MEDICINE AND LAW

SCENARIO

Barbara Johnson is the new office manager for two neurologists in an urban area. Recently she was subpoenaed to appear in court with medical records to testify about a patient. This particular patient was referred to one of the physicians in the clinic, Dr. Rebecca Patrick. Dr. Patrick saw the patient several years ago, and the patient has brought a medical professional liability case against a surgeon in another city. Barbara is considered the custodian of medical records and will take them to court and answer questions about the information in them.

One of Barbara’s first priorities at her new job is to make sure the office is operating in compliance with the legal regulations that affect the facility. She is knowledgeable about the requirements of the federal Occupational Safety and Health Administration (OSHA), and because her father was an attorney, she is very familiar with legal issues.

Two of the employees Barbara supervises, Samantha and Lynda, are newly graduated from medical assisting school and are anxious to learn more about the statutes and laws that affect the physicians’ office. Barbara is more than happy to share what she has learned with them. She is excited about her new job and eager to be a great success.

While studying this chapter, think about the following questions:

- How can the medical assistant help the staff comply with legal regulations in the medical office?
- How can new graduates learn about the laws that affect them in their state?
- What are some ways medical professional liability suits can be prevented?
- What should the medical assistant do if the employer is not in compliance with legal regulations?

LEARNING OBJECTIVES

1. Define, spell, and pronounce the terms listed in the vocabulary.
2. Discuss all levels of governmental legislation and regulation as they apply to medical assisting practice, including FDA and DEA regulations.
3. Distinguish among an act, a statute, and an ordinance.
4. Compare criminal and civil law as they apply to the practicing medical assistant.
5. Explain the three basic categories of criminal law.
6. Distinguish which type of civil law deals with medical professional liability.
7. Provide an example of tort law as it would apply to a medical assistant.
8. Explain the four essential elements of a valid contract.
9. Distinguish between interrogatories and depositions.
10. List three things to remember when testifying in court.
11. Discuss the advantages of arbitration.
12. Differentiate among malfeasance, misfeasance, and nonfeasance.
13. Explain the “four Ds” of negligence.
14. Define the types of damages.
15. Compare and contrast physician and medical assistant roles in terms of standard of care.
16. Describe liability, professional and personal injury, and third-party insurance.
17. Discuss the legal scope of practice for medical assistants.
18. Explain the importance of informed consent.
19. List several legal disclosures the physician must make.
20. Identify where to report illegal and/or unsafe activities and behaviors that affect health, safety, and welfare of others.
21. Explain how the medical assistant’s practice is affected by negligence, malpractice, statutes of limitation, Good Samaritan Acts, Uniform Anatomical Gift Act, Living Wills/Advanced Directives, and the Medical Durable Power of Attorney.
22. Summarize the Patient’s Bill of Rights.
23. Describe the implications of the Health Insurance Portability and Accountability Act (HIPAA) for the medical assistant in various medical settings.
24. Distinguish between OSHA and CLIA; indicate which one is an actual agency.
25. Describe personal protective equipment.
26. Describe the importance of Material Safety Data Sheets (MSDS) in a healthcare setting.
27. Discuss requirements for responding to hazardous materials disposal.
28. Identify how the Americans with Disabilities Act (ADA) applies to the medical assisting profession.
29. Discuss licensure and certification as it applies to healthcare providers.
30. Discuss ways a physician might lose the license to practice medicine.
abandonment  To withdraw protection or support; in medicine,
to discontinue medical care without proper notice after accept-
ing a patient.
act  The formal action of a legislative body; a decision or deter-
mination of a sovereign state, a legislative council, or a court
of justice.
allegation  (a-li-ga'-shun)  A statement by a party to a legal action
of what the party undertakes to prove; an assertion made
without proof.
appeal  A legal proceeding by which a case is brought before
a higher court for review of the decision of a lower court.
appellate  (uh-pe'-lut)  Having the power to review the judgment
of another tribunal or body of jurisdiction, such as an appellate
court.
arbitration  (ar-buh-tra'-shun)  The hearing and determination
of a cause in controversy by a person or persons either chosen
by the parties involved or appointed under statutory
authority.
arbitrator  (ar-buh-tra'-ter)  A neutral person chosen to settle
differences between two parties in a controversy.
assault  An intentional, unlawful attempt of bodily injury to
another by force.
assent  To agree to something, especially after thoughtful
consideration.
bailiff  An officer of some U. S. courts who usually serves as a
messenger or usher, who keeps order at the request of the
judge.
battery  A willful and unlawful use of force or violence on
the person of another.

Code of Federal Regulations (CFR)  A coded delineation of the
rules and regulations published in the Federal Register by the
various departments and agencies of the federal government.
The CFR is divided into 50 titles that represent broad subject
areas and chapters that provide specific detail.
concurrently  Occurring at the same time.
contributory negligence  Statutes in some states that may
prevent a party from recovering some damages if he or she
contributed in any way to the injury or condition.
damages  Loss or harm resulting from injury to person, property,
or reputation; compensation in money imposed by law for
losses or injuries.
decedent  (di-se'-dent)  A legal term for a deceased person.
defendant  A person required to answer in a legal action or suit;
in criminal cases, the person accused of a crime.
docket  A formal record of judicial proceedings; a list of legal
cases to be tried.
due process  A fundamental constitutional guarantee that all
legal proceedings will be fair; that one will be given notice of
the proceedings and given an opportunity to be heard before
the government acts to take away life, liberty, or property; a
constitutional guarantee that a law will not be unreasonable or
arbitrary.
emancipated minor  A person under legal age who is self-
supporting and living apart from parents or a guardian;
a mature minor considered by the courts to possess a sufficient
understanding of self-care and responsibility.
expert witnesses  People who provide testimony to a court as
experts in certain fields or subjects to verify facts presented by
one or both sides in a lawsuit, often compensated and used to
refute or disprove the claims of one party.
felony  A major crime, such as murder, rape, or burglary; punish-
able by a more stringent sentence than that given for a
demeanor.
fine  A sum imposed as punishment for an offense; a forfeiture
or penalty paid to an injured party or the government in a civil
or criminal action.
guardian ad litem  Legal representative for a minor.
implied consent  Presumed consent, such as when a patient
offers an arm for a phlebotomy procedure.
implied consent  A consent, usually written, which states
understanding of what treatment is to be undertaken and of
the risks involved, why it should be done, and alternative
methods of treatment available (including no treatment) and
their attendant risks.
infractions  (in-frak'-shuns)  Breaking the law; minor offenses
against the rules, usually punishable by fines.
judicial  (ju-di'-shul)  Of or relating to a judgment, the
function of judging, the administration of justice, or the
judiciary.
jurisdiction  (jur-ush-dik'-shun)  A power constitutionally con-
firmed on a judge or magistrate to decide cases according to
law and to carry sentence into execution; jurisdiction is origi-
nal when it is conferred on the court in the first instance, called
original jurisdiction; or it is appellate when an appeal is given
from the judgment of another court.
jurisprudence  (jur-ush-proof'-dens)  The science or philosophy
of law; a system or body of law or the course of court
decisions.

law  A binding custom or practice of a community; a rule of
conduct or action prescribed or formally recognized as binding
or enforceable by a controlling authority.
liable  (li'-uh-buhl)  Obligated according to law or equity;
responsible for an act or circumstance.
bilb  A written defamatory statement or representation that
conveys an unjustly unfavorable impression.
litigious  (luh-ti'-juhs)  Prone to engage in lawsuits.
manifestation  (ma-nuh-fuh-stra'-shun)  Something that is easily
understood or recognized by the mind.
misdemeanor  (mis-duh-mee'-nuhr)  A minor crime, as opposed
to a felony, punishable by fine or imprisonment in a city or
county jail rather than in a penitentiary.
municipal  (mu-yu'-nuh-puhl) courts  Courts that sit in some
cities and larger towns and that usually have civil and criminal
jurisdiction over cases arising within the municipality.
negligence  (ne'-gli-jents)  Failure to exercise the care a prudent
person usually exercises; implies inattention to one's duty
or business; implies want of due or necessary diligence or
care.
recourse A turning to something or someone for help or protection.
relevant Having significant and demonstrable bearing on the matter at hand.
respondent (ri-spahn'-dunt) The person required to make answer in a civil legal action or suit; similar to a defendant in a criminal trial.
slander Oral defamation; a harmful, false statement made about another person.
statutes (sta'-choots) Laws enacted by the legislative branch of a government.
stipulate To specify as a condition or requirement of an agreement or offer; to make an agreement or covenant to do or forbear from doing something.
subpoena (su'-peh-nuh) A writ or document commanding a person to appear in court under a penalty for failure to appear.
subpoena duces tecum A legally binding request to appear in court and provide records or documents that pertain to a particular case.
testimony A solemn declaration usually made orally by a witness under oath in response to interrogation by a lawyer or authorized public official.

Uniform Commercial Code (UCC) A unified set of rules covering many business transactions; it has been adopted in all 50 states, the District of Columbia, and most U.S. territories. It regulates the fields of sales of goods; commercial paper, such as checks; secured transactions in personal property; and particular aspects of banking, letters of credit, warehouse receipts, bills of lading, and investment securities.
verdict The finding or decision of a jury on a matter submitted to it in trial.

The law is a fascinating subject. When law is applied to medicine, it can provoke interesting case studies and complex decisions. In today's litigious society, medical assistants, as well as physicians and other staff members, must take steps to protect themselves from lawsuits. Legal issues underlie many aspects of the provision of healthcare in a physician's office. Although the wording of statutes and regulations often is long and complicated, medical assistants must stay abreast of the rules governing medical facilities and do everything possible to remain in compliance with the standards and regulations for all organizations that oversee the medical industry.

Generally, the law holds that every person is liable for the consequences of his or her own negligence when another person is injured as a result. In some situations, this liability also extends to the employer. Physicians may be held responsible for the mistakes of those who work in their healthcare facility, and sometimes they must pay damages for the negligent acts of their employees.

Under the doctrine of respondeat superior, physicians are legally responsible for the acts of their employees when the employees are acting within the scope of their duties or employment. Physicians are also responsible for the acts of assistants who are not their own employees if the assistant commits acts of negligence in the presence of the physician while under the physician's immediate supervision. Respondeat superior is a Latin term meaning "let the master answer." When physicians practice as partners, they are liable not only for their own acts and those of their partners, but also for the negligent acts of any agent or employee of the partnership. A medical assistant acting within the scope of the employment contract is considered an agent of the employer.

Medical assistants guilty of negligence are liable for their own actions, but the injured party generally sues the physician, because the chance of collecting damages is greater. However, even an assistant who has no money can be liable for any negligent action. This fact illustrates the continuing importance of exercising extreme care in performing all duties in the professional office and maintaining liability coverage once employed in the healthcare industry.

| JURISPRUDENCE AND THE CLASSIFICATIONS OF LAW |

Jurisprudence, the science and philosophy of law, comes from the Latin words juris, which means "law, right, equity, or justice," and prudencia, which means "skill or good judgment."
Law is a custom or practice of a community. It is a rule of conduct or action prescribed or formally recognized as binding or enforceable by a controlling authority. Law is the system by which society gives order to our lives. The U.S. Constitution is the supreme law of the United States; it takes precedence over federal statutes, court opinions, and state constitutions. The state constitution is the supreme law within the boundaries of each state unless it conflicts with the U.S. Constitution. States cannot pass laws that conflict with the U.S. Constitution, nor can local governments pass laws that conflict with the state constitution.

A law enacted at the federal level, which must be passed by Congress, is called an act. Statutes are laws that have been enacted by state legislatures. Local governments create and enact ordinances. Much of our law is based on previous judicial and jury decisions, which are called precedents. Often judges and juries follow precedents when making a decision on a case. The two basic categories of jurisprudence are criminal law and civil law.

**Criminal Law**

Criminal law governs violations of the law punishable as offenses against the state or the federal government. Such offenses involve the welfare and safety of the public as a whole rather than of one individual. Criminal offenses are classified into three basic categories: misdemeanors, felonies, and treason. To ensure fair treatment under the law, all physicians are entitled to due process, which guarantees that the accused will have an opportunity to defend himself or herself against any charges brought in opposition.

**Misdemeanors**

A minor crime is called a misdemeanor. Such a crime is punishable by fine or imprisonment in a city or county jail rather than in a penitentiary. Misdemeanors vary from state to state and often are divided into subgroups or classes, such as class A, class B, or class C misdemeanors. In most states the subgroups are divided from most serious offenses to lesser offenses. Some states have created a subcategory of misdemeanors for infractions, which are called violations. Infractions are minor offenses, such as traffic tickets, which are punishable only by a fine.

**Felonies**

A felony is a major crime, such as murder, rape, or burglary. It is punishable by a more stringent sentence than for misdemeanors. Federal law and most state statutes classify felonies as crimes punishable by imprisonment for more than 1 year, whereas misdemeanors are punishable by imprisonment for 1 year or less. Usually a convicted felon cannot vote, hold public office, own a firearm. Felonies often are divided into subgroups or degrees, such as first degree, second degree, and third degree. A first-degree offense is normally the most serious.

**Treason**

Treason, the most serious crime, is the offense of attempting to overthrow the government. High treason constitutes a serious threat to the stability or continuity of the government, such as an attempt to kill the president. The president of the United States has the right to declare an action against the United States an act of war rather than an act of treason, which is considered a crime. For instance, although the terrorist attacks of September 11, 2001, were certainly a threat against the United States, they were declared acts of war.

**Civil Law**

Civil law is concerned with acts that are not criminal in nature but involve relationships of individuals with other individuals, organizations, or government agencies. Many types of civil law address numerous issues. The three that most directly affect the medical profession include tort law, contract law, and administrative law.

