

THE SCOPE

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EXECUTIVE MESSAGE

Dear Policyholders,

This season can be one of reflection and it certainly is in the realm of healthcare risk management. Fall is the time when national leaders in the field attend the ASHRM national conference and the time when risk professionals attend the New York-specific AHRMNY conference. Program topics are developed to learn from mistakes and successes of the past and to look ahead toward developing risks in the ever-changing world of healthcare. Not surprisingly, this year's prospective topics included AI in healthcare, shifting federal policies, regulatory uncertainty and economic pressures and their impact on patient safety and risk. Remarkably, as quickly and significantly as medicine can change and is being changed by these forces, foundational topics return to what my colleagues call the "RM trifecta", communication, documentation, and follow-up.

This issue's feature article explores the relatively recent use of patient portals, but at its core brings lessons in one trifecta component, effective communication. The medical and dental case studies in this issue both hit the full trifecta. MLMIC Claims files are filled with fact patterns that hit all and every combination of communication, documentation, and follow-up. Any one of these components can render a case difficult to defend and can certainly lead to poor patient outcome.

It is axiomatic that the delivery of effective and safe healthcare is grown from the experience of others. I offer those reflective lessons within the peerless MLMIC database in New York, coupled with shared resources in the healthcare risk management associations, can help in your focus on patient care and away from the stressors of claim defenses.

A handwritten signature in black ink, appearing to read "Tom Gray", written in a cursive style.

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Patient Portals:

Healthcare Communication Boon?

Patient portals are a useful tool to improve patient adherence to treatment plans and generate patient-provider communication, but their low rate of adoption and use, often due to limited access to technology or low technological literacy, can prevent portals from achieving their intended outcomes.¹ Moreover, the practice of immediately releasing test results without context provided by clinician counseling is controversial. While patients may be satisfied receiving test results online, portals provide inadequate guidance on interpreting abnormal results, which may contribute to misinformation.² This article will address these obstacles and offer guidance to improve the patient experience and make portal use by patients more engaging.



Perhaps the biggest advantage of patient portals is the opportunity they provide to increase patient engagement by allowing and encouraging the patient to ask questions and otherwise communicate with their physician in a way that may enhance the physician-patient relationship. Some patients feel a greater sense of control over their communication with their provider, since portals allow the patient and physician to address concerns and process information without feeling hurried or uncomfortable, as is often the case with in-person encounters. Portals also allow for the patient to ask a question when it is fresh in their mind, rather than waiting for their next visit.

Despite these benefits, portals can come with certain inherent risks. One of these is a patient's inability to understand the data given on the portal — data they may now be seeing before speaking with their physician, which may increase the patient's discomfort and worries. There is also the risk of information overload and the potential for misinterpretation of information. This overload can create confusion about managing health, especially for those with chronic conditions who must interpret various test results and medical notes. Providers need to offer clear guidance on how to understand this information and give concise explanations alongside test results or offer a caveat that the doctor will provide context as soon as possible.³

While patients often expect quick responses, providers need time to review and give context. It is important to ensure, at the onset of portal access, that patients understand the portal is not for urgent matters and are encouraged to contact the practice for clarification of any information provided. This message should be periodically reinforced. Practices should consider adding language to their patient encounter forms, reminding patients and their guardians/support persons of what to expect with portal communication. It is crucial that practices make clear to patients that the portal is intended

for asynchronous communication and that time is needed to respond to inquiries.

It is important to ensure, at the onset of portal access, that patients understand the portal is not for urgent matters and are encouraged to contact the practice for clarification of any information provided.

Much like returning telephone calls, practices should have clear policies on response times for portal messages. For example, is a 72-hour response time suitable for your patient population and within the capabilities of the practice? Any stated expected response time should be followed, and the practice should have a metric to measure whether inquiries are addressed within the stated time frames. From a liability perspective, it would be difficult to defend the timing of responses to pertinent portal inquiries that fall outside the practice's policies.

