# MEDICAL PROFESSIONAL LIABILITY POLICY

This Policy Issued By and On Behalf of the
**PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION**
(Established By Act 111 of October 15, 1975)
VEVA 14, Suite 300, 1777 Sentry Parkway West, Blue Bell, PA 19422

**RENEWAL AGREEMENT**

**THIS IS A CLAIMS-MADE POLICY**

Insured: Michael Irwin Cheikin MD
Mailing Address: Center for Optimal Health
832 Germantown Pike
Suite 3
Plymouth Meeting PA 19462

Broker: GCG Risk Management Consultants, LLC
701 N. Hermitage Rd.
Suite 14
Hermitage PA 16148

Policy Number: **D17930-10**

From: 6/30/2020 12:01A.M. To: 6/30/2021 12:01A.M.

RENEWAL OF: **D17930- 09**

**PRIOR COVERAGE SCHEDULE**

Prior Policy: Policy:
Prior Coverage Expiration Date:

| Coverage Provided | Specialty | Code | Premium |
|---|---|---|---|
| A [x] Individual Professional Liability<br>B ☐ Association ☐ Corp. ☐ Partnership | Physicians Not Otherwise Classified - No Surgery (NOC) | 000799 | $ 7,683 |
| | | Mcare | $ 1730 |
| | | Total Amount | $ 9,413 |

**LIMITS OF LIABILITY***

$ 500,000 each occurrence / $ 1,500,000 annual aggregate

**Retroactive Date**: 6/30/2003

In return for payment of premium shown, this policy is renewed by this renewal agreement. This renewal policy is subject to all the terms and conditions applicable to the expiring policy unless otherwise specified on the declarations, schedules or endorsements forming a part of this policy.

# CLAIM REPORTING GUIDELINES

*When in doubt, report…*

As outlined in your policy, you are required to provide immediate written notification to the PAJUA upon becoming aware of any incident or alleged injury to which your policy may apply. Failure to do so in a timely manner could jeopardize your coverage. Mcare and Licensure Board investigations should also be reported.

To report a claim, write to us:

**PAJUA**
1777 Sentry Parkway West
VEVA 14, Suite 300
Blue Bell, PA 19422

Or fax us:
(610) 825-0688

Any questions, please call:
(610) 828-8890

***And . . .if Mcare should be involved in your claim, you should be aware that a recent Pennsylvania Supreme Court case held that prejudice need not be shown in order to permit the denial of a late claim by the Mcare Fund. Thank you.***

# Risk Management Education

The Pennsylvania Professional Liability JUA is pleased to offer web-based risk management education program for our policyholders. JUA policyholders may take 4 courses to earn CME hours for each course per policy year.

A second and third block of courses is available to those who have successfully completed the first / second block.

For details, visit our website www.pajua.com.

To access this new program, you will go to the course by accessing the internet and going to:

*http://pajua.med-iq.net*

**(please note: there is no 'www' in this address).**

It is important that you retain the above address as it will not be included on our website.

The first time you go to this website, you will be asked to sign up. Click on the box that says "Click Here to Sign Up". You will be asked for a valid email address, your first and last name, and your license number. The CME certificate will reflect the information that you enter, so please make sure it is correct.

# Med-IQ FOCUS: Volume 273: COVID-19 Cognitive Bias in Virtual Care: Downstream Implications

**Consider**
*What duty do providers have to mitigate the risk of diagnostic error due to cognitive bias when providing virtual care during the COVID-19 pandemic?*

***About the author:*** *Elizabeth Wiley, MD/JD, MPH, is a board-certified family and preventive medicine physician and Med-IQ faculty member practicing in both Washington (state) and Maryland, currently providing virtual health services.*


The COVID-19 pandemic has profoundly altered care delivery and access for patients and providers across the country. No specialty or care setting has gone unaffected. In this evolving context, it is important to acknowledge the unprecedented challenges and risks that the provider community currently faces and recognize the incredible work providers across the country are doing to serve and protect patients in the midst of this pandemic.