**Tort Law**

Tort law provides a remedy for a person or group that has been harmed by the wrongful acts of others. Four elements must be established in every tort action: (1) the plaintiff must establish that the respondent or defendant was under a legal duty to act in a particular fashion; (2) the plaintiff must demonstrate that the defendant breached this duty by failing to conform his or her behavior accordingly; (3) the plaintiff must prove that the breach of the legal duty proximately caused some injury or damage; and (4) the plaintiff must prove damages, the injury or loss suffered. Medical professional liability, or medical malpractice, falls into the category of tort law. Libel and slander are common complaints that fall into the category of tort law.

**Contract Law**

A contract is an agreement that creates an obligation. Contract law touches our lives in many ways practically every day, but we usually do not give much thought to its influences. If a person parks a car in a parking garage for a monthly fee and signs a contract for a year, then begins parking elsewhere and refuses to pay the fee, the person may be liable for the fees for the duration of the entire contract. If the person’s vehicle is damaged while parked in the garage, the garage may be responsible for reimbursement, if the contract does not stipulate otherwise. A contract does not have to be formalized in writing to be binding on the parties involved. Oral contracts also are valid in many states in most situations. The Uniform Commercial Code (UCC) is a long, elaborate act that attempts to harmonize the law of sales and other commercial transactions in all 50 states. This code directly affects contract law.

**Administrative Law**

Administrative law involves regulations set forth by governmental agencies. For example, the Internal Revenue Service (IRS) has thousands of regulations and codes, and the typical American does not understand all of them, which may result in errors when filing taxes. The laws that allow the IRS to collect taxes and pursue restitution are administrative laws. Other agencies that are involved with administrative law are the Social Security Administration (SSA), Citizenship and Immigration Services (USCIS), and the Centers for Medicare and Medicaid Services (CMS).
ANATOMY OF A MEDICAL PROFESSIONAL LIABILITY LAWSUIT

A medical liability case often stems from a breach of trust or miscommunication between the physician and the patient. These cases fall into the category of tort law. Even when the physician has made an error, often the level of trust between the physician and patient determines whether a lawsuit is pursued. First, the physician-patient relationship must be formed. Before this relationship can be discussed, the requirements for a valid, enforceable contract must be understood.

What Constitutes a Valid Contract?

A valid legal contract has four essential elements. First, a manifestation of assent or “meeting of the minds” must exist. This element is proven by an “offer” and the “acceptance” of that offer. The parties to the contract must understand and agree on the intent of the contract. Second, the contract must involve legal subject matter. An obligation that requires an illegal action, such as a gambling contract, is not an enforceable contract. Third, both parties must have the legal capacity to enter into a contract. This means that each party must be an adult of sound mind or an emancipated minor. Fourth, some type of consideration must be involved. Consideration is an exchange of something of value (e.g., money) for the physician’s time.

CRITICAL THINKING APPLICATION 7-1

Barbara works for Dr. Rebecca Patrick, who saw the patient bringing the lawsuit against the surgeon as a referral patient. Does Dr. Patrick have a contract with the patient, based on a physician-patient relationship? Why or why not?

The physician-patient relationship is generally held by courts to be a contractual relationship that is the result of three steps:

- The physician invites an offer by establishing his availability (e.g., posting office hours or making himself available during office hours).
- The patient accepts the appointment and makes an offer by arriving for or requesting treatment.
- The physician accepts the patient’s offer by examining the patient and beginning treatment. Physicians also accept the offer by exercising independent medical judgment on behalf of the patient.

Before accepting a patient, the physician is under no obligation, and no contract exists. However, once the physician has accepted the patient, an implied contract exists (Figure 7-1). This implied contract assumes that the physician will treat the patient using reasonable care and that the physician has a degree of knowledge, skill, and judgment that might be expected of any other physician in the same locality and under similar circumstances. It is extremely important that no express promise of a cure be made by anyone in the office, including the physician, because this would become a part of the contract.

The patient’s responsibility in this agreement includes the liability of payment for services and a willingness to follow the advice of the physician. Most physician-patient contracts are implied contracts. Although many forms may be completed by the patient before he or she is accepted by the physician, they do not in most cases constitute a formal contract for each specific visit to the physician.

CRITICAL THINKING APPLICATION 7-2

- If the patient does not pay for the services rendered by the physician, does this negate the physician-patient contract?
- How might Barbara, Samantha, and Lynda ensure that patients understand that they are expected to follow the advice of the physician?

After the physician-patient relationship has been established, the physician is obligated to attend the patient as long as attention is required, unless the physician or patient terminates the contract. When a physician terminates the contract, the patient must be given notice of the physician’s intentions so that the patient has sufficient time to secure another physician. The physician may write a letter of withdrawal from medical care of the patient, and it should be delivered by certified mail, return receipt requested. A copy of the letter and the return receipt should be attached to the patient’s chart and permanently retained. Reasonable time should be allowed for the patient to secure other medical care.

To protect the physician against a lawsuit for abandonment, the details of the circumstances under which the physician is withdrawing from the case should be included in the patient’s medical chart. The letter of withdrawal does not have to specify a reason for withdrawal unless the physician so chooses. However, some physicians include a brief reason in the letter, such as missing appointments or failing to comply with treatment orders. In either case, the letter should state the following:

- That professional care is being discontinued
- That the physician will provide copies of the patient’s records to another physician on request
- That the patient should seek the attention of another physician as soon as possible

A patient who wants to terminate the physician-patient relationship simply no longer seeks the physician for treatment. The patient does not have to inform the office; however, if this is done, the office manager or physician should follow up with a
confirmation letter, stating that the patient has ended the relationship.

### Breach of Contract

An unjustifiable failure to perform all or some part of a contractual duty is a breach of contract. For example, if a surgeon prepares a surgery estimate and says that the fee will be no more than $6,500, but then charges the patient $7,200, a breach of contract exists. Although most physicians state that the document is just an estimate, this particular physician stated a clear amount that the surgery costs would not exceed.

### The Statute of Frauds

In 1677 a statute was adopted in England to reduce the occurrence of perjured testimony. It provided that certain contracts could not be enforced if they depended on the testimony of witnesses alone and were not evidenced in writing. The provisions of this English statute have been closely followed by statutes adopted in all 50 states in the United States.

A promise to pay the debts of another person is an example of a contract that usually must be made in writing. If a third party who is not otherwise legally responsible for a patient’s medical bills agrees to pay them, the agreement cannot be enforced unless it is in writing. If a physician were to enter into an agreement to perform a series of treatments for a given sum and this series covered a time span of more than 1 year, the contract would have to be in writing to be enforceable.

**CRITICAL THINKING APPLICATION 7-3**

- For what reasons might a physician not want to accept a patient?
- Must the physician treat every patient who attempts to make an appointment?
- How might Barbara tactfully explain that the physician will not accept the patient into treatment?

### Preliminaries of Litigation

Lawsuits are filed in a variety of different courts, and different states have different types of courts at various levels. The state judiciary has several branches. At the local level are usually municipal courts. These are courts in a city or town that usually deal with ordinance violations. Municipal judges may issue search and arrest warrants. Some states also have justice of the peace courts, which have jurisdiction over many misdemeanors and some civil matters, as well as concurrent jurisdiction over some matters along with the municipal courts. The judges that preside over justice of the peace courts may also issue search and arrest warrants. They often function as small claims courts, with which the medical assistant may have contact in cases of patients who do not pay their bills. Both municipal and justice of the peace courts are local trial courts with limited jurisdiction.

County courts are higher than municipal and justice of the peace courts. These courts handle misdemeanors and civil matters up to a certain monetary limit. District courts have unlimited jurisdiction in criminal and civil matters. They are the highest state courts, other than appellate courts. If one party to a lawsuit is dissatisfied with a lower court’s decision, it has the right to appeal to a higher court for review and possible reversal of the decision. Most states have an appellate court for both criminal and civil matters. The U.S. District Court handles federal matters of a criminal or a civil nature. States also have Supreme Courts that handle a limited number of appellate cases.

Under Article III, Section One of the U.S. Constitution, the U.S. Supreme Court has the authority to ensure equal justice under the law (Figure 7-2). The Supreme Court interprets and guards the Constitution. The court’s one chief justice and eight associate justices are appointed by the president and confirmed by Congress. Approximately 8,000 cases are on the docket per term, which runs from the first Monday in October to the first Monday in October of the next year. Only 80 to 90 cases are chosen each year for full oral argument in front of the justices.

**CRITICAL THINKING APPLICATION 7-4**

Samantha and Lynda are curious as to how Supreme Court’s decisions affect the individual physician’s office. What Supreme Court decisions have affected the medical profession?

### Preparing for Court

Medical professional liability suits are far from rare, and every physician faces the probability of being sued at least once during his or her career. When a suit is filed, preparation for court should start expeditiously. A medical assistant may be involved in preparing materials for court and scheduling or participating in depositions. The best advice for a medical assistant in this position is to remember to tell the truth. Attorneys help prepare the defense of the physician and the staff, but everyone should be truthful in answering in court to prevent the loss of his or her credibility in the trial and charges of perjury. Be especially careful to present a true, complete statement to the representing attorney. Unless he or she knows the whole truth, an appropriate defense cannot be prepared.

### Interrogatories

Before the trial, the physician may be asked to complete an interrogatory, which is a list of questions from each party to the other
in the lawsuit. Answers to the interrogatory must be provided within a specified time, and the answers are considered to be given under oath. Only the parties named in the lawsuit may be questioned through interrogatories.

### Depositions

A deposition is testimony taken from a party or witness to the litigation and is not limited to the parties named in the lawsuit. A witness who is not a party to the lawsuit may be summoned by subpoena for the deposition. The deposition usually is taken in an attorney's office in the presence of a court reporter and is taken under oath. The person giving the deposition is called the deponent. The transcribed deposition, once finished, is sent to the deponent for review, and the deponent is at liberty to request any necessary changes or corrections in the document.

### Discovery

Discovery is the pretrial disclosure of pertinent facts or documents by one or both parties to a legal action or proceeding. Many states have extensive discovery statutes that require each side to reveal to the other the facts that they “discover” while investigating the case. Discovery is also considered the process of uncovering facts in a lawsuit before the court proceedings.

Presentation of evidence may be done by testimony. A witness is called who has some information about an aspect of the case and is asked questions by one or both attorneys. The witness does not know about every part of the case, but something the person knows is relevant.

Another type of evidence may be documentary evidence. This is any type of evidence brought before the court by document or display. It could be a patient's chart, a letter, a laboratory result, or a photograph. All of these are usually entered into evidence and numbered for easy reference.

### Preparing Witnesses and Testifying

Attorneys prepare witnesses who may be called to testify during the court proceedings. They review the questions that will be asked and potential questions the opposite side may present. The attorney helps the witness to clarify the answers he or she gives so that they are sharp and succinct. One of the first rules law students learn is never to ask a question to which they do not already know the answer.

Witnesses should always be on time for a court appearance, because the judge and jury may frown on those who appear late; and that frown may include a fine or confinement in jail for contempt of court! It is critical that witnesses dress conservatively...
and in a manner that shows respect for the court. If any documents are to be referenced while testifying, the witness should review the documents before the court appearance if possible, so that the needed information is easy to locate and discuss. The witness should speak clearly and at a volume audible to the attorneys and parties to the suit, the judge, the jury, and the court reporter. The witness should always answer each question aloud, because the court reporter must record those answers and cannot specify that the witness "nodded yes" as a response to a question.

If a question is confusing, the witness should ask the attorney to restate or repeat it. If the witness does not know the answer to a question or does not recall, that should be stated clearly and confidently. Above all, the parties involved are expected to tell the truth and must be seen as credible witnesses (Figure 7-3). Lying under oath constitutes perjury, which carries stiff penalties. Listening is as important as speaking; therefore the witness should be sure to listen to the question and answer it, elaborating only if the attorney asks for more details.

If an attorney lodges an objection to a question, the witness should be silent until the judge rules on the objection. The objection may be sustained or overruled. Sustaining the objection means that the judge agrees with the objection and will not allow the question stated in that manner. If the judge allows the question, he or she will overrule the objection. Then the witness will be allowed to answer. The witness should never display a combative or hostile attitude and should not make sarcastic remarks while testifying in court. The witness should be professional at all times and refrain from inappropriate comments and belligerent behavior. Using "yes, sir" and "no, ma'am" is appropriate in the courtroom. Always address the judge as "Your Honor."

Inside the Courtroom

Today's courtrooms are a far cry from the ones depicted on television shows representing the Old West. Modern courtrooms are equipped with computer and video equipment, and elaborate security systems often monitor those entering the building. The advent of truTV (originally Court TV) has changed the way Americans see the justice system. By simply turning on our televisions, we can watch justice at work.

Knowing the role of each person in a court of law can be helpful. The person or body bringing the lawsuit to court is referred to by different terms, depending on the type of case. In a criminal court, the government brings the case and is represented by a prosecutor. For example, in criminal cases, legal documents read, The State of Texas v. Robert Smith. In this case, the fictitious Robert Smith is the defendant. In civil court, the person or group bringing the case to court is called the plaintiff (or complainant in some court systems), and the opposite party is called the defendant or respondent. A judge presides over the case, giving instructions concerning the law to the jury, if a jury is present. If no jury is present, the judge decides the case; this is called a bench trial. A witness is a person who knows some pertinent information about the case and gives testimony. Often a court reporter takes notes of the proceedings, and a bailiff may be present, who assists in keeping order. All of these individuals should be treated with respect and courtesy.