An article in the Journal of the American Board of Family Medicine by S. El-Toukhy et al. addresses how a patient's age, education level, and sex may act as barriers to the use of portals. Individuals who lack vocational or high school education or have limited proficiency in English are less likely to use patient portals to access their medical records or communicate with their healthcare providers. Interestingly, El-Toukhy et al. found that women tend to access portals more than men and suggest this is related to women's tendency to be the primary healthcare decision-makers for their families.

Patient portals offer conceivable opportunities to increase health literacy and potentially achieve better health outcomes for patients by promoting education, self-management, and access to healthcare. Limited health literacy goes hand in

1 <https://www.thieme-connect.com/products/ejournals/abstract/10.1055/s-0043-1770901>

2 <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2802672>

3 <https://www.simbo.ai/blog/evaluating-the-advantages-and-disadvantages-of-implementing-patient-portals-in-healthcare-practices-1866311/>

hand with poor outcomes, increased expenditures, and health disparities, with studies revealing that at least 88% of adults living in the United States do not have the health literacy required to adequately navigate the healthcare system and promote their well-being. To improve health literacy, there has been growing recognition of the potential of digital communication tools to empower individuals to take a more active role in managing their health.⁴ Taking the time to educate patients with low health literacy on the benefits of portals and how to access them can only help to improve their health outcomes and enhance their patient experience.

Limited health literacy goes hand in hand with poor outcomes, increased expenditures, and health disparities, with studies revealing that at least 88% of adults living in the United States do not have the health literacy required to adequately navigate the healthcare system and promote their well-being.

Limited English proficiency is also a barrier to portal use. Practices should inquire with their portal vendor about whether they have translation tools available in their system for languages commonly spoken by the practice's patient population. If such tools exist, any instructions or notices related to the portal should likewise be translated into those languages.

Some studies show that low computer or technological literacy, when patients are not familiar with using smart devices or even the internet, is also a concern. Unfortunately, this has been associated with less awareness, use, and perceived usefulness

of portals.⁵ Along with that, some patients, regardless of health literacy, computer literacy, access to technology, or age, will still find the use of patient portals overwhelming or uninviting because they find the portal impersonal compared to speaking to a human being. While convenient, some patients feel that portals cannot replace face-to-face interactions with their physician or care team. Lack of computer literacy may affect proper logging in and use. For example, older patients may not recall passwords or login procedures for their portal. As with addressing patients with low health literacy, it is important to train staff to be efficient and patient and to offer older patients resources and guidance, such as in-office demonstrations on portal use, to help those patients understand and utilize the portal effectively.

Providers and patients often have conflicting views on how much information needs to be shared with patients. Even the sharing of medical notes might create confusion for patients. When patients get concerned over something they see in their health record, it could result in more phone calls or scheduled visits, even if the information is not of concern.⁶ Remember that how you document an encounter can have an effect on your patient. When documenting care, be cognizant that your patient will have access to the documentation, so be careful not to sound judgmental in your notes. Avoid terms that may be offensive or emotionally charged. For example, document "Patient reports s/he did not take medications" rather than "noncompliant" or "unreliable."⁷

There are subjects that may be inappropriate for the patient to discuss on a portal, especially sensitive issues or concerns, and the patient may not realize that the person who checks the portal may well be office staff and not the physician. This may also hold true for complex information, which

4 [https://pmc.ncbi.nlm.nih.gov/articles/PMC10693297/#:~:text=Introduction,health%20\(9%E2%80%93312\)](https://pmc.ncbi.nlm.nih.gov/articles/PMC10693297/#:~:text=Introduction,health%20(9%E2%80%93312))

5 <https://pmc.ncbi.nlm.nih.gov/articles/PMC9919456/#:~:text=Conclusions,but%20patients'%20eHL%20did%20not>

6 <https://etactics.com/blog/disadvantages-of-patient-portals#:~:text=Patient%20portals%20are%20set%20up,are%20stuck%20doing%20more%20work>

