician to make an effort to understand limitations due to cultural/ethnic and racial differences, when treating the patient. Clinicians should look for the following differences in doing evaluations:

1. **History-taking.**

   Some cultural/ethnic groups are reluctant to admit to issues involving:

   - Domestic violence;
   - Gay lifestyles;
   - Fears;
   - Mental symptoms;
   - Pain;
   - Sex;
   - Suicide; and
   - Herbal remedies.

2. **Mental diagnosis.**

   The patient may interpret questions differently related to mental health and neuro-cognitive issues.

3. **Genetic differences.**

   These can affect patient risk and response to medications. A greater incidence of any disorder within the patient's racialor ethnic group requires a higher suspicion, and the clinician must place a higher priority on use of diagnostic studies for that disorder if indicated how clinical findings, and requires taking other measures to protect the patient. Genetic disorder prevalence by racial/ethnic group includes:
   African:

   - Beta thalassemia
   - Sickle cell anemia

French Canadian:

   - Tay-Sachs disease
   - Tyrosinemia

Jewish descent from Eastern Europe (Ashkenazi):

   - Bloom syndrome
   - Canavan disease
   - Cystic fibrosis
   - Fanconi anemia
   - Gaucher disease

- Niemann-Pick disease
- Tay-Sachs disease

Mediterranean:

- Beta thalassemia

Northern European:

- Alpha-antitrypsin deficiency
- Hemochromatosis

Southeast Asian:

- Alpha thalassemia
- Beta thalassemia

4. **Dietary and life style differences.**

5. **Fear of government agencies (e.g., undocumented alien).**

6. **Mistrust of the health care system.**

7. **Cognitive screening scales.**

   Patients who are not native English speakers or who are from different cultures may score poorly. Therefore, cultural and language differences may influence results adversely due to a lack of nouns.

8. **Incidence of serious disorders.**

   The following examples of ethnic or racial influence on incidence of serious medical disorders have been described in the medical literature:

   - **African Americans** have a high incidence of colorectal cancer, prostate cancer, diabetes, hypertension, stroke and congestive heart failure. **African Americans** also have a high incidence of almost every type of surgical complications. This is probably due to access to poor quality medical care resulting in frequent emergency surgeries and co-morbid medical disorders;
   - **Caucasians** have a high incidence of osteoporosis;

- **Hispanics** have a high incidence of diabetes and alcohol-related suicide;
- **Hispanic women** have a high incidence of breast cancer due to genetic predisposition (BRCA genes). There is also delay in seeking medical evaluation after discovery of a breast lump in this population;
- **Japanese Americans** have a high incidence of diabetes;
- **Native Americans** have a high incidence of stroke, lethal outcomes from stroke, and alcohol-related suicide; and
- **Native Hawaiians** have a high incidence of diabetes.

II. Language issues

1. Medical histories obtained from non-English speaking patients through family member interpreters.

These may be unreliable. As they are sometimes biased reporting the severity of symptoms, either exaggerating or minimizing the family member patient's responses. They may also distort the clinician's questions to the patient that lead to a biased answer.

It is unethical to omit taking an adequate patient history due to the inconvenience of obtaining a competent interpreter.

Use of a telephone interpreter service is a good option and such services are readily available and can easily be found online.

2. Informed consent.

Language barriers can prevent the patient from receiving an adequate understanding of the limitations, benefits, alternatives, and risks of treatments.

3. Use of mental health and neuro-cognitive dysfunction rating scales.

If the patient is not native English speaking, most mental health and neuro-cognitive rating scales may be unreliable, as they may not have been normed on the population being tested.

4. Non-compliance.

Instructions given to non-English speaking patients through family interpreters may be unreliable. Written instructions should be considered to avoid non-compliance by the patient.

III. Religious beliefs

Religious beliefs may conflict with some medical advice. For instance, patient may refuse to be vaccinated or to receive blood products (including transfusion and bone marrow transplant). This is especially true for Jehovah Witnesses, Christian Scientists, and some faith healing sects.

Dietary restrictions (e.g., Jewish and Muslim patients) are sometimes a reason for refusing medical products produced from swine. (e.g., heparin, produced from swine. Refusal may be based on the misconception that the rule is absolute. Actually, deviation from the rule is usually allowed if a medical necessity exists.

IV. Socio-economic status

1. Low income.

Inability to afford the cost of care or health insurance can lead to non-compliance by the patient. Such non-compliance may impair the following actions:

- Fill prescriptions;
- Follow dietary regimens;
- Obtain recommended diagnostic studies and specialty consultations;
- Seek medical evaluation promptly after symptoms appear; and
- Seek preventive care.

2. Low educational level.

Inability to understand medical instructions can affect the following:

- Mental health and neuro-cognitive dysfunction assessment;
- Cognitive screening tests; and
- Non-compliance due to errors in following written instructions.

12. CONTINUING QUALITY IMPROVEMENT PROGRAMS.

Continuing quality improvement (CQI) programs are intended to detect problems in patient care in time to correct them before harm to patients can result. System failures can include:

- an incompetent staff member;
- delays in responding to emergencies; and
- loss of contact information from patients.

These may create risks to patients that are correctable.

Failure to have a CQI program in place is a common cause of repeated systems failures in medical offices, as well as in hospitals. Medical practices usually lack effective CQI programs because the clinician does not (1) appreciate CQI, and (2) spend time to implement CQI practices.

The CQI process:

1. **Identification.**
   A reasonable method is required to recognize a problem. This could be accomplished by patient surveys, incident reports staff meetings to discuss problems that arose, etc.

2. **Assessment.**
   The extent of the identified problem is determined and the problem is prioritized. This can be done by staff members counting each occurrence of the problem. It can also be accomplished by using a well-designed patient satisfaction survey.

3. **Prioritization.**
   Priorities for managing problems are established. Problems that create immediate risk of harm to patients get highest priority. How serious the risk to patients determines the number of occurrences allowed to take action. Frequency of a risk may also be a factor in determining priority.

4. **Investigation.**
   Causes of the problem must be determined in deciding remedies. This may best be accomplished by discussing probable causes with staff members who encounter the problem.

5. **Improvements.**

Improvements are recognized and implemented. This is done by a plan implemented by staff members. Implementation is followed by monitoring.

6. **Monitoring.**
Information is collected at regular intervals to assess the effectiveness of the instituted improvements.

An example of an implemented CQI program follows:

Step 1: Responses from a patient satisfaction survey indicate that patients calling the medical office or hospital are unable to speak to a clinician when they feel they should.

Step 2: The receptionist(s) who answer the telephone start keeping records of all telephone calls where the caller asks to speak to a clinician, or asks questions that require clinician knowledge, but do not in fact speak to a clinician. The total number of such telephone calls are counted over one week, or longer if necessary. The records are kept in a CQI file.

Step 3: This problem is determined to be a high priority because of the danger both of patient injury and of patient dissatisfaction with the way the practice is run.

Step 4: Investigation reveals that the receptionist(s) have never received training in recognizing circumstances requiring that callers be connected to a clinician, and also reveals that there is no office policy on the matter.

Step 5: Clinicians meet with their receptionist(s) to develop a written policy and a written telephone protocol for the receptionist(s) to follow. The receptionist(s) are trained in using the protocol. Records of the meeting and copies of the written policy and protocol are kept in a CQI file.

Step 6: After one month, a repeat patient satisfaction survey reveals few responses where the caller was dissatisfied with not speaking to a clinician. The receptionist(s) keep records as they did in Step 2 for a period of one week and there are no such calls recorded. These records are kept in a CQI file. The problem will be monitored again in six months.

13. WARNINGS TO PATIENTS REGARDING DRUG-RELATED RISKS FROM USE OF OTHER SUBSTANCES.

"*Other substances*" includes the following categories:

- Foods;
- Herbal remedies;
- Medications prescribed by other clinicians;
- Medications prescribed for others in the family;
- Non-prescription drugs;
- Old prescription medications; and
- Street drugs.

A clinician should routinely take a history of drug use. Patients sometimes consider many substances not to be "drugs" or "medications," and deny they take other drugs. Clinicians should expressly ask about each category. If a questionnaire is used to take a history, it should list these categories.

A clinician should also consider using a "*Brown Bag Test"* to identify all drugs and herbal remedies that the patient is currently using. A *Brown Bag Test* is performed by instructing the patient to fill a brown paper bag with the containers of all the drugs and other remedies the patient regularly or sometimes takes, and bring the bag to the next office visit.

Sample *Brown Bag Test* instructions:

> *"Before your next appointment (or first) at this office, gather up ALL prescription medications, non-prescription drugs, cold medicines, laxatives, suppositories, creams and lotions, vitamins, supplements, herbal remedies, herbal medicines, natural remedies, home remedies, and anything else you take or use regularly or on occasion. Include everything, no matter how old, who prescribed it, or where you got it. Put them all in a bag, and bring them with you to your appointment."*

A clinician should routinely warn patients against the use of the above categories of substances while taking the medication(s) prescribed. The warning should include the reasons for not using the substances and the harm that may otherwise result. Failure to give warning is negligent, and is an unethical conflict of interest based on not taking the time to make the effort to protect the patient.

Food interactions with medications

Where potentially dangerous food interactions may occur, the patient should be warned. Some known food interactions are:

1. **Direct effects.**
   E.g., caffeine may counteract the effects of certain medications used for control of blood pressure or insomnia.

