

Physician Office Practice Medical/Legal Self-Assessment Workbook 3rd Edition



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Dear Subscriber,

In our efforts to serve you with the highest level of current information on ways to improve your practice and reduce your risk of medical professional liability claims, we are pleased to provide you this newly revised copy of the **Physician Office Practice Medical/Legal Self-Assessment Workbook – 3rd Edition**.

We hope you will find this workbook useful in your day-to-day medical practice. Please feel free to contact us if you have any questions or would like additional copies.

Sincerely,

A handwritten signature in black ink that reads "James C. Hooban". The signature is written in a cursive, flowing style.

James C. Hooban
President and CEO

ABOUT THE AUTHOR

Idora Silver, M.A., CPCU, CSP, CMC is IND's Director of Risk Management. She is the author of The Chutzpah Connection: Blueprint for Success Real Life Stories of Inspiration and Achievement. She is named in "Who's Who of Executive Women," "Who's Who in the West," "Sterling's Who's Who," and "2000 Notable American Women." She has received the Distinguished Alumni Award from the Leadership Reno Alumni Association, the Woman of Achievement Award from the Nevada Woman's Fund, the Excellence in Commerce Award from Greater Reno-Sparks Chamber of Commerce, and the Distinguished Service Award from the Sierra Nevada Chapter of ASTD. Idora is a Certified Management Consultant (CMC), a Certified Speaking Professional (CSP), and an insurance CPCU (Certified Property and Casualty Underwriter).

H o m e M e a n s N e v a d a



PHYSICIAN OFFICE PRACTICE MEDICAL / LEGAL SELF-ASSESSMENT WORKBOOK

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INTRODUCTION

How to Use This Manual

This manual comprises two distinct parts. Part I addresses loss prevention, or those areas which can prevent a claim from being filed. Part II addresses loss mitigation, or those areas which must be attended to after a loss has occurred.

Answer the questions in the self-assessment for each section to the best of your knowledge as they pertain to your office and its procedures. Then read the “Preferred Answers” and compare with your responses. Remember these are preferred answers. There are many gray areas which may be open to discussion and adaptation in your own practice. After you have completed the self-assessment, you can use this document as a working manual. Your physicians, office manager, and key employees can use it to increase their awareness of areas of risk and develop strategies and procedures to address them. Sections can be discussed individually at staff meetings and during training programs. Information should be reviewed and re-reviewed at regular intervals to ensure no slippage has occurred in key areas.

Disclaimer

The areas covered in this workbook are representative of the areas of risk in physician practices. Answers are general enough to be applicable to many specialities. However, there is neither a warranty nor guaranty this workbook is all-inclusive. There may be other areas of risk particular to your practice or specialty which are not covered herein. This survey is a look at the non-clinical areas of your medical practice only. Your clinical practice should always be evaluated and upgraded, and continuing education is a must. There is no warranty or guaranty that you will avoid being sued for malpractice. The discussions in this workbook are suggestions only and must be evaluated in light of your practice’s individual needs.

You should refer specific questions to your attorney, insurance broker or IND.



I. LOSS PREVENTION

A. Initial Appointments, First Impressions, On-Going Visits	Yes	No
1. The reception area is kept clean throughout the day and has enough seating and entertainment for all patients.	<input type="checkbox"/>	<input type="checkbox"/>
2. The receptionist is pleasant, friendly and helpful.	<input type="checkbox"/>	<input type="checkbox"/>
3. There is a protocol for handling emergency appointments.	<input type="checkbox"/>	<input type="checkbox"/>
4. Your patient information form is easy to read and to complete.	<input type="checkbox"/>	<input type="checkbox"/>
5. There is help available to complete the patient information in privacy.	<input type="checkbox"/>	<input type="checkbox"/>
6. We provide an office brochure to each new patient.	<input type="checkbox"/>	<input type="checkbox"/>
7. Ongoing patients are asked about new medical information, drugs and other changes.	<input type="checkbox"/>	<input type="checkbox"/>
8. Patients are given written pre-op, post-op and educational materials.	<input type="checkbox"/>	<input type="checkbox"/>
9. Patient complaints are analyzed.	<input type="checkbox"/>	<input type="checkbox"/>
10. We occasionally use a patient satisfaction survey to make office improvements.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

- 1. YES.** Very important. First impressions make lasting impressions. Make certain that your reception area (no longer referred to as “waiting rooms” for obvious reasons) reflects an office that is clean, comfortable and caring.
- 2. YES.** Hopefully your practice has found – and nurtures – the best person for this position. In addition to the first impression this person makes, he can be the one consistent contact for patients during all their visits.
- 3. YES.** Make certain that everyone knows what to do when a patient calls and needs to be seen immediately. The patient may, of course, be referred to the emergency department of the hospital, but there may be some patients or conditions that your practice prefers to see and will make the necessary scheduling adjustments to get this patient in.
- 4. YES.** It should be. The information you receive during the initial intake process is vital for helping to assess patient needs and track patient changes. Make the form as easy to fill out as possible.
- 5. YES.** Have someone available to help patients complete the patient information form in privacy. You might also need to have forms in other languages, like Spanish, and have interpreters available if patients have not brought along their own. The goal is to improve communication with patients, thereby reducing potential misunderstandings for all parties.



