

THE SCOPE

MEDICAL EDITION

ISSUE 21

SECOND QUARTER 2025



INSIDE THIS ISSUE

Communicating With Patients Who Have **Limited English Proficiency**

Risk Management Tip: Infection Control Techniques

Case Study: Traumatic Delivery, or Poorly Managed Gestational Diabetes?

INSIDE

- 2 Communicating With Patients Who Have Limited English Proficiency
- 7 Strategies for Patient Safety – Navigating the Risks and Benefits of Artificial Intelligence in Clinical Diagnosis
- 8 Risk Management Tip: Infection Control Techniques
- 10 Case Study: Traumatic Delivery, or Poorly Managed Gestational Diabetes?
- 14 From MLMIC.com

EDITORIAL STAFF

Publisher

Thomas Gray, Esq.

Editor

John Scott

Staff

Kathleen Harth

Pastor Jorge

Shelly Kriete

Matthew Lamb, Esq.

John W. Lombardo, M.D., FACS

Patricia Mozzillo

Elizabeth Ollinick, Esq.

Tammie Smeltz

Daniela Stallone



EXECUTIVE MESSAGE



Dear Policyholders,

With the foresight of our founder, Donald J. Fager, MLMIC has been collecting and featuring claims data in its educational efforts for 50 years, and, having personally reviewed more than a few of these cases with the goal of learning from each one, it is clear to me that better communication often leads to better outcomes.

The education and training that you, as physicians, dentists, and other healthcare providers receive, along with your knowledge of science, anatomy, and physiology, allow for peer-to-peer communication with an ease and depth of understanding that few patients share, often making clear communication with patients regarding treatment challenging. Further challenging clear communication with some patients is that, according to the New York State Office of General Services, New Yorkers speak over 800 languages and about 30% (5.8 million) speak a language other than English at home.

As we at MLMIC continually strive to better communicate with our policyholders and acknowledge the irony that *The Scope* is published only in English, I hope that you find this edition useful as you endeavor to achieve clear communication and understanding with your patients to provide the best possible care.

Warmest regards,

A handwritten signature in black ink, appearing to read "Tom Gray". The signature is fluid and cursive, written on a light-colored background.

Tom Gray, Esq.

Senior Vice President, MLMIC Risk Management

tgray@mlmic.com

Communicating With Patients Who Have **Limited English Proficiency**



In practically every region in this state, medical providers care for patients who are culturally and linguistically diverse. Sometimes, these individuals do not speak English as their primary language, or they have a limited ability to read, write, speak, or understand English.

Approximately 68 million people in the United States speak a language other than English at home, and of those, 8.2 percent speak English less than very well.¹ Legally, such patients are termed patients with Limited English Proficiency (LEP). As with any patient, it is important to ensure effective communication so that you can provide appropriate care and avoid undue risk.

Studies show that LEP can significantly impact communication, leading to poor care, poor outcomes, and poor patient satisfaction.² Implementing strategies to address language barriers is critical for ensuring that all individuals receive quality healthcare. Addressing language barriers is also required by law.

Legal Concerns

Title VI of the 1964 Civil Rights Act (Title VI) and Section 1557 of the Affordable Care Act protect the LEP population in federally funded health-related services and coverage.³ These laws require healthcare providers who receive federal financial assistance to take “reasonable steps” to provide meaningful access to their services for LEP patients. There are a number of resources to assist providers to effectively communicate with the LEP population and thereby comply with the law, increase access to care, and avoid patient harm. These resources include the U.S. Department of Health and Human Services’ (HHS) *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting*

Limited English Proficient Persons (the “LEP Guidance”), which outlines standards for providing language interpretation and document translation services to LEP individuals.⁴ HHS recognizes that there is no one-size-fits-all solution for Title VI compliance with respect to what constitutes “reasonable steps.” Instead, the LEP Guidance sets forth four factors that covered practices should consider: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come into contact with the program; (3) the nature and importance of the program, activity, or service provided by the recipient to its beneficiaries; and (4) the resources available to the grantee/recipient and the costs of interpretation/translation services.⁵

These laws require healthcare providers who receive federal financial assistance to take “reasonable steps” to provide meaningful access to their services by LEP patients.