2. **Antagonist effects.**
   E.g., kale may increase vitamin K blood levels, antagonistic to Coumadin therapy.

3. **Decreased absorption from the GI tract.**
   E.g., tetracycline GI uptake may be blocked by dairy products.

4. **Change in renal function.**
   E.g., licorice and rhubarb have diuretic effects that may decrease the duration of action of medications due to being excreted in the urine.

5. **Change in metabolism.**
   E.g., grapefruit juice may lower blood levels of certain medications or increase blood levels of medications which are metabolized by CYP-450 3A4 in the liver.
   E.g., tyrosine-containing foods (e.g., fermented foods like ripe cheese) may adversely interact with monoamine oxidase inhibitors.

Herbal remedies

Herbal remedies use a plant's seeds, berries, roots, leaves, bark, or flowers for medicinal purposes. Nutritional supplements provide vitamins, minerals, fiber, fatty acids, and amino acids that augment a person's diet. Herbal remedies are not the occasional cup of herbal tea and herbs used in cooking. Herbal remedies contain “medicinal” doses. They are a multi-billion-dollar industry and are in widespread use by patients, who believe that they are safe because they are “natural. ”Herbal remedies, however, are:

a. Not standardized regarding their potency;
b. Usually, not accompanied by instructions for safe use;

c. Likely to be counterfeit;
d. Unregulated and may have contaminants (e.g., heavy metals or drugs); and
e. Poorly understood to have drug interactions, contra-indications, and side effects.

Medications prescribed by other clinicians

Patients may fail to inform clinicians when they are being treated by other clinicians.

An adverse drug interaction could result. Warning the patient about such risks may help in acquiring this information.

Prescribed medications to others

Family and friends may tell the patient about the benefits of medications they take for symptoms or disorders similar to the patient's. Patients who take others' medications may be naïve or embarrassed and not disclose this information in giving their history. Warning the patient about interactions with medications prescribed for others may result in disclosure of this information by the patient.

OTC drugs

Patients may not consider non-prescription (OTC) drugs when giving a history of drug use. After all, OTC drugs require no prescription and may be assumed by the patient safe. As a result, it is helpful for clinicians to ask patients about them. If questionnaires are used, they should specifically address OTC drugs. Detecting the use of OTC drugs is a good reason to use the "Brown Bag Test" at the outset of the patient's care. Then the physician can warn the patient about any OTC drugs specifically contra-indicated, and the to inform the clinician before taking any new OTC drugs.

Old medications

Patients may fail to discard old medications because:

(1) they believe that they may need them again;
(2) if similar symptoms occur, the patient can treat themselves without the clinician's help; or

(3) to give the old meds to a family member or friend who may have similar symptoms.

Physicians should advise patients to discard any unused medications following the completion of treatment. Detecting the patient's use of old medications is another good reason to use the *Brown Bag Test* at the outset of the patient's care.

Street drugs

Clinicians should take a history for any use of street drugs or excessive alcohol before prescribing any medication. They may also warn of the dangers of drug interactions. Use of medication questionnaires may help to detect street drug use.

Clinicians should review prior patient records for street drug or alcohol use or diagnosis of substance use disorder, or behaviors suggesting it. The incidence of street drug and/or excessive alcohol use is a co-occurring behavior in some mental disorders.

If street drug or excessive alcohol use are present, these behaviors should be addressed before prescribing medications (except in emergencies). The physician may need to do a drug screen before prescribing in caring for certain patients. Importantly, if medication is prescribed that could interact with a street drug or alcohol, closely monitoring, along with warning are advised.

14. ADEQUATELY DOCUMENTING CLINICAL FINDINGS.

It is important to determine the progression or regression of the findings. This information is important for accurate diagnosis, therapeutic success or failure, extent of impairment, and prognosis for many disorders. It is also critical for insurance claims and for medical-legal actions.

These include vital signs, pulse oximetry, weight, orientation, and other clinical findings. Sometimes no reasonable mode of measurement is available or practical, it should be accurately documented in the patient's medical record. Unwillingness to take the time to perform the required measurements may be considered a conflict of interest by the clinician. Some of the measurements that are helpful:

1. **Validated rating scales.**

There are hundreds of easily-administered printed rating scales for a variety of disorders. Some are completed by the clinician and some by the patient. Examples are: *Activities of Daily Living Scale, Addiction Severity Index, Fibromyalgia Impact Questionnaire, Beck Depression Inventory, Mini Mental State Exam (MMSE), Caregiver Strain Index, Motor Assessment Scale, Pain Assessment and Documentation Tool, Sickness Impact Profile,* etc.

2. Office tests and measurement of impairment, pain, etc.

Office tests include: *Bonnet's Sign, Claudication Test, Full Cup Test, Jump Sign, Patellar Apprehension Test, Sacro-Iliac Distraction Test, Six-Minute Walk Test*, *Babcock's Sentence, Animal Names, Spurling Test, etc*. It is especially useful to perform and document these tests serially on repeated office visits.

3. Pain measurement.

Several facts and tests indirectly assess whether pain is improved: analgesic drug usage, changes in daily activities, effect on mental state, pain rating scales, and a patient-kept pain journal. These alternative measures of pain monitoring are helpful because pain is subjective, and impacts any impairment, disability, analgesic use, and mental health. Failure to measure such parameters may be an unethical conflict of interest.

15. PRINTED PATIENT HANDOUTS FOR PATIENTS.

Printed handouts to help patients remember instructions are an inexpensive adjunct to provide patient education, and may improve patient compliance.

Good patient instructions are essential; failure to give adequate instructions may be a form of medical negligence. Systematic failure to have appropriate printed instructions may also be an unethical conflict of interest that could increase risks of injury for patients.

Printed instructions are a valuable adjunct for patient education, but not a substitute for verbal instructions which must first be provided. They both must be adapted to aspecific patient's ability to understand. Printed handouts can serve as an ongoing reminder for patients. The handouts are important because patients remember only a fraction of the verbal instructions. Some electronic

medical record programs automatically print instruction sheets, but if they are not effective, they are likely to be unhelpful.

Requirements for effective printed handouts:

a. one page in length;
b. large print (e.g., 14 point);
c. written in clear non-technical language;
d. avoid excessive detail;
e. well-organized (e.g., lists of points to remember rather than dense narrative text). Bullet points are also helpful; and
f. Contain warnings with reasons to immediately contact the clinician, go to a hospital emergency department, or take other immediate actions.

Printed handouts are helpful, along with verbal instructions for:

1. Disorders associated with high risk conditions.

The symptoms should be listed, along with a warning that (1) immediate treatment advised, and (2) the complication or illness may be life-threatening.

2. Complex instructions difficult to remember.

E.g., special diets.

3. Medications that have a narrow therapeutic window index.

Pharmaceutical manufacturers may provide patient instruction sheets, but they are frequently long and detailed, and, therefore, not usually read or retained by patients. Pharmacists are also required to offer drug counseling to patients, but this is frequently declined. Instructions should containthe following:

a. medication instructions;
b. risks for serious adverse effects;
c. actions needed if adverse effects occur;
d. frequency and importance of follow-up visits, if indicated; and
e. warnings needed (e.g., not driving).

The printed instructions should be given to family members or other caregivers if the patient lacks the capacity.

VII. TIMING OF DOCUMENTATION OF RECORD

16. DELAYED AND ANTICIPATORY RECORD KEEPING.

Accuracy and adequacy of a medical record depends in part on how soon after the contact that the record is documented. Delay in documentation diminishes the accuracy and adequacy due to:

a. memory decay;
b. interference due to other patients seen subsequently; and
c. how dramatic the contact with the patient.

If documentation delay is necessary, a portable notebook or recording device is helpful in order to make temporary notes. Later, the notes can assist to document the permanent record and the notes can be discarded.

An inadequate or inaccurate record is considered unprofessional conduct. Delaying documentation is a risk for the patient, and is an unethical conflict of interest for the clinician.

Clinicians may anticipate an action and record it in the medical record before it actually occurs. This is poor record keeping and can lead to document ation errors if the action does not occur. For example, a clinician who intends to examine a surgical incision site, and to save time, writes that the examination was performed before the examination. The clinician may fully intend to examine the patient at that time, but is distracted with another patient before doing so, and then completely forgets to do the examination. If the clinician also forgets about the documentation, the erroneous entry may remain unchanged in the medical record. Anticipatory record keeping would destroy the credibility not only of the record, but of the clinician. It also may be considered intentionally inaccurate record keeping which is unprofessional conduct. Documenting actions not yet taken as though they have already been taken is dishonest or fraudulent record keeping and considered unethical. Anticipatory record keeping can become obvious and used to attacking the clinician's credibility when:

a. The action could not be taken and is crossed out; or
b. The action could not have been taken to start with; or
c. The action is inconsistent with some other documentation in the record.

Some examples of anticipatory record keeping:

a. The clinician writes, “Heparin started” in the progress notes, fully intending to order it, but forgets. The doctor's orders and nurse's record show that heparin was not ordered nor started until hours later.
b. The clinician writes, “Pt examined. Negative for DVT” in the patient's record, but gets busy and fails to get around to examining the patient. An hour later, a consultant examines the patient and finds evidence of DVT that has been present for many hours.

17. JOUSTING.

“Jousting” is when two or more clinicians argue or make accusations against each other through documentation in the patient's record.

