To Disclose Or Not To Disclose? That Is The Question.

By Drew Balac, Esq.
Weldon-Linne & Vogt

The expectation of confidentiality is essential in developing the vital trust and confidence between a psychiatrist and a patient. Maintaining patient confidentiality is both an ethical and legal duty. As a result, child and adolescent psychiatrists, more often than not, err on the side of caution and refuse to provide copies of their patient chart without a signed consent form from the patient, parent or guardian. However, requests for information or records are not always accompanied by a signed consent form. Even if such a request arrives with a signed consent, some psychiatrists may not feel comfortable releasing the records because of the information contained within. Thus, it may be confusing whether or not to release the records.

A psychiatrist’s legal obligations are defined by federal / state laws and statutes, and the courts. The most notable federal law governing patient confidentiality is HIPAA. The HIPAA Privacy Rule defines and limits the circumstances in which a patient’s protected health information (PHI) may be used or disclosed. Various provisions of the Privacy Rule set forth the circumstances where practitioners are permitted to use or disclose PHI, without the authorization of the patient, including the following circumstances.
Practitioners are permitted to disclose PHI:

- To the parent, guardian, and/or patient who is the subject of the information.

- For “treatment, payment, and health care operations.” An example of “treatment” includes consultation between mental health providers. “Health care operations” includes such things as quality control, credentialing and legal services. “Payment” is self-explanatory.

- When a patient is incapacitated, in an emergency, and it is in the best interests of the patient based on the practitioner’s clinical judgment. Under this scenario, a practitioner may disclose the patient’s name, location, and limited and general information regarding the patient’s condition.

- In situations where a minor patient requests that information not be shared with their parents/guardians, most jurisdictions will permit disclosure in situations where there is an imminent risk of harm.

- To state and federal public health authorities to prevent or control disease, injury, or disability, and to government authorities authorized to receive reports of child abuse and neglect.

- To appropriate government authorities in limited circumstances regarding victims of abuse, neglect, or domestic violence.

- To health oversight agencies such as state licensing boards.

- Pursuant to a court order, subpoena, or other lawful process.

- To law enforcement when required by law, or pursuant to a court order, subpoena, or summons.

- To prevent or lessen a serious and imminent physical threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat). (See note below.)

- To certain government programs providing public benefits or for enrollment in government benefit programs if the sharing of information is required or expressly authorized by statute or regulation, or other limited circumstances.²

**Note:** HIPAA allows individual states to enact laws that are more protective of an individual’s health information than those set forth in the HIPAA regulations; it does not permit state law to diminish HIPAA’s privacy protections afforded to patients. Therefore, to the extent a law diminishes the degree to which a patient’s health information is protected, it is preempted by the more restrictive HIPAA rules. Each state (and the District of Columbia) has statutes specifically governing some aspect of mental health records and their disclosure. State laws governing the disclosure of mental health information tend to be more stringent in limiting the disclosure of patient information.

When there is a conflict between the provisions of HIPAA and the state statute governing mental health information, the psychiatrist must comply with the law that provides greater privacy protections with respect to the mental health information of his/her patients.

**HIPAA ADDRESSES PSYCHOTHERAPY NOTES**

“Psychotherapy notes,” also referred to as “process notes,” are provided a higher level of confidentiality under HIPAA, but only if they are kept distinct from the patient’s clinical record. These notes capture the provider’s impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions.

In addition, under the new HIPAA Final Rule, if the provider maintains psychotherapy/process notes, the Notice of Privacy Practices must include a statement that these notes will only be used/disclosed with the patient’s authorization.

For further information on psychotherapy notes, please contact your risk management professional.

**Note:** With respect to disclosure of PHI in “duty to warn” situations, it is important to remember that duty to warn laws vary from state to state. For example, some states have “permissive warning” that allows mental health professionals to ease confidentiality discretionarily, but do not mandate it, and do not impose liability for failing to warn. Other states have not established a statutory duty to warn, although it may be imposed by caselaw. Some states have not clarified the duty either by statute or in caselaw. Twenty-two states have mandatory duty to warn statutes.³ So, while HIPAA has the language concerning disclosure
(as previously set forth), it is important that you know the language within your state concerning this issue and whether you can or cannot disclose confidential patient information in “duty to warn” situations.

