New Law Alert
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California edition

New laws focus patient safety and confidentiality of medical information

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In 1999, the California legislature enacted a law to ensure patient safety in an outpatient setting by requiring a minimum of two staff persons on the premises whenever a physician and/or surgeon performs a procedure. The new law also mandates reporting to the Medical Board of California outpatient procedures that result in a patient's death or a greater than 24-hour post-operative hospital admission. Other new laws protect patients from false advertising, and from having medical information released without permission. Civil Code §56.104 establishes a special protection for the release of outpatient psychotherapy information.

Under Senate Bill 21, health care services plans have a "duty of ordinary care" for the provision of medically necessary health care services; health plans will incur liability should a patient suffer "substantial harm" resulting from denied, delayed or modified recommended care.

To prevent health care facilities from allowing unlicensed personnel to perform nursing functions, Assembly Bill 394 sets nurse-to-patient staffing ratios and limits the duties of unlicensed personnel.

Advance directive laws have been revised or repealed with the passing of Assembly Bill 891. Effective July 1, 2000, California's "Health Care Decisions Law" streamlines existing laws, and delineates the rights and obligations of physicians and other care givers.

Cosmetic and Outpatient Surgery Patient Protection Act

Assembly Bill 271 added sections 2216.1, 2216.2, and 2240 to California's Business and Professions (B&P) Code. Effective July 1, 2000, it will be considered
unprofessional conduct for a physician and surgeon to perform procedures in an outpatient setting unless a minimum of two staff persons are on the premises "as long as a patient is present who has not been discharged from supervised care."

One of the two staff members must be either a licensed physician and surgeon, or a licensed health care professional with current advanced cardiac life support certification.

Business & Professions Code §2216.2 will require a physician and/or surgeon doing procedures in an outpatient setting to carry liability insurance or participate in an interindemnity trust. The Medical Board of California (MBC) will determine what constitutes adequate liability insurance coverage.

**Important note:** Effective January 1, 2000, B&P Code §2240 mandates that any scheduled medical procedure performed by a physician, surgeon, or person supervised by a physician or surgeon, outside of a general acute hospital that results in the patient's death, or - in - a transfer to a hospital or emergency center for treatment that exceeds a 24-hour stay, must be reported in writing to the MBC within 15 days of the incident. The latter reporting (>24-hour admission) will be anonymous (i.e., the identity of a physician, surgeon or patient need not be disclosed).

The MBC has developed two reporting forms. Physicians reporting a patient's death can obtain a copy of the "Outpatient Surgery - Patient Death Reporting Form (Interim)" from the MBC's Central Complaint Unit, 800/633-2322 or 916/263-2424. To report a transfer, physicians should use the "Patient Transfer Reporting Form" available from the MBC's Program Support and Research Unit at 916/263-2466.

**Beware of False Advertising**

As of January 1, 2000, amended Business & Professions Code §651 makes it unlawful for any person licensed in the healing arts to disseminate "public communication" that contains "false, fraudulent, misleading, or deceptive statements or claims" made for the purpose of selling professional services or products. A violation is a misdemeanor, and constitutes "good cause" for revocation or suspension of the practitioner's license. Physicians and surgeons, or doctors of podiatry, who "knowingly and intentionally" violate this law may be cited and assessed an administrative fine of no more than $10,000 per event.

**Confidentiality of Medical Information Act amended**

Senate Bill 19 amended the **Confidentiality of Medical Information Act (CMIA)**, effective January 1, 2000. Changes in the Act:

1. disclosure laws apply to health care providers, health care service plans and any contractor of a health care provider;

2. health care service plans, providers or contractors are prohibited from sharing, selling, or otherwise using any medical information for any purpose not necessary to provide health care services to the patient;

3. medical information must be disposed of or destroyed in a confidential manner;

4. a violation of the Act is a misdemeanor; and
(5) a maximum fine of $25,000 for each non-commercial disclosure, and a maximum fine of $250,000 applies for each commercial disclosure of medical information.

Outpatient psychotherapy treatment records

Newly enacted Civil Code §56.104 (also part of the Confidentiality of Medical Information Act) prohibits a provider of health care, health care services plan, or contractor from releasing records regarding participation in outpatient psychotherapy treatment to persons or entities to whom disclosure might ordinarily be made (including other providers treating the patient, payors and peer review bodies) unless certain conditions are met. The requesting party must submit a signed request to the health care provider and to the patient. The written request must state:

(1) The specific information requested and its intended use;

(2) the length of time the information will be retained;

(3) a statement that the information will not be used for any purpose other than its intended use; and

(4) a statement that the information will be not be retained beyond the length of time specified, and that it will be destroyed or returned to the health care provider.