Failure to exercise impulse control in a clinical setting is harmful both to the patient and to the morale and cohesiveness of the health care team. This is an unethical conflict of interest, often due to arrogance and/or inflexibility.

Disagreements about proper patient care an appropriately handled in peer review committees of the medical staff, not in the patient's hospital record nor in the office medical records. If such disagreements appear in patient records, they are not protected by any legal privilege. They may be seen by attorneys, and used for the attorneys’ own purposes in prosecuting or defending a legal action against one of the clinicians.

Anytime a clinician attacks another clinician(s) in the patient’s record (especially after a poor outcome) the comments in the record will usually be viewed as self-serving, defensive, and not in the patient's best interest. They are usually not believed if offered in defense of the clinician who wrote them. That clinician's credibility will also be questioned, and it diminishes the credibility of all that clinician's records.

18. PATIENT LABELING.

“Labeling” is using a descriptive term for a patient, often with negative connotations. This may be due to pejorative feelings toward the patient. Other clinicians who read the patient's record may be adversely influenced toward the patient if this labeling is manifested in the patient’s medical record. For example, labeling the patient as a “complainer” in the record may suggest to any other clinicians who read the record that the patient chronically complains about minor symptoms, or other matters.

Labeling the patient as “malingering” may cause significant problems if the label is unfounded. Other clinicians may then not believe the symptoms described by the patient. Real pathology may be missed.

Labeling can also take the form of suspicions about disease processes that may not be present. For example, labeling a patient as an “alcoholic” assumes that the patient has a substance use disorder. Most clinicians have negative attitudes towards patients with substance use disorders. Unless supported by clinical evidence, a patient should not be labeled as being an alcoholic or as a drug abuser.

Labeling may lead other clinicians to negatively prejudge the patient, and not provide the indicated full level of care. They may either disbelieve or disregard the patient's physical complaints. This can lead to inadequate treatment.

Labeling is due to a clinician’s failure to exercise impulse control, related to the clinician's frustrations in the patient's record. Due to the risk of harm to the patient, this is medically unethical conduct.

19. DEFENSIVE RECORD KEEPING.

Documenting information in the patient's record for the purpose of avoiding blame following a bad clinical outcome is unacceptable and contrary to purposes for medical record documentation, which are:

1. Continuity of care;
2. Communicating with members of the health care team;
3. Billing and corporate compliance; and
4. Supervision.

Any other purpose of documenting a patient’s record is improper. Of course, defensive record keeping is unethical based upon it being conflict of interest, as it is self-serving. It also dilutes the record such that fact-based information may be more difficult to identify.

JCAHO guidelines require clinicians meet with patients and family as soon as practical following an adverse outcome to discuss the situation. This meeting should be documented as it is part of corporate compliance.

If the purpose for documenting specific comments by the patient that show the clinician in a favorable light and is not consistent with one of the acceptable purposes listed above, the record is probably self-serving and defensive.

Defensive record keeping diminishes the credibility of all the clinician's records. Anything in the record that harms the clinician's case is more likely to be believed by a trier of fact, and anything that helps the clinician's case is likely to be disregarded.

A common example of defensive record keeping is for the clinician, following discovery of a patient injury describes how good the care provided prior to the injury or poor clinical outcome. Such defensive documentation provides no benefit to the patient, and is self-serving. If good care was given, it should have been documented concurrently rather than after the discovered injury.

Assume the clinician saw a patient who complained of onset of pain radiating down his left arm a few hours before the visit. The clinician diagnosed a muscle strain and sent the patient home. Later that day, the clinician received notice that the patient had been admitted to the hospital for an acute myocardial infarction. The clinician then wrote a note in the patient's record stating; “Patient admitted to hospital with MI. Had no chest pain, nausea, S.O.B., or abnormal vital signs when I saw him earlier.” The findings described in this note, since not recorded concurrent with the patient’s visit, is a defensive record. The findings are not credible, nor would the clinician be seen as credible.

Other common examples of defensive record keeping include:

a. Suggesting a false cause for a bad outcome, while ignoring the real cause that might imply that the clinician was at fault; and
b. Blaming the patient for non-compliance or an unhealthy lifestyle as the cause of the bad outcome.

20. PRIOR PATIENT RECORDS.

Clinicians sometimes find it burdensome to obtain and review a patient’s prior clinical records. This may be time consuming, especially if the records are extensive. For chronic or potentially serious medical conditions, clinicians have a duty to obtain prior records of the patient if available and relevant. If records are not available, the clinician may need to do a more thorough evaluation.

Not all prior records need be obtained. Only those records that are considered relevant for good care. Prior hospital discharge summaries are effective to

identify relevant information. (e.g., other treating clinicians and hospitals that the patient did not disclose).

Recent office records can provide relevant information, such as current medications, records of specialists whose care may be relevant, diagnostic study reports, and laboratory reports.

Sometimes summaries of care are provided by prior clinicians. They should contain no less than the following:

(1) Diagnoses;
(2) Prescribed medications;
(3) Reports of other treatment received;
(4) Compliance history;
(5) Diagnostic studies done; and
(6) Clinical findings relevant to the impairment.

The summary received may be in writing or verbal; if verbal, it should be documented in the patient's record.

Once the records or summaries are received, they become part of the clinician's patient record.

Failure to make an effort to obtain, and/or failure to carefully review the patient's prior records is unethical based on a conflict of interest regarding the devotion of the clinician’s time and effort.

VIII. BIAS

21. DISPARAGING COMMENTS ABOUT ALTERNATIVE MEDICINE.

Many clinicians are skeptical of the effectiveness of alternative medicine treatments and of alternative medicine practitioners. Alternative medicine, sometimes called “holistic medicine,” is not traditional nor is it taught in most medical schools or residency training programs. Alternative medicine techniques and treatments include:

- acupuncture
- behavioral medicine
- biofeedback
- chiropractic

- herbal therapy
- homeopathic medicine
- hypnotherapy
- kinesiology
- magnetic field therapy
- massage therapy
- meditation
- mind/body medicine
- naturopathy
- nutritional biotherapy
- orthomolecular medicine (megavitamin therapy)
- reflexology
- spiritual healing

Alternative medicine treatments provide placebo effect; therefore, they are beneficial. Placebo effects are magnified by trust in the practitioner. Alternative medicine provides support to patients who have an emotional need for attention, reassurance, and treatment. Traditional clinicians may not take the time to provide such patients with the attention they may need. If the patient is not at risk, attacks on alternative medicine may undermine the benefits that alternative medicine offers to the patient as adjunctive care. Because statements may be inaccurate, they could be detrimental to the patient, and may also be unethical.

22. REFERRAL TO ALTERNATIVE MEDICINE PRACTITIONERS.

Traditional clinicians may refer patients for alternative medicine care. This may be where the patient's medical condition, attitude, and/or emotional state could benefit from alternative medicine care. The danger from alternative medicine is excessive reliance on it by some patients who do not seek evaluation and may not accept traditional clinicians. These patients can suffer harm from lack of proper care. Some of these patients self-medicate with recommended herbal remedies that may cause toxic injuries.

If a serious medical disorder is suspected, clinicians should warn those patients who rely on alternative medicine about the need for care from traditional care. This warning should describe the seriousness and the urgency of the need for proper care. The warning need not attack alternative medicine as quackery. It should only address the need for traditional care for that patient due to the risk to the patient. For example, a patient who relies on alternative medicine treatment for may delay seeking evaluation and treatment with fatal results. This is the type of patient who needs to be warned of the danger and the urgency.

The parents of a child with a serious medical disorder who choose to rely on spiritual healing for the child, should also be warned. The parents' avoidance of traditional care may constitute child abuse due to child endangerment that could result in: serious harm to the child; loss of custody of the child; and/or prosecution of the parents. A warning is indicated in such situation. The courts and child protective services agencies do not take the position that the parents have this unfettered right. Judges rule against the parents if there is **any** significant risk to the child. On such situations, failure to warn may be unethical.

Although there may be benefits from alternative medicine, clinicians should use caution when incorporating alternative medicine practitioners into their practice or regularly referring patients to them without adequate screening. Clinicians are seldom aware of the nature and scope of the training and skills of alternative medicine practitioners. Furthermore, the patient's reliance on alternative medicine must also be considered.

Trusting aspects of patient care to alternative practitioners without knowledge of their abilities, can endanger the patient and may be unethical conduct by the clinician.

23. PATIENTS WHO LACK CONFIDENCE IN MEDICAL SCIENCE.

There are many reasons why patients may appear to show lack of confidence in medical science:

1. **Prior poor medical outcomes in past care.**

   These patients recurrently need reassurance that they will receive better care this time.

2. **Patients who tell clinicians that friends were victims of negligence by clinicians or hospitals.**

   Telling a clinician this implies that the patient will sue the clinician if anything goes wrong.

3. **Patients who say they have friends or relatives who were treated differently for similar symptoms, or discuss complications they had resulting from the same treatment advised by the clinician.**

4. **Patients who receive care from alternative medicine practitioners (including chiropractors, naturopaths, etc.) while receiving care from a clinician.**

   The clinician should discuss with the patient the purposes for the alternative practitioner concurrently. It is not necessarily due to a patient's lack of confidence in the traditional practitioner. A patient may be treated by the practitioner for a long-term cure for low back pain while treating with a chiropractor for short-term symptom relief.

