Proposal Tightens Privacy Protection

BY MARY ELLEN SCHNEIDER

Patients could gain greater access to their health information and have more power to limit disclosures of certain personal information to health plans under a new proposal from the Health and Human Services department.

The new requirements are aimed at beefing up privacy and security, as the Obama administration pushes to get more physicians using electronic health records over the next few years.

"The benefits of health IT can only be fully realized if patients and providers are confident that electronic health information is kept private and secure at all times," Georgina Verdugo, director of the HHS Office for Civil Rights, said in a statement. "This proposed rule … is an integral piece of the administration's efforts to broaden the use of health information technology in health care today."

The proposal alters the Health Insurance Portability and Accountability Act (HIPAA) rules by setting new limits on the use of disclosure of protected health information for marketing and fundraising and by requiring business associates of HIPAA-covered entities to follow most of the same rules that covered entities follow. The proposal would also bar the sale of protected health information without explicit authorization from the patient.

The proposal also implements elements of the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, which requires physicians and other covered entities to grant patient requests to restrict certain information from their health plans. For example, the proposed rule states that patients must be allowed to restrict protected health information if that information is related only to a service for which the patient paid in full and the information is not otherwise required by law to be reported.

Individuals can provide comments on the rule for 60 days, beginning on July 14. ■

Technical Requirements For EHRs Released

BY ALICIA AULT

The federal government published regulations that will allow for temporary certification of electronic health records—the first step in helping physicians and other providers get the software and hardware required to be eligible for bonus payments under federal health programs.

According to the Office of the National Coordinator for Health Information Technology (ONC), the rule "establishes processes that organizations will need to follow in order to be authorized by the National Coordinator to test and certify [electronic health record] technology."

"We hope that all [health information technology] stakeholders view this rule as the federal government's commitment to reduce uncertainty in the health IT marketplace and advance the successful implementation of EHR incentive programs," Dr. David Blumenthal, national coordinator for health information technology, said in a statement.

Certification means that the EHR package has been tested and includes the required capabilities to meet the "meaningful use" standards issued by ONC. Hospitals and physicians will have the assurance that the certified EHRs can help them improve the quality of care and qualify for bonus payments under Medicare or Medicaid.

By purchasing certified EHR technology, hospitals and eligible professionals will be able to make EHR purchasing decisions knowing that the technology will allow them to become meaningful users of electronic health records, qualify for the payment incentives, and begin to use EHRs in a way that will improve quality and efficiency in our health care system, Dr. Blumenthal said.

This rule is for a temporary program. A final rule on permanent certification of EHRs will be issued in the fall. ■

For more information about the temporary certification program and rule, please visit http://healthit.hhs.gov/certification.

LAW & MEDICINE

Liability of Graduate Medical Education Programs

Question: After being on call for 30 hours, the first-year medical resident caused a pneumothorax during a thoracentesis, which was unsupervised because of short staffing. The Accreditation Council for Graduate Medical Education (ACGME) has a rule that limits in-hospital on-call duty to 24 consecutive hours. The residency program itself requires all first-year residents to be physically supervised for procedures such as a thoracentesis. On his way home, the resident momentarily fell asleep at the wheel, struck a car, and injured its driver. Which of the following choices best describes the liability issues involved:

BY S.Y. TAN, M.D., J.D.

A. Residency program is liable for pneumothorax because it violated its own rules regarding supervision of procedures.

B. Residency program is liable for auto accident because unreasonable work-hours were a substantial contributory cause.

C. Resident and program are jointly liable for both injuries.

D. ACGME regulations as well as residency program's own rules are likely to be used as evidentiary standards during litigation.

E. A good plaintiff lawyer will invoke all of the above.

Answer: E. Graduate medical education (GME) programs, commonly called residency programs, are mandated to provide the requisite services and supervision for the education of their trainees. ACGME is the overriding authority that is responsible for the accreditation of post-MD medical training programs within the United States. GME programs that violate their own rules naturally place themselves at risk for liability.

Examples are written rules stating that catheters are to be inserted under the supervision of an attending physician, or that all elective procedures are to be performed with an attending present.

In 1984, an 18-year-old woman named Libby Zion presented to a New York hospital with fever and agitation, and died less than 24 hours after admission with an undiagnosed illness. The intern and resident caring for Ms. Zion were questioned about issues including the delay in the patient being seen, use of restraints, lack of supervision, the contraindicated administration of meperidine in a patient who was taking phenelzine, and failure to make a diagnosis. Although a Manhattan grand jury unanimously dismissed criminal charges, the New York State Board of Regents voted to censure and reprimand the residents for grossly negligent care.

This case alerted the nation to the issue of resident work conditions and led to the creation of the Bell Commission, which found that "inadequate attending supervision, combined with impaired house-staff judgment due to fatigue, were contributory causes of the patient's death." In 1988, the New York State Health Code implemented recommendations from the Bell Commission, limiting weekly work hours to 80 hours, and consecutive hospital duty hours to 24 hours. These reforms were soon adopted nationwide.

Supervising physicians are commonly named as codefendants for resident error, but program directors and teaching faculty who are uninvolved in direct patient care might also face legal liability, although the chances of plaintiff success are much lower. Take *Swidryk v. St. Michaels Medical Center* as an example. Dr. Swidryk was in his third week of obstetrical training when he delivered an infant who developed birth difficulties and brain damage. When he was sued, Dr. Swidryk in turn sued the director of medical education, alleging that the director's failure to educate and supervise adequately was the proximate cause of his negligent care. The New Jersey Appellate Court dismissed those claims, reasoning that to decide otherwise would be to interfere with the academic decisions of the university and to encourage a pattern of educational malpractice against schools and residency programs each time a resident is sued.

In *Maxwell v. Cole*, the chairman of ob.gyn. was successfully sued for failure to develop and enforce rules regarding qualifications and supervision of trainees. The chairman was not personally involved in the care of a woman who sustained a bladder perforation caused by resident physicians. The court disagreed with the defendant that he owed no duty because no doctor-patient relationship was formed, stating: "If the chief of service fails to provide medically acceptable rules and regulations which would insure appropriate supervision of ill patients, then it is reasonable to find that a breach of the standards of medical care by that individual has occurred."

Training programs face liabilities other than those arising from medical malpractice, such as disciplinary actions, employer-employee disputes, sexual harassment, etc. One issue deserving of attention: auto accidents in overfatigued medical trainees. The incidence of such trainees falling asleep at the wheel is very high, in some surveys close to 50%, and accidents are more likely to occur in the immediate post-call period. Court decisions in analogous factual circumstances, though not involving medical trainees, have favored the accident victim. In one case, the court noted that " … the appellee (Norfolk & Western Railway Company, the employer) could have reasonably foreseen that its exhausted employee, who had been required to work 27 hours without rest, would pose a risk of harm to other motorists … "

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