For many providers, the COVID-19 pandemic has resulted in a rapid shift to virtual care delivery to minimize the risk of transmission in healthcare settings.1,2 This Focus highlights some of the challenges and opportunities for virtual care delivery during the COVID-19 pandemic.

| Pre-COVID | Intra-COVID |
|---|---|
| Virtual care deployed with sufficient training and support | Unprecedented virtual care volume and demand for services |
| Scope of virtual care aligned with provider/ patient comfort and preference | Increased scope of virtual care demand and delivery of services |
| Availability of face-to-face evaluation and physical evaluation if needed | Potential disruptions in face-to-face care access (clinical service delivery realignment) |
| Face-to-face encounters prioritized in organizations of clinical service delivery | Increased risk of COVID-19 transmission with face-to-face access and PPE shortages |
| Stable regulatory framework | Limited access to on-site support for virtual care delivery |
| Patient access issues | Potential disruptions in face-to-face care access (clinical service delivery realignment) |
| | Increased risk of COVID-19 transmission with face-to-face access |
| | Testing access issues |

In this special edition Focus series, we began by addressing the importance of appropriately documenting virtual visits in a high-volume practice during (and beyond) the COVID-19 crisis. We now discuss the risk of cognitive bias and diagnostic error when delivering care virtually in the midst of a pandemic, as well as the potential downstream implications from patient safety and professional liability perspectives.

A 32-year-old woman, Ms. B, presents for a virtual visit with her PCP, Dr. Q, with worsening abdominal pain, a fever of 101°F, and nausea/vomiting for 3 days. Ms. B expresses concern that she has heard that many patients with COVID-19 have "stomach symptoms" and is worried that she has the virus. She denies any cough, congestion, sore throat, loss of sense of taste or smell, or shortness of breath. She has been feeling "fatigued." She helps take care of her elderly grandmother who lives alone, and she is worried about transmitting the virus to her. Dr. Q notes that Ms. B seems anxious and uncomfortable, but she attributes this to anxiety to fear of having COVID-19.

*Consider the following question, and following scenarios.*

## *How might Dr. Q respond?*

*A. Presumptively diagnose Ms. B with COVID-19 without testing and recommend self-isolation*

Dr. Q informs Ms. B that she does not meet the current clinical criteria for testing in her area but confirms that COVID-19 can have gastrointestinal symptoms. She counsels Ms. B on self-isolation and advises that she should go to the ED if she has any trouble breathing.

A few days later, Dr. Q is notified that Ms. B has been admitted to a local hospital. Oh no, she thinks to herself, she must have developed respiratory symptoms. Dr. Q quickly skims over the admission history and physical. She is horrified to read that Ms. B's primary admitting diagnosis is perforated appendicitis.

Dr. Q wonders how she could have missed that diagnosis.

*B. Recommend COVID-19 testing and self-isolation for Ms. B*

Dr. Q informs Ms. B that she does not meet the current clinical criteria for testing in her area, but, given Ms. B's concern, advises her that she will order testing. Dr. Q confirms Ms. B's fear that COVID-19 can have gastrointestinal symptoms. She counsels Ms. B on self-isolation and advises that she should go to the ED if she has any trouble breathing.

Ms. B undergoes COVID-19 testing. Two days later, Dr. Q receives Ms. B's test results showing that she is negative for COVID-19. She sends Ms. B a message using her practice's patient portal and asks how she is doing.

The following day, Dr. Q is notified that Ms. B has been admitted to a local hospital. Oh no, she thinks to herself, she must have developed respiratory symptoms. Dr. Q quickly skims over the admission history and physical. She is horrified to read that Ms. B's primary admitting diagnosis is perforated appendicitis.

Dr. Q wonders how she could have missed that diagnosis.

*C. Refer Ms. B for further evaluation*

Dr. Q informs Ms. B that she does not meet the current clinical criteria for testing in her area but confirms that COVID-19 can have gastrointestinal symptoms. However, she tells Ms. B that she is not sure that her symptoms are due to COVID-19. She asks Ms. B additional questions about her abdominal pain and learns that it is localized to the right lower quadrant. Although Dr. Q still suspects that Ms. B's symptoms could be an atypical presentation of COVID-19, she wonders if Ms. B could have appendicitis.

Dr. Q tells Ms. B that she recommends that she be evaluated in the ED. Ms. B is initially reluctant, but Dr. Q is able to persuade her. In the ED, Ms. B is diagnosed with acute appendicitis. She undergoes an appendectomy without any significant complications.