5. **Patients who tell the clinician that the alternative medicine practitioner disagrees with the traditional medical clinician's care.**

   This is most likely a manipulative splitting behavior by the patient, however, it may engender bias by the clinician against the patient.

6. **Patients who question the clinician's care based on the patient's "research".**

Patients tend to rely on direct to consumer advertisements. Discussion with the patient may generate bias due to the time it takes and the difficulty of convincing the patient of the basis for treatment being proper. These patients frequently need reassurance about the treatment being provided. They also need to know that they retain control about what will or will not be done for them and have a right to refuse treatment. Providing substandard care because that is easier is unethical.

24. PATIENTS IN LITIGATION.

Patients who enhance the severity of an injury or illness may be considered malingerers. This is common in litigation and insurance claims. There is bias against malingerers due to their dishonesty, greed, and manipulativeness. However, malingering can be difficult to prove.

Patients who malinger usually provide inconsistent histories, lack of physical findings, manifest over-reactions during physical examination, tend to be non-compliant with treatment, and be manipulative. Nevertheless, clinicians cannot be certain that symptoms are feigned. Furthermore, these patients may have factitious disorder or a conversion disorder, or another psychiatric diagnosis.

Certain populations are more likely to malinger:

a. Plaintiffs in personal injury litigation;
b. Claimants in unemployment insurance claims;
c. Applicants in workers' compensation claims; and
d. Defendants in criminal prosecutions.

There are sometimes other purposes for deliberately feigned or enhanced symptoms, for purposes such as:

- drug seeking,
- establishing an excuse for failure,
- attracting attention, and
- evoking sympathy by others.

25. HYPOCHONDRIASIS.

"Hypochondriacs" are patients who are aware of every minor sensation in their body, panic at every twinge, and have an irrational fear that some terrible disease is responsible. They continually consult clinicians seeking reassurance. The pattern soon becomes apparent to the clinician who tires of the patient. Such patients seem to have "all systems disease," with symptoms and complaints emanating from every body system. Too much time may be spent determining:

(1) which complaints or symptoms to evaluate/treat first;
(2) whether or not the patient's problem is urgent;
(3) whether or not the patient's complaints might be manifesting a real physical problem; and
(4) how to best handle a patient whose complaints are too extensive to properly address what is going on. Sometimes this can be frustrating because no diagnosis of a physical disorder is made and no treatment may be effective. Clinicians who have such patients should request psychiatric consultation. Failure to request such consultation may be negligent because such somatization disorder us usually treatable.

Reduction in symptoms occur with psychotherapy, including cognitive behavioral therapy, and medications such as antidepressants. It also may be a manifestation of an underlying anxiety/depressive syndrome or other co-occurring mental disorder that needs psychiatric attention. A discussion with the patient (and patient's family) to explain the nature of the condition may allow reduction of somatic symptoms. Some clinicians may suspect that some somatic symptoms are deliberately feigned or exaggerated. However, it is well-accepted that a patient's irrational fear of disease can exaggerate symptoms. The patient

may sincerely believe the symptoms have a real physical basis and that they are severe. Hypochondriacs are only rarely not malingering by intentionally exaggerating their symptoms.

An additional problem with these patients is that they seek attention from friends and family, alienating them in their need confirmation from clinicians. They then may fear that they would look foolish if there is nothing physically wrong with them. The need to be sick may further aggravate and/or maintain the patient's symptoms. They may then overstate their symptoms, hoping clinicians will react with great concern. This is often a secondary cause for development of a factitious disorder.

The patient's symptoms require a proper investigation. If no physical cause is found, the patient may be disappointed. Such patients are often suspected by the clinician to want a serious physically-based diagnosis for some face-saving purpose, hoping to further bolster this diagnosis with an impressive treatment.

Hypochondriacs are frustrating and time consuming for clinicians who may develop a negative bias toward the patient. As a result, some clinicians may string the patient along, unable to offer any effective care. If a clinician suspects the patient to be suffering from hypochondriasis, the following responses by the clinician may be unethical:

a. treating the patient for medical disorders that do not exist;
b. accusing the patient of feigning or exaggerating symptoms;
c. verbally abusing or ridiculing the patient for having hypochondriacal symptoms; or
d. not referring the patient for psychiatric consultation.

Ethical conduct requires discussing with the patient the lack of findings that would support a physical diagnosis, and that the clinician’s remedy is to acquire consultation for some or all of the patient’s complaints. The clinician who fails to have this discussion with such a patient may be acting unethically based on being dishonest.

26. PATIENTS WHO REJECT RECOMMENDED CARE.

Many patients these days research diseases on the Internet, or hear from friends about how other doctors treated certain symptoms that sound similar to their own. They develop opinions about their diagnosis and treatment, and may demand some specific treatment or diagnostic studies. The clinician must spend the necessary time correcting the patient's misconceptions. Direct-to-consumer

advertising has added to this problem, causing some patients to demand the advertised drug or other treatment to be prescribed or ordered. When the clinician tries to reason with the patient, there may arise a disagreement, with the patient continuing to demand the care. Some patients may say that they will take the responsibility ("assume the risk")for a bad outcome.

Patients can withhold consent for care, but they cannot demand specific care, especially if the care is inappropriate. When the patient demands care that the clinician believes is not indicated, the clinician must refuse to provide it.

A common example is the patient who demands an antibiotic for a sore throat even though the clinician has already explained that the cause is viral. Patients sometimes argue that their symptoms have always needed antibiotics in the past or they didn't get better. Some creative patients may even say they need the antibiotic for a bacterial super-infection accompanying the virus. The clinician must decline. Patients cannot "assume the risk" for care.

Sometimes a patient threatens to sue if they don't receive the care they demand. The clinician should ignore the threat, but document the patient's words in quotes in the patient's record. Patients are unlikely to actually sue the clinician under such circumstances. Patient threats to sue are usually a manipulative tactic. Clinicians frequently form a negative bias toward argumentative patients because their demands are frustrating to the clinician. Nevertheless, clinicians have the responsibility to stand their ground without losing their tempers, and must not respond to the patient in a belligerent manner.

27. PATIENTS WITH CONCURRENTMENTALHEALTH DISORDERS OR HAVE DIFFICULT PERSONALITY TRAITS.

Some clinicians have difficulty accepting the concept of mental disorders as real. Since there is no physical manifestations of disease, and the mental symptoms appear that they can be controlled if only the patient tried harder. Clinicians may blame the patient for having disordered thinking. For example, the patient who is not functioning well and is non-compliant with medication prescribed for blood pressure control and the hypertension is uncontrolled, and the clinician feels frustrated by this uncooperative patient. The clinician may fail to accept the fact that the presence of two concurrent diseases can make the treatment of both diseases more difficult. Such a situation requires a coordinated treatment plan. In this case, treatment of the depression is also treatment of the hypertension. However, the clinician may not be a psychiatrist, and may be unqualified treating the depression that may require psychotherapy and cannot be treated by

medication alone. Clinicians who cannot treat mental disorders are not uncommon. Some clinicians, however, may form negative value judgments about the patient's non-compliant behavior when caused by a mental disorder.

The clinician must realize that mental disorders can interfere with medical care of co-occurring physical illness. Examples include the following:

1. **Personality disorders.**

   These patients comprise over 14% of the general population. Many may exhibit poor impulse control, manipulative behaviors, intolerance to criticism, disregard for others, and other behaviors that antagonize clinicians' efforts. They sometimes require a great deal of a clinician's time and effort.

2. **Anxiety disorders.**

   Anxiety attacks are easily treated, but patients with such anxiety or panic attacks may cause frustration for clinicians due to repeated episodes stimulating a call to the clinician for intervention actions. Manifestations of hyperventilation can occur with shortness of breath, anxiety and chest pain that suggest a heart attack.

3. **Suicide attempts.**

   Frequently this act consists of taking overdoses or the patient's cutting their wrists. Clinicians sometimes resent the time spent handling the patient's attempt since the clinician may view the entire matter as unnecessary rather than making a serious effort to explore the causes.

4. **Patients who need an excuse for problems in their lives.**

   These patients sometimes seek to be diagnosed with some debilitating disorder as an explanation for their failure. They may present to multiple clinicians with exaggerated symptoms, feeling frustrated that no clinician has made a physical diagnosis that serves the patient's purpose. Such patients are usually unaware of the dynamics for their symptoms and behavior. Clinicians who have no competence with mentally disordered patients may be unable to identify that this is based on a diagnosable and treatable mental disorder. Clinicians may then form a negative bias and respond to the patients with intolerance for these behaviors. Recognizing, but not acknowledging the patient's mental health needs is unethical conduct. These patients would benefit from being concurrently and collaboratively treated by a mental health professional while the primary clinician provides support for

the patient's physical issues. The fact that the medical issues do not constitute serious physical disease is not an acceptable reason for refusing to acknowledge them. If the patient refuses to see a mental health professional, the clinician should consider terminating the patient's care.

28. ANGRY PATIENTS.

Clinicians tend to be highly motivated professionals with self-control who respect these same qualities in others. They sometimes dislike certain patients with poor anger or hostility control. The patient who makes accusations, yells, uses profane language, or threats may be labeled in the medical record as hostile or lacking impulse control. Every clinician who subsequently reads that record may then be biased against the patient. However, symptomatic patients under distress due to fears may also lose control. Clinicians who cannot tolerate such behaviors in their practices, and confront these patients with demands to control themselves do not do well, as the patient's behavior is likely to lead to an angry confrontation.