**What is required in order to respond to a request for information regarding a minor patient’s mental health treatment?**

**Release of Medical Records**
Under the HIPAA Privacy Rule, whether parents have full rights to access their child's medical record and act on his/her behalf depends on whether they are recognized as the “personal representative.” (However, see below specific to mental health records.) In many cases, the parents are the personal representatives, but in certain instances, the parents are not. In these situations, the Privacy Rule defers to state law to determine the rights of the parents to access the information. Prior to releasing medical records, be familiar with the legal and custodial rights of parents particularly in divorce, custody, or termination of parental rights situations. There also may be times when one parent wants to use the records against another in a custody and/or divorce action. If you have questions about these issues, it is encouraged to contact your risk management professional prior to releasing the medical records.

**Release of Mental Health Records**
State laws differ on parental access to a minor’s mental health records. In Illinois, for example, if a patient is between 12 and 18 years of age, the consent form must contain the signature of both the minor patient and a parent or guardian. The signature of both parents is not required. By contrast, in Pennsylvania, patients age 14 or older control the release of their records if they understand the nature of the release. It is important to know the specific rules of your state when treating minors.

**Note:** States may have additional laws concerning release of records pertaining to HIV, substance abuse or other issues. Where applicable, it is important to be aware of these specific rules as well.

**Can you respond to a request for information/records made by the non-custodial parent?**
HIPAA does not specifically address whether a non-custodial parent can be a personal representative so we must turn to the individual state laws for guidance. For example, Illinois has a state regulation—the Illinois Mental Health and Developmental Disabilities Confidentiality Act (Act)—which does not make a distinction between a custodial and a non-custodial parent. The courts have interpreted the silence as a non-custodial parent being entitled to information/records regarding the minor patient’s treatment. However, other states have taken the contrary position. As such, you should be familiar with your state laws and consider discussing the parental rights with both parents before treatment of the minor is initiated.

**When can you respond to a request for a deceased patient’s records?**
HIPAA permits only executors, administrators, and others who have the legal authority to act on behalf of the deceased individual or his/her estate, to gain access to the medical records. In Illinois, for example, mental health records and communications remain confidential after the death of a patient. You cannot disclose the records unless the patient’s representative, as defined by the Illinois Probate Act of 1975, and the therapist consent to the disclosure. For purposes of this question, the Probate Act defines the “representative” as an executor, administrator or a guardian.

Under HIPAA’s new Final Rule, providers may now release PHI to family members of a deceased patient, if they were regularly involved in treatment or involved with payment for treatment, provided the patient did not expressly prohibit disclosure. Some states have rules and regulations which allow a provider to disclose information to a deceased patient’s surviving spouse, adult children, parents or siblings if the decedent is not represented by an executor or administrator. However, other states may specifically prohibit disclosure unless the person is legally authorized to receive information.

**Is an executed consent form required in order to respond to a request from the Internal Revenue Service or other federal agencies?**
No. This issue was addressed by the U.S. District Court for the Central District of Illinois in [U.S. v. Wettstein](https://www.courtlistener.com/docket/7330), 733 F.Supp. 1212 (C.D. Ill. 1990). In that case, the IRS was investigating the owner of a mental health clinic where a
A psychologist was employed. The IRS served a summons on the psychologist seeking a copy of her appointment book that contained a list of the names of the patients she treated while employed at the clinic. The psychologist filed a motion to quash the IRS subpoena on the basis that the Act prohibited the disclosure of her appointment book. The district court denied the psychologist’s motion to quash and granted the IRS’ motion to enforce the production of records. The court held that in the absence of express directions from Congress, the broad authority of the IRS to obtain information under 26 U.S.C.S § 7602 could not be impaired by state-law privileges or other state-created exceptions. The court ruled that the Supremacy Clause dictated that the right to privacy under the Act had to yield to the summons power of the IRS. The Secretary of the Treasury is authorized to examine any books, papers, records or other data for the purpose of determining the correctness of any tax return (26 U.S.C.S. § 7602(1)).