Title VI and the LEP Guidance apply only to healthcare providers who receive federal financial assistance. The receipt of federal monies triggers an obligation to comply with the federal requirements for non-discrimination and Section 1557 of the Affordable Care Act. “Federal financial assistance” is defined as grants, training, use of equipment, donations of surplus property, and other forms of

1 U.S. Census Bureau 2021 American Community Survey, *Why We Ask Questions About Languages Spoken At Home* (Nov. 14, 2022), <https://www.census.gov/acs/www/about/why-we-ask-each-question/language/>

2 Twersky SE, Jefferson R, Garcia-Ortiz L, Williams E, Pina C. *The Impact of Limited English Proficiency on Healthcare Access and Outcomes in the U.S.: A Scoping Review*. *Healthcare* (Basel). (Jan. 31, 2024); 12(3):364. doi: 10.3390/healthcare12030364. PMID: 38338249; PMCID: PMC10855368.

3 Section 1557 protects individuals from discrimination based on the basis of race, color, national origin, age, disability, and sex in federally funded health-related services and coverage. Title VI prohibits discrimination based upon race, color, or national origin in obtaining access to any program or activity receiving federal financial assistance.

4 *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*. The Guidance and other related information may be accessed at <https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/guidance-federal-financial-assistance-title-vi/index.html>

5 A summary of the guidance can be found at <https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/guidance-federal-financial-assistance-title-vi/index.html>



Misunderstandings about diagnoses, treatment plans, and medication instructions can lead to incorrect treatment and worse health outcomes.⁸

federal assistance. It does not, however, encompass Medicare Part B payments or receipt of payment for furnishing services to Medicaid patients. Providers who only receive payment from federal sources “by way of insurance or guaranty contracts” are not subject to these federal laws.⁶

This does not mean, however, that non-recipient providers are free from the obligations to provide language interpretation and translation services. New York medical providers are also subject to the New York State Human Rights Law and regulations implemented by the New York State Department of Health. For example, New York hospitals are required to develop a language assistance program, designate a language assistance coordinator, identify and document each patient’s language preference and the acceptance or refusal of language assistance, and abide by regulatory limits (including age restrictions) on the use of friends, strangers, and family members as interpreters.⁷

Clinical Concerns

Communication is essential in the patient-provider relationship. Without effective communication, you cannot obtain an accurate health history from your patient, potentially leading to errors in important

6 45 CFR 80.2.

7 10 N.Y.C.R.R. § 405.7(a)(7).

medications or health conditions. Misunderstandings about diagnoses, treatment plans, and medication instructions can lead to incorrect treatment and worse health outcomes.⁸ Moreover, a language barrier may prevent you from obtaining the patient's informed consent to the treatment plan you present. Lack of informed consent is a common theory alleged in medical malpractice cases. New York Public Health Law § 2805-d defines lack of informed consent as the failure of the provider to disclose to the patient alternative methods of treatment and their reasonably foreseeable risks and benefits in a manner permitting the patient to make a knowledgeable and informed decision whether to consent to the treatment. Patients must understand the information presented well enough to assess their choices and make an informed decision. Patients with LEP who have no language assistance cannot give informed consent to treatment plans, thus exposing you to malpractice liability.

Identifying LEP Patients

The best way to determine if you have an LEP patient in your practice is to simply ask. Various federal and state agencies, including the HHS, have online resources such as “I speak” cards. Questions like “What is your preferred language?” or “Do you require any assistance in communicating with our providers?” should be asked when the patient calls for an initial appointment. This will avoid unexpected surprises at the patient's visit. Other clues that the patient has LEP may be non-verbal. If a patient does not speak much, simply nods, or does not respond to questions, it may be a signal that he or she does not understand the conversation. This should prompt you to ask them to repeat what you have said so that you can be sure they understood the encounter.

Providing Assistance

Once you become aware that a patient requires language assistance, you must decide how best

to meet that patient's needs. A qualified language interpreter must be provided. According to HHS, “A qualified interpreter is an individual who is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any specialized vocabulary required by the circumstances.”⁹ Qualified interpreters may be dedicated staff members, contracted interpreters, or telephonic and video-remote interpreters.

Patients may also bring a family member or friend to interpret, but providers should be cautious about using family members or friends.