Clinicians who lose control and shout back at the patient are acting in an unprofessional and unethical manner. If the clinician believes the behavior is due to the patient's symptoms or medical fears and not likely to be repeated, no further action may be necessary. Otherwise, the clinician's appropriate and ethical course of action is to sit down with the patient and explain the following:

a. A professional practice must be quiet and calm for the benefit of all patients and staff not chaotic due to yelling, profane language, or threats;
b. Patients who cannot control their behavior cannot be tolerated;
c. If self-control is difficult for the patient, referral to a mental health professional is an important consideration; and
d. If a referral is refused and the intolerable behavior is repeated, there may be no choice but to terminate care.

If the patient refuses to discuss the matter, the clinician may have no choice but to start the process of terminating care of the patient since there is little chance of developing an effective therapeutic resolution. If such occurs at the initial assessment, the care may be refused without additional precautions needed.

29.NON-COMPLIANCE.

Patient non-compliance may be defined as failure by the patient to fully cooperate in the health care process. Patient non-compliance often leads to

patient injury or diminished benefit from medical care. Non-compliance may include the following:

1. **Not following instructions.**

2. **Risky actions.**

   E.g., the use of herbal remedies purchased on the Internet

3. **Failure to take actions without a clinician's knowledge or approval.**

   E.g., notifying the prescriber when an adverse reaction to the medication occurs. Sometimes patients are non-compliant due to influence of friends or family. Friends or family may provide their medications to the patient because the patient's symptoms resemble their own.

   Clinicians may have a negative bias towards non-compliant patients, and may label the patients as non-compliant in the medical record, influencing other clinicians to adopt the bias and cause a clinician to make less effort to provide care because:

   (1) the patient is assumed to not care about his or her own health;
   (2) the non-compliant behavior may make the care futile; and
   (3) the belief that medical resources would be of more value if redirected elsewhere.

   This would be unethical conduct, as clinicians have an ethical obligation to provide good care whether or not the patient has manifested non-compliance.

Frequently, non-compliance is involuntary on the patient's part. The following examples are not uncommon:

1. **Intolerable medication side effects;**

2. **Inability to afford the cost of the medication prescribed;**

3. **Inability to understand or remember the instructions given;**

4. **Inability to comply with instructions when the patient is physically impaired, e.g., poor vision causing inability to follow written instructions;**
5. **Conflicting instructions given by collaborating clinicians;**

6. **Lack of awareness of the need to follow instructions;**

7. **Lack of understanding the urgency of the actions required;**

8. **Lack of needed assistance from family members or friends;**

9. **A decision by the patient that the medical benefits of the recommended care do not warrant the risks;**

10. **The patient not following instructions due to contrary information received from an authoritative source;**

11. **Religious beliefs;**

12. **Phobias about the diagnostic studies or treatment;**

13. **Distrust due to bad experiences;**

14. **Over-complexity of the treatment regimen.**

15. **Symptoms due to the prescribed drug;**

16. **Behaviors due to poor emotional control;**

17. **Language barriers;**

18. **Confusion due to inaccuracy or unreliability of the measures needed; and**

19. **Illiteracy causing errors in following written instructions.**

Many of the above causes of non-compliance are preventable if the clinician discusses the instructions and asks the patient if there is any reason they may be unable to follow instructions. Many situations where a patient appears to be non-compliant may actually be the result of inadequate instructions. The clinician must take corrective measures to reduce the risk of repeated non-compliance. Otherwise, what appears to be repeated non-compliance is not non-compliance at all.

30. PATIENTS WITH HIGH RISK BEHAVIORS.

Clinicians may be frustrated by patients who intentionally place themselves in situations where harm is likely. Patients who intentionally increase the risk to themselves include the following:

1. Patients who engage in self-destructive behaviors.

Examples are repeatedly contracting sexually transmitted diseases, driving while intoxicated, substance use disorders, and driving motorcycles.

2. Patients who place themselves in situations where harm is likely.

Examples are joining a gang, selling drugs, the battered spouse who returns to the same living circumstances, and the worker who does not wear protective clothing or masks.

3. Patients who make no effort to adopt a healthier lifestyle.

Examples are failing to lose excessive weight or adhere to a regular exercise program.

Clinicians may be negatively biased toward these patients. As with non-compliant patients, the presence of the bias may cause a clinician to make less effort to provide good. This is unethical conduct because clinicians have an ethical obligation to provide good care whether or not the patient participates in risky behaviors.

These patients often benefit from consultations with a mental health professional. Sometimes the behaviors are due to mental disorders associated with poor impulse control, such as manic episodes of bipolar disorder, ADHD, traumatic brain injury, and others. All clinicians should be able to recognize the existence of an underlying mental disorder. Some of these patients may have already been treated for one of these disorders by a mental health professional.

31.PATIENTS WHO MAY BEA DANGER TOOTHERS.

Clinicians tend to favor law and order and may negatively judge those who do not follow rules. Clinicians sometimes treat victims of crime, and may become advocates for the victims and take a hard line against perpetrators. This may lead to a reduced effort to provide high quality medical care to perpetrators. Reduction in the quality of care by reason of bias is always unethical, irrespective

of the behaviors of the patient. Clinicians must accept their ethical obligation to give a criminal the same quality of medical care as a victim.

Examples of patients with a history of criminal conduct encountered by clinicians include the following:

1. **Perpetrators of violent crimes.**

   For purposes of criminal prosecution, a clinician may be encouraged to exaggerate a victim's injuries in the medical records in order to elevate a minor injury into great bodily harm. This is unethical conduct by reason of dishonesty.

2. **Perpetrators of criminally negligent acts likely to cause injuries to others.**

   A common example is owning an uncontrollable dangerous dog that attacks people.

3. **Child abusers.**

   Some clinicians may prejudge the parent or other person who could be charged with child abuse, and may be encouraged to exaggerate a child's injuries in the medical records in order to increase the likelihood of a prosecution. This is also unethical conduct by reason of dishonesty.

4. **Driving while intoxicated.**

5. **Patients intentionally infecting others.**

   Patients who contract sexually transmitted diseases (STDs) who knowingly expose others are examples as well as patients who return to work with others who have an infectious disease. Sometimes food workers with hepatitis A are such patients, to the detriment of patrons who ingest such contaminated products.

32. PATIENTS WITH POOR PROGNOSIS DESPITE TREATMENT.

Many clinicians want to feel that their efforts will provide benefit to the patient. They sometimes make less effort to give good care if they believe the patient has a poor prognosis. Such an approach to a patient’s case would be unethical if the clinician prejudges the benefit offered based on the patient's prognosis, who

make less effort to provide good care. This sometimes occurs when not offering the patient options for expensive treatment that can lengthen life or improve the patient's quality of life. Some clinicians find little satisfaction in treating certain patients:

1. **The elderly.**

   Some clinicians believe that medical resources should not be wasted on the elderly, including, preventive care (e.g., colonoscopy). The rationalization may that if a polyp is found, it probably won't kill the patient before other causes. While there may be support for this opinion in some patients, clinicians who believe that the patient will live only a statistically average lifespan are making an assumption that may not apply to a particular patient. Patients in their 70swith no major medical disorders with a family history of longevity, might expect several more years of quality life.

2. **Patients with incurable disease.**

   Clinicians may give up on patients within curable disease and then make less effort than required. the patient may have metastatic cancer, dementia, or severe emphysema, etc.

3. **Patients with reduced quality of life(brain damage, paralysis, amputations, or arthritis)**

4. **Incurable patients who expect long lives and tolerate their impairment.**

   Examples include major psychiatric disorders, poorly-controlled diabetes, brain injury with mild to moderate impairment, and atherosclerosis with compromised blood flow. Success for treatment of other disorders suffered by these patients may be perceived as unlikely to provide a quality of life.

33. SPOUSES,PARENTS, OR OTHER FAMILYMEMBERS.

Demanding behavior by the patient's spouse, parent, or other family member sometimes is related to feelings of guilt by the family member. In these cases, there may be an over-reaction by the family member to the patient's symptoms. Dealing with such demanding behavior requires an investment of time and patience by the clinician.

It is unethical for a clinician to agree to comply with inappropriate demands by family. The clinician is ethically obligated to treat the family member with respect, explaining the risk of complying with demands in treating the patient, and answer the family member's questions. The clinician is obligated to maintain self-control and professionalism, and not get into arguments with the family member.

Some over-assertive family members may threaten to sue the clinician. Clinicians should not argue with the family member. An appropriate response is to say, “Do what you feel you must do,” and walk away. The clinician's lack of argument sends a message that the clinician knows there is no basis for lawsuit. This form of attempted manipulation by the family member will thereby be ineffective.

Examples of unethical conduct by the clinician that can result from a demanding family member include the following:

a. Providing confidential information to a family member without the patient's authorization nor related to and family member assisting in patient care.
b. Writing untrue statements to an insurer to get compensated forcare not covered by forms of the insurance. This also constitutes fraud by the clinician.
c. Making efforts to keep a terminal patient alive despite these efforts not medically indicated.

Sometimes family members ask the clinician to withhold information from the patient. It may be appropriate to do this if it would be unnecessarily emotionally distressing to the patient. This is a decision that may rely in part on the opinions of family members.