Other federal agencies, such as the Department of Justice, may also make a request to review your patient records for purposes of funding, accreditation, investigation or audit. Again, it is important to consider what the purpose of the review is and what type of information the investigator needs to review in order to accomplish his goals. You may be able to supply the information necessary for the audit or investigation without turning over your individual patient files.

The U.S. Patriot Act also gives federal agents broad powers to gain access to patient files without the patient’s consent. The Patriot Act and its impact on the provision of mental health services could be the topic of several articles alone.

**If you are being reviewed/investigated for the purpose of licensure, do you need consent from your patients, their parents or guardians, to provide the records to the individual conducting the review?**

No, you do not need consent from your patients, their parents or guardians. HIPAA, as well as numerous state statutes, allows the disclosure of information for this purpose. However, there may be circumstances where a patient, parent, or guardian files a complaint against you with the Board of Medicine and you may need to disclose information in response to the complaint. Personally identifiable information would include such things as names, addresses, ages, occupations, insurance claim numbers, etc. If you prefer not to take the extra steps to remove the personal information from the records, then you must obtain consent from your patients, their parents, or guardian, to use the records for the review.

**Note:** Prior to providing any information, whether redacted or otherwise, consider consulting your risk management professional. Likewise, it is suggested that you seek out assistance when you receive a request from a licensing board either in written or verbal format. In addition, be aware of your specific state regulations regarding the legal age of consent.

**Conclusion**

The above examples are by no means exhaustive of the various scenarios that a psychiatrist may face concerning the release of medical records. Prior to providing any information about your patients, determine the purpose of the request and whether the patient (if of age to do so), parent, or guardian, would give you consent to provide the information. Obtaining consent is always ideal. However, if that is not possible, it is best to consult with an attorney who is familiar with the state and federal laws governing patient confidentiality. Ultimately, the best advice is to be extremely cautious when disseminating any patient information, even if it is just the name of your patient.
Culture Corner

By Moira K. Wertheimer, Assistant Vice President, Healthcare Risk Management, AWAC Services Company, a member company of Allied World, and Thao Vo, Senior Accountant, Allied World

Child and adolescent psychiatrists often encounter patients and family members from diverse cultures and backgrounds. Although there are many differences and variations within a culture, we feature different cultural groups which may be of interest to you in your daily practice as well as some relevant legal issues which you may encounter. It is important not to stereotype a person from a specific culture by assuming that he/she has the same beliefs as someone else from that same culture. Learning whether a patient considers himself typical or different from others in his cultural group is important as there are many factors which influence how an individual views his own culture/beliefs. You may never encounter some of the featured cultures in your practice; however, we hope you find the information on the featured cultures interesting nevertheless. In this newsletter, we feature the Vietnamese culture.

Vietnamese

(Please note that throughout this article you may observe words that appear different from what you may be used to—for example, Viet Nam versus Vietnam and Sai Gon versus Saigon. Vietnamese words are written/separated by each pronunciation. However, people in the U.S. typically write Vietnam or Saigon.)

Background: Viet Nam is located in Southeast Asia and has a total land area measuring 127,247 square miles, slightly larger than New Mexico. The country is bordered by China to the north, Laos and Cambodia to the west, and the South China Sea to the south and east. Viet Nam’s topography is diverse and includes rugged mountains, lowlands and coastal areas, along with densely forested areas. Major Vietnamese cities include Ha Noi in the North, Da Nang in the mid-coastal area, and Ho Chi Minh City (formerly Sai Gon) located in the South. Viet Nam’s population is approximately 91,519,289 with most living near the two major river deltas—Mekong and Red. The Vietnamese culture is complex due to the influence of numerous ethnic groups that include Khmer (people of Cambodia), Laotian, Chinese, Portuguese, and French. Currently the Vietnamese people comprise 87% of the population, with another 53 ethnic groups totaling eight million people, throughout the country.