7 <https://www.mlmic.com/blog/open-notes-in-the-ehr/>



the patient may not explain appropriately, making more work for the physician. Be mindful of different patient preferences and digital literacy levels when implementing and promoting the portal, and make sure your policies are clear on the role of the portal in the physician-patient relationship.⁸

Privacy, security, and concerns about data breaches arise with the use of portals. Some patients do not wish to share confidential information and would rather speak directly to the provider. Likewise, a patient's spouse, caretaker, guardian, or parent may have access to the patient's portal, and the patient may wish to restrict the information shared with such third parties. The concern regarding who can see protected health information (PHI) is what keeps many individuals from using the portal. It is common knowledge that healthcare institutions are at high risk for cyber security and data breaches, with the patient portal being no exception. Patient portals store sensitive personal and health information; therefore, robust security measures must be in place. Implement security measures to protect PHI. Require strong passwords with multifactor authentication, and reset passwords every 90-180 days.

Lastly, patient portals are also grounds for discovery during a malpractice suit. Plaintiff attorneys now

routinely demand portal metadata, including when a provider accessed the patient information, what information was accessed, and the length of time the provider spent responding to a patient inquiry. It is recommended that practices learn what type of information would be revealed in an audit trail from their portal vendor before any malpractice claims are asserted against their practice.

In sum, though patient portals are a useful tool for communication between healthcare providers and their patients and they can potentially improve outcomes and enhance the patient experience, not all patients use them due to a wide variety of factors.⁹ It will take time and perhaps a new generation of computer-literate people to increase the use of patient portals, and perhaps there can be a choice of languages beyond English that might increase portal use.



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⁸ <https://www.vozehealth.com/blog/top-4-barriers-to-patient-portal-adoption-in-2021>

⁹ <https://www.benchmarksystems.com/blog/advantages-and-disadvantages-of-patient-portals/>

TIP #22:

The Proper Use of Patient Portals

(As a note, there is also Tip #29, Risk Management Tip: Documentation Considerations for EHR Open Notes.)

The Risk

Patient portals are an effective tool to actively engage patients in their care to improve health outcomes. However, healthcare professionals must be aware of the potential risks presented by this technology. Some of these risks include reliance on the patient portal as the sole method of patient communication; patient transmission of urgent/emergent messages via the portal; posting critical diagnostic results prior to provider discussions with patients; and possible security breaches resulting in HIPAA violations. Implementing appropriate policies and procedures in the use of portals will enhance patient communication and mitigate liability risks for the practice.

Recommendations

1. Develop comprehensive patient portal policies, which include:
 - Patient username and password requirements (minimum number of characters, including capitals and non-alphabet characters)
 - A privacy/confidentiality statement on all outgoing messages
 - Encryption updates
 - Account lockout after a specified number of failed login attempts
 - A mechanism to ensure termination of user access when indicated (e.g., the patient leaves the practice, death, or inappropriate use of the portal)
 - Time frames for responding to patient communication
 - Designating responsibility for replying to patients when the primary provider is not available
 - Utilizing a two-patient identifier system for the importation of diagnostic studies into the patient portal
 - Monitoring patient access to posted diagnostic results
 - A follow-up system for patients who do not access the portal
 - A mechanism to notify patients if the portal is not functioning properly; a notification should be placed on the practice's website and also included in any prerecorded telephone message

2. Advise patients of the reporting mechanism for:
 - Email address changes
 - Questions regarding portal use
 - Potential errors in their information
 - Suspected breaches of privacy
3. Providers should not use the portal as the means to communicate critical/significant diagnostic results. Diagnostic results should not be posted to the portal until this communication occurs.
4. Instruct patients that the portal is not to be used to evaluate and treat new problems.
5. Utilize a disclaimer on the portal that clearly states it is not to be used for emergencies/urgent problems, and include instructions for patients to instead call 911 or go to the nearest emergency department.
6. Consider the use of a patient portal user agreement that:
 - Defines the information patients may access (e.g., appointments, medication refills and referral requests, form downloads, routine appointment reminders, and laboratory reports)
 - Prohibits requests for narcotic medication refills
 - States that the patient portal is the only permissible method of electronic communication with the practice
 - Includes the disclaimer statement regarding urgent/emergent/new problems
7. Have staff educate patients regarding the use of the portal and the contents of the portal user agreement upon patient sign-up and as necessary.