Some clinicians may document in the patient's record that the family member is “difficult, demanding, controlling,” or “manipulative.”Such value judgments may project a bias against the patient, the patient thereby viewed by other clinicians as undesirable. A letter note in the medical record would be to describe briefly what the family member demanded, and the clinician's response to it.

34.SUBSTANCE USE DISORDERS AND DRUG-SEEKING.

Clinicians tend to be biased against substance use disordered patients, especially if they are drug-seeking patients. These patients have certain predisposing issues:

a. Chronic pain patients or anxious patients who need higher doses of narcotic analgesics or anti-anxiety meds to control their pain or anxiety;
b. Patients with dependencies who do no have a diagnosable disorder;
c. Patients who have needs for recurrent prescriptions for sedatives, anxiolytics, laxatives, etc.;
d. Patients who abuse amphetamines or cocaine; and
e. Patients who diver prescribed drugs.

When the patient is identified as drug-seeking, most clinicians react by refusing to prescribe more of the drug, and distrusting the patient.

Clinicians may feel it is a waste of time to help patients who will not help themselves by controlling their dependence, and assume that they are hopelessly non-compliant. The patient may be unable to control addictive behavior or have a psychiatric disorder, yet the clinician may still have a bias against that patient. Acting on such a bias may be unethical.

Before concluding that the patient should be prevented from obtaining the drugs, the clinician should try to determine the cause of the behavior. If the problem is under-treated pain or mental disorder, the patient should be further evaluated for this problem. Referral to a specialist may be indicated and should be considered.

If the problem is narcotic dependency without pain, or dependency on other drugs, the patient should be referred to an addiction specialist. Referring the patient to a mental health professional may also be appropriate if the patient has a co-occurring mental disorder. More than half of patients with substance use disorders also have one or more co-occurring mental disorders.

If the patient is selling the drugs on the street, clinicians may be well advised to initiate termination of care and consider a report to the sheriff or police department.

IX. ACTIONS TO DECREASE RISK OF PATIENT INJURY

35. FAILURE TO TAKEACTIONSTO DECREASE THE RISKSOF INJURING PATIENTS.

Negligent care is not intentional, thereby not necessarily unethical conduct, even though it can be the basis for malpractice lawsuits. However, many actions may

be taken to **reduce the risk** of negligent care. Failure to take actions due to the time, expense, or other expending reasonable resources needed is unethical based upon a conflict of interest.

Many clinicians, although recognizing the need, do not take measures to reduce the risk of negligence. This is considered an **intentional omission** that may endangers patients and is therefore unethical.

Some situations where an act or omission seems like simple negligence is in fact motivated by an unethical conflict of interest. For example, a surgeon who admits a patient to a small Southern California hospital where that surgeon had a financial interest to do elective surgery that carries the risk of a serious complication. The hospital lacked an intensive care unit necessary to treat the complication if it occurred. Following surgery, the patient died from the complication. This led to a licensing board accusation resulting in discipline of the surgeon. The surgeon's conduct was unethical, whether or not the complication developed, because financial considerations more likely played a role in the surgeon's decision to admit the patient to the hospital.

The field of “risk management” addresses reduction of liability risk. The following are examples:

1. Actions to reduce the risk of patient injury;

2. Actions to reduce the risk of a lawsuit following patient injury.

This includes (1) good communications with patients and their families, and (2) good record keeping practices (reduces the risk that an attorney will opine that the patient would prove negligence was the cause of injury).

36. ACTIONS TO TAKE TO IMPROVE DOCUMENTATION OF PATIENT HISTORY.

1. Patient questionnaires on current medications.

Medication questionnaires describe all medications currently taken by the patient. This can detect many problems, such as:

a. medications being prescribed by other clinicians,
b. old medications thought to have been discontinued,

c. medications the patient is taking that were prescribed for other family members,
d. herbal remedies and non-prescription drugs that could interact with prescribed medications.

These questionnaires should be completed regularly by the patient. The completed questionnaire is added to the patient record. A verbal medication history must still be taken, but need not be as extensive and time-consuming as it would be without a medication questionnaire. These medication questionnaires can be completed by the patient at home or in the waiting room, and take up none of the clinician's time. Regular review of data on a Prescription Monitoring Program (PMP or CURES) is also important if the patient is being prescribed controlled medications such as opiates, amphetamines, and anxiolytics.

2. Development and administration of patient questionnaires adapted to the patient population served.

Completed prior to the office visit, such questionnaires can systematically evaluate aspects of medical history without taking exorbitant time from the patient visit. The completed questionnaire is added to the patient record. A verbal history must still be taken, but need not be as extensive and time-consuming. These questionnaires can be completed by the patient at home orin the waiting room prior to the visit.

3. Templates for verbal history-taking.

These may be customized within an EMR or on printed forms added to hard copy records. Such templates reduce the risk that elements of the patient's history will be overlooked during an office visit. Be aware that the presence of an item on the form implies that item should be asked about and documented. Therefore, a “not applicable” (N/A)box should be added to each item on the form so that every item can be documented whether or not it was discussed. For example, the patient is seen by a primary care clinician for a routine examination. The patient has a history of total hysterectomy. A question on the history form pertains to her menstrualperiods. No questions are asked, and theN/A box is checked.

37. PATIENT TEACHING MEASURES

1. Verbal instructions:

Instructions, such as how to take a medication, are essential for good patient care, as well as to avoid noncompliance. A printed protocol can be helpful in guiding the instructions so that no component is omitted. A protocol can be developed pertaining to a range of medical conditions encountered in the practice. Patient instructions may include some or all of the following:

a. A discussion with the patient stating that the instructions should be followed carefully to prevent complications and/or treatment failure;
b. A discussion of each component of the instructions (e.g., medication use, diet, activities, dressing changes, work, etc;
c. A warning about complications that require discontinuing a medication, promptly contacting the clinician's office, or seeking emergency care, etc.;
d. A warning about activities to avoid (e.g., not driving);
e. A discussion of the importance of follow-up visits;
f. The purpose and necessity of ancillary services (e.g., laboratory testing, imaging studies, or consultations); and
g. Printed handouts, if applicable;
h. The opportunity for the patient/family to ask questions.

2. Patient teaching:

The components of instructions for each commonly treated disorder should be in writing by the supervising clinician for use by mid-level practitioners who will be doing the teaching. The first few times, the supervisor should be present to be certain the teaching is done properly. The delegation of such responsibilities to unlicensed personnel may be unethical, not only because professional training may be necessary, but because patients may not accept warnings if they come from unlicensed personnel.

3. Printed warnings. For commonly treated disorders:

Verbal warnings maybe better reinforced with written warnings. Preprinted warning sheets can be prepared for common warnings. There are books available containing sample warning sheets. The clinician can write these warnings, print them, and photocopy sheets for distribution to patients, as needed.

Warning sheets should be no more than one side of a sheet, in large print, addressing:

(1) activities to avoid;
(2) risks to watch for; and
(3) patient's response should a particular complication occur.

4. Interpreter services.

Taking an adequate patient history is mandatory. Clinicians are ethically obligated to obtain a competent interpreter. Family members, although commonly used may be unreliable. A bilingual staff member may be an alternative, but if none are available, interpreter services should be used. There are many sources for such services.

38. SUPERVISION.

1. Supervision of staff.

When duties are delegated to staff, supervision is necessary. This includes mid-level practitioners(e.g., nurse practitioners and physician assistants).

Supervision should include initial instruction followed by direct proctoring of performance until the clinician is satisfied that the duty will be carried out safely and correctly. Subsequently, the staff member's performance should occasionally be reviewed to be certain the task is being performed correctly. Failure to adequately supervise staff may be negligent and/or unethical.

2. Protocols for supervised staff performance.

If complex duties are required, written protocols are definitely important describing how the duty should be carried out. These protocols must be updated to remain current.

In California, registered nurses practicing in expanded roles may perform some duties beyond the scope of RN licensure. Expanded role nursing requires written protocols in collaboration with the supervising clinician which must be followed. These protocols must also be reviewed regularly and updated as necessary. California (NPs) who have furnishing certificates are licensed to prescribe, but may prescribe only within the limits set by law, and only for medications expressly listed on the certification, by written protocols in collaboration of supervising physicians.

3. Patient records by midlevel practitioners.

Physicians who supervise mid-level practitioners must regularly review some of the patient records kept by the mid-level practitioners to be certain that

appropriate care is being provided. This includes a check on whether an adequate patient history was taken, appropriate physical examination done, correct treatment given, and appropriate consultation when indicated. The clinician cannot determine from the records if the physical examination was competently performed, but can assess other documented elements of the patient's care.

4. Telephone protocols.

Telephone calls from patients and family members handled by office staff are important and can be a cause of patient injuries. Inadequate training of staff, poor control over telephone practices in the office setting, and lack of written protocols for staff on telephone calls can be a basis for litigation. Components of written protocols for handling telephone calls should include:

a. Who may give medical advice over the telephone;
b. What medical advice is allowed;
c. What constitutes an emergency based on information received over the telephone. It is good to expand to specifically describe emergencies most often presented in that practice's patient population. For example, in an ophthalmology practice, everyone answering the telephone must be aware of common ophthalmologic emergencies such as retinal detachment, globe pain suggesting acute glaucoma, metallic corneal foreign bodies, etc.;
d. Appropriate responses to emergencies;
e. Conditions that require urgent appointments even if not emergencies;
f. Requests for medication refills and other calls from pharmacists;
g. Assuring that telephone calls are returned in a timely manner;
h. Handling complaints of dissatisfaction;
i. Handling manipulative or abusive patients or family members; and
j. Documenting the telephone call, including telephone discussions with consultants and ancillary services. Enough information must be documented to later ascertain important contents of the call.