Patients may also bring a family member or friend to interpret, but providers should be cautious about using family members or friends. On May 6, 2024, the Office of Civil Rights published a final rule updating regulations implementing Section 1557 of the Affordable Care Act, which are applicable to recipients of federal funding.¹⁰ Under Section 1557, a patient's child or any accompanying minor or adult cannot be relied on as a medical interpreter, except in the case of a medical emergency or if the patient specifically requests the adult family member or friend be present. In addition, a bilingual staff member may be used only if the staff member is formally trained, and oral interpretation is included in the person's job description and duties.

Regardless of federal funding status, providers should be cautious about using friends or family members. There may be sensitive issues regarding privacy (e.g., mental health conditions), cultural beliefs and practices, and conflicts of interest such as domestic abuse or undue influence. Further, a lay person may not be familiar with the specific language and terminology used in healthcare, potentially leading to misinterpretations. He or she may not be able to adequately translate complicated treatment conditions, options, and instructions. Indeed, any time you use an oral interpreter, you

8 The Joint Commission, *Quick Safety 13: Overcoming the Challenges of Providing Care to Limited English Proficient Patients*, Updated Oct. 2021, available at <https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety--issue-13-overcoming-the-challenges-of-providing-care-to-lep-patients/overcoming-the-challenges-of-providing-care-to-lep-patients/>, accessed May 12, 2025.

9 U.S. Department of Health and Human Services, *Civil Rights FAQs: 709-May an LEP Person Use a Family Member or Friend as His or Her Interpreter*, available at <https://www.hhs.gov/civil-rights/for-individuals/faqs/may-an-lep-person-use-a-family-member-as-an-interpreter/709/index.html>, accessed May 12, 2025.

10 *Nondiscrimination in Health Programs and Activities*, 89 Fed. Reg. 37522 (May 6, 2024).

must ensure that the interpreter is fluent in clinical terminology as well as payment and insurance terms so that the interpreter is able to fully explain such matters to the patient. If at any time you sense that relying upon a friend or family member is not appropriate, it is recommended that you reiterate the importance of utilizing a trained interpreter. Of course, patients still have the right to refuse a qualified interpreter and have a family member or friend interpret, but it is prudent to explain the potential risks of using an untrained interpreter, and the patient's refusal should be documented.

Trained medical interpreters can be accessed by contacting local healthcare organizations, such as local hospitals, which are likely covered by the stricter LEP requirements of federal law.

Interpreters must be provided free of charge. If you require the services of an interpreter, there are resources in your local community. Trained medical interpreters can be accessed by contacting local healthcare organizations, such as local hospitals, which are likely covered by the stricter LEP requirements of federal law. Local colleges, cultural or social service organizations, or the court system are other possible sources for

locating interpreters. Oral interpretation may also be provided by a telephone interpretation service. There are a number of national companies that offer telephonic interpretation 24 hours a day, 7 days a week. Such services have the advantage of offering trained interpreters who speak a great number of languages and dialects. This type of service may be a cost effective and timely option for language interpretation. It is especially effective for routine or noncritical patient encounters. Utilizing this type of service may be as simple as placing a call through a good quality speaker phone. Telephonic interpretation may also be particularly attractive to practices that have a diverse, multilingual patient population.

You cannot pass on the cost of providing interpretation or translation services to your patients. It is your obligation to provide access to your services for LEP patients at no cost to the patient. Under the Human Rights Law, you can only be excused from your obligation if you are able to establish that it imposes an "undue burden" upon you. Under New York law, undue burden has a specific definition, and the difficulty or expense to you is measured by certain criteria. The cost of providing an interpreter in relation to your professional fee is not enough to establish an undue burden. Rather, undue burden is measured according to the overall financial resources of all your practice locations, as well as any parent corporation

Continued on page 16





Strategies for Patient Safety — Navigating the Risks and Benefits of Artificial Intelligence in Clinical Diagnosis

Healthcare systems are exploring the potential of artificial intelligence (AI) to optimize services and reduce risks, as AI demonstrates the capacity to transform the industry, offering significant benefits in these areas.

Candello's recent **"Strategies for Patient Safety"** focuses on the use of AI in healthcare by offering information on how diagnostic services constitute a significant area where AI could reduce patient harm and potentially decrease medical malpractice costs. Recommendations on how to mitigate the risks of using AI by taking a balanced approach that embraces innovation, as well as patient safety, are also shared.