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<https://www.benchmarksystems.com>



CASE STUDY:

Long-Term Care... and Big Problems

A MLMIC-insured dentist started his treatment of this patient at five years of age. When the patient was 36, he developed an abscess between teeth #18 and #19. The dentist prescribed antibiotics and a saline rinse. The extent of the abscess and any further treatment were not documented in the chart. When the patient returned one month later, a crown was placed on tooth #19, and an X-ray was taken. There was no documentation as to why the crown was placed.

First Documentation of Bone Loss

The patient returned one year later. The dentist's records documented severe bone loss in a molar but failed to identify the specific molar. A cleaning was performed, but the record was devoid of further mention of the bone loss.

The patient returned to the office four months later and was told that his prognosis was poor due to bone loss, but the difference in the patient's bone between this visit and earlier ones was not documented.

The dentist continued to see the patient approximately every three months. During those visits, the dentist failed to make any notes regarding the patient's overall dental appearance. However, the dentist extracted tooth #3 and placed a temporary crown on tooth #2. He also had the patient fitted for a bridge, and a permanent bridge was placed.

During those visits, the dentist failed to make any notes regarding the patient's overall dental appearance.

The patient returned the following year for a cleaning, at which time it was noted that he had severe bone loss. However, there was no indication that the dentist had any discussion with the patient about the bone loss or made further recommendations regarding his care or treatment. The patient continued with frequent office visits during the following years. At each visit, cleaning was performed. However, the dentist made no indication in the patient's chart regarding his gum health or further bone loss.

Oral Surgeon Seen

The patient eventually went to an oral surgeon, who suggested that he needed three teeth extracted. There were six loose teeth, and some teeth were malpositioned. A panorex was performed that revealed significant periodontal bone loss around almost all remaining teeth and very large defects in the upper and lower left quadrants and around the anterior teeth. There was only a very thin layer of bone at the sinus floor, and there was no bone around the roots of a few teeth.

The patient returned to the dentist's office to discuss the oral surgeon's findings. The dentist's chart indicated that the patient was told his

teeth were in jeopardy. However, there was no documentation of discussions or recommendations to the patient or any indication that the dentist reached out to the oral surgeon.

The patient eventually had three more teeth extracted by the oral surgeon. The patient was urged to get a cone beam CT and biopsy performed, and the oral surgeon recommended that tooth #18 or #19 be extracted.

The dentist restored teeth #25 and #27 and later spoke with the oral surgeon, who strongly urged that teeth #18, #19, and possibly #14 be extracted.

The oral surgeon subsequently extracted teeth #18 and #19, and the patient was later diagnosed with a benign odontogenic cyst in his lower jaw. He was also noted to have advanced to moderate periodontal disease, with severe periodontal disease involving teeth #2, 4, 11, 12, 13, 14, 15, 18, 19, and 31. As a result, the patient sought to discuss this with the dentist. An impression was taken for a bridge. There was no other treatment noted or any indication that the patient and dentist discussed the oral surgeon's recommendations.

There was no other treatment noted or any indication that the patient and dentist discussed the oral surgeon's recommendations.

At the patient's last visit to the dentist, upper and lower alginate impressions were made for a lower bridge, which was subsequently fitted and adjusted for the patient.

The dentist subsequently received a call from the patient, who informed the dentist that he was under the care of a periodontist, who suggested that he required a three-quadrant osseous surgery to treat advanced periodontal disease.

Lawsuit Filed

The patient subsequently brought a lawsuit against the MLMIC-insured dentist.

The case was reviewed by two expert dentists, both of whom opined that the dentist's records were incomplete and poorly documented. The records lacked notes depicting the patient's bone loss and did not document the aggressiveness of the patient's periodontal disease.

The records lacked notes depicting the patient's bone loss and did not document the aggressiveness of the patient's periodontal disease.