Burden of Proof

In a criminal case the burden of proof is on the prosecution, which must prove guilt beyond any reasonable doubt. Reasonable doubt is defined as the level of certainty a juror must have to find a defendant guilty of a crime. It is real doubt, based on reason and common sense after careful and impartial consideration of all the evidence, or lack of evidence, is a case.

Civil cases must be proven by a preponderance of the evidence. This means that the greater weight of evidence must point to the defendant or respondent as being responsible for the act involved in the case.

To understand the difference between reasonable doubt and preponderance of the evidence, think of the scales of justice (Figure 7-4). For a case to be proven beyond a reasonable doubt, the scales should tip heavily toward either guilt or innocence. However, for a case to be proven by preponderance of the evidence, the scales need tip only slightly one way or the other.

To illustrate the difference in the burden of proof in criminal and civil cases, consider The People of the State of California v. Orenthal James Simpson. In O. J. Simpson’s criminal trial, much circumstantial evidence was presented; however, enough doubt also existed that the scales could not tip heavily toward a verdict of guilty, and Mr. Simpson was acquitted. In the civil trial brought by family members of Nicole Brown Simpson and Ron Goldman after the criminal trial had ended, just enough evidence existed to tip the scales in favor of the families’ claim that Mr. Simpson was somehow responsible for the deaths of the two victims. This is the equivalent of a preponderance of the evidence.

Critical Thinking Application

A discussion of the burden of proof prompts Barbara, Samantha, and Lynda to discuss the case of O. J. Simpson. Discuss whether reasonable doubt existed in his criminal trial.
Outcome of the Case

Once both sides have presented their case to the judge or jury, they usually are given the opportunity to present a final summation of their case. The jury then retires to consider the verdict. This can take minutes, hours, days, or weeks. After the jury reaches a decision, the judge may enter it as a final verdict or may disregard it if the evidence does not support the jury’s decision. The judge may also revise the verdict to comply with statutes, such as statutory limits on the amount of punitive damages. The final decision of the trial court is reflected in the judgment, signed by the judge.

Either side normally has the right to appeal the decision to a higher court. However, not all appellate courts are required to hear all cases. For instance, the U.S. Supreme Court chooses the cases it hears each year, and it is restricted to cases that involve interpretation of the Constitution and how that interpretation affects the people it governs.

In criminal cases, if the defendant is found guilty of the crime, a sentencing date is set, usually a few weeks to a few months after the verdict is announced. At this time the punishment is announced.

Arbitration

Arbitration is an alternative to trial in which a third party is chosen to hear evidence and make a decision because of the individual’s familiarity with or knowledge of the law or the issues involved. Arbitration is common in modern business life. It is recognized by statute in most states and usually is available to the medical profession, offering an alternative for resolving legal disputes between physician and patient. Many physicians and attorneys see arbitration as one way to solve the crisis of litigation in this country. Court battles can take years and can be extremely expensive, and much of the money reverts to the attorneys rather than the victors in the lawsuit.

In arbitration, the patient and the physician agree to submit the dispute to an arbitrator in an informal hearing. The arbitrator renders a legally binding decision based on very specific rules of arbitration. Arbitration applies essentially the same rights and the same measure of damages as a court. It is fair, less expensive, faster, and more confidential than court litigation.

The staff of each medical office should know whether arbitration statutes exist in the state where the office conducts business. The state medical board or local medical society should be able to provide this information. An arbitration agreement is a contract and is subject to the judgment of the courts only as to the fairness of the agreement. The agreement is precisely worded by an attorney and should not be paraphrased when explained to a patient. Signing the agreement is a voluntary act by the patient, who has a grace period in which to revoke the agreement if he or she later decides against it. Likewise, a physician always has the option to decide not to care for a patient but must formally notify a patient if the decision is made to no longer render care.

If a physician elects to implement an arbitration agreement procedure with patients, every member of the physician’s staff should know the details of the agreement, how and when the patient should sign up, and how to answer the patient’s questions. The way the program is presented to the patient and the office staff’s willingness to answer the patient’s questions play a large part in whether courts uphold the arbitration agreement as fair and legal.

The patient and the physician both have the opportunity to agree on who will arbitrate the case, so that one side is not favored over the other. By prior agreement, the arbitrator (or arbitrators) may be appointed by or from the American Arbitration Association, which is a neutral, private, nonprofit association dedicated to the advancement of out of court remedies. Its panels of arbitrators are made up of people from business, the professions, and public interest groups.

Medical Professional Liability and Negligence

When a patient is injured as a result of a physician’s negligence, the patient may initiate a malpractice lawsuit to recover financial damages. However, experience has shown that the incidence of malpractice claims is directly related to the personal relationship and trust that exist between the physician and the patient. Deterioration of the physician-patient relationship is a common reason patients sue physicians for malpractice, even when the patient has sustained no real injury.

Medical professional liability, commonly called medical malpractice, is governed by the law of torts. The term medical professional liability encompasses all possible civil liability that can be incurred during the delivery of medical care. Medical professional liability is much more easily prevented than defended.

To understand medical malpractice, the term negligence first must be understood. Negligence, in general, implies inattention to one’s duty or business, or the implication of a lack of necessary
diligence or care. In medicine, negligence is defined as the performance of an act that a reasonable and prudent physician would not do or the failure to do an act that a reasonable and prudent physician would do. This, of course, also applies to any other healthcare professional. The standard of prudent care and conduct is not defined by law but is left to the determination of a judge or jury, usually with the help of expert witnesses. Expert witnesses are members of the profession involved, in this case, medicine. To be considered an expert witness, a person usually belongs to a certifying or qualifying organization, against which the defendant's qualities may be compared.

Professional negligence in medicine falls into one of three general classifications:
- *Malfeasance*, or performance of an act that is wholly wrongful and unlawful
- *Misfeasance*, or improper performance of a lawful act
- *Nonfeasance*, or failure to perform an act that should have been performed

A physician who performs an operation carelessly or fails to render care that should have been given may be found to have been negligent. Although a medical assistant acts as an agent of the physician in carrying out most of his or her duties, the medical assistant may perform an act that can result in litigation. For instance, if the medical assistant gives a patient the wrong medication or the wrong dose of medication, both the physician and the medical assistant can be held liable for the error. Some states limit the scope of practice of medical assistants where medications are involved; however, if medical assistants are performing within the realm of duties for which they have received training and the physician is accepting responsibility for the actions of those in the medical office, they usually are allowed to dispense and administer medications unless prohibited by state law. The medical assistant should always practice within the legal boundaries of the state (Procedure 7-1).

### CRITICAL THINKING APPLICATION 7-8
Lynda is curious as to whether a physician is guilty of medical professional liability if he or she makes a mistake in diagnosing a patient. When might this be considered malpractice and when might it not be considered malpractice?

What if the patient makes his or her condition worse? Is the physician then fully responsible? Contributory negligence exists when the patient contributes to his or her own condition, and it can lessen the damages that can be collected or even prevent them from being collected altogether.

### The Four Ds of Negligence
Negligence is not presumed; it must be proven. The Committee on Medicolegal Problems of the American Medical Association (AMA) has determined that patients must present evidence of four elements before negligence has been proven. These elements have become known as the four Ds of negligence:

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### PROCEDURE 7-1
**Perform Within the Scope Of Practice**

**GOAL:** To perform duties within legal boundaries and within the scope of practice in the state where employed as a medical assistant.

**EQUIPMENT and SUPPLIES**
- Computer with Internet access
- Access to text of laws and regulations affecting the practice and scope of practice for medical assistants

**PROCEDURAL STEPS**

1. Read the laws and regulations that apply to medical practices thoroughly. **PURPOSE:** To understand the content and intent of the laws and regulations.
2. Become familiar with the laws that affect medical practices in your state. **PURPOSE:** To understand which laws apply to the employer's facility.
3. Obtain additional training on compliance with the laws and regulations, if necessary. **PURPOSE:** To make sure all actions and procedures in the office are in compliance with the current applicable laws.
4. Read journals and other information, either in print or on the Internet, about the laws and regulations. **PURPOSE:** To remain current in compliance activities.
5. Stay aware of licensure issues that affect the physician, including:
   - Licensure
   - Registration
   - Certification
   - Suspension
   - Revocation
   **PURPOSE:** To ensure that the physician is practicing medicine legally according to all laws and regulations.
6. Know the scope of practice for a medical assistant. **PURPOSE:** To ensure that the medical assistant is practicing legally according to the scope of practice.
7. Make certain information is available on current laws and regulations at all times.
8. Perform all activities in accordance with applicable laws and regulations. **PURPOSE:** To ensure compliance with applicable laws and regulations.
9. Demonstrate an awareness of the consequences of not working within the legal scope of practice. **PURPOSE:** Follow the laws and regulations to ensure compliance in the medical facility.
1. **Duty**: Duty exists when the physician-patient relationship has been established. The patient has sought the assistance of the physician, and the physician has knowingly undertaken to provide the needed medical service.

2. **Dereliction**: Dereliction is failure to perform a duty. Proof must exist that the physician somehow neglected the duty to the patient.

3. **Direct cause**: Proof must exist that the patient was harmed directly because of the physician’s actions or failure to act and that the harm would not otherwise have occurred.

4. **Damages**: The patient must prove that a loss or harm has resulted from the physician’s actions.

If all four of these elements exist, the patient may obtain a judgment against the physician in a medical professional liability case.

### Types of Damages

Five types of damages are common in tort cases: nominal, punitive, compensatory, general, and special damages.

- **Nominal damages** are small awards that are token compensations for the invasion of a legal right in which no actual injury was suffered. For instance, if an unauthorized medical facility employee accesses a patient’s medical record and is discovered but was not revealed by any of the information in the record, the patient has not actually been harmed but may be awarded nominal damages in a lawsuit for the invasion of the patient’s privacy.

- **Punitive damages** are designed to punish the party who committed the wrong in such a way so as to deter repetition of the act; these are sometimes called exemplary damages. These damages were historically set so that the amounts would discourage intentional wrongdoing, misconduct, and outrageous behavior. The amount of damages awarded coincides in some percentage with the wealth of the defendant. Tort reform, currently a much-discussed subject, would cap the amount of money that could be collected during personal injury litigation, including medical malpractice cases. A specific monetary figure (e.g., $500,000) has been suggested as a limit on punitive damages; some believe that plaintiffs should be allowed to collect only up to three times the amount of compensatory damages. Some states have passed legislation that caps one or more of the categories of damages.

- **Compensatory damages** are designed to compensate for any actual damages caused by the negligent person. They are intended to make the injured person “whole.” Of course, nothing can substitute for the loss of an arm or a leg, for example, but compensatory damages help the patient or the family recover from the loss.

- **General damages** include compensation for pain and suffering, for loss of a bodily member or faculty, for disfigurement, or for other similar direct losses or injuries. The fact of the losses must be proven, but the monetary value does not.

- **Special damages** are awarded for injuries or losses that are not a necessary consequence of the physician’s negligent act or omission. These may include the loss of earnings or costs of travel. Both the fact of these losses and the monetary value must be proven.

### Standard of Care

The standard of care as it pertains to a medical assistant must be distinguished from the medical assistant’s scope of practice. From a legal perspective, each medical assistant is required to perform all duties in a manner that meets or exceeds that of a reasonably competent and knowledgeable medical assistant. Also, medical assistants cannot perform any duties for which they have not been trained. A medical assistant should treat every chart touched as if it will end up in a court of law. Remember, if it is not in the chart, there is no way to prove an event happened. The courts hold that a physician must do the following:

- Use reasonable care, attention, and diligence in the performance of professional services
- Follow his or her best judgment in treating patients
- Have and exercise reasonable skill and care that are commonly had and exercised by other reputable physicians in the same type of practice in the same or a similar locality

In the worst case, a physician or medical facility may be faced with wrongful death litigation. A wrongful death *allegation* is one in which the physician or medical facility is blamed for the death of a patient because of error or inappropriate treatment. A wrongful death suit usually is brought by the family of the *decedent* against the physician or others involved with the patient.

### Consent

A physician must have consent to treat a patient, even though this consent usually is implied by the patient’s appearance at the office for treatment. This implied consent is sufficient for common or simple procedures generally understood to involve little risk, such as phlebotomy and taking vital signs. When more complex procedures are anticipated, the physician must obtain the patient’s *informed consent*.* A physician who fails to secure some formal expression of consent could be charged with the crime of *battery*. Make sure the patient’s identity has been verified before asking him or her to sign the consent form.

Informed consent involves a deeper understanding of the patient’s condition and a full explanation of the plan for treatment. Informed consent is not satisfied merely by having the patient sign a form. A discussion must occur during which the physician provides the patient or the patient’s legal representative with enough information to decide whether the patient will undergo the treatment or seek an alternative. The medical assistant cannot hold this conversation about consent with the patient; the discussion must be initiated by the physician. However, the medical assistant can witness the document and ask the patient to sign the consent form. After such discussion, the patient either consents to the proposed therapy and signs a
consent form or refuses to consent. According to the AMA’s standards for informed consent, the discussion should include at least the following elements:

- Patient's diagnosis, if known
- Nature and purpose of the proposed treatment or procedure
- Risks and benefits of the proposed treatment or procedure
- Alternative treatments or procedures, regardless of the cost or the extent to which the treatment options are covered by health insurance
- Risks and benefits of the alternative treatment(s) or procedure(s)
- Risks and benefits of not receiving or undergoing a treatment or procedure

The discussion should be fully documented in the patient’s medical record, and a copy of the signed form should be placed in the record. Treatment may not exceed the scope of the consent that the patient has given. Often the consent forms are lengthy and mention excessive possibilities and complications. Some language may attempt to be all inclusive (e.g., “included, but not limited to”) when risks are listed. It is wise to have an attorney review the forms used for informed consent, because those that are too broad or too specific can be detrimental to the physician in a medical professional liability case.