5. Triage.

Written protocols to assist mid-level practitioners' appropriate triage can prevent common errors. For example, "Protocol 42" lists the following:

a. Symptoms described by the patient;
b. Recent history;
c. Other symptoms;
d. Suspected diagnosis; and
e. Advice and warnings.

The mid-level practitioner identifies which protocol applies, follows the protocol, then documents the telephone call in the patient's record as:

“Sept 25,2015. 2:30 pm. Telephone call; Information is based on Protocol 42followed.”

No further documentation is necessary unless there was a deviation from “Protocol 42.” Evidence of what was discussed is provided by “Protocol 42”which is included in the list of written telephone protocols, and automatically incorporated by reference into the patient's record. Books of telephone advice protocols have been published to assist clinicians. The clinician may still need specialized protocols for specific patient populations.

6. Telephone answering services for after-hours calls.

This protocol should include the circumstances and procedures for the following:

a. Contacting the clinician after hours;
b. Referring patients to emergency departments if delay in reaching the clinician;
c. Warnings to be given if patient fails to seek emergency care if referred to an emergency department; and
d. How to contact a substitute clinician if the primary clinician is unavailable.

7. Over-delegating.

Some tasks may not be able to be delegated to staff or mid-level practitioners because they require a level of training beyond what can reasonably be provided on-the-job. Supervising clinicians have the responsibility of knowing the scope of practice of every licensed professional under their supervision, and not delegate tasks that exceed their licensure. If over-delegation of responsibility by a clinician results in a task being carried out that is beyond the licensure of the person assigned the task, the clinician may be prosecuted for the crime of aiding and abetting the unlicensed practice.

For example, asking an unlicensed receptionist to examine a patient's legs for evidence of thrombophlebitis probably constitutes aiding and abetting the unlicensed practice of nursing. Asking a practical/vocational nurse, who cannot engage in expanded role nursing, to suture a laceration probably constitutes aiding and abetting the unlicensed practice of medicine. This is true even if the

nurse is under direct physician supervision at the time. **No-one can practice "under someone else's license "in the health care professions.**

39. MEDICAL EQUIPMENT.

1. Inspection of equipment before use.

Inspection is necessary to be certain the equipment is in proper operating condition and does not pose a risk to the patient. This includes electrical equipment(e.g., ECG machines, x-ray machines, and autoclaves);it also includes disposable equipment such as IV lines and supportive equipment (e.g., examining tables and wheelchairs).

A protocol should be written incorporating the warnings in the equipment's instruction manual. The staff member preparing the equipment for use should briefly check the equipment according to the protocol before it is used.

2. Maintenance and repair of equipment.

Manufacturers often recommend regular maintenance schedules, and that malfunctions be reported to the manufacturer for repair. Regular maintenance and repair is a worthwhile investment as risk management. Exposing patients to injury in order to save this cost is unethical. Promptly requesting repair if a defect is found in the equipment is also good risk management.

3. Instructions on use of equipment.

Anyone using medical equipment must be familiar with the manufacturer's instruction manual. This is similar to being familiar with the FDA-approved package insert for a medication. Those using the equipment for the first time should read through the manufacturer's instruction manual before use. If there is evidence discovered that the equipment poses a risk of patient injury, a warning sheet could be added to the instruction manual.

40. ADMINISTERED MEDICATIONS.

1. Inspection.

Inspection of injectable medications before administration is necessary. Looking for discoloration or a precipitate and examining the container cap for is essential. Those who administer the medication should inspect prior to every administration.

2. Mislabeling stored medications.

Patient injuries have resulted from medication label errors. Injuries occur due to errors in reading the concentration of solutions, especially if labels look alike on containers with different concentrations. Transfers of medications or solutions between containers can pose a risk and must be done correctly.

Sometimes labels become detached, and may be reattached to the wrong container. If labels are similar, it is safer to have the concentration or contents prominently marked in large print on the label with a color coding scheme. If a label falls off and there is any question of what contents are in the container, it should immediately be discarded if unable to assure correct contents. A written protocol covering these measures can be most helpful to reduce these risks.

3. Package insert information.

Clinicians who prescribe or administer medications must be familiar with the FDA-approved package. Every year or two, the package insert should again be reviewed to be aware of any changes that may occur.

4. Storage.

Medications may be adversely affected by excessive heat or light. Storage of medications in proper conditions assures potency and minimal degradation. Most medications retain their potency well beyond the expiration date if properly stored. However, by law medications beyond expiration date must be discarded.

41. CONTINUINGEDUCATION.

1. Medical literature.

Clinicians are expected to remain current in the law, ethics, and medical literature affecting their practice. Most journals are now available online; many on-line versions are free to subscribers.

Clinicians should subscribe to peer-reviewed online journals relevant to their specialty and patient population. Failure to keep current is an unethical conflict of interest.

Clinicians should, of course, develop the ability to distinguish reliable from unreliable research. Clinicians should also be familiar with statistics used to describe medical research. Clinicians should consider the following factors when deciding if the conclusions of a research study are reliable:

a. Size of patient population;
b. Commercially sponsorship;
c. Statistical reliability and validity;
d. Topics associated with strong bias;
e. Self-reported data;
f. Control group;
g. Patient population;
h. Validity of conclusion; and
i. Causality controls.

2. Attending continuing medical education (CME)

There are CME requirements of the state licensing board, and sometimes also of a specialty board. No specific course must be chosen in most situations. However, courses that provide inadequate information about current practice do not fulfill ethical requirements. The clinician's knowledge of relevant subjects could be deficient. Ethical conduct requires that courses chosen be for the value of the information to the clinician's practice.

3. Applicable law

Knowledge of applicable law is not part of medical school training, and the relevant law may not be easy to find for clinicians. Most books on medical law are too general to be very useful. Nevertheless, ignorance of the law cannot be an excuse. The law PRESUMES that a clinician knows the law affecting the clinician's practice. Knowledge of the law can also help clinicians better protect the legal rights of their patients which is an ethical obligation of clinicians.
Licensing boards may provide booklets containing concise statements of the law affecting medical practice. The Medical Board of California publishes *Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons*. Every California clinician should read this; and since the law governing physicians is mostly the same of similar in all states, if a particular state does not have such a guide, it is worth reviewing by other state-based physicians, as well.

The California licensing board also publishes quarterly newsletters containing articles on the law and legal updates that should be read by clinicians. Continuing medical education courses for clinicians on law can be the best way to keep up on the current law.

42. MEASURES TO REDUCE OFFICE SYSTEMS ERRORS.

1. Laboratory/imaging/consultant reports.

Patients do not always go to consultants for imaging studies or for lab tests. Sometimes the report is lost or never sent. This may not be discovered until the next time the patient returns for an office visit, which could be months later. With electronic medical records, a notice window may pop up telling the clinician or staff that the report is overdue. A fail-safe system must be in place to warn of missing or overdue reports. The clinician has an ethical as well as a legal duty to track down reports not received. The system need only predict when the report should have been received, and give warning when that date arrives. Electronic medical records can do this easily. Hard copy records require a calendar system that marks the date when the report should have been received. On that date, a staff member needs to check the patient record and the office in-box to determine if the report was received. If not, the clinician should be notified, and the consultant or ancillary service provider should be contacted to determine if the patient followed through and if a report was sent.

2. Procedures needed

The clinician should review all reports before being filed in the patient's record. The usual procedure is for the clinician to receive every report to review, date and initial before the report is filed in the record.

3. Protocol for an effective office CQI program.

See the prior section in these Enduring Materials: *Lack of an office continuous quality improvement program*. Office CQI programs may take time to set up, but are essential for correcting office systems errors before they can cause patient injuries.

3. Patient scheduling.

Scheduling system failures that interfere with adequate patient care:

a. Failure to use a structured scheduling system;
b. Lack of written scheduling policies and procedures;
c. Inadequate staff training on correct scheduling techniques and how to communicate appropriately with patients calling to make appointments;
d. Using a scheduling system that leaves no open time in each day's schedule; and
e. Lack of a system to alert staff to patients that have special scheduling needs.

5. Accessibility by patients.

Patients must be made aware of how to reach their clinician's office by telephone, and must be able to talk to someone who can competently handle their problems. Clinicians may consider providing printed brochures for their patients with telephone numbers. If the clinician maintains a web site, this information can be on the web site. Email contact is problematic due to the dangers of delay in emergencies, and the lack of firewalls incorporated into the patient's computer system in order to protect personal health information.

Patients should be able to easily reach a live person, and telephone systems should have a provision for notifying callers when a substitute clinician is covering the practice who has patient care responsibility, and how to reach that substitute clinician by telephone.

6. Patient follow-up.

Adequate measures are important to be sure of patients returning for their follow-up office visits, seeing a consultant, and/or obtaining ancillary services such as prescriptions, laboratory testing, and imaging studies. Failure to have and correctly use these measures is considered an unethical conflict of interest.