The case was presented to the Dental Claims Committee, which determined that the treatment was below the standard of care, and a moderate settlement was made prior to the time of trial.

A Risk Management and Legal Analysis

This case demonstrates the importance of thorough documentation.

The dentist in this case may have advised the patient to seek additional treatment and increase at-home oral hygiene practices, but there is no record to support this defense. There is also no record of any additional or appropriate treatment the dentist provided. The weaknesses in record-keeping certainly played a role in the decision to settle rather than defend the case.

Malpractice cases are less challenging to defend if accurate and thorough documentation clearly reflects the entirety of patient encounters.

Documentation should include patient information: medical history (smoker, alcohol use, current medications, allergies, and diseases); past dental history; detailed clinical exams; diagnostic information and results of all tests; treatment plans (proposed and approved plans, and that options were discussed); progress and treatment notes, including details of all treatment during all visits (dates, procedures, findings, concerns, and instructions); informed consent discussions and refusals regarding risks, benefits, or alternatives, including consent or refusal forms; radiographic



Malpractice cases are less challenging to defend if accurate and thorough documentation clearly reflects the entirety of patient encounters.

images; referrals; homecare instructions; and follow-up appointments.

All communications via telephone, email, letter, and text messages regarding referrals and prescriptions should be sent to dental labs; appointments made, missed, canceled, or rescheduled should be documented; and photographs should be included in patient records.

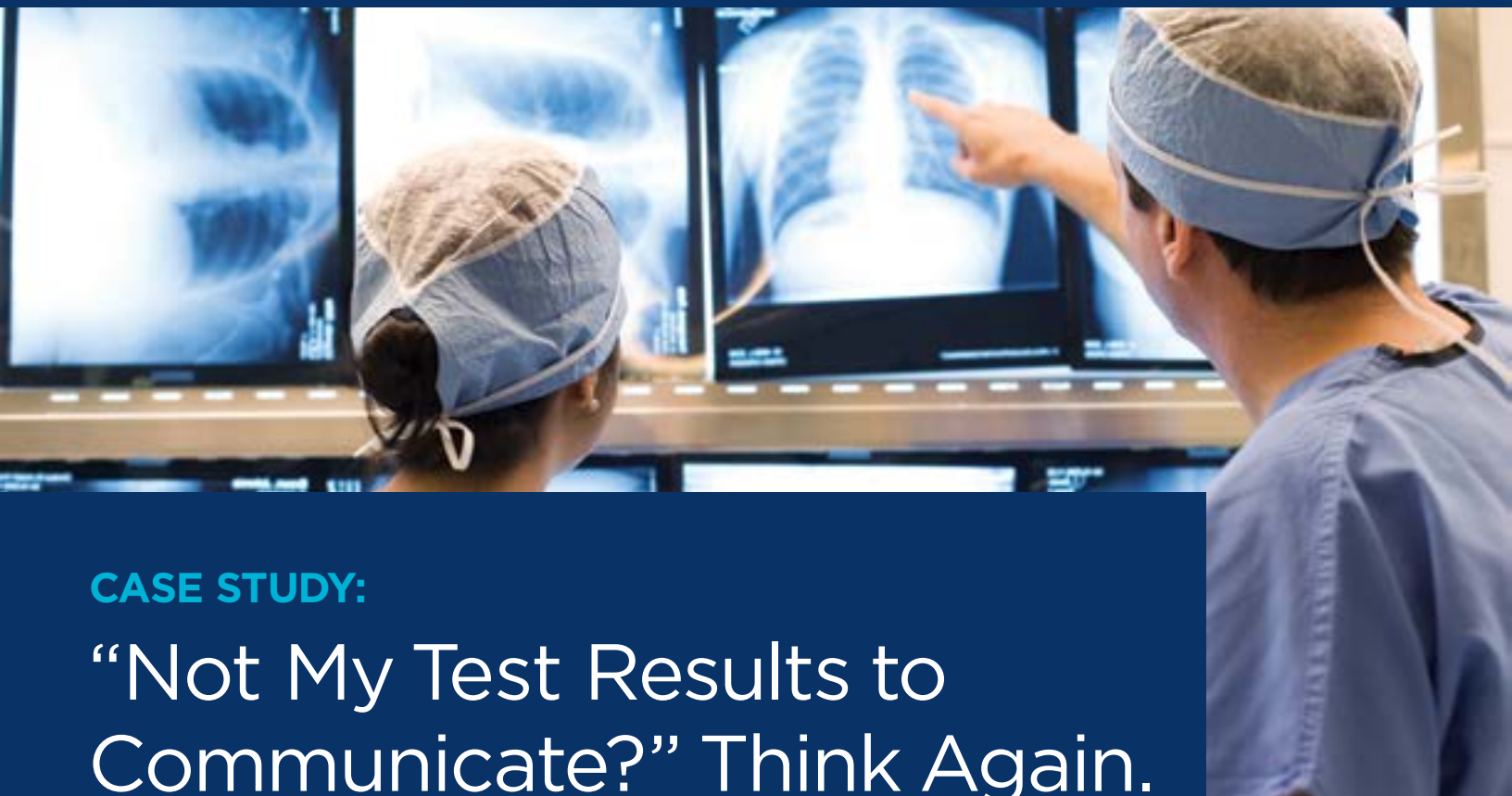
It is recommended that records of adult patients (18 and older) be kept for at least 10 years from the date of receipt of payment of an insurance claim. Records of minors (under 18) should be kept for 10 years or until the patient reaches the age of 22, whichever is longer.