6. **YES.** Please do. A short, clean, informative office brochure will give patients important information like phone numbers, after-hours call procedures, your office policies regarding fees and insurance billings, and even pictures of your physicians and staff. It will reduce unnecessary phone calls and increase patient compliance.
7. **YES.** Every time a patient returns, he should be asked about changes – in address, phone numbers, employment, insurance, emergency contact, and the like. Some of this is important for medical reasons and some for billing concerns.
8. **YES.** Patients should be given plenty of information in writing. Document the chart to show what information was provided to the patient. This will reduce confusion, answer questions, and help defend you if a patient says he was not aware of certain requirements after a surgery.
9. **YES.** You might consider having a system for collecting and analyzing patient complaints. These can be a rich source of information regarding what might be irritating patients. Let patients know of the improvements you have made due to their input. This is great customer service.
10. **YES.** This is a good way to get to those patient complaints. It is also a great way to discern what your patients like so you can provide more of the same.



B. Scheduling and Appointment Systems

Yes No

1. I agree that scheduling problems and long waits are frequent complaints of patients. Yes No
2. I have done an analysis of my patients and understand who they are and what their needs are so that I can better schedule for them. Yes No
3. We schedule patients according to their "problems." Yes No
4. Some patients are seen by others in the practice, so these patients are scheduled separately. Yes No
5. Due to the nature of my practice, we use either a wave system, modified wave system or stream system of scheduling. Yes No
6. Rarely do our patients have to wait over 20 minutes to be seen by me. Yes No
7. When waiting times become long, my staff is instructed to apologize for the wait and offer rescheduling as an alternative. Yes No
8. When patients arrive for their appointments, they are advised of the approximate waiting time. Yes No
9. When the wait is extremely long, I stay away from the unhappy people in the waiting room. Yes No
10. Our staff has been known to offer soft drinks and other refreshments to people who have to wait a long time. Yes No
11. Our office schedules extra open slots on Monday and Friday because of the busy loads. Yes No



PREFERRED ANSWERS

Patients often complain about long waits at physician offices. Patients who become angry in the waiting room can cause grief for you and your staff and discomfort for others waiting there. It is important to have your scheduling and appointment systems as efficient and patient-oriented as possible.

1. **YES.** Physician offices that send out patient questionnaires often find the biggest complaint is the long wait for medical care.
2. **YES.** Good idea. Knowing the demographics of your patient population can make your scheduling more efficient. Follow-ups can be scheduled for shorter periods of time, working people can be scheduled when children are not overrunning your waiting room, and some retired folks do not mind waiting. The more you know about your patients and their needs, the better you can schedule them for your mutual convenience.
3. **YES.** Many offices schedule according to patient medical problems so problems can be grouped. It is efficient to schedule all pap smears in a day or period of time, as an example, because of the equipment and staff that are needed. Perhaps your office can also benefit from this “trouble sorting.”
4. **YES.** If your patients are only going to be seen for blood pressure checks, for example, by someone other than yourself, separate scheduling can be provided for them.
5. **YES.** Good. There are a number of systems for scheduling based on the needs of your practice. Whichever system you use, review it periodically to make certain it is both efficient for you and for your patients.
6. **YES.** Good. Twenty minutes seems to be the golden time. Patients feel it is very rude to have to wait over twenty minutes. Refer to question #7.
7. **YES.** Good idea. There is nothing worse than ignoring patients during long waits. Your staff should be as honest as possible with your patients, apologizing for the delay and making whatever provisions they can to help, either by rescheduling or calling in advance. Some offices even give discounts to patients who have to wait an inordinate period of time.
8. **YES.** Please do. Patients need to know emergencies will always take precedence. However, letting people know how long they might be waiting is a good practice and good medicine.
9. **NO.** It is amazing how patients appreciate seeing that the doctor is actually there and knows the wait is long. It only takes a few seconds to walk through the waiting room, thank your patients for waiting, and tell them you will see them as soon as you can. Try it.
10. **YES.** Great. Much better to have happy patients in the waiting room than grumpy ones.
11. **YES.** Good idea. Many offices know that calls from patients requesting appointments increase on Monday and Friday. Why not schedule open slots to accommodate these needs? You may also need to do some rearranging with your staff to make them available at peak times.