The following procedures must be effectively carried out:

a. Proper patient instruction on the importance and urgency of follow-up visits, diagnostic studies, specialty referrals, filling prescriptions, and other recommended care. This may be by verbal instruction from the clinician or a staff member who has appropriate training, and perhaps by a printed handout. Clinicians have a duty to warn patients of the dangers of non-compliance.
b. A calendar system that notifies the clinician when recommended diagnostic studies or referrals have not been obtained by the patient, or reports for them have not been returned to the office. Without a

working calendar system, the clinician may be unaware of the failure until the next patient visit, perhaps months later.

c. A calendar system that notifies the clinician or staff when recommended return office visits have not been scheduled by the patient or have not taken place in a timely manner. These systems must have the ability to extend more than 12 months into the future for patients who need annual follow-up.
d. A process for notifying the patient when further care is necessary based on reports received from diagnostic studies or from consultants.

43. RISK MANAGEMENT PREVENTS PATIENT INJURIES

1. **Excessive patient load.**

Clinician work load frequently impacts quality of care. Clinicians who have inadequate time to take proper histories, perform appropriate examinations, give instructions to patients, and/or make proper clinical decisions are behaving unethically.

Clinicians who accept so many patients into a practice that the daily patient load remains at an unsafe level are much more likely to make negligent errors that cause patient injuries. Excessive patient load may increase income, but it may endanger patients. Therefore, it is unethical due to a conflict of interest.

2. **Computer.**

Electronic medical record (EMR) systems contain software that automatically checks the patient record for potential adverse medication interactions that open a warning window. Hard copy records require a separate system for this purpose.

3. **Prescription record form.**

These are present in electronic medical record systems. In hardcopy records, prescription record forms allow all medications to be viewed on the same page. This allows recognition of:

(1) unnecessary medications that can be discontinued;
(2) necessary medications that may be needed; and
(3) potential medication adverse interactions. Having a form also allows easier input into a computer app that can check for risks of medication adverse interactions.

4. **Substitute coverage.**

Failure to provide a substitute clinician to cover for the primary clinician when unavailable is patient abandonment. It has both legal and ethical implications.

The substitute clinician agrees to cover, and the primary clinical provides a WRITTEN statement of the dates when the substitute clinician is to assume responsibility for care. This statement may be provided by mail, email, or fax. Verbal statements are not considered adequate due to the risk of miscommunication.

If the substitute clinician will not have direct access to the patient records, the primary clinician should prepare a written description of the medical issues and appropriate treatment of any patients who are especially likely to have need for urgent care during the time when the substitute clinician will have responsibility. This description should be sent to the substitute clinician by mail, email, or fax. Failure to take this step may lead to patient injury.

5. **Complaints**

Lack of a system to properly handle patient complaints increases the risk of patient injuries. The following measures are necessary:

a) All patients and family members should have access to anonymous complaint/ suggestions forms. Those forms may be completed and placed in a "suggestions box." The contents should be reviewed daily by the office manager.

b) Patient satisfaction surveys may also be utilized. These surveys are best kept anonymously and must allow narrative descriptions by the patient or family member of problems encountered. A few "yes" or "no" questions will not suffice.

c) Staff should be instructed to look for and investigate evidence of patient dissatisfaction. Patient dissatisfaction may be assumed if manifested by behaviors such as:

(1) obvious anger,
(2) past-due delinquent bill for services provided;
(3) non-compliance with advice and
(4) failure to keep appointments.

Office staff should be trained on the following:

(1) behaviors to look for;
(2) what to ask the patient or family member;
(3) how to recognize dissatisfaction; and
(4) how to act on receiving a complaint.

A written protocol can help to facilitate this training. Certain patient complaints should be handled personally by the clinician. If the clinician does not get directly involved in some complaints, the patient may not be protected.

X. OTHER ETHICAL MISCONDUCT

44. CRIMINAL MISCONDUCT

Clinicians have an ethical responsibility to know what conduct constitutes a crime, and an ethical responsibility not to commit a crime. Failure to learn and obey criminal laws is unethical. Criminal laws are contained in statutes and regulations. Proof that a law was violated does not require the testimony of an expert witness to testify about standard of care. A law violation, therefore, can make a medical malpractice lawsuit difficult or nearly impossible to defend.

Examples of criminal violations that arise from or relate to health care practice include the following:

a. Aiding and abetting unlicensed practice: delegating responsibilities to someone not licensed to carry out those responsibilities;
b. Controlled substance prescribing without a proper documented indication;
c. Controlled substance self-prescribing;
d. Fraudulent prescriptions: any prescription containing untrue information such as the wrong patient's name or erroneous date issued;
e. Insurance and Medicare fraud: any false statement for the purpose of increasing or decreasing reimbursement for care;
f. Making a false document: any false statement in a document relating to health care practice, licensure, employment, hospital staff privileges, legal proceedings, etc.;
g. Prescribing function-enhancing medications such as stimulants, glucocorticoids, vasodilators, serotonergics, etc, for non-medical reasons;

h. Paying or receiving referral fees: any form of compensation for referring a patient;
i. Sexual battery based on a boundary violation; and
j. Violation of mandatory reporting statutes.

Examples of reportable conditions are:

- Suspected child abuse;
- criminal acts causing injury;
- reportable infectious diseases; and
- disorders characterized by lapses in consciousness, etc.

45 SOCIAL MEDIA.

Typically, clinicians who post unprofessional material do it on sites like: Twitter, Facebook, or YouTube. The argument that postings were done as a joke is no defense to their being unprofessional and unethical. They can undermine patient confidence in the clinician and in the health care team, and in some cases, are dishonest or misleading. The following types of unethical online postings by clinicians have occurred:

1. Confidential patient information;
2. Contact with a former patient through an online dating site;
3. Discriminatory language or practices;
4. Disrespectful language when describing the conduct of a patient;
5. Lewd photos of the clinician;
6. Misrepresentation of a clinician's credentials;
7. (7) Photos or videos depicting the clinician drinking alcoholic beverages;
8. Profane language;
9. Videos of a clinician performing a medical procedure, with the patient's face visible; and
10. Videos of the clinician's unprofessional behavior in a clinic or hospital setting.

Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice

The following guidelines are recommended for physicians who use social media and social networking in their personal and professional lives.

Interacting with Patients

Physicians are discouraged from interacting with current or past patients on social networking sites. Online interaction with patients should be confined to discussing the patient's medical treatment within the physician-patient relationship. These interactions should never occur on social media web sites..

Medicine Online

Social networking web sites may be useful places for physicians to gather and share their experiences, as well as to discuss areas of medicine and particular treatments. These types of professional interactions with other physicians represent an ancillary and convenient means for peer-to-peer education and dialogue. One current example is Doximity, a professional network with more than 567,000 U.S. physician members in 87 specialties. Using Doximity, physicians are said to be able to exchange HIPAA-compliant messages and images by text or fax and discuss the latest treatment guidelines and medical news in their specialty. While such networks may be useful, it is the responsibility of the physician to ensure that professional networks for physicians are secure and that only verified and registered users have access to the information. These web sites should be password protected so that non-physicians do not gain access and view discussions that may be misunderstood as implying medical advice. Physicians should also confirm that any medical information from an online discussion that they plan to incorporate into their medical practice is corroborated and supported by current medical research.

Privacy/Confidentiality

Patient privacy and confidentiality must be pro- tected at all times, especially on social media and social networking web sites. Any

breaches in confidentiality could be harmful to the patient and in violation of federal and state privacy laws, such as HIPAA and CMIA (California). While physicians may discuss their experiences in non-clinical settings, they should not provide any information that could be used to identify patients. Physicians should not mention patients' room numbers, refer to them by code names, or post their picture. If pictures of patients were to be viewed by others, such an occurrence may constitute a serious HIPAA violation.

Disclosure

At times, physicians may be asked to write online about their experiences as a health professional, or they may post comments on a website as a physician. When doing so, physicians must reveal any existing conflicts of interest and be honest about their credentials.

Posting Content

Clinicians should be aware that any information they post on a social networking site may be disseminated (whether intended or not) to a larger audience, and that what they say may be taken out of context or remain publicly available online in perpetuity. (Love may not be forever, but the internet is!) When posting content online, they should remember that they are also representing the medical community. Physicians should always act professionally and take caution not to post information that is ambiguous or that could be misconstrued or taken out of context. Physician employees of health care institutions should be aware that employers may have reserved the right to edit, modify, delete, or review Internet communications. Physician writers assume all risks related to the security, privacy, confidentiality of their posts and should be aware that their professional liability insurance may not cover breaches of privacy incurred during blogging activity performed outside the scope of their employment by their patients. When moderating any website, physicians should delete inaccurate information or other's posts that violate the privacy and confidentiality of patients or that are of an unprofessional nature.

Professionalism

To use social media and social networking sites professionally, physicians should also strive to adhere to the following general suggestions:

- Use separate personal and professional social networking sites. Others who view a professional e-mail attached to an online profile may

misinterpret the physician's actions as representing the medical profession or a particular institution;

- Report any unprofessional behavior that is witnessed to supervisory and/or regulatory authorities;
- Always adhere to the same principles of professionalism online as offline;
- Cyber-bullying by a physician towards any individual is inappropriate and unprofessional; and
- Refer, as appropriate, to an employer's social media or social networking policy for direction on the proper use of social media and social networking in relation to their employment.