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CASE STUDY:

“Not My Test Results to Communicate?” Think Again.

A 46-year-old married female with two adult children and one minor child became a patient at the MLMIC-insured PMD’s (primary medical doctor) office and was seen for various medical conditions over a four-year period for well-care, complaints of constipation, abdominal pain, and periodic problems with renal stones. She was followed several times a year for treatment of URI, sinusitis, renal stones, and prediabetes.

When the patient noticed a movable dime-sized cyst on the right side of her neck, she saw her dermatologist, who referred her to an ENT. The patient never discussed this cyst or the treatment she was receiving with her PMD; however, it was recorded in the ENT’s records that the patient had a referral from the PMD’s office, rather than the dermatologist who actually provided the referral.

After the appointment with the ENT, a follow-up CT scan was performed, and the patient was referred to an endocrine surgeon for a needle biopsy of the cyst. The cytopathology reported scattered abnormal-appearing mononuclear and binucleated

Reed-Sternberg cells. The overall findings were atypical and morphologically suggestive of Hodgkin’s lymphoma. The endocrine surgeon suggested admission to the hospital to remove the entire cyst.

The patient was admitted to the hospital and underwent surgery to remove the cyst. However, she did not follow up with her surgeon for the pathology results. The results were sent to the PMD, who mailed them to the patient. The patient never returned to the PMD’s office, and there was no further communication between the PMD and the patient.

Cancer Appears

Approximately one year later, after reporting what she thought was a hemorrhoid, the patient was diagnosed with anal cancer. The patient was admitted to the hospital for a PET scan, at which time she was told that she most likely had cancer in her neck from Hodgkin's lymphoma that had metastasized throughout her body during the prior year.

The patient underwent five weeks of radiation and chemotherapy for anal cancer and subsequently started treatment for Hodgkin's lymphoma. She expired three years later.

Lawsuit Filed

After learning of her diagnosis of Hodgkin's lymphoma, the patient (the plaintiff) brought a lawsuit against the noninsured surgeon, their practice, the hospital where the cyst was removed, and the MLMIC-insured PMD and his practice. The lawsuit alleged that the patient never received test results from anyone, including the PMD, resulting in a delay in diagnosis of Hodgkin's lymphoma, the treatment for which required extensive chemotherapy and radiation therapy. Subsequently, the plaintiff suffered severe pain and emotional distress and lost her general enjoyment of life. The patient's husband and family also claimed that they were deprived of her services and society, including loss of consortium.