Patients cannot be forced to undergo any type of medical treatment or care. The ultimate decision about care must be left to the patient, and although medical professionals should disclose information to help the patient make a good, informed decision, the patient should never be persuaded to act in any manner or accept any treatment with which he or she does not agree. Should the patient decide not to undergo treatment the physician feels is necessary, an informed refusal of treatment or care should be signed. This should be a statement similar to the informed consent, but it indicates that the patient has elected not to undergo treatment. Some physicians discontinue all treatment if a patient does not participate in the care the physician recommends. This document, once signed, should be added to the patient’s medical record.

Each state has its own consent laws. Medical assistants should be familiar with the laws in their own state that apply to their particular facility. Most of the laws can be found easily by searching the Internet.

**CRITICAL THINKING APPLICATION 7-10**

Barbara stresses to Samantha and Lynda that at some time in their professional career, a patient will ask for their advice regarding whether the patient should undergo a certain procedure or treatment. Barbara explains that patients often consider advice from the medical assistants in the office to be an extension of the physician’s opinions. How might they handle such questions from patients? Should a medical assistant offer any type of advice?

**Giving Consent to Medical Procedures**

Mentally competent adults certainly are able to consent to medical procedures. However, if an act is unlawful, the consent is invalid. For instance, if an abortion is performed in a state where abortion is illegal, the consent to that procedure is null. Consent is also invalid if it is given by a person who is unauthorized to do so or if it is obtained by misrepresentation or fraud.

In an emergency, one may render aid or care to prevent loss of life or serious illness or injury. However, implied consent in this circumstance lasts only as long as the emergency exists, and formal consent must be obtained for further treatment as soon as the emergency has passed.

Physicians sometimes are reluctant to render aid in an emergency to someone who is not their patient for fear they will later be charged with negligence or abandonment. In 1959 California passed the first Good Samaritan Act. Under this law, volunteers at the scene of an accident are given immunity to liability for any civil damages resulting from the rendering of emergency care. Most states now have either Good Samaritan or Volunteer Protection statutes. As long as the emergency care is given in good faith and without gross negligence, and the healthcare worker provides only emergency care that he or she has been trained to provide, the likelihood of a successful lawsuit against that individual is very slim.

Adults who have been found by a court to be insane or incompetent usually cannot consent to medical treatment. Consent must be obtained from the guardian, except in emergency situations.

Generally, when the patient is a minor, consent for surgery or treatment must be obtained from a parent, guardian, or guardian ad litem, except in an emergency requiring immediate treatment. If the parents are legally divorced or separated, consent should be obtained from the custodial parent, but if the child is visiting the second parent, consent may be obtained from that parent, because in such a situation that parent has temporary custody.

Consent is not required for minors in the following circumstances:

- When consent may be assumed, such as in a life-threatening situation
- When a certain treatment is required by law, such as a vaccination or x-ray evaluation for school entry or safety
- When a court order has been issued, as in a situation in which parents withhold consent for a necessary treatment because of religious reasons

In many states, treatment of sexually transmitted diseases, drug abuse, alcohol dependency, pregnancy, or providing birth control measures does not require parental consent.

Emancipation is defined by statute and varies from state to state. An emancipated minor is a person younger than the age of majority (usually 18 to 21 years) who meets one or more of the following conditions:

- Married
- In the armed forces
- Living separately and apart from parents or a legal guardian
- Self-supporting

Some states include a minimum age for emancipation. Unless a statute declares otherwise, a minor who has the right to consent to treatment is entitled to the protection of his or her confidence, even from parents.
Statute of Limitations

A statute of limitations is a period of time after which a lawsuit cannot be filed. The statute of limitations varies from state to state and differs for various types of litigation. Many states have a 2-year statute of limitations for medical malpractice issues. However, in some instances, the statute of limitations may be extended because of a delay in the discovery of an injury. For example, a patient has surgery to replace a valve in the heart, and the surgery seems successful. Two years later, the patient undergoes a routine echocardiogram and the physician discovers that the surgeon mistakenly replaced the aortic valve when the surgery was intended for the pulmonary valve. Although 2 years have already passed, the statute of limitations begins at the point of discovery of the injury; therefore the patient could now bring suit against the surgeon for the error.

Confidentiality

Confidentiality is one of the most sacred trusts the patient places in the hands of the physician and staff (Figure 7-5). Breach of patient confidentiality is grounds for immediate dismissal of a healthcare professional. The strictest care must be taken when handling patient records and discussing information about patients.

In many special cases, patient confidentiality plays a vital role. A patient who tests positive for the human immunodeficiency virus (HIV) may face discrimination if the information surfaces. Physicians who treat such patients may want to take extra care when leaving phone messages or sending mail. Instead of leaving a message for a patient from “Dr. Watson’s office,” the medical assistant could say that the message is from “Terry Watson’s office.” This could indicate an attorney, accountant, or real estate broker. Curious co-workers or relatives may not grow as suspicious as they might if they were to encounter a message from a physician’s office.

Patients receiving treatment for substance abuse are protected by federal statutes. Confidentiality also is of utmost importance to patients receiving treatment for mental health issues, sexually transmitted diseases, sexual assault, and any type of abuse.

LAW AND MEDICAL PRACTICE

Law affects the physician’s day-to-day practice. Some of the ways the medical assistant encounters legal issues in the physician’s offices are discussed in this section. Medical assistants must comply with both state and federal laws and regulations while performing the duties associated with their job (Procedure 7-2).

PROCEDURE 7-2

Practice Within the Standard of Care for a Medical Assistant

GOAL: To perform duties within the standard of care in the state where employed as a medical assistant.

EQUIPMENT and SUPPLIES
- Computer with Internet access
- Access to text of laws and regulations affecting the standard of care for medical assistants

PROCEDURAL STEPS

1. Become familiar with the standard of care expected of a medical assistant in your state.
   PURPOSE: To make certain that the laws and regulations that apply to the specific practice are applied with each patient.
2. Approach every patient, every day, in a professional manner.
3. During your introduction, identify yourself as a medical assistant.
   PURPOSE: To ensure that the patient understands the medical assistant’s position.
4. Use reasonable care, attention, and diligence during each encounter with patients.
Legal Disclosure

The physician is charged with safeguarding patient confidences within the constraints of the law, but according to state laws, which vary somewhat across the nation, certain disclosures must be made. Frequently the medical assistant is involved with the responsibility for reporting these events.

Births and deaths must be reported. In some states, detailed information about stillbirths is required. Physicians also must report cases that may have been a result of violence, such as gunshot wounds, knife injuries, or poisonings. Any death from accidental, suspicious, or unexplained causes must also be reported. In some states, occupational diseases and injuries must be reported within specific time limits.

Sexually transmitted diseases are reportable in every state. All 50 states require that patients with confirmed cases of acquired immunodeficiency syndrome (AIDS) be reported by name to the local health department. However, more than half of the fifty states require that patients who test positive for HIV be reported. Individuals are reported either by name or by unique identifiers. A continuing controversy exists as to whether the reporting prompts patients to receive care or deters individuals in high-risk groups from seeking care.

Child abuse is a leading cause of death among children younger than 5 years of age, and healthcare professionals are required by law to report any suspected cases of child abuse. The report should be made as soon as evidence is discovered that gives the physician “cause to believe” that abuse or neglect has occurred. Even if the evidence is uncertain, the physician should report it and allow the government to investigate and determine what action to take to protect the child. However, it is essential to make every attempt to ensure that the report is legitimate, because it could lead to the child’s being removed from the home and placed in foster care. Cases of spousal and elder abuse are difficult, because the person being abused often is reluctant to report the situation for fear of further mistreatment. The law requires that suspected cases of abuse of children, the elderly, or any others at risk be reported to the authorities.

Local health departments publish lists of reportable diseases and the method to use in reporting them. Often this can be done by telephone or mail. Appropriate forms must be used for mail reporting and are supplied by the health department or available on their Web sites. County and state health departments periodically issue bulletins that are sent to healthcare providers with information about disease outbreaks and various statistics. Local health departments should be consulted for specific procedures and reporting protocols.

Patient Self-Determination Act

The Patient Self-Determination Act of 1990 brought the term advance directives to the forefront of medical care. This act requires healthcare facilities to develop and maintain written procedures that ensure that all adult patients receive information about living wills, durable powers of attorney for healthcare, and advance directives. These documents place the decision-making power in the hands of the patient and the family, providing them with written notification of their right to consent to or refuse medical treatment.

Patients' Bill of Rights

In March of 1998, President Bill Clinton received the final report from the President’s Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. The commission was created to advise the president on current issues in the healthcare industry and to make recommendations to ensure that patients would receive high-quality healthcare services. The report, “Quality First: Better Healthcare for All Americans,” led to the development of a Consumer Bill of Rights and Responsibilities for the healthcare industry. This usually is called the Patients’ Bill of Rights. The document, which has eight sections, lists three specific goals:

1. To strengthen consumer confidence by ensuring that the healthcare system is fair and responsive to consumer’s needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and ensuring their health
2. To reassert the importance of a strong relationship between patients and their healthcare professionals
3. To reaffirm the critical role consumers play in safeguarding their health by establishing rights and responsibilities for all participants in improving their health

Most healthcare facilities have adopted a Patients’ Bill of Rights that provides a condensed version of the entire report. Often this information is presented to patients when they are admitted to healthcare facilities, or it may be posted in a prominent place in the facility. The medical assistant must consider the rights of the patient in each encounter. Explain procedures to patients and make sure they consent to treatment. The Patients’ Bill of Rights is honored when written consent is obtained from patients, but the medical staff must always consider the patient and his or her individual desires and preferences in all phases of medical treatment. Office information booklets or bulletin board postings often contain information on where a patient may make a complaint about the care received at a facility. Policies and procedures should honor the provisions of the Patients’ Bill of Rights that apply in that particular medical facility (Procedure 7-3).
PROCEDURE 7-3

Incorporate the Patients' Bill of Rights into Personal Practice and Medical Office Policies and Procedures

GOAL: To ensure that the patient's rights are honored in the daily procedures performed and policies enacted in the physician's office.

EQUIPMENT and SUPPLIES
- Copy of the Patients' Bill of Rights
- Office Policy and Procedure Manuals

PROCEDURAL STEPS

1. Review the eight points in the Patients' Bill of Rights.
   PURPOSE: To become familiar with the points and content of the document.
2. Review the office policy regarding information disclosure to make sure patients have the right to receive information about their health plan, professionals, facilities, and personal care.
   PURPOSE: To comply with the first article in the Patient's Bill of Rights.
3. Review the office policy regarding choice of providers, realizing that some patients may have restrictions on those choices according to their insurance plan.
   PURPOSE: To comply with the second article in the Patient's Bill of Rights.
4. Review the office policy regarding emergency treatment, paying close attention to the procedures for referral to emergency facilities and for emergency treatment in the office.
   PURPOSE: To comply with the third article in the Patient's Bill of Rights.
5. Review the office policy regarding consent for treatment and discussion of healthcare options to ensure that patients are given the ultimate choice in making decisions about their medical care.
   PURPOSE: To comply with the fourth article in the Patient's Bill of Rights.
6. Review the office policy regarding discrimination to make sure the policy is nondiscriminatory and that all employees are expected to be courteous and considerate to every patient and visitor to the office.
   PURPOSE: To comply with the fifth article in the Patient's Bill of Rights.
7. Review the office policy's sections on confidentiality to make certain that they comply with the patient's rights to see their records and to expect confidential treatment of their healthcare information.
   PURPOSE: To comply with the sixth article in the Patient's Bill of Rights.
8. Review the office policy regarding patient complaints and appeals (if applicable) to ascertain whether patients are given information about filing such grievances.
   PURPOSE: To comply with the seventh article in the Patient's Bill of Rights.
9. Review the office policy regarding quality improvement and cost-consciousness to make certain the office maintains the utmost level of quality while remaining cost-conscious.
   PURPOSE: To comply with the eighth article in the Patient's Bill of Rights.
10. Consider each of the eight articles while completing daily duties and performing patient care and treatment in the medical facility.
    PURPOSE: To incorporate the Patient's Bill of Rights into everyday practice.
11. Demonstrate sensitivity to patient rights.
    PURPOSE: To reassure patients so that they know healthcare professionals are sensitive to their needs and desires.

and stabilization emergency services whenever and wherever needed, without prior authorization or financial penalty.

IV. Participation in Treatment Decisions
You have the right to know all your treatment options and to participate in decisions about your care. Parents, guardians, family members, or other individuals whom you designate can represent you if you cannot make your own decisions.

V. Respect and Nondiscrimination
You have a right to be considered, respectful, and nondiscriminatory care from your doctors, health plan representatives, and other healthcare providers.

VI. Confidentiality of Health Information
You have the right to talk in confidence with healthcare providers and to have your healthcare information protected. You also have the right to review and copy your own medical record and request that your physician amend your record if it is not accurate, relevant, or complete.

VII. Complaints and Appeals
You have the right to a fair, fast, and objective review of any complaint you have against your health plan, doctors, hospitals, or other healthcare personnel. This includes complaints about waiting times, operating hours, the conduct of healthcare personnel, and the adequacy of healthcare facilities.

VIII. Consumer Responsibilities
In a healthcare system that protects consumer rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality-improvement, cost-conscious environment.