Penalties for violation of the new law include: $1,000 damages even in the absence of economic loss; any actual damages; possible punitive damages; a civil fine up to $2,500; additional civil penalties when disclosure is repeated or for financial gain; and potential MBC discipline.

MIEC will publish more information about the CMIA in April 2000.

Health care service plans and denial of care

On or after January 1, 2001, a health care service plan or managed care entity will have a "duty of ordinary care" to arrange for the provision of medically necessary health care services to its subscribers and enrollee, if the service is a covered benefit. The health care service plan or managed care entity will be held liable if a subscriber or enrollee suffers "substantial harm" as a result of denied, delayed, or modified recommeded health care. "Substantial harm" is defined as "loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss."

Before a subscriber or enrollee may sue a health care service plan, he/she must exhaust procedures provided by an independent review system, unless the person has sustained substantial harm or harm will occur before the independent review has been completed. By January 2001, health care plans must give subscribers and enrollees the opportunity for independent medical review of health care services that have been denied, delayed or modified, because treatment was deemed medically unnecessary.

Under the new provisions, health care plans and managed care entities are not considered health care providers, and are therefore not protected by the damage limitations set forth under MICRA [California's tort reform law]. A health care plan cannot seek indemnity, "whether contractual or equitable," from a health care
provider for the liability imposed on the plan by the new law, and the plan is not liable for the negligence of treating providers. [Civil Code Division 4, Part 1, Title 7 (commencing at §3428)]

Hospital nurse-staffing ratios

Assembly Bill 394, the nurse-staffing ratio bill, added §1276.4 to the Health & Safety Code and §2725.3 of the Business & Professions Code. By January 1, 2001, California's Department of Health Services must adopt regulations that establish "minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for all health facilities."

Section 2725.3 of the B&P Code prohibits health care facilities from assigning unlicensed personnel to perform nursing functions (other than functions allowed under preexisting law), even under the direct supervision of a registered nurse, especially procedures that require scientific knowledge and technical skills such as: (1) Administration of medication; (2) Venipuncture or intravenous therapy; (3) Parenteral or tube feedings; (4) Invasive procedures, including inserting nasogastric tubes, catheters, or tracheal suctioning; (5) Assessment of patient condition; (6) Educating patients and their families concerning the patient's health care problems, including post-discharge care; and (7) "Moderate complexity lab tests."

Advance directive laws revised

Effective July 1, 2000, California's new "Health Care Decisions Law" repeals or revises a hodgepodge of statutes that have governed decisions about health care made by others on behalf of a patient when the patient is no longer able to make personal decisions. In addition to streamlining and reconciling existing laws, the new statute spells out rights and obligations of physicians and other health care providers.

Despite the new statute, existing directives and "powers of attorney" executed before July 1, 2000 remain valid. Printed forms which were valid under prior law can be used after the effective date; however, use of the new forms is recommended.

Under the "Health Care Decisions Law," patients can select from three options: (1) Designate another individual to act as the patient's agent, by executing a "power of attorney for health care;" (2) execute "instructions for health care," whether or not an agent is appointed; or (3) designate a "surrogate," to make health care decisions, by personally informing the "supervising health care provider," usually the primary physician.

A new form is set out in the law (beginning with §4600 of the Probate Code). The form, which must be witnessed by two qualified persons or notarized, has four parts: Part 1 is the power of attorney for health care; Part 2 contains instructions for health care, including end-of-life decisions and provisions for relief from pain; Part 3 permits the donation of organs at death; and Part 4 allows the patient to designate a specific physician as the primary physicians, and allows for alternative designations.

Part 2, "Instructions for Health Care," contains language describing various "end-of-life decisions," which may --authorize or prohibit the withholding of care in the event of an incurable and irreversible condition that will result in death within a relatively short time, or if the patient will not regain consciousness "to reasonable degree of medical certainty." The patient may also authorize relief from pain, even if it hastens the patient's death. The patient is free to select from these options, or to express other health care instructions.
Both physicians and health care institutions are obligated to comply with individual health care instructions, and with reasonable interpretations of these instructions and decisions made by a person acting with the patient's authority, unless specific exceptions apply. Physicians and other health care personnel may decline to comply for "reasons of conscience." Institutions may refuse to follow instructions or decisions contrary to institutional policy reflecting reasons of conscience, so long as the policy is communicated to either the patient or to the person authorized to make health care decisions. Neither individuals nor institutions are obligated to comply with instructions or decisions that require "medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution."