After the plaintiff expired, a wrongful death claim was added to the suit. At that time, the co-defendant surgeon opted to settle their portion of the case for a premium amount.

Subsequently, the plaintiff suffered severe pain and emotional distress and lost her general enjoyment of life. The patient's husband and family also claimed that they were deprived of her services and society, including loss of consortium.

Expert Reviews

Reviewers felt that the major weakness for our insured and the other co-defendants was the

failure to inform the patient that she had Hodgkin's lymphoma at the time the cyst was removed. This clearly resulted in a delay in treatment and the progression of the disease.

This clearly resulted in a delay in treatment and the progression of the disease.

MLMIC retained an internal medicine expert who felt that a PMD should make referrals to specialists to address complaints, and that ends their duty. Had the patient initially presented to our insured PMD with complaints of the neck mass, it would have been incumbent upon the PMD to make the appropriate referrals, and the standard of care would have been met.

However, the patient went directly to the ENT, who ultimately referred the patient to the surgeon. The patient was treated by the appropriate specialist, and our PMD was under no obligation to contribute to the care.

Unfortunately, mailing the test results confirming abnormal lymph nodes and instructing the patient to make an appointment within one week implicated the PMD in the lack of prompt treatment. Once the results arrived in the PMD's office, it was his duty to follow up regarding these life-threatening results. Furthermore, sending it by regular mail was not reliable enough to prove that the patient received the result.

It was concluded that the MLMIC-insured PMD deviated from the standard of care by not following up to ensure the patient was aware of the test result. Therefore, negotiations ensued, and the case was ultimately settled on behalf of our insured.

A Legal and Risk Management Analysis

Communication and Follow-up: The Bedrock of Healthcare Risk Management

The lawsuit in this case did not result from any treatment mistakes the PMD made but rather from a failure to adequately inform the patient of potentially life-altering results from a test ordered *by another physician*.

The plaintiff alleged that the results were never received, despite the PMD claiming they were sent via regular mail. This, the plaintiffs argued, resulted in a delay in treatment, which meant the disease progressed unchecked. What should have been a relatively simple process of communication instead became the subject of a lawsuit.

Physicians have a duty to timely relay any medical information that is relevant, especially when it is life-threatening, and failure to do so could mean facing a misconduct claim or being subjected to a lawsuit.

Adequate Communication

Absent any notification that the patient was no longer under his care, the PMD, in this case, had a duty to inform the patient of the biopsy results, despite not ordering the tests.

Mail with Follow-Up

While the physician claimed he sent the test results to the patient by regular mail, simply mailing the results to the patient, without following up to ensure the patient received and understood the findings, was insufficient. Even when correspondence is sent with a certificate of mailing, there is no guarantee or proof that the letter was actually received. While office procedures that call for standard mailing might be sufficient for notifying the patient of routine results, a method that ensures receipt by the patient is required for sharing significant test results.

Patient Portals

Today, many healthcare providers use patient portals to share test results with patients. The inherent risk that patient portals pose as the sole method of communication, however, is that providers cannot be certain that patients access and comprehend portal entries. Simply relying on portals and assuming that patients access, review, and understand portal entries is an inappropriate and dangerous practice to follow. Rather, providers must ensure timely follow-up with patients to confirm receipt and provide explanations of test results, with directions on how to proceed.

Best Practices

Important information should be sent to patients by certified mail, which will generate a signed receipt for proof that the letters were actually received by patients. However, it is essential that communication with patients also consists of reaching out to them to elaborate on the next steps to address their conditions in a timely and thorough manner. A telephone conversation with a patient that is well documented can provide concrete proof that test results were discussed with the patient and that appropriate follow-up was also addressed. Documentation should clearly reflect all efforts made to clearly address positive findings so that nothing falls between the cracks.

A telephone conversation with a patient that is well documented can provide concrete proof that test results were discussed with the patient and that appropriate follow-up was also addressed.