France’s conquest of Viet Nam began in 1858, and it became part of French Indochina in 1887. Viet Nam declared its independence after World War II, but France continued its rule until its defeat by Communist forces in 1954. At that time, Viet Nam was divided into Communist North and anti-Communist South. United States economic and military assistance to the South grew throughout the
Viet Nam's continuing political turmoil caused three distinct immigration waves to the United States. The first wave (in 1975) comprised 130,000 Vietnamese people who sympathized with the south and feared for their lives. They were mostly young, well educated, English speaking, urban dwellers. Fifty-five percent of this group was Catholic, and many were able to bring their entire families over. In the second wave, occurring between 1979-1983, 455,000 additional Southeast Asians immigrated to the United States. The immigrants in the second wave comprised a more diverse ethnic group and included people with diverse ethnicities, nationalities, religions and languages. In addition, this group generally was less educated and less familiar with Western culture, with most speaking only Vietnamese. The third wave of Vietnamese immigration began in 1985 and continues to present day. This wave of immigrants is a result of family reunification programs. As of 2009, there were 1.1 million Vietnamese immigrants in the United States, constituting the fifth largest immigrant group. The majority of Vietnamese immigrants reside in six states — California, Texas, Washington, Virginia, Florida and Massachusetts.

**Major Language/Dialects:** The Vietnamese people speak three major languages — Vietnamese, French, and Chinese, though many are likely fluent in English. Although the majority of the Vietnamese people speak Vietnamese, several regional accents exist within the language. In your communications, it is important to be aware of cultural sensitivities of the subjects being discussed, particularly concerning gender issues. Conversing privately with patients (if possible) may help them feel more comfortable talking about sensitive issues.

**Nonverbal Communications:** Respect is a cornerstone of the Vietnamese culture, and is often reflected in their communications and relationships. The Vietnamese typically greet with a smile and bow. Older generations, however, will show respect by avoiding eye contact with those of “higher status,” which may include doctors and nurses. Respect may also be portrayed by bowing the head, and by using both hands when giving something to someone. In general, touch during conversation is appropriate, but again may be more limited with older generations. Personal space may be important.

**Tone of Voice:** Vietnamese people are generally soft spoken; they may use restraint when expressing disagreement and may not openly express emotion. In addition, raising a voice or pointing a finger may be viewed as a sign of disrespect.

**Religion:** Vietnamese Americans are more likely to be Christians than Vietnamese who reside in Viet Nam. While Christians (mainly Roman Catholics) make up about 6% of Viet Nam’s total population, they compose as much as 23% of the total Vietnamese American population. The majority of Vietnamese Americans are Buddhist, but there are an increasing percentage of those who are Protestants as well.

**Consents:** It is important to explain treatment as precisely as practicable. Whenever possible, ask patients, parents, or guardians to verbalize what was discussed in order to verify understanding, as they may often nod their head to show they heard, and not necessarily because they understand the communication. Vietnamese patients may hesitate to ask questions in a group setting, and thus the opportunity should be given for patients to ask questions individually.

**The Family Unit:** Traditionally, the Vietnamese highly value the family unit. In Viet Nam, the majority of families are extended, and often many generations live together and care for each other. Older family members usually have the strongest voice and are in charge of the household. In the United States, acculturation has caused a shift in the “nuclear” family system, with decisions more often being made by the spousal couple, without a duty to seek advice/consent from older family members. Often the oldest male will act as the family spokesman and it is not uncommon for women to be subordinate in decision making. In addition, women may withdraw from spousal conflict in order to maintain familial harmony. Women often have the responsibility of primary caretaker for ailing family members. Typically, sick, older family members are cared for at home by younger family members until circumstances require placing them in a healthcare setting.

**Concept of Health:** The Vietnamese may believe in both Western medicine as well as traditional folk medicine. As a result of family experiences as refugees, Vietnamese people may have difficulty trusting authority figures, including healthcare providers. Using interpreters with
those Vietnamese patients not fluent in English may help establish a more trusting environment. These interpreters can help avoid misunderstandings related to culture, language, tone of voice, or actions.