AI in healthcare applications topped ECRI's **2025 report** on the most significant health technology hazards. **ECRI**, a global healthcare safety nonprofit organization, cautions that "while AI has the potential to improve efficiency and outcomes, it poses significant risks to patients if not properly assessed and managed."

MLMIC policyholders can contact our Risk Management Department for questions regarding AI and patient safety by submitting a [question here](#).

Infection Control Techniques

The Risk

Maintaining a robust infection control program is a crucial factor in providing safe and effective care. Utilizing proper techniques and protocols not only reduces the risk of infection claims, but will also serve to improve workplace safety and the patient experience. Here, we look at some of the infection control principles that should keep practitioners, patients, and staff safe in the practice setting.

Recommendations

1. Identify a coordinator for your infection control program. This person should be knowledgeable in infection control protocols, and manage the acquisition of the protective equipment and supplies that staff require to maintain safety in the workplace.
2. Use appropriate hand hygiene techniques.
3. Wear personal protective equipment, depending upon the procedure and potential for exposure to bodily fluids.
 - Gloves for handling potentially infectious materials or body fluids
 - Masks for protection against aerosols and respiratory droplets
 - Eye protection/face shields, including shields with solid sides, to protect from splashes or sprays
 - Gowns/aprons for procedures that may cause splattering of potentially infectious fluids and materials
4. Clean, disinfect, and sterilize all reusable instruments according to manufacturer guidelines. Autoclaves should be inspected and maintained per manufacturer specifications.
5. Implement safe practices for handling and disposing of sharp instruments like needles and blades to prevent injuries to patients and staff alike. Follow aseptic techniques when administering injections. Consider single-use needles and syringes.
6. Regularly clean and disinfect all surfaces, including chairs, countertops, and waiting room materials.
7. Practice proper respiratory hygiene and cough etiquette. Post signs in prominent areas reminding patients of proper coughing/sneezing habits.
8. Ensure there are adequate resources for performing hand hygiene.



9. Keep a supply of masks on hand for patients who may request or require one.
10. Consider the placement of seating in waiting areas and that it may need to be reconfigured at times of increased community illness, e.g., annual cold and flu seasons.
11. Ensure there is adequate ventilation to remove airborne particles and prevent the spread of respiratory infections.
12. Perform proper water treatment methods and flush waterlines regularly to maintain the quality of water used by the practice and prevent the build-up of biofilm and microbial contamination.
13. Screen your patients in advance of their encounter. Perform initial screenings for active illness and recommend that patients reschedule appointments for when they are feeling better.
14. For urgent needs, patients may be referred to a more appropriate venue; or these patients can be scheduled as a last appointment to allow for a thorough cleaning of the care environment after the patient is seen.
15. Ensure that infection control principles are applied uniformly and consistently to all patients, regardless of their perceived infection status.
16. Ensure that all staff are adequately trained on infection control procedures and guidelines, and include regular reinforcement of the practice's infection control protocols. Education about standard precaution practices are not limited to healthcare staff alone: the minimal principles of infection control and transmission should be expected from all who enter the practice space. Knowing that safety and risk mitigation is everyone's responsibility will help patients be more at ease during their care and confident that their treatment is delivered in a manner where the safety of all involved is a priority.

Sources:

<https://www.cdc.gov/infection-control/media/pdfs/Guideline-Infection-Control-HCP-H.pdf>

<https://www.cdc.gov/infection-control/about/index.html#:~:text=Healthcare providers can perform basic,or colonized with certain germs>

https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/key_infection_control_practices.htm

CASE STUDY:

Traumatic Delivery, or Poorly Managed Gestational Diabetes?

This case involved allegations of negligent labor and delivery on a woman with gestational diabetes, with the use of a vacuum extractor. There was also a claim of negligent neonatal care for hypoglycemia in the hours after the child's birth. Damages included fracture of the left humerus, a right Erb's palsy, cognitive impairments, developmental delays, and severe and permanent brain damage.

Patient Presentation and Treatment

The patient in this action, a then 34-year-old female, had an obstetrical history of four pregnancies and no live births. Her prenatal course was complicated by gestational diabetes requiring glyburide, and she had a prenatal history of hypertension and was on hydrochlorothiazide.