It is important to have in place written policies that outline how to notify patients of significant test results and to ensure that results are received and understood. Thorough office protocols should be implemented and followed so that essential care is not overlooked, neglected, or forgotten.

Cases such as this one illustrate the importance of having a competent and experienced legal and risk management team by your side. MLMIC's team of experts is well versed in all legal and risk management aspects of the medical profession and is at your disposal to help you with any challenges that might arise.



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FROM **MLMIC.COM**

Elevate Your Practice

Curated Insights for Your Medical Office



OCTOBER 2025

Elevate Your Practice: October's Curated Insights for Your Medical Office

Navigating the ever-expanding volume of information in the medical field can be a daunting task. How do you efficiently discern critical insights that truly make a difference in your daily practice? At MLMIC, we recognize this challenge. That's precisely why we've meticulously compiled a selection of vital articles, providing you with clear, concise summaries and direct access to the most impactful industry news and analysis. Think of this as your essential guide to staying sharp and comprehensively informed.

[Read More >>](#)

Drilling Down: October's Essential Dental Reads From MLMIC

- **Heart Attacks May Be Linked to Bacterial Infections Found in the Mouth**
- **ADA Joins National Coalition for Mental Health Protections**
- **Mediterranean Diet Linked to Better Gum Health**

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SEPTEMBER 2025

The Verdict: Navigating Social Care Networks in New York

In this episode of “The Verdict,” host Tammie Smeltz, RPLU, welcomes special guest Salvatore Volpe, M.D., FACS, to explore the growing importance of social care networks and social determinants of health.

Dr. Volpe shares his expertise on how factors such as housing, food security, and transportation are crucial to patient outcomes and how New York’s “**health home**” model is designed to integrate medical and social services.

Tune in to learn how these networks are reshaping the healthcare landscape and what this means for providing comprehensive patient care.

[Listen Here >>](#)

The Verdict: The Jury’s Out — Uncovering the Truth About Dental Malpractice Trials

In this episode, host Tammie Smeltz, RPLU, welcomes back Roy Kaufman, Esq., a distinguished partner at [Rubin Paterniti Gonzalez Rizzo Kaufman](#).

Join us as we pull back the curtain on dental malpractice trials in New York. Roy shares insights about what goes on inside the courtroom and, more importantly, inside the minds of jurors.

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Open Bar: The Proper Use of Service Animals

Question: Can my practice prohibit dogs from the office?

Response: By law, a doctor’s office is required to permit patients to bring their service animals into the parts of the office that are open to the public. A service animal is a dog that is individually trained to do work or perform tasks for the benefit of a person with a disability. Under the federal Americans with Disabilities Act (ADA) and New York Civil Rights law, a doctor’s office may not discriminate against individuals with disabilities. Furthermore, many people with disabilities are not perceived as disabled and are nevertheless protected by this law. When a person presents a dog in the office, and it is not readily apparent that the dog qualifies as a service animal, only certain questions are permitted to be asked. Those in the doctor’s office may *not* inquire about that person’s disability, but may ask only:

1. Is the dog required because of a disability?
2. What work or task has the dog been trained to perform?⁵

[Read More >>](#)





A Message of Thanks From MLMIC

As another year draws to a close, MLMIC Insurance Company would like to take this opportunity to express sincere thanks and gratitude to all of you — our healthcare heroes, our loyal policyholders, and everyone working on both the front lines and behind the scenes to ensure the highest quality of care possible is delivered to our fellow New Yorkers.

We appreciate your continued trust in MLMIC. We remain vigilant in defending you and the practice of medicine within the State of New York.

Built on 50 years of New York-specific experience, MLMIC has successfully defended more New York physicians than any other New York medical professional liability insurer.

As a valued policyholder, the following benefits are available to you.

-  **MLMIC Risk Protect**
Take advantage of New York-specific risk management services designed to help manage risk, reduce exposure, and prevent adverse outcomes.
-  **MLMIC 24/7 Hotline**
Gain 24/7 immediate access to New York-specific risk management advice, guidance, and resources.
-  **MLMIC Analytics**
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