C. The Telephone in Your Practice

	Yes	No
1. All people in our practice answer the telephone with “Good morning / Good afternoon, Dr____’s office. This is (name). May I help you?”	<input type="checkbox"/>	<input type="checkbox"/>
2. We document all medical phone calls in the patient’s record.	<input type="checkbox"/>	<input type="checkbox"/>
3. The messages are on scratch pads and are thrown away after the call is handled.	<input type="checkbox"/>	<input type="checkbox"/>
4. Even when a patient’s family member calls, I try to speak directly with the patient.	<input type="checkbox"/>	<input type="checkbox"/>
5. Telephone calls at night or on weekends are not documented in the patient’s chart.	<input type="checkbox"/>	<input type="checkbox"/>
6. When I go to the hospital, I review the nurses’ notes regarding our telephone conversations to make certain they are recorded clearly and accurately.	<input type="checkbox"/>	<input type="checkbox"/>
7. Sometimes I prescribe psychotropic drugs to patients from a phone call.	<input type="checkbox"/>	<input type="checkbox"/>
8. When we receive reports from the laboratory over the phone, we document who called, the date and time of the call, and we check the written report against our note when it is received.	<input type="checkbox"/>	<input type="checkbox"/>
9. Our patients must be put on hold a great deal, especially on busy days.	<input type="checkbox"/>	<input type="checkbox"/>
10. I often call my own office to see how telephone calls are handled.	<input type="checkbox"/>	<input type="checkbox"/>
11. The people in this office who answer the phone seem to enjoy their job.	<input type="checkbox"/>	<input type="checkbox"/>
12. We have a protocol for handling abusive callers.	<input type="checkbox"/>	<input type="checkbox"/>
13. Even when patients’ calls seem trivial, we thank them for calling.	<input type="checkbox"/>	<input type="checkbox"/>
14. My staff has been trained on how to avoid giving confidential information to people over the phone.	<input type="checkbox"/>	<input type="checkbox"/>
15. Many of our phone calls can be overheard by patients in the waiting room and in the office.	<input type="checkbox"/>	<input type="checkbox"/>
16. When patients call to speak with me, my staff tells them when they can expect my return call.	<input type="checkbox"/>	<input type="checkbox"/>
17. My staff who answer the phone have a protocol on how to deal politely with patients who insist on speaking only to the doctor.	<input type="checkbox"/>	<input type="checkbox"/>
18. My staff has a list of which people can get through to me immediately, like my spouse, children, and other physicians.	<input type="checkbox"/>	<input type="checkbox"/>



PREFERRED ANSWERS

1. **YES.** Good telephone technique dictates that the doctor's office be identified as well as the person answering the call. This is helpful to patients who may be transferred around and cannot remember who was to help them. Everyone in the practice should answer and transfer calls using their name.
2. **YES.** A pertinent medical telephone call which is not documented in the record is no proof of what was said by you or by the patient. In a court of law, it would be your word against the patient's. It is recommended that the telephone slip, including all the pertinent data, be put directly into the patient's medical chart along with the follow-up information; specifically, the date and time of the call, who returned the call, and what instructions were given to the patient. Night calls should be handled in the same manner. You might consider dictating your evening and weekend calls or writing them down and getting them into the chart in a timely manner.
3. **NO.** See Answer #2. The telephone note or a clearly dictated note regarding the call should be permanently attached in the record. Its time and date should be put into the chart.
4. **YES.** Whenever possible, you or your staff should speak directly to the patient. The further removed the physician is from the patient, the more difficult it is to get an accurate picture of the situation. When family members relay information, it is not as accurate as when speaking directly to the patient. Also, the more people involved in relaying a message, the greater the possibility of a garbled message.
5. **NO.** Telephone calls in the evening and on weekends need to be documented as well as those in the daytime.
6. **YES.** You should review the nurses' hospital notes against your telephone orders in the hospital chart to make certain the information is as you recall giving it. If it is not, you should then make the necessary alterations in the chart in the acceptable ways.
7. **NO.** Research shows that psychotropic drugs are more likely to be prescribed over the phone than in person. You do not need to prescribe such drugs to people, especially those who are not your patient, no matter what their reason. In resort towns where there are many visitors, it can be tempting to provide such drugs over the phone. However, this should not be done without first seeing the patient.
8. **YES.** Whoever is responsible for calling for laboratory reports in your office should be advised to clearly write down the name of the technician who called, his shift, the date and time of the call, verify the patient's name, and clearly read back the values. Please make certain that when the written lab report comes in it is checked against the oral report taken.
9. **NO.** People dislike being placed on hold. They especially dislike being placed on hold before they have been able to describe the reason for the phone call. Most telephone calls can be diverted to someone else in the practice within a few seconds. It is more time-efficient and considerate to try to handle each call first and then place it on hold for a short time, if necessary. If this is a recurring problem in your practice, consider adding more help for the telephone, especially during peak calling times.