At 35 ½ weeks gestation, the patient presented to Labor and Delivery at a hospital following premature rupture of membranes. She was 3-4 cm dilated, and contractions were 2-3 minutes apart. The patient was admitted and the MLMIC-insured OB-GYN physician was contacted, as he was the physician on call. It should be noted that all of the patient's prenatal treatment was rendered

by another physician, who was not named in the eventual lawsuit. The patient was administered an epidural for pain, and the fetal monitoring strips revealed mild late decelerations followed by a normal reactive pattern. The labor was augmented by Pitocin, and she was making good progress.

The patient pushed for approximately 2 ½ hours and was experiencing maternal exhaustion. The OB-GYN performed a vaginal delivery that included vacuum assistance with three to four pulls of moderate force. Shoulder dystocia was encountered, with one loop of cord around the fetus's neck. Due to the shoulder dystocia, suprapubic pressure and the McRoberts' maneuver were employed. A 7 lb. 15 oz. male was delivered with an Apgar score of 3/7/8. The neonatology team was present and the MLMIC-insured neonatologist immediately started tending to the infant. The infant required bagging with 100% O₂. He was then intubated and transferred to the NICU.

The OB-GYN performed a vaginal delivery that included vacuum assistance with three to four pulls of moderate force.

The infant was diagnosed with perinatal distress/depression, respiratory distress, hypoglycemia, a left humerus fracture, right shoulder dystocia, and he had mild hypotonia, molding, and a small abrasion on the right parietal scalp. His glucose level was 11 (50 is normal). Bolus injections were ordered with hourly checks. The neonatologist then placed an umbilical artery catheter and an umbilical venous catheter (UVC). After confirmation of position of the catheters by radiology, an IV of dextrose 15% in water was started at 80ml per day. The dextrose was subsequently increased to 20%. The glucose level was brought up to normal within 6 hours.

The infant was transferred to another hospital where he remained in neonatal intensive

care for almost 2 months. He was then transferred to Pediatric Intensive Care, where he had a stormy course that included three surgeries. A subsequent MRI demonstrated a subarachnoid and a subdural hemorrhage.

Lawsuit Filed

The mother and natural guardian brought a lawsuit against the MLMIC-insured OB-GYN and neonatologist and the hospital. She claimed that the OB-GYN failed to promptly recognize the potential for shoulder dystocia and that a cesarian section should have been performed based on the fetal monitoring strips. In addition, the plaintiff claimed that the events, including the late decelerations and the difficulty in extracting and affecting delivery, resulted in a traumatic delivery and a hypoxic ischemic event.

The plaintiff claimed that the neonatologist failed to timely and appropriately treat the infant's hypoglycemia in the hours after birth. Specifically, he did not properly administer intravenous glucose and, as result, the infant suffered from brain damage.

Prior to trial, the plaintiff settled the case with the OB/GYN in the amount of \$2.3 million. As there was no offer of settlement on behalf of the neonatologist, the case against him went to trial with the claims focused solely on the management of the infant's hypoglycemia immediately after birth.

Specifically, it was alleged the neonatologist should have started a continuous IV drip sooner to run the continuous glucose.

At trial, the plaintiff's expert testified to departures from the standard of care in the treatment of the infant's hypoglycemia. Specifically, it was alleged that the neonatologist should have started a continuous IV drip sooner to run the continuous



She claimed that the OB-GYN failed to promptly recognize the potential for shoulder dystocia and that a cesarian section should have been performed based on the fetal monitoring strips.

glucose. Also, it was alleged that he unnecessarily delayed treatment by waiting for radiologic confirmation of the UVC line placement instead of checking the film himself and starting the infusion sooner.

The now 5-year-old plaintiff was brought into the courtroom in a stroller and examined by his pediatric neurologist in front of the jury. The child was shown to have poor muscle tone, he could not stand on his own for longer than 30 seconds, and he had limited vocabulary, saying only “hi” and “bye.” The jury smiled at the cuteness of the child, but none cried or got exceptionally emotional. It was evident, however, that the child was severely damaged and developmentally delayed. As expected, there was testimony from an economist who opined that the child’s medical expenses and lost income would be close to \$24 million.

The jury smiled at the cuteness of the child, but none cried or got exceptionally emotional.

MLMIC's neonatology expert testified that the infant was treated correctly and in accordance with the American Academy of Pediatric guidelines, which say you can treat neonate hypoglycemia with either a bolus or continuous IV dextrose. Our expert also testified regarding causation. He opined that the plaintiff's gestational diabetes was poorly managed, which caused the infant's brain to suffer during the in-utero period.