In the Vietnamese culture, physical illness may be attributed to a variety of sources including: directly observable circumstances (e.g., spoiled food), imbalance between the yin and yang (term used to describe how seemingly opposite or contrary forces are interconnected and interdependent in the natural world), punishment for a personality fault or violation of a religious taboo, and “western” causes such as germs. In Vietnamese culture, the body is typically given high respect, and as a result organ donation is generally not permitted, particularly among less acculturated immigrants. In addition, for the same reasons, autopsies are not generally conducted unless necessary.

The Vietnamese culture values politeness, respect for authority, and avoidance of shame. As a result, they may not ask questions, or voice disagreement with a physician. If patients disagree or do not understand, they may simply listen and answer yes in respect, and then may not return for further care or comply with recommendations.

Mental Illness: Mental health issues are generally stigmatized in Vietnamese culture. Patient’s families may deny signs and symptoms of mental illness to preserve their public appearance and save face for themselves and their family. They may worry that others in their community will view mental illness as a reflection of poor moral character, spiritual weakness, or improper upbringing by the family. In addition, reflections on personal experiences in Viet Nam (where mental illness was associated with institutionalization or imprisonment) may shape their perceptions of mental illness.

Some traditional Vietnamese believe that mental illness is caused by a disruption of harmony in an individual or that it is caused by an ancestral spirit returning to haunt them for past bad behavior. These persons may seek out traditional treatments prior to seeing a Western healthcare provider.

- Depression: As a result of experiences of war trauma, post-traumatic stress disorder and resettlement challenges, Vietnamese Americans exhibit more than twice the need for outpatient mental health services than the general Asian population. Individuals may not report depression unless asked directly by a healthcare provider due to the stigma associated with mental illness. In fact, the Vietnamese language does not contain a word for “depression.” If a patient is sad, often a family member/friend may try and tell them a funny story to try and distract them from their sadness.

- Substance abuse: Among Vietnamese adults, those who were born in the United States tend to have higher rates of past month alcohol use, binge alcohol use, and illicit drug use than those who were not born in the United States. Additionally, data shows that substance abuse rates tend to be lower among Vietnamese females than males.

- Suicide: Although not specific solely to the Vietnamese culture, Asian American women aged 65 and older have the highest suicide rates of any ethnic group, a trend that has persisted since 1990. In addition, death and suicidal ideation rates for elderly Asian Americans seeking primary care are higher than for any other racial group. Also, although there has been a slight decline in recent years, Asian American women ages 15–24 have the highest suicide rates of all racial groups for that age group.

About Our Co-Author

Thao Vo is originally from Viet Nam. At the age of 16, Thao fled her war ravaged country with her aunt and others on a crowded fishing boat. After four days, they landed in Indonesia where they struggled for 3 1/2 years as refugees in a camp with little food or clean drinking water. Many people died of sickness. Others committed suicide, fearful of being sent back to Viet Nam.

As a result of Thao’s father helping Americans during the Viet Nam War, she was granted admission to the United States in 1993. Once in America, she attended high school in Holyoke, Massachusetts while working nights until 1:00 a.m. in a factory. After graduating high school in 2 1/2 years, Thao enrolled at UMass Amherst where she earned her accounting degree in 2000. In 2001, she joined CIGNA Corporation as an accountant. Since 2009, she has worked as a Senior Accountant in Allied World’s Finance Department.

Thao has returned to visit family in Viet Nam over the years. On one trip she met her husband. Together, they have two children.
We recently resolved a challenging malpractice claim that illustrates some of the issues and considerations that can result when treating adolescent patients.

This case involved a psychiatrist who is employed in a private day program for distressed teens (the “Program”). The psychiatrist was two years post residency.

In early 2006, the patient, a twelve year-old male, was referred to the Program with a history of depression with psychotic features and a history of impulsive behavior. The patient lived at home with his father and attended the Program three to four days a week after school. As part of the treatment, the patient received individual and family therapy, tutoring and medication management.