-
10. **YES.** Good idea. A number of physicians like to call their own office to see how calls are handled. This can give you great insights into how your office sounds to patients.
 11. **YES.** During their employee training, telephone companies ask if you can “hear a smile over the phone?” Of course a smile can be heard. Hopefully, the people answering the phone in your office enjoy their jobs and smile to the patients, even on the phone. They should be told how important their jobs are and how much their efforts to take care of patients are appreciated by everyone. Telephone work is very demanding and it should be considered very important to a well-run, patient-oriented practice.
 12. **YES.** No one in your office should be subjected to verbal abuse. There should be a protocol for handling abusive callers, to calm them down, or to transfer them to a higher authority in the office.
 13. **YES.** Many times patients do not call their doctor’s office for fear that the call is trivial and they are causing an inconvenience. You need to encourage your patients to call so they feel their needs are being met. “Thank you for calling” is a wonderful way to make the patient feel important.
 14. **YES.** The entire staff needs to be trained on how to avoid revealing confidential information. They need to be warned of common ploys people use to try to get information about their spouses, children, employees and others, when it is not their right to have this information. Offices have been sued for breach of patient confidentiality. This easily happens over the phone.
 15. **NO.** Patients love to listen and see everything that goes on in your office. If they are able to overhear telephone calls, then patient confidentiality is certainly compromised. It might also hinder them from making calls to your office when they know other people can easily overhear.
 16. **YES.** Many times patients who call to speak with the doctor are told the doctor will return their call. However, if the patient does not know when to expect the call, the doctor and the patient might miss one another. This can be a serious problem. If your staff knows you return morning calls between 12:00 and 1:00 p.m. and afternoon calls between 5:00 and 6:00 p.m., for example, they should tell the patient to expect the call then. They should further ask the patient for the best number at which they can be reached during that period of time.
 17. **YES.** Many patients insist on speaking only with the doctor. Most busy practices these days do not afford the physician the opportunity to take patient calls when they come in. However, patients should not be browbeaten into telling others what their concerns are. They can be asked if they would like to speak to the nurse or office manager. If they still do not want to, then the doctor should make every effort to speak directly with the patient.
 18. **YES.** It is helpful for all people answering the phone to know which calls go immediately to the doctor. This list should be updated as necessary and also provided to new employees.



D. Office Procedures and Tracking

	Yes	No
1. All test results are reviewed by the physician, followed up, signed, dated, and entered into the patient's chart.	<input type="checkbox"/>	<input type="checkbox"/>
2. There is a tickler system for follow-up on abnormal test results, missed appointments, referrals and consults.	<input type="checkbox"/>	<input type="checkbox"/>
3. Office equipment is well-maintained on a regular schedule.	<input type="checkbox"/>	<input type="checkbox"/>
4. Prescription pads, drugs, and syringes are kept out of sight.	<input type="checkbox"/>	<input type="checkbox"/>
5. Physicians covering in my absence are similarly qualified.	<input type="checkbox"/>	<input type="checkbox"/>
6. Covering physicians communicate with one another about patients before and after off-time.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

- 1. YES.** With many providers often involved in each patient's care, it is possible that patients may "fall through the cracks" with some of their tests and visits. Patient tracking systems for monitoring lab, x-ray and other tests and follow-ups are crucial to good patient care. All tests and follow-ups should be documented in the patient chart and developed with computer or diary systems.
- 2. YES.** Use some fail-proof system so that patients can be notified and important tests can be tracked, followed up and documented. With still too many claims brought on by failure to diagnose serious conditions, it is imperative for all treating offices to track critical tests and information.
- 3. YES.** All office equipment should be well-maintained, especially a crash cart which would be used in the case of a sudden serious problem. While some staff member calls for 911, appropriate personnel should be helping the patient with appropriate equipment.
- 4. YES.** Do not let patients get near any of these items.
- 5. YES.** They should be. When you turn your patients over to another physician, both of you become responsible for that patient. If you knowingly refer a provider, or have one cover for you whom you know to be inferior, you may expose yourself to increased liability if something untoward happens to the patient. It is your responsibility to make certain those physicians covering for you are qualified.
- 6. YES.** Please do! Covering physicians are at a big disadvantage when they have no information about your patients and are unable to access such history or current conditions. There should be a discussion both before and after the covering time in order to clear the information. Computer systems with email can be helpful, but nothing connects quite like a conversation