MLMIC's pediatric neurology expert did an effective job explaining that the child's injuries were not related to hypoglycemia, as none of the MRIs obtained showed any evidence of acute hypoglycemia and none of the doctors treating the child had ever documented that the infant's injury was caused by hypoglycemia. The expert further testified that there very likely was a genetic component to the child's problems.

Due to the highly sympathetic nature of this case, while the jury deliberated, MLMIC and the plaintiff discussed a possible high/low agreement, which places a ceiling and a floor on the amount of money awarded at trial, guaranteeing that a minimum amount will be received by the plaintiff regardless of the verdict. Before any figures could be finalized, the jury returned 75 minutes later with a verdict in favor of the neonatologist.

When the defense counsel was able to speak with the jurors after the verdict, they all felt neonatologist did not substantially contribute to the infant's severe neurological damage. Interestingly, they felt the real culprit was the traumatic delivery.

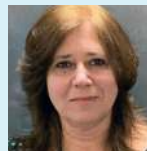
Legal Analysis

The plaintiff in this case criticized the MLMIC-insured neonatologist's clinical judgment with respect to choosing the treatment course of

continuous IV versus bolus. Clinical judgment is often a factor contributing to malpractice allegations. When clinical judgment is called into question, as it was in this case, the defense must establish that the judgment of the physician was in accordance with the standard of care.

When clinical judgment is called into question, as it was in this case, the defense must establish that the judgment of the physician was in accordance with the standard of care.

This trial came down to a battle of the experts. Fortunately, MLMIC's expert was able to point to the American Academy of Pediatric guidelines to establish the standard of care for treating hypoglycemia in an infant. While this was a catastrophic case for the infant, an incorrect verdict was avoided when the jury agreed that the neonatologist's clinical judgment was in accordance with the standard of care.



Carol Kebbe is a Claims Specialist with MLMIC Insurance Company.
ckebbe@mlmic.com



Elizabeth Ollinick is an Attorney with MLMIC Insurance Company's Legal Department.
eollinick@mlmic.com

FROM **MLMIC.COM**



May 20, 2025

Understanding MLMIC's Waiver of Consent Discount: A Potential Savings Opportunity for Physicians

As a physician insured by MLMIC and practicing in New York State, you understand the importance of medical professional liability coverage. You also value having a role in resolving any potential medical malpractice claim. MLMIC has traditionally empowered its policyholders with the right to consent to settle claims, a significant aspect of our commitment to physician autonomy.

However, MLMIC also recognizes that some policyholders may be willing to consider alternative approaches in exchange for potential cost savings. This is where the Waiver of Consent to Settle discount comes into play.

What Is the Waiver of Consent to Settle?

The Waiver of Consent to Settle is an optional 5% discount offered by MLMIC that allows policyholders to waive their right to not accept a settlement recommended by the company.

[Read More >>](#)

May 7, 2025

New York State Department of Health Announces Revision of Medical Orders for Life-Sustaining Treatment (MOLST) Form

The New York State Department of Health announced a revision to the Medical Orders for Life-Sustaining Treatment (MOLST) Form, which records patient preferences for life-sustaining treatments. The revision was a collaboration between multiple agencies, including the New York

State Office for People with Developmental Disabilities (OPWDD) and the New York State Office of Mental Health (OMH). Excellus also updated the electronic form (eMOLST) to match. The revised forms aim to ensure that a patient's current medical condition, values, and treatment preferences are communicated and respected across all healthcare settings. Previous versions of the forms remain valid.

[Read the entire announcement from the Department of Health here.](#)

MLMIC offers an online and in-person continuing medical education (CME) program to its policyholders entitled "MOLST Orders and End-of-Life Treatment." Insureds can log onto [their portal](#) to view the program or [contact our risk management department here.](#)

MLMIC policyholders can reach out to our legal department for questions regarding MOLST or to ask any other healthcare law inquiries by calling (877) 426-9555, Monday-Friday, 8 a.m.-6 p.m. or by [email here.](#)