During the patient’s first month of attendance in the Program, the psychiatrist weaned the patient off of his current medications, and prescribed a new medication off-label. Prior to instituting the change in medication, the psychiatrist and the Program’s attending physician met with the patient and his father to review the medication changes and provide education for the new medication. As part of this discussion, the psychiatrist reviewed the possible risks and benefits of the medication, as well as provided information concerning off-label uses of this medication. The psychiatrist explained that he would gradually increase the dose until reaching a therapeutic level. The psychiatrist instructed the father to watch for mood changes, and signs of increasing depression, anxiety, and impulsive behavior.

The psychiatrist documented each dosage increase, as well as patient (and father’s) reported response and tolerance of the medication changes. During this time, the patient continued to meet weekly with his counselor as well as the family therapist. The Program’s attending physician reviewed and signed off on each of the notes.

Approximately two weeks after an appointment with the patient, the psychiatrist learned from the patient’s counselor that the patient had been threatening students at school and had allegedly pushed a fellow student into oncoming traffic. The psychiatrist also learned that the patient had an altercation with his father and held a knife over his own head saying “he had enough.”

Case Closed — Claims Insights

By Susan Lynch, Assistant Vice President, Allied World APA Claims
Later that week, on Friday afternoon, the psychiatrist met with the patient and inquired about the incident. The patient reported that although he had been feeling agitated lately, he did not intend to hurt his classmate. He stated that he was just angry at his father and was not feeling suicidal or homicidal. The father reported that he had not noticed any other changes in the patient’s behavior. The doctor again increased the patient’s medication dose.

On Sunday, following an argument with his father about staying out late the night before, the patient jumped from his apartment building roof, resulting in traumatic brain injury and quadriplegia.

Throughout the litigation, Allied World’s claim analysts partnered with defense counsel to defend our insured psychiatrist.

As a result of the patient’s injuries, the father filed a lawsuit against the psychiatrist, the Program, and the supervising physician alleging that the psychiatrist negligently prescribed and increased the patient’s medication, particularly in light of the patient’s recent impulsive behavior. The plaintiff claimed that the psychiatrist was inexperienced and negligently prescribed antipsychotic medication resulting in catastrophic injury to the patient — brain and spinal cord injury. In addition, he alleged that the attending (supervising) physician failed to adequately supervise the Insured.

The plaintiff retained a Board Certified Child and Adolescent psychiatrist expert who testified that the patient’s increasingly violent and impulsive behavior should have alerted the psychiatrist to the potential for self-injurious behavior.

Throughout the litigation, Allied World’s claim analysts partnered with defense counsel to defend our insured psychiatrist. Allied World’s analysts evaluated the facts of the case and assessed the risk of proceeding to trial while simultaneously — and with the insured psychiatrist’s consent — exploring settlement options.

The components of this case were optimal for the defense, including:

- The defense team consulted with a renowned psychiatrist who specializes in pharmacology issues when treating adolescents and supported all aspects of the insured psychiatrist’s care.
- The insured’s thorough documentation in the medical chart supported his rationale for proceeding with the medication change and subsequent increases.
- The insured followed all of the Program’s policies and procedures, including having the father and patient sign a separate informed consent form regarding the prescribing of the medication for an off-label use.
- The insured psychiatrist made a compelling witness on his own behalf.

Ultimately, and with the agreement of both defense counsel and the insured psychiatrist, Allied World made the decision to prepare the case for trial. Prior to jury selection, however, the Court granted several defense motions which restricted the plaintiff’s expert’s testimony and significantly impaired the plaintiff’s case against the psychiatrist. Ultimately, the plaintiff voluntarily dismissed the psychiatrist from the case.