Controlled Substances Act
On May 1, 1971, the Controlled Substances Act of 1970 became effective. In October, 1973, the Drug Enforcement Administration (DEA) became a part of the U. S. Department of Justice. The DEA works with local, state, federal, and international agencies and organizations to address and regulate the serious issues of drug use and abuse in the United States.

Before administering, prescribing, or dispensing any drugs, a physician is required to register with the regional office of the DEA. This registration is renewable every 3 years. If a physician
works from more than one office, he or she must register each individual office. Regulations on the writing, telephoning, and refilling of prescriptions vary, depending on which drug schedule is involved.

Under the Controlled Substances Act, drugs are categorized into schedules I to V. Drugs in schedule I have the highest potential for abuse and addiction, and those in schedule V have the lowest abuse potential.

Schedule I substances have no accepted medical use in the United States (e.g., heroin and lysergic acid diethylamide [LSD]). Only a physician involved in research with such drugs is concerned with schedule I substances.

Schedule II drugs have a high abuse potential, with severe risk of mental and physical dependence. These include certain narcotic, stimulant, and depressant drugs (e.g., opium, morphine, codeine, and methadone [Ritalin]). Controlled substances in schedule II can be obtained only with a federal triplicate order form obtained from the DEA. A special inventory must be maintained on controlled substances and retained for 2 to 3 years, depending on state requirements. When a controlled substance is removed from inventory, it must be recorded. The record must show the date, the name of the drug, the dosage, and the name of the patient, physician, and employee involved. Substances in schedules III, IV, and V do not require triplicate forms.

Schedule III substances have an abuse potential that is lower than that of drugs in the first two schedules. They include compounds that have limited amounts of certain narcotic drugs combined with nonnarcotic substances (e.g., acetaminophen [Tylenol] with codeine, hydrocodone, butalbital with aspirin and caffeine [Fiorinal]) and several steroids.

Schedule IV substances have still lower potential for abuse; for example, phenobarbital, diazepam (Valium), propoxyphene (Darvon and Darvocet), alprazolam (Xanax), chloral hydrate (Librium), and pentazocine lactate (Talwin).

Schedule V substances have lower abuse potential than those in schedule IV but still warrant control. They include preparations that contain moderate amounts of certain narcotics, as may be found in cough medicines and antidiarrheal products.

The physician may call in a prescription to the pharmacist, but the pharmacist must transcribe it in writing before filling it. With permission from the physician, the medical assistant may orally transmit a prescription for controlled substances only in schedules III, IV, or V, and the dispensing pharmacist must put the prescription into writing before filling it. The medical assistant cannot under any circumstances orally transmit a prescription for a schedule II drug. These prescriptions must be presented in writing to the pharmacist on the appropriate form.

Stored controlled substances must be kept in a locked cabinet or safe. Any loss of controlled drugs by theft must be reported to the regional office of the DEA when the theft is discovered. If a physician discovers that his or her DEA number is being used in the unauthorized prescription of controlled substances, he or she should report the incident to the DEA, to the state regulatory agency, and to the local police. This is especially important in the case of employees whose employment has been terminated and who are suspected of drug theft in the office. In numerous cases fired employees have retaliated by reporting to the DEA exactly what they themselves took, but they accuse the physician or other staff members of taking the controlled substances. This results in messy investigations and months of follow-up; therefore any suspected employee drug use or abuse should be documented and reported to the local authorities. Periodic drug testing of employees is one way to help prevent office drug abuse. Many states now have laws to prevent the filing of false reports; therefore if the physician is wrongly accused by a disgruntled employee, the physician often has some recourse.

A physician who discontinues medical practice must return the registration certificate and any unused order forms and triplicate prescription pads to the nearest office of the DEA. The regional DEA office advises the physician on the disposition of any controlled drugs still on hand.

**CRITICAL THINKING APPLICATION 7-11**

Barbara explains the importance of reporting any employee who is suspected of using drugs or taking drugs from the office. This may be difficult, because coworkers often are friendly with one another and may hesitate to report such acts. Discuss ways to handle this situation.

**The Uniform Anatomical Gift Act**

The Uniform Anatomical Gift Act was approved by the National Conference of Commissioners on Uniform State Laws in 1968. Although many states already had passed laws that permitted living persons to make a gift of their body or portions of it after death, the laws were so different from state to state that arrangements for a donation in one state might not be recognized in another. All states have adopted the Uniform Anatomical Gift Act or similar legislation.

Essentially, the model law for donation states the following:

- Any person of sound mind and 18 years of age or older may give all or any part of his or her body after death for research, transplantation, or placement in a tissue bank.
- A donor's valid statement of gift is paramount to the rights of others except when a state autopsy law may prevail.
- If a donor has not indicated an intent to donate during his or her lifetime, his or her survivors, in a specified order of priority, may do so.
- Physicians who accept organs or tissues, relying in good faith on the documents, are protected from lawsuits. The physician attending at the time of death, if acquainted with the donor's wishes, may dispose of the body under the Uniform Anatomical Gift Act.
- The time of death must be determined by a physician who is not involved in the transplantation, and the attending physician cannot be a member of the transplant team.
- The donor may revoke the gift, or the gift may be rejected by the proposed recipient.

The most important clause of the act permits the donation to be made by a will (without waiting for probate) or by other written or witnessed documents, such as a card designed to be carried by the person or a Uniform Donor Card (Figure 7-6). The Uniform Donor Card is considered a legal document in all 50 states. Many states now list donor preference on the driver's license as well.
The provisions of the Uniform Anatomical Gift Act are so designed that the offer is exercised only after death. Therefore, donors should reveal their intentions to as many of their relatives and friends as possible and to their physician. Because the human body and its parts are not commodities in commerce, no money can be exchanged in making an anatomic donation itself. Fees are charged for performing the transplant and various procedures, but organs cannot be bought and sold. It also is important to note that family members should be prepared to receive the body of the person who has donated his or her entire body to research once the research facility has completed its study. This can often be a traumatic experience, rekindling the grief process once again, so the procedures and final disposition of the body should be decided at the time of the donation to avoid this difficult situation.

The Health Insurance Portability and Accountability Act

HIPAA was signed into law on August 21, 1996, and all healthcare providers were required to comply with HIPAA’s privacy standards by April 2003. Its history began in the Clinton healthcare reform proposals. HIPAA was designed for several purposes, with many goals in mind. Limiting the administrative costs of healthcare and privacy issues and preventing fraud and abuse are of primary importance in the HIPAA regulations. The law has two provisions: Title I (Insurance Reform) and Title II (Administration Simplification). The use of electronic transmissions ideally lowers the administrative costs of providing healthcare, but it has led to problems with privacy regarding health information. The law also had to provide security and confidentiality guarantees for the individual patient. Extensive privacy rules, including the use of unique identifiers, have shaped the law.

The final regulations regarding the privacy legislation sections of HIPAA were published in December, 2000, after the Centers for Medicare and Medicaid Services (CMS) reviewed more than 50,000 comments on and concerns about this important subject. All healthcare organizations that transmit any health information electronically must comply with HIPAA; fines as well as prison terms can be imposed on those who do not comply with the regulations.

HIPAA has had a tremendous effect on the healthcare industry. All healthcare providers, clearinghouses, and health plans that use electronic information must comply with HIPAA regulations. The benefits of HIPAA compliance include:
- Lower administrative costs
- Increased accuracy of data
- Increased patient and consumer satisfaction
- Reduced revenue cycle time
- Improved financial management

Title I, which deals with insurance reform, includes several provisions that protect individuals and their insured dependents if they change jobs or lose a job.

Title II details the process of administrative simplification. Standardization of the exchange of healthcare data is one way HIPAA promotes computer to computer transactions. This standardization process helps reduce the number of forms and methods used in the claims processing cycle, including electronic transactions and standard code sets (e.g., diagnosis, procedure, and supply codes). It also provides for unique identifiers for providers, employers, health plans, and plans. Medical professionals who access medical information must use log-in and password systems that prevent unauthorized individuals from accessing protected health information.

The Occupational Safety and Health Act and the Bloodborne Pathogens Standard

In 1970 President Richard Nixon signed the Occupational Safety and Health Act, which created what has become the Occupational Safety and Health Administration (OSHA). OSHA is a division of the U.S. Department of Labor, and since its creation, workplace injuries, illnesses, and fatalities have been reduced significantly. OSHA’s mission is to ensure workplace safety and a healthy environment in the workplace.

OSHA commonly is considered the regulatory agency that requires steel-toe boots and hard hats; however, the medical industry moved into the OSHA spotlight in the late 1980s, when the threat of HIV infection extended to healthcare workers. Hepatitis and other pathogens already were a concern for healthcare workers, but when HIV, the virus that causes AIDS, was identified, action was needed to better protect the individuals who cared for patients with these infectious diseases. OSHA’s Final Ruling on Bloodborne Pathogens became fully effective in July, 1992, and since then various additions have been made to update the regulations in light of new information about bloodborne pathogens.

The law requires medical facilities to comply with the Bloodborne Pathogens standard and to be able to prove that compliance to OSHA inspectors if necessary. The actual standard can be found in 29 Code of Federal Regulations (CFR) 1910.1030. The following information details the legal requirements of the OSHA standard as it pertains to the physician's office.

General Duty Clause

No law can cover every single situation that may arise in the course of daily living. Because of this, OSHA’s general duty clause is a catchall regulation that fits almost any situation not specified in any other section of the law. The general duty clause simply states that a workplace must be free of any hazard that might cause serious harm or death. For example, one breach of the general duty clause is failure of a facility to provide reasonable security procedures at a retail store. Although not a specific breach of any regulation, this fits nicely into the general duty clause.
Emergency Preparedness

OSHA requires that all facilities with more than 10 employees have a written emergency action plan in place. The plan must include procedures that cover:

- Reporting a fire or other emergency
- Performing an emergency evacuation, including the type of evacuation and exit route assignments
- Establishing rules for employees who remain to run critical equipment before they evacuate
- Accounting for all employees after evacuation
- Establishing procedures to be followed by employees performing rescue or medical duties
- Providing the name or title of the person (or persons) to be contacted for information about the plan or an explanation of the individual's duties under the plan

The plan also must have an alarm system to notify employees in case of an emergency, and the system must use a separate, distinct signal for each type of emergency. The employees must be trained in safe evacuation procedures. Also, the employer must review the plan with each employee at four specific times: (1) when the plan is developed, (2) when the employee is initially assigned to a job, (3) when the employee's responsibilities change, and (4) when the plan is changed.

Facilities with more than 10 employees also must have a written fire prevention plan. The fire prevention plan must include:

- A list of all major fire hazards and the proper handling and storage of each
- The type of fire prevention equipment necessary to control each major hazard
- Procedures to control accumulations of flammable and combustible waste materials
- Procedures for regular maintenance of safeguards installed on heat-producing equipment to prevent the accidental ignition of combustible materials
- The name or job title of the person responsible for maintaining equipment, preventing or controlling sources of ignition or fires, and controlling fuel source hazards

Employers must tell employees about the fire hazards associated with their job, as well as ways the employee can protect himself or herself. The office policy manual should include information about procedures to follow during natural disasters, such as hurricanes, tornadoes, and other weather-related events, as well as during crime incidents at the facility (e.g., robbery and vandalism). Large-scale events, such as terrorist attacks or bioterrorism, also should be addressed, because medical professionals will be called upon to help in these situations. Obtain a copy of the local hospital's emergency preparedness plan and use it as a guideline if the office needs a written plan. (More information about emergency preparedness can be found in Chapters 27 and 58.)

OSHA inspectors can recommend fines when a facility is found to be out of compliance with an OSHA standard. One of the most common infractions involves a facility that has an Exposure Control Plan but is not using it or following its procedures and policies. This could cause an inspector to declare the facility willfully negligent. Willful negligence exists when “an employer representative was aware of the requirements of the [OSHA] Act, or the existence of an applicable standard or regula-

COMMON OSHA VIOLATIONS

- No eyewash facilities available
- No labeling or improper labeling of hazardous chemicals
- No MSDS for each hazardous chemical
- Storage of contaminated laboratory coats with clean ones
- Not communicating hazards to employees
- No documentation of initial employee training
- No documentation of annual employee training
- No annual hazard assessment
- Having an Exposure Control Plan but not following it
- No proof of destruction of hazardous waste
- No Emergency Action Plan in the facility
- No written Exposure Control Plan
- OSHA Form 300 not posted during required period
- No records of hepatitis B vaccinations or declination forms
- MSDS, Material Safety Data Sheet; OSHA, Occupational Safety and Health Administration.

Exposure Control Plan

The Exposure Control Plan can be a part of the regular safety plan written for the medical facility or a stand-alone document, but it must cover all the elements required by OSHA. The plan must be put in writing, must be reviewed annually, and written documentation must exist that the plan was reviewed and updated or revised, if needed. A hard copy must be provided to employees on their request within 15 working days, and the plan must be available at all times in the workplace.

The plan must delineate the tasks employees perform in which the risk of blood exposure is present. It also must classify jobs in the facility according to the likelihood of exposure. For instance, some duties always expose the employee to blood or other potentially infectious materials (OPIM), often on a daily basis. Some duties only occasionally expose the employee, and other duties never expose the employee to blood or OPIM. Employees must be told to which category they belong and what duties they will perform that could lead to exposure. In addition, a clear follow-up procedure must be in place that details how the medical facility will track employee exposures. The employee cannot be abandoned after an exposure incident. Periodic counseling must take place in which the facility determines and documents the progress of the employee who has had an exposure, including laboratory tests and medical treatment received.