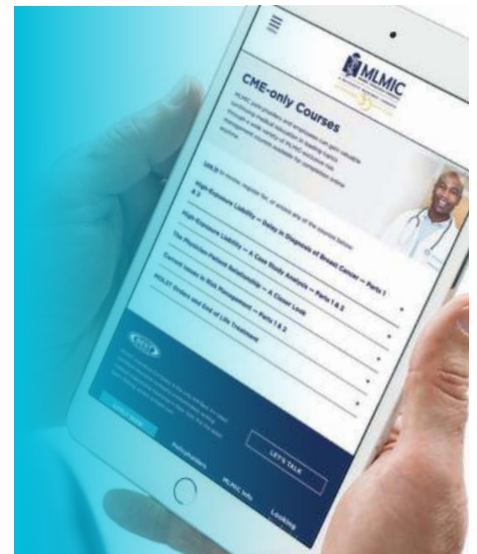
Our 24/7 hotline is also available for urgent matters after hours at (877) 426-9555 or by emailing hotline@tmglawny.com.

New CME+ title:

2025 Healthcare Law Review

Nancy May-Skinner, Esq., managing attorney, MLMIC Legal Department, and Marc Crow, Esq. of the MLMIC General Counsel Office, provide an overview of the recent legislative, regulatory and case law developments that impact healthcare liability.

Available credit:
1.00 *AMA PRA Category 1 Credit*[™]



[Login >>](#)

CME+ New York-Focused Risk Management Courses for MLMIC Policyholders

Communicating With Patients Who Have Limited English Proficiency (continued)

or entity.¹¹ When you look at the financial health of your practice as an entire entity, it may be extremely difficult to prove that you are subjected to an undue burden by providing language interpreters.

Documentation

Documentation of the patient's LEP status and the assistance you provided is extremely important. You should conspicuously note in the medical record if the patient is LEP, as well as his or her primary language. You should document the type of interpretation service you have provided to the patient. If the patient refuses interpretation services or declines to utilize a trained interpreter, it is highly recommended that you document your offer and the patient's refusal. Where an interpreter is used, you should record the name of the person, as well as the name of any outside company, and the method of translation (telephonic, in-person, or telehealth service).

With the emergence of mobile technologies, patients may refuse oral interpretation and choose to use machine translation applications. As many of these applications have not been developed or evaluated for reliability in the healthcare setting, these technologies present a risk of harm due to mistranslation. A patient's preference for machine translation over a qualified interpreter should be documented and considered a refusal to accept a qualified interpreter.

Privacy Concerns

You do not need a patient's written authorization to disclose health information to an interpreter if the interpreter is a member of your workforce. If you are a covered entity under HIPAA, such disclosures are permissible under the exception for "treatment, payment, and healthcare operations."¹² If the patient has brought a friend or family member to interpret, you should document that fact, and you may infer the patient's agreement to the disclosure of their health information. If you are utilizing the services of an outside interpretation service (in-person or telephonic), then disclosure is still permitted as long as you have a HIPAA business associate agreement in place.

Conclusion

The LEP population is growing and becoming more diverse. Knowing in advance what your legal obligations are will assist you in planning for effective communication with your LEP patients. Locating and contracting interpretation services, translating vital documents and signage, and utilizing qualified bilingual staff are all effective strategies for clear communication with your LEP patients.¹³



Elizabeth Ollinick is an Attorney with MLMIC Insurance Company's Legal Department.

eollinick@mlmic.com

¹¹ New York Human Rights Law § 296(2)(d).

¹² 45 CFR 164.506; 45 CFR 164.501

¹³ U.S. Department of Health and Human Services, Office of Civil Rights, *HIPAA Frequent Questions*, accessed at <https://www.hhs.gov/hipaa/for-professionals/faq/index.html>.



CELEBRATING **50** FIFTY YEARS



Put the power of MLMIC at your fingertips.

Stay connected. Get the latest updates and industry news from New York's #1 medical professional liability insurer.



Follow us for important industry updates and risk management resources.

Follow us.



Get headlines and alerts that impact patient care in New York.

Follow us.



MLMIC Healthcare Weekly

Stay current with MLMIC's *Healthcare Weekly* newsletter.

Sign up.



Follow MLMIC on Facebook to stay connected.

Follow us.



PLUS



Follow us on

Instagram





P.O. Box 1287
Latham, NY 12110

New York City | Long Island | Colonie | Syracuse | Buffalo

(800) ASK-MLMIC