## Documenting Virtual Visits and COVID-19 Test Denials

**Takeaway**

*During the COVID-19 pandemic, providers should be aware of the risk of cognitive bias and diagnostic error when delivering virtual care and take steps to mitigate the potential for bias.*

In the midst of the COVID-19 outbreak, availability bias—a cognitive error in which a provider relies on the most "available" diagnosis—may increase the risk of misdiagnosis. Whether providing virtual or face-to-face care, strategies for minimizing the risk of bias include:

- Acknowledging the potential for bias, particularly in the context of the COVID-19 pandemic
- Engaging patients, caregivers, and family members when confronting diagnostic uncertainty and limited availability of evidence with respect to COVID-19
- Referring patients for physical examinations or seeking consults (virtual or otherwise) and second opinions, when appropriate
- Using diagnostic decision tools and processes, as available and appropriate
- Addressing systemic factors that may contribute to errors, such as workflow design, inadequate support or time, poor communication, and lack of teamwork
- Documenting virtual care encounters in a manner similar to face-to-face care, including with regard to clinical decision-making

## FAQ

| Question | Answer |
|---|---|
| Could I be held liable for making a misdiagnosis, causing a delay in diagnosis, or failing to make a diagnosis while providing virtual care? | There is no easy answer to this question. We know that there is very limited case law related to virtual care delivery and that the case law that does exist varies across jurisdictions. In terms of the steps providers can take to protect themselves, recognizing the potential for diagnostic error in the context of virtual care, ensuring that patients who require further evaluation are appropriately identified and referred, and comprehensively documenting virtual encounters—including with regard to clinical decision making—may be helpful. However, there remains significant uncertainty with respect to potential provider liability in the context of the COVID-19 pandemic and virtual care delivery.<br><br>It is important to note that some states have adopted new protections for providers in the context of the COVID-19 pandemic, so it is important to be familiar with your state's current regulatory framework. The Federation of State Medical Boards has maintained a summary of state actions with respect to physician licensure requirements during the COVID-19 pandemic, available here.[3] |
| I read a headline about HIPAA during the COVID-19 pandemic. What has changed? | In March 2020, the Department of Health & Human Services (HHS) Office of Civil Rights (OCR) announced that it would exercise its discretion and not impose penalties for covered healthcare providers "in connection with the good faith provision of telehealth" during the COVID-19 pandemic.[4] This means that covered providers can use communication technologies to deliver virtual care that may not fully meet HIPAA requirements without penalty during the COVID-19 pandemic. Of note, providers should refrain from using public-facing applications, such as Facebook Live, TikTok, and Twitch, for virtual care delivery. In general, providers should make every effort to ensure the privacy and security of protected health information whether providing virtual or face-to-face care. |
| What is required in terms of consent for virtual care during the COVID-19 pandemic? | In general, obtaining patient consent is recommended for care delivered virtually. However, during the COVID-19 pandemic, some states have waived this requirement. For example, Gov. Newsom of California has issued an Executive Order suspending verbal and written consent requirements for telehealth services during the pandemic.[5] Accordingly, it is important to be familiar with consent requirements in your state during the pandemic. |

## Resources

- Greenleigh T, Koh GCH, Car J. COVID-19: a remote assessment in primary care. BMJ. 2020;368:m1182.
- BMJ Publishing Group Ltd. COVID-19: remote consultations. Version 1.3. March 25, 2020.
- Dewey C, Hingle S, Goelz E, Linzer M. Supporting clinicians during the COVID-19 pandemic. Ann Int Med. March 20, 2020.


1. HR 6074. Coronavirus Preparedness an22wd Response Supplemental Appropriations Act, 2020. 116th Congress (2019-2020). https://www.congress.gov/116/bills/hr6074/BILLS-116hr6074enr.pdf. Accessed April 6, 2020.

2. HR 748 – Cares Act. 116th Congress (2019-2020). https://www.congress.gov/bill/116th-congress/house-bill/748/. Accessed April 6, 2020.

3. Federation of State Medical Boards. COVID-19. https://www.fsmb.org/advocacy/covid-19/. Accessed April 27, 2020.

4. US Department of Health & Human Services. Notification of enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html. Last reviewed March 30, 2020. Accessed April 27, 2020.

5. Gov. Gavin Newsom. State of California. Executive Order N-43-20. https://www.gov.ca.gov/wp-content/uploads/2020/04/4.3.20-EO-N-43-20-text.pdf. April 3, 2020. Accessed April 27, 2020.