Physicians and other individuals providing care, and institutions, must promptly inform the patient, if possible, and any person authorized to make health care decisions for the patient, when declining to comply with instructions or decisions. All reasonable efforts must be made to assist in the transfer of the patient to another physician or institution willing to comply with the instruction or decision. Pending transfer, or until it appears that a transfer cannot be accomplished, continuing care must be provided, including appropriate pain relief and other palliative care.

In addition to the obligation to comply with patient instructions or decisions made on the patient's behalf, physicians and others caring for the patient must make entries in the medical record when certain events occur. Primary physicians who know of the existence of an advance health care directive must properly record the fact that the directive exists. The physician must also request a copy and "arrange for its maintenance in the patient's health care record." Presumably, this refers to the physician's own patient chart, but it would be prudent to place a copy in the hospital chart if the patient is hospitalized when the copy is obtained.

A patient may revoke the power of attorney which formally appointed the patient's agent, either by a signed writing or by personal communication with the primary physician. Divorce or annulment revokes a power of attorney previously naming a spouse. Revocation by any means requires a chart note, and a reasonable effort to notify the agent. Other individuals providing health care, as well as agents, conservators, or surrogates, are required to promptly notify the primary physician and any health care institution where the patient is receiving care, if they are informed that an advance directive has been revoked.

Chart notes are required when the primary physician determines or is informed of a determination that the patient either lacks capacity or has recovered capacity, or that some other condition affecting individual health care instructions, or the authority granted to a third person, has occurred. The same information must be communicated to the patient, if possible, and to a person then authorized to make health care decisions for the patient.

A patient may designate a "health care surrogate" simply by personally informing the primary physician of the designation. An oral designation, which must be properly documented in the medical record, is effective only during the course of treatment or illness existing when the designation is made, or during a stay as an inpatient. The legislature has not addressed a conflict created by execution of a formal power of attorney followed by later appointment of a surrogate. Whenever a patient attempts to appoint a surrogate by advising the primary physician, it would be prudent to ask the patient if he/she has also executed a power of attorney. If so, the patient should be asked to clarify the implied revocation.
Physicians who act in good faith in accordance with generally accepted standards of medical practice will not be subject to civil or criminal liability, or to discipline for unprofessional conduct, when complying with a health care decision made by a person who the physician believes in good faith has the authority to make such a decision. There is no liability for declining to comply with the decision made by a person believed in good faith to lack such authority. A physician who assumes in good faith that a directive was properly made, and has not been revoked or terminated, should not be liable for complying, even if revocation or termination previously occurred. There is no liability for declining to comply with health care instructions in good faith, for reasons of conscience or because the instructions would violate good medical practice.

The law does provide for penalties in the event of intentional violations of health care instructions, falsifications with respect to such instructions, or for the exercise of coercion.

The new legislation also recognizes requests to forego resuscitative measures and provides that, in the absence of knowledge to the contrary, a health care provider may presume that a request to forego resuscitative measures is valid and unrevoked. "Do not resuscitate" forms and "DNR" medallions may be evidence of such requests.

Other provisions in the new law deal with the appointment of conservators, who can be authorized to make health care decisions when the patient is incompetent to make those decisions, and for petitions to the Superior Court, so that health care decisions can be made for patients unable to make them.

Finally, the new law requires the Secretary of State to establish a registry system which will allow for immediate availability of information regarding the existence of individual advance health care directives. It cannot be predicted when this resource will become available.

Our thanks to David E. Willett, Esq., a senior partner in the law firm of Hassard Bonnington LLP, San Francisco, for his help in the preparation of this newsletter.

Legislative website

A copy of the bills reviewed in this issue of the New Law Alert can be downloaded from the Official California Legislative Information website at: www.leginfo.ca.gov.

(1) Cosmetic and outpatient surgery:  
Assembly Bill (AB) 271 and Senate Bill (SB) 450

(2) False Advertising: SB 836

(3) Confidentiality of medical information: SB 19

(4) Outpatient psychotherapy records: AB 416

(5) Health care plans/denial of care: SB 21 and AB 55

(6) Nurse-to-patient staffing ratios: AB 394

(7) Advance Directives: AB 891
To reach MIEC

Bay Area: 510/428-9411
Outside 510: 800/227-4527
Honolulu Office: 808/545-7231
Boise Office: 208/344-6378

Loss Prevention Fax: 510/420-7066
Main Oakland Fax: 510/654-4634
Honolulu Fax: 808/531-5224
Boise Fax: 208/344-7903

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