The Exposure Control Plan must contain a Waste Management section that details how waste is removed from the facility and destroyed. Most medical offices contract with companies that specialize in removing and destroying medical waste. The office must keep the receipts given by the company that prove that the waste was taken away from the facility and then incinerated or otherwise destroyed.

The plan must also contain a section on Hazardous Materials Communication, which explains what substances in the facility
are hazardous and how to handle a spill or exposure to those products. Only the manufacturer of a chemical can determine whether it is hazardous, and Material Safety Data Sheets (MSDS) must be kept on almost all chemicals and reagents in the facility. Recent rulings have exempted some chemicals, but without the MSDS information, a medical assistant could not determine what type of health, reactivity, flammability, or other risks the chemical could have.

If the facility has equipment for X-ray studies, a Radiation Safety Plan must also be written and followed. All facilities should have an Emergency Action Plan in place, which provides procedures in case of tornadoes, fires, floods, or any other type of emergency that might occur in the office. This plan should contain floor plans of the facility, diagrams depicting the most efficient exits from the building, and the chain of command in an emergency. Diagrams with exit routes should be posted in every room of the medical office. At least annually, a hazard assessment must be performed on the entire facility. The hazard assessment is an inspection for problem areas in which the facility might be out of compliance. The facility must have documentation that the hazard assessment was done.

**OSHA Record-keeping Regulations**

An injury or illness is considered to be work related when an event or exposure in the work environment contributed to or caused the condition or significantly aggravated a pre-existing condition. OSHA made several changes in the regulations covering record keeping on work-related injury to simplify forms, protect employee privacy, encourage employee involvement, and enable computer use for meeting OSHA requirements. The revised rules took effect January 1, 2002. Three basic forms now are used to keep records on injuries, accidents, and illnesses related to the workplace. The forms are:

- **OSHA Form 300—Log of Work-Related Injuries and Illnesses**: Information is posted on form 300 regarding work-related deaths and every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. An OSHA Form 301 (Injury and Illness Incident Report) should be completed for each entry on the log.
- **OSHA Form 300A—Summary of Work-Related Injuries and Illnesses**: Form 300A must be completed even if no injuries or illnesses occurred during the year that were work related. It must be posted in a common area for viewing by all employees, and provides the total number of accidents, illnesses, and injuries in the facility for the previous year. The length of time that this information must be posted has increased from 1 month to 3 months, specifically from February 1 to April 30 each year. An additional change is the certification of the form. A company executive must examine the document and certify that it is accurate.
- **OSHA Form 301—Injury and Illness Incident Report**: Form 301 is used to report what actually happened when an employee suffers a work-related injury or illness. This form, or an acceptable substitute, such as a state worker's compensation form, must be completed within 7 calendar days after notification of the illness or injury. The form should be completed as quickly as possible so that an exact recollection of events can be documented (Procedure 7-4). Now that the new

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**PROCEDURE 7-4**

**Complete an Incident Report**

**GOAL:** To fill out an accurate, complete incident report that provides all legally required information.

**EQUIPMENT and SUPPLIES**

- OSHA Form 301 (or other incident report form)
- Pen
- Notes taken regarding incident

**PROCEDURAL STEPS**

1. Interview the employee(s) involved in the incident.
2. Review the notes taken by those who witnessed the incident.
   **PURPOSE:** To gain an understanding of what happened during the incident.
3. Interview those who may have additional information or those who provided the original notes, if clarification on the issues is needed.
   **PURPOSE:** To be clear about the exact sequence of events during the incident.
4. Read through OSHA Form 301 before filling out any sections.
   **PURPOSE:** To avoid making mistakes while putting the information in the spaces on the form.
5. Complete information about the employee(s) and the healthcare professional who treated the employee(s).
6. Detail the information requested about the incident, including the actual injury or illness, a narrative of what happened, and what object(s) were involved in the injury.
   **PURPOSE:** To document the incident and the principles involved.
7. Sign the report and, if possible, review it with the employee(s).
   **PURPOSE:** To prove that the report was submitted and reviewed by a supervisor.
8. If the injured employee(s) completes the incident report, make sure it is reviewed and signed by a supervisor.
   **PURPOSE:** Some facilities have incident reports the employee completes that detail the events surrounding the incident. These must be reviewed by a supervisor.
9. Make sure the incident was reported in a timely manner and within any state regulatory times.
10. Refer the employee(s) to the proper persons for medical care.
   **PURPOSE:** To make sure that employee(s) obtain timely and proper medical care.
record-keeping regulations have become effective, employees are guaranteed access to their OSHA 301 forms for the first time.

The log and summary forms must be kept on file for a minimum of 5 years. Only the Summary should be posted during the specified time period from February 1 to April 30 each year, reflecting information from the previous calendar year. The forms are not sent to OSHA unless specifically requested. (To view these forms, visit the Evolve site at evolve.elsevier.com/kinn.)

CRITICAL THINKING APPLICATION 7-12
Barbara quickly realizes that the office is using older versions of OSHA forms 300 and 301. Where might she look for or go to find updated information and forms?

It is wise to keep a communication log of calls to OSHA in which questions were asked or information verified. Note the day and time called, the first and last name of the person spoken to, the person's title, and the question asked and response given. Take detailed notes while discussing the issue on the phone. This log could be invaluable if a question ever arises about a subject discussed with a local OSHA official. It may make the difference when an OSHA inspector suggests a hefty fine. If the medical facility can show documentation that a certain procedure was discussed with an OSHA official and decisions were made based on that discussion, the facility may have sufficient evidence that the law was considered and the facility did its best to comply.

Needlestick Safety and Prevention Act
An estimated 600,000 to 800,000 injuries occur annually among healthcare workers. One third of these injuries happen during the disposal process. In an effort to reduce these injuries, which can lead to exposure to HIV, hepatitis B virus (HBV), or other blood-borne pathogens, OSHA revised its Bloodborne Pathogens standard to comply with the Needlestick Safety and Prevention Act, which became law on November 6, 2000. The regulations became effective on April 18, 2001.

Employers are now required to involve employees in the selection of needle safety devices. The facility must be able to prove that consideration was given to various types of devices that promote needle safety, what led to the decision to choose the device currently in use, and which employees were involved in these decisions. A list should be kept of which employees contributed to the selection decisions. Minutes from meetings, copies of employee response forms, and the forms used to solicit input are good methods of proving that employees were involved in the selection process.

A needlestick and sharps injury log must also be kept in the medical facility. At a minimum, the log must include the following information:
- Description of the incident
- Type and brand of device used when the incident took place
- Location of the incident

The regulations that took effect in 2001 require all needlestick and sharps injuries to be reported and documented, not just the ones that result in injury or illness.

OSHA Training Requirements
All employees, including full-time, part-time, and temporary employees with a risk of occupational exposure, must receive training in the facility in which they are employed at two very specific times. Initial training must be conducted before a new employee starts any work-related duties. In addition, training must be conducted annually to update and inform employees about new regulations and procedures related to OSHA compliance. The initial training requirement is one of the most frequently breached regulations, yet it is critical to the employee's safety. Training must include the following:
- Making accessible a copy of the regulatory text of the standard and explanation of its contents
- General discussion of blood-borne diseases and their transmission
- Universal precautions and body substance isolation
- The Exposure Control Plan
- Engineering and work practice controls, including handling of needles and sharps
- Personal protective equipment
- Hepatitis B vaccine
- Response to emergencies involving blood
- Potential sources of infection and tasks that might pre-empt exposure
- Written schedules for cleaning
- Handling of contaminated laundry
- Handling of exposure incidents and spills
- Post-exposure evaluation and follow-up program
- Reading of MSDS, signs, labels, and color coding (Figure 7-7) and locations of these items

The employee must be given an opportunity to ask questions and receive answers, and the trainer must be knowledgeable about the subject matter. Documentation of the training sessions should be kept in each employee's personnel file or a special file for OSHA-related information.

CRITICAL THINKING APPLICATION 7-14
Barbara reviews the employee files and finds that neither Samantha nor Lynda received OSHA training when they were initially hired. How might Barbara rectify this, and what documentation would be helpful?

Hepatitis B Vaccination
The hepatitis B vaccination series must be offered to employees at risk of occupational exposure at no cost to the employee. The employee cannot be asked to pay in advance for the vac-
Material Safety Data Sheets communicate hazards to employees about the products and chemicals used in the medical office. They also inform the employee as to what to do in case of an exposure. OSHA requires that MSDS are kept on all hazardous chemicals, unless exempted. Only the manufacturer can determine if a product is hazardous. MSDS can be obtained from either the manufacturer or the medical supply company from which the product was ordered. They must be provided after requested from the manufacturer within 30 days. Keep copies of requests to prove that an attempt has been made to obtain the MSDS information.

The appropriate number should be placed inside each box that applies in the figure above. Most offices use the National Fire Protection Association Rating System. Many MSDS provide the labeling information on the sheet. Others must be read thoroughly to determine how the labels should be completed. If the MSDS says that a chemical has a "moderate to high" hazard, label it high. If it says "low to moderate," label it moderate. Never guess at the numbers used for the label—always consult the MSDS. If individual containers are labeled, the facility is said to always be out of compliance, because it is easy to miss a container that may have just arrived in a shipment. Many medical facilities place labels on a permanent fixture next to where the product is stored, but it must be permanently stored in that area.

**Simple Rating Guide**

0—no hazard
1—slight hazard
2—moderate hazard
3—high hazard
4—extreme hazard

<table>
<thead>
<tr>
<th>NFPA Rating Summary</th>
<th>Reactivity (Yellow)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health (Blue)</strong></td>
<td></td>
</tr>
<tr>
<td>4 Danger</td>
<td>Danger</td>
</tr>
<tr>
<td>Specialized protective equipment required.</td>
<td>Explosive material at room temperature.</td>
</tr>
<tr>
<td>3 Warning</td>
<td>Danger</td>
</tr>
<tr>
<td>Corrosive or toxic. Avoid skin contact or inhalation.</td>
<td>May be explosive if shocked, heated under confinement, or mixed with water.</td>
</tr>
<tr>
<td>2 Warning</td>
<td>Warning</td>
</tr>
<tr>
<td>May be harmful if inhaled or absorbed.</td>
<td>Unstable or may react violently if mixed with water.</td>
</tr>
<tr>
<td>1 Caution</td>
<td>Caution</td>
</tr>
<tr>
<td>May be irritating.</td>
<td>May react if heated or mixed with water but not violently.</td>
</tr>
<tr>
<td>0</td>
<td>Stable</td>
</tr>
<tr>
<td>No unusual hazard.</td>
<td>Not reactive when mixed with water.</td>
</tr>
<tr>
<td><strong>Flammability (Red)</strong></td>
<td>Special Notice Key (White)</td>
</tr>
<tr>
<td>4 Danger</td>
<td>W</td>
</tr>
<tr>
<td>Flammable gas or extremely flammable liquid.</td>
<td>Water reactive.</td>
</tr>
<tr>
<td>3 Warning</td>
<td>Oxy</td>
</tr>
<tr>
<td>Flammable liquid flash point below 100°F.</td>
<td>Oxidizing agent.</td>
</tr>
<tr>
<td>2 Caution</td>
<td></td>
</tr>
<tr>
<td>Combustible liquid flash point of 100°F to 200°F.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Combustible if heated.</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Not combustible.</td>
<td></td>
</tr>
</tbody>
</table>

**FIGURE 7-7** Labelling and the National Fire Protection Association (NFPA) Rating System. (Courtesy National Fire Protection Association, Quincy, Mass.)

cination and be reimbursed, nor can the employee be asked to put the vaccination series on his or her personal health insurance policy. It must be made available to the employee within 10 working days of initial hire or assignment. The vaccination series can be declined by the employee, who must sign a declination form. If at any time the employee decides to receive the vaccination series, this must still be offered at no cost. The employee does not have to offer a reason for the declination.

Prescreening and postvaccination serologic tests cannot be required.

The vaccination series is completed within a 6-month period. The second vaccination is given 1 month after the first, and the third 5 months after the second. Documentation should be provided to the employee for each vaccination received. Currently a booster dose of the hepatitis B vaccine is not required. However, if a routine booster is recommended by the U. S. Public Health
Service in the future, it must be made available at no cost to employees.

**CRITICAL THINKING APPLICATION 7-15**
Lynda has not disclosed to anyone at the facility that she has had a case of hepatitis. Should she discuss this matter with Barbara? Is Lynda required to discuss this matter with Barbara? Is Lynda placing her patients at risk? If Lynda declines the hepatitis vaccination, must she explain why on the declination form?

**Clinical Laboratory Improvement Amendments**
The Clinical Laboratory Improvement Amendments (CLIA) was a result of the Congressional investigation of physician office laboratories (POLs) and the deficiencies in the quality of the services and results provided by these laboratories. A set of minimum standards for laboratories was established, which improved the quality of test procedures. Quality control and assurance, as well as personnel and proficiency testing, are of utmost importance to the facility complying with CLIA.

CLIA regulations set the minimum standard for laboratory practice and quality. Remember that CLIA is not a governmental agency, but a law. CLIA is enforced by the Department of Health and Human Services (DHHS). OSHA is both a law (Occupational Safety and Health Act) and an agency (Occupational Safety and Health Administration). This is an important difference between CLIA and OSHA.