As mentioned in prior issues of In Session, in catastrophic injury cases such as this, grieving families often search for someone to blame. While this devastating injury is a tragedy for the patient and his family, placing responsibility on the psychiatrist in this case was misdirected. Allied World’s experienced claims handlers, in tandem with highly regarded, expert defense counsel, worked closely with the insured psychiatrist to bring this case to a successful resolution. By taking the time to provide quality patient care, supported by thorough documentation of the care and treatment decisions, our insured psychiatrist was able to defend successfully against the plaintiff’s claims.
Attention Florida Psychiatrists: Recent Court Decision

The Florida Supreme Court recently ruled on a treating physician’s right to legal counsel in a medical malpractice case, when that physician is not a defendant in the lawsuit. In *Hasan v. Garvar, D.M.D.*, (Fla. 2012), the Court addressed whether a treating physician in a medical malpractice case, who was not a defendant in the case, was permitted to have an ex parte pre-deposition conference with counsel provided by her insurance carrier. The Latin term “ex parte” in this type of situation refers to when only one side of the dispute is present at a meeting or conference with an attorney. Ex parte communications are generally disfavored in legal proceedings. The idea is that if there is an ongoing legal dispute, both the plaintiff and defendant are entitled to have access to information. If there is ex parte communication, one of the parties would not be entitled to the benefit of having access to the same information as the other party, potentially creating an unfair disadvantage.

Florida’s physician-patient confidentiality statute, Section 456.057, among other things, makes it unlawful for a physician to disclose confidential patient information to anyone outside the physician-patient relationship, without the patient’s consent. This law does not apply in situations where the patient consents to the disclosure, or where the disclosure is compelled by subpoena at a deposition, evidentiary hearing, or trial.

In *Hasan*, the Court further refined the meaning of Section 456.057 and found that a patient’s privacy outweighs a physician’s right to consult with an attorney regarding the physician’s treatment of the patient, when the physician is not a defendant, even if the discussion does not disclose any confidential patient information. However, under the statute, a nonparty physician may consult with an attorney if they “reasonably expect to be named as a defendant.” At this time there has not been clarification to define the meaning of “reasonably expect to be named as a defendant.”

The Court’s decision highlights that physicians be aware of what type of communications are permitted under Florida’s physician-patient confidentiality statutes. Specifically, Florida physicians should understand that absent certain exceptions listed in the statute, they may not discuss a patient’s medical condition with anyone outside the physician-patient relationship, without the patient’s consent.


*Note:* The Bill awaits the governor’s signature and, if signed, would become effective July 1, 2013. We encourage you to keep apprised of any potential subsequent decisions, regulation changes or updates.

Allied World's Experienced Claims Team:

As the largest insurer for mental health providers, Allied World’s analysts understand the intricacies of psychiatric claims, including the unique challenges associated with patient complexities, patient rights and various state regulations. Possessing both the legal and clinical backgrounds that are critical for handling psychiatric claims, each team member has experience handling claims specific to child and adolescent psychiatrists.
End Notes
To Disclose Or Not To Disclose? That Is The Question.
2 Id. at 45 CFR Section 164.103.

Culture Corner: Vietnamese
6 The World Fact Book.
7 Id.
8 La Borde, P.
9 The World Fact Book.
10 Id.
12 La Borde, P.
13 Id.
14 Id.
15 Id.
16 Id.
18 Id.
19 Id.
21 Id.
22 VietnamOnLine.com
23 Lipson
24 Lipson
26 Lipson
27 La Borde
29 Lipson
32 Lipson
36 Id.
37 Id.
38 Id.
39 Id.
40 Id.

OUR RISK MANAGEMENT TEAM: IN THE NEWS
KRISTEN LAMBERT has recently been named a Fellow of the American Society for Healthcare Risk Management.

The American Psychiatric Nurses Association recently appointed MOIRA WERTHEIMER as a member of the “Institute for Safe Environments Steering Committee.” The Institute for Safe Environments identifies, explores and recommends strategies to promote safe, evidence-based best practices impacting the safety of persons served as well as service providers.

Risk Management Services
For members of the AACAP who are Allied World policyholders, we provide:
• 24-hour risk management hotline access.
• Risk management seminars.
• Individual CME Education through our relationship with Medical Risk Management, Inc.
• Access to our library of risk management resources.
In Session with Allied World for AACAP is published in support of the American Professional Agency’s child and adolescent psychiatrist insurance program, exclusively for members of the American Academy of Child & Adolescent Psychiatry.

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