Some tests conducted in the laboratory are exempt from CLIA standards:
- Nonautomated dipstick or tablet urinalysis
- Fecal occult blood
- Ovulation using visual color comparison
- Urine pregnancy using visual color comparison
- Erythrocyte sedimentation rate
- Hemoglobin by copper sulfate method
- Spun microhematocrit
- Blood glucose testing using certain devices cleared by the U.S. Food and Drug Administration (FDA) for home use
- Specialized self-contained hemoglobin tests

Offices that perform only these tests may obtain a certificate of waiver and are not routinely inspected for CLIA compliance. Tests of moderate or high complexity must be performed by trained personnel with education and experience in the test areas in which they are working. A list of the moderate- and high-complexity procedures can be found in the July 26, 1993, issue of the Federal Register, and updates are published periodically that detail any changes in the list or regulations for testing procedures. Laboratories apply for a CLIA certificate through their local health departments and are periodically inspected for compliance.

**Americans with Disabilities Act**
In 1990 the Americans with Disabilities Act (ADA) was signed into law with the intent of eliminating discrimination against individuals with disabilities. The act is comprehensive legislation that addresses many areas in which a person might experience discrimination, including telecommunications, housing, public transportation, air carrier access, voting accessibility, education, and rehabilitation. The physician's office falls in the category of public accommodations, which are defined as private entities that own, lease, lease to, or operate public facilities.

Public accommodations must comply with basic nondiscrimination requirements that prohibit exclusion, segregation, and unequal treatment. They also must comply with specific requirements related to architectural standards for new and altered buildings; reasonable modifications to policies, practices, and procedures; effective communication with people with hearing, vision, or speech disabilities; and other access requirements. Public accommodations also must remove barriers in existing buildings, where it can be done without much difficulty or expense given the public accommodation's resources.

These regulations affect the physician's office because individuals with disabilities must be able to enter and exit the facility without difficulty. This means that a person in a wheelchair needs a ramp to enter and exit the building. They also must be able to navigate throughout the office without major barriers. Any facility with 15 or more employees must comply with the ADA. To be protected by the act, a person must have a disability or a relationship or association with an individual with a disability. An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities; a person who has a history or record of an impairment; or a person who is perceived by others as having an impairment. The ADA does not specifically name all the impairments covered. Every medical facility must comply with the ADA. The law requires that public medical facilities must allow persons with disabilities to easily and safely:
- Reach door handles for opening and closing
- Enter and exit buildings
- Move through doors and hallways
- Use drinking fountains, phones, and restrooms
- Move from floor to floor (elevators are required for multi-level buildings)
- Do everything the general public can do in a public place

**PHYSICIAN LICENSURE AND REGISTRATION**
A graduate of a medical school must be licensed before beginning the practice of medicine. Licensure is regulated by state statutes through the Medical Practice Acts. It is important for a medical assistant to understand licensing and other laws and regulations intended to protect patients, physicians, medical assistants, and other healthcare workers.

**Medical Practice Acts**
Medical practice acts existed as early as colonial days. However, these acts were later repealed, and in the midnineteenth century, practically none of the states had laws governing the practice of medicine. As one might expect, a rapid decline in professional standards followed. The general welfare of the people was endangered by medical quackery and inadequate care. By the begin-
ning of the twentieth century, medical practice acts were established by statute and were again in effect in every state. The purpose of the medical practice acts is to:

- Define what is included in the practice of medicine in that state
- Govern the methods and requirements of licensure
- Establish the grounds for suspension or revocation of license

All physicians’ offices must follow the laws and regulations set forth by the city and state where the practice is located (Procedure 7-5). Medical assistants are required to report situations in which the law is being broken or that may lead to the harm of another person, including the patient (Procedure 7-6). However, before taking action that could do irreparable harm to another person’s character, verify the facts and follow the facility’s chain of command.

**Licensure**

A Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) degree is conferred upon graduation from a medical or chiropractic school. The license to practice medicine or chiropractic is granted by a state board, frequently known as the State Board of Medical Examiners or Board of Registration. Licensure may be accomplished by examination, reciprocity, or endorsement.

**Examination**

Every state requires medical doctors to pass a written examination. The Federation of State Medical Boards and the National Board of Medical Examiners agreed in 1990 to establish a single licensing examination, the Federation Licensing Examination (FLEX), for graduates of accredited medical schools. Medical graduates in the United States must pass either the FLEX examination, the U. S. Medical Licensing Examination (USMLE), or the National Board of Medical Examiners Examination (NBME). Osteopathic physicians pass the National Board of Osteopathic Medical Examiners’ Comprehensive Osteopathic Medical Licensing Examination (COMLEX).

**Reciprocity**

Some states grant the license to practice medicine by reciprocity; that is, they automatically recognize that the requirements of the

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**PROCEDURE 7-5**

**Apply Local, State, and Federal Healthcare Laws and Regulations That Affect the Medical Assisting Practice Setting**

**GOAL:** To be aware of local, federal, and state laws and regulations that apply to the employer’s facility and recognize the importance of compliance with such laws and regulations.

**EQUIPMENT and SUPPLIES**

- Computer
- Access to organizational Web sites that have established legislation and regulations that pertain to medical facilities
- Information about changes to and new federal and state legislation and regulations

**PROCEDURAL STEPS**

1. Consistently review applicable legislation and regulations that apply to the facility.
   **PURPOSE:** To ensure compliance with the law.
2. Discover the federal and state ramifications of issues related to healthcare workers, such as:
   - Regulatory bodies
   - Education and credentials
   - Scope of practice
   - Job qualifications
   - Continuing Education Unit (CEU) requirements
   - Loss of credentials
   **PURPOSE:** To ensure full compliance in the medical facility.
3. Review and understand federal and state legislation and regulations related to:
   - Americans with Disabilities Act
   - Controlled substance schedules
   - Occupational Safety and Health Administration (OSHA)
   - Centers for Disease Control and Prevention (CDC)
   - Local Public Health Departments
   - Materials Safety Data Sheets (MSDS)
   **PURPOSE:** To ensure full compliance in the medical facility.
4. Review and understand accrediting agency requirements that affect the facility.
   **PURPOSE:** To recognize the importance of local, state, and federal legislation and regulations in the practice setting.
5. Stay aware of new state and federal legislation and regulations as well as the consequences of noncompliance.
6. Always follow office policy when performing any actions at the facility.
   **PURPOSE:** To ensure full compliance in the medical facility.
7. Apply all local, state, and federal regulations to the daily duties of the medical facility.
   **PURPOSE:** To ensure full compliance with laws and regulations that affect the medical facility.
8. Report new or changed regulations to the appropriate supervisor in the medical facility.
   **PURPOSE:** To incorporate new regulations or changes into the office policy manual.
9. Facilitate or attend training sessions that explain new or changed regulations.
   **PURPOSE:** To ensure full compliance with laws and regulations that affect the medical facility.
PROCEDURE 7-6

Report Illegal and/or Unsafe Behaviors That Affect Health, Safety, and Welfare of Others to Proper Authorities

GOAL: To provide a proper procedure for the medical assistant to follow when legal or ethical regulations have been breached.

EQUIPMENT and SUPPLIES
- Contact information for regulatory and law enforcement agencies.
- Written reports or documentation of breaches of regulations, if available.

PROCEDURAL STEPS
1. Compile a list of all regulatory and law enforcement agencies that have jurisdiction over the medical facility.
2. Construct an office directory of contact information for each agency.
   PURPOSE: To have contact information close at hand when needed.
3. Document any illegal and/or unsafe act that occurs in the medical office.
   PURPOSE: To have a record of questionable incidents so that the medical assistant will not have to rely on memory.
4. Consider each aspect of the incident and make sure that it was truly a breach of law or ethics before acting. If unsure, discuss the situation with a trusted peer.

PURPOSE: To prevent false accusations and the filing of a false report.
5. Report the incident to the direct supervisor and give him or her an opportunity to act.
   PURPOSE: To follow the chain of command.
6. If the situation is not resolved, report the incident to the next person in the chain of command unless the situation is critical and could cause harm to the patient.
   PURPOSE: To follow the chain of command.
7. If the situation still is not resolved, report the incident to the proper authorities, depending on the nature of the incident.
   PURPOSE: To comply with the law and ethical standards for medical practice.

state in which the license was granted meet the standards of the second state.

Endorsement
Most graduates of medical schools in the United States have been licensed by endorsement of the National Board certificate. In simpler terms, a state offers a license to a physician based on the examinations taken to grant the license, not by virtue of the license granted from another state. Licensure by endorsement is granted on a case-by-case basis. Graduates who have not been licensed by endorsement are required to pass a state board examination.

In all states, graduates of foreign medical schools who are seeking licensure by endorsement must meet the same requirements as graduates of medical schools in the United States, in addition to various other qualifying factors.

Exemptions
Some graduates may not want to engage in the practice of medicine; their interests may lie in research, administration, or even in the practice of law with a special interest in medical liability. In such instances, licensure is not required. Licensed physicians in the Armed Forces, Public Health Service, and Veterans Administration facilities need not be licensed in the state in which they are employed. However, the Department of Defense is encouraging states to require full licensure of military personnel.

Registration and Reregistration
After a license has been granted, reregistration is required annually or biennially. A physician can be concurrently registered in more than one state. The issuing body notifies the physician when reregistration is due. A medical assistant can aid the physician by being aware of when the registration fees are due, preventing a possible lapsing of the registration.

Many states require proof of continuing education in addition to payment of a registration fee. Continuing education units (CEUs) are granted to physicians for attending approved seminars, lectures, scientific meetings, and formal courses in accredited colleges and universities. A total of 50 hours per year is the average requirement for a license renewal. A medical assistant may be expected to help the physician arrange to complete the required units for license renewal.

Revocation or Suspension
Under certain conditions, the license to practice medicine may be revoked or suspended. Grounds for revocation or suspension of the license to practice medicine fall within one of three categories:
- Conviction of a crime: This may include felonies (e.g., murder, rape, larceny) and narcotic violations.
- Unprofessional conduct: Failure to uphold the ethical standards of the medical profession may be indicated by betrayal of patient confidence, giving or receiving rebates, and excessive use of narcotics or alcohol.
- Personal or professional incapacity: Such incapacity is difficult to label or prove. For example, advanced age or an injury may reduce the apparent capacity of some physicians. Certain illnesses can affect the memory or judgment necessary to practice medicine.

A physician studies many years to learn the profession before becoming licensed by the state to practice medicine. A medical assistant is not licensed to practice medicine and must never
prescribe or attempt to diagnose a patient's ailment; this is the illegal practice of medicine. For this reason, a medical assistant must use great care in discussing patients' complaints and treatment with them, because patients identify the medical assistant's remarks as being the opinion of the physician.

**Closing Comments**

Most patients never entertain the thought of taking legal action against their physicians, and a medical assistant should not develop an attitude of skepticism. However, a medical assistant can play an important role in preventing medical claims.

- Give scrupulous attention to the needs of each patient and do not leave them alone for long periods. This especially applies to young children and elderly patients. Do not criticize other physicians or healthcare facilities. Never give out any information about the patient without written consent, and verify the identity of anyone asking for information about a patient.
- Use discretion in phone and office conversations. One never knows who may be standing nearby. Be aware of tone of voice and attitude during spoken conversations. Communicate office policies and procedures to patients clearly before treatment whenever possible.
- Keep accurate records that show exactly what was done to the patient and when it was done. The medical assistant must never make any promises as to the outcome of treatment. Record cancelled and no-show appointments and record the facts if a patient discontinues treatment.
- Check office equipment often to ensure that it is working properly. Keep drug samples and prescription pads out of sight. Never diagnose, prescribe, or offer a prognosis. Perform only the tasks for which you are trained and keep abreast of new findings and procedures in healthcare. Correctly follow all federal and state regulations.
- Play a positive part in the prevention of medical liability claims. Take care of the patient in a compassionate and competent way, and malpractice will not be a frequent issue in the medical facility.

**Patient Education**

Perhaps the most important detail to remember with regard to patient education and law is patience. Many medical forms are complicated, and regulations change often. Patients usually are not as well educated as the medical assistant on matters concerning legal policies and procedures. Often patients become frustrated with the number of changes with which they are expected to contend, and they unintentionally may project this frustration onto the medical assistant. Remain calm and answer questions, offering as much assistance to the patient as possible.

**Legal and Ethical Issues**

Generally, the law holds that every person is liable for the consequences of his or her own negligence when another person is injured as a result. In some situations, this liability extends to the employer. Physicians may be held responsible for the mistakes of those who work in their healthcare facility, and sometimes they must pay damages for the negligent acts of their employees.

Under the doctrine of *respondeat superior*, physicians are legally responsible for the acts of their employees when they are acting within the scope of their duties or employment. Physicians also are responsible for the acts of assistants who are not their own employees if they commit acts of negligence in the presence of the physician while under the physicians immediate supervision. When physicians practice as partners, they are liable not only for their own acts and those of their partners, but also for the negligent acts of any agent or employee of the partnership.

Medical assistants guilty of negligence are liable for their own actions, but the injured party generally sues the physician, because the chances of collecting damages are better. However, even assistants with no money can be held liable for any negligent action, and liens can be placed on their property in anticipation of its sale and potential profit. This fact illustrates the continuing importance of exercising extreme care in performing all duties accurately and professionally in the healthcare facility.

**Summary of Scenario**

Barbara is enthusiastic about her new job and duties. She is confident about appearing in court to represent Dr. Patrick and discuss the contents of the medical record of the patient suing his surgeon. Dr. Patrick is not a party to the lawsuit but has a physician-patient relationship with the patient just the same. An offer existed, as well as the acceptance of that offer. The relationship was based on legal subject matter, and the physician and the patient had the legal capacity to enter into a contract. Consideration existed as well, because the patient paid for services and the physician treated the patient. Both received something of value. Samantha and Lynda would like to accompany Barbara to the court proceedings to watch and learn.

Even if a patient does not pay for treatment, a contract still exists. The physician may elect to terminate the physician-patient relationship if the patient does not pay, but the trust that the patient places in the physician can be considered a thing of value. Patients should understand their role in their treatment and their responsibilities to the physician. Often this information is communicated in the patient policy brochure, or it may be discussed orally with the patient. Physicians are not required to accept all patients; for instance, not all physicians deliver babies. Some physicians do not treat patients with workers' compensation claims. Physicians do have the right to see the types of patients they want to and are competent to treat, but they should never discriminate on the basis of race, gender, or any other protected status. A physician may not always be correct in his or her diagnosis, but this does not mean that the physician has committed malpractice. However, if expert witnesses feel that the physician should have made a different diagnosis based on the case, then the physician might be held liable for negligence. If an employee has information about a case that is embarrassing to the physician, he or she is ethically
SUMMARY OF SCENARIO—cont’d

obligated to report the information, but rarely legally liable to speak up unless a law has been broken.

Samantha and Lynda have learned many new concepts about law from Barbara and are anxious to follow the court proceedings. They will learn more by watching the actual process of law at work. Barbara looks forward to sharing more knowledge with the employees as they continue to work together.

Medical assistants can help the physician comply with legal regulations in the office by making sure that they understand the policies and procedures required by the facility. Rules are made to ensure compliance so that both patients and employees are kept safe and risks in the office are kept at a minimum. Patient confidentiality is one of the most important rules to remember. New graduates can learn about the laws that affect medical facilities in their area by discussing them with their supervisors and by attending seminars and training. Much information is available on the Internet regarding legal issues. Trust is a critical factor in avoiding medical professional liability lawsuits.

When the patient trusts the physician, he or she is much more likely to work through issues that otherwise might lead to legal action against the physician. Keeping accurate patient records and documenting all information required in the patient chart helps prove that the physician adequately cared for the patient. Clearly, legible handwriting is vital in this process.

The medical assistant may find that the physician is not in compliance with certain rules and regulations. Never jump to conclusions and assume that the physician has no intention of complying. There are various reasons for noncompliance, and any issues should be brought to the attention of the office manager or the physician for clarification. It is the medical assistant’s responsibility to question noncompliance and make every effort to bring the facility into compliance with the cooperation of supervisors, co-workers, and the physician. As a team, medical professionals can remain in compliance and deliver excellent care to all patients.

SUMMARY OF LEARNING OBJECTIVES

1. Define, spell, and pronounce the terms listed in the vocabulary.
   Spelling and pronouncing medical terms correctly bolster the medical assistant’s credibility. Knowing the definition of these terms promotes confidence in communication with patients and co-workers.

2. Discuss all levels of government legislation and regulation as they apply to medical assisting practice, including FDA and DEA regulations.
   An exhaustive listing of government legislation and regulation is available to the medical assistant through Internet research, useful for those situations when asked to keep the facility in compliance with the law. The person charged with this duty must be able to interpret lengthy legalese and determine the exact tasks and precautions that the facility is being asked to do. Some offices form a compliance committee to help ensure that all pertinent laws that govern the medical practice are followed meticulously.

3. Distinguish among an act, a statute, and an ordinance.
   Different types of laws and regulations affect us, depending on the origination of the law. Acts are introduced at the federal level and must be passed by Congress. State legislative bodies develop statutes, and local governments create ordinances.

4. Compare criminal and civil law as they apply to the practicing medical assistant.
   Criminal law governs violations punishable as offenses against the state or government. Civil law is concerned with acts that are not criminal but involve relationships between individuals and other individuals, groups, or government agencies. The medical assistant needs to understand the differences between the types of law and how they affect the physician’s medical practice. Medical assistants must personally review those laws that influence medical assistant practice and make sure that they are followed on a constant basis, with documentation to prove so if necessary in a courtroom.

5. Explain the three basic categories of criminal law.

   - Infractions are the lowest on the criminal law scale, usually resulting in a fine. Misdemeanors are minor crimes punishable by a fine or imprisonment in a city or county jail. Felonies are major crimes, such as rape, murder, or burglary. Most felonies carry punishment of imprisonment for at least 1 year, and they are divided into subgroups, usually first-, second-, and third-degree felonies. Treason is a higher crime, usually an attempt to overthrow the government. High treason constitutes a serious threat to the stability of the government, such as an attempt on the life of the president.

6. Distinguish which type of civil law deals with medical professional liability.
   Tort law is the division of civil law that deals with medical professional liability. Tort law provides relief for those who have suffered harm from the actions of others. The plaintiff must establish duty, breach of duty, and damages as a result of the breach of duty, and the extent of the damages suffered.

7. Provide an example of tort law as it would apply to a medical assistant.
   If a medical assistant committed a breach of patient confidentiality, his or her error would fall under the category of tort law, and could be held liable for the error, resulting in damages being paid to the patient by the physician and/or his liability insurer.

8. Explain the four essential elements of a valid contract.
   Four elements are essential to a valid, legal contract: (1) there must be a "meeting of the minds" or manifestation of assent; (2) the contract must involve legal subject matter; (3) the parties to the contract must have the legal capacity to enter into a contract; and (4) some type of consideration must be offered.

9. Distinguish between interrogatories and depositions.
   Interrogatories are lists of questions directed from each party of a lawsuit to the other. Interrogatories are answered under oath and directed only to the parties actually named in the lawsuit. Depositions can be taken
10. List three things to remember when testifying in court.
Testifying in court can be an intimidating experience, but good preparation can alleviate many anxieties. Discussing potential questions with the attorney helps prepare the witness for giving testimony. Always tell the truth to prevent charges of perjury. Speak clearly and distinctly, and do not hesitate to ask the attorney to repeat a question. A brief pause to think about an answer causes no harm. Dress conservatively, know the location and room of the court in advance, and always arrive on time. Credibility is critical in a medical professional liability trial.

11. Discuss the advantages of arbitration.
Arbitration is a popular alternative to court trials. It involves the use of a third party familiar with law or the issues at hand. It is recognized by statute in most states and provides a faster, confidential, fair, and less expensive resolution to a dispute.

12. Differentiate among malfeasance, misfeasance, and nonfeasance.
Malfeasance, misfeasance, and nonfeasance are types of negligence often involved in medical professional liability cases. Malfeasance is performing an act that is completely wrong or unlawful. Misfeasance, comparable to a mistake, is the improper performance of a lawful act. Nonfeasance is the failure to perform some act that should have been performed.

13. Explain the “four Ds” of negligence.
The four Ds of negligence are (1) the duty to care for the patient; (2) dereliction, or failure to perform that duty; (3) proof that this failure was the direct cause of a patient’s injury; and (4) proof that the patient suffered damages from the injury.

14. Define the types of damages.
Nominal damages are token compensations for invasion of a legal right. Punitive damages are designed to punish an offender and discourage repetition of the act. Compensatory damages are designed to compensate for the actual damages suffered, whereas general damages include compensation for pain and suffering, loss of a body member, disfigurement, and other similar losses. Special damages can include such losses as earnings or travel costs.

15. Compare and contrast physician and medical assistant roles in terms of standard of care.
Physicians are highly trained and skilled professionals who are licensed to diagnose and treat patients. Medical assistants cannot diagnose, treat, or advise patients toward any course of action and must be careful to remain within the medical assistant scope of practice when carrying out their duties at work.

16. Describe liability, professional and personal injury, and third-party insurance.
When a person is liable for an act, he or she is obligated or responsible according to the law. Professional and personal injuries are types of torts, meaning that a person or group has injured someone or something else. Physicians carry professional liability insurance, a type of third-party insurance, to help guard them from liability costs. Medical assistants can also invest in liability insurance.

17. Discuss the legal scope of practice for medical assistants.
From a legal perspective, each medical assistant is required to perform all duties in a manner that meets or exceeds that of a reasonably competent and knowledgeable medical assistant. Also, medical assistants cannot perform any duties for which they have not been trained.

18. Explain the importance of informed consent.
Informed consent gives the patient a full understanding of the condition that has been diagnosed, including what could happen if the patient undergoes treatment, refuses treatment, or delays treatment. It provides the patient with information on the advantages and risks of a medical procedure and alternative treatments the patient may want to consider. Informed consent places control in the hands of the patient, who is given the opportunity to make the decisions about his or her healthcare. Patients can never be forced to undergo any type of procedure or treatment.

19. List several legal disclosures the physician must make.
The physician must make several types of legal disclosures with regard to a patient’s health that do not require patient consent. Information about births and deaths, injuries or illnesses as a result of violence, accidental or suspicious deaths, sexually transmitted diseases, and any type of abuse are examples of legal disclosures that must be made by healthcare professionals.

20. Identify where to report illegal and/or unsafe activities and behaviors that affect health, safety, and welfare of others.
In any emergency situation, the medical assistant should call 911. Keep a list of contact information for agencies that provide community assistance. Hospitals often keep an exhaustive list of agencies that can help patients receive various types of assistance. Governmental agencies are usually listed in the blue pages of a telephone directory and can be easily found using Internet search engines.

21. Explain how the medical assistant’s practice is affected by negligence, malpractice, statutes of limitations, Good Samaritan Acts, Uniform Anatomical Gift Act, Living Wills/Advanced Directives, and the Medical Durable Power of Attorney.
Since medical assistants are required to perform all duties in a manner that meets or exceeds that of a reasonably competent and knowledgeable medical assistant, they must be aware of state and federal laws and regulations that affect their practice. Many physicians keep copies of the laws that affect the practice in the policy and procedure manual. All employees are responsible for knowing the law and following procedures that are outlined in the policy manual.

22. Summarize the Patient’s Bill of Rights.
The Patient’s Bill of Rights was designed to strengthen consumer confidence by ensuring that the healthcare system is fair and responsive to consumer’s needs; provide consumers with credible and effective mechanisms to address their concerns; encourage consumers to take an active role in improving and ensuring their health; to affirm the importance of a strong relationship between patients and their healthcare professionals; and affirm the critical role consumers play in safeguarding their health by establishing rights and responsibilities for all participants in improving their health.
23. Describe the implications of the Health Insurance Portability and Accountability Act (HIPAA) for the medical assistant in various medical settings.

Passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 established extensive privacy rules and regulations for the healthcare profession concerning the electronic transfer of information. The act also limited administrative costs by supporting the use of electronic transfer of information and presented guidelines for preventing fraud and abuse. However, the privacy issues raised by HIPAA have been the most discussed and debated topics related to this law.

24. Distinguish between OSHA and CLIA; indicate which one is an actual agency.

OSHA is an agency, a division of the U.S. Department of Labor. More than 2,300 employees work for OSHA, and the agency runs on an annual budget of approximately $443 million as of 2002. Twenty-six states have their own OSHA programs, which adds an additional 3,100 employees. The Occupational Safety and Health Act of 1970 created this agency to ensure safety in the workplace. CLIA (the Clinical Laboratory Improvement Act) is a law that regulates the quality of services provided by laboratories. CLIA is enforced by the Department of Health and Human Services.

25. Describe personal protective equipment.

Personal protective equipment is designed to protect the wearer from bloodborne pathogens and/or other potentially infectious materials. OSHA requires that employees provide personal protective equipment (PPE) if the employee is at risk of exposure to bloodborne pathogens.

26. Describe the importance of Materials Safety Data Sheets (MSDS) in a healthcare setting.

The Materials Safety Data Sheets (MSDS) provide vital information about products and chemicals used in the medical facility. The MSDS is used to explain the proper use of the product and to determine the appropriate action when a spill occurs.

27. Discuss requirements for responding to hazardous materials disposal.

Hazardous materials must be disposed of according to the information provided on the MSDS. Spill kits, used to dispose of waste safely, are required in medical facilities. Most biologically hazardous waste is disposed by waste removal companies and is usually incinerated. The medical facility is provided with receipts both when the waste is picked up and when it is finally incinerated. OSHA requires that these receipts be kept for specific time periods.

28. Identify how the Americans with Disabilities Act (ADA) applies to the medical assisting profession.

Medical assistants must comply with the ADA as it applies to the medical facility employer. Know the provisions of the act and assist in making certain that the facility is in full compliance. Assist ADA patients as they make their way into, through, and out of the facility. Offer to help with undressing and dressing before assuming that the patient needs assistance.

29. Discuss licensure and certification as it applies to healthcare providers.

Physicians may receive a license to practice medicine through examination, reciprocity, or endorsement. FLEX, USMLE, and NBME are all designed for graduates of accredited medical schools. Some states recognize the requirements of another state in which a license was conferred and through reciprocity grant a physician a license to practice medicine. Endorsement is the method of obtaining a license by recognition of the examinations passed instead of by virtue of the license obtained in another state. Most physicians in the United States are licensed by endorsement, because they take the examination after graduating from medical school. This prompts receipt of the license, after proper application and provision of all required documentation. Practicing medicine without a license is illegal.

30. Discuss ways a physician might lose the license to practice medicine.

A physician may lose the license to practice medicine if convicted of a crime, if found guilty of unprofessional conduct, or as a result of personal or professional incapacity. An arrest does not cause a physician to lose the license, because this is an allegation not yet proven in court. Unprofessional conduct usually is determined by local medical societies or other organizations, such as a hospital, with which the physician is affiliated.

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CONNECTIONS

- Study Guide Connection: Go to the Chapter 7 Study Guide. Read and complete the activities.

- Evolve Connection: Go to the Chapter 7 link at evolve.elsevier.com/kimm to complete the Chapter Review and Chapter Quiz. Purse other resources listed for this chapter to increase your knowledge of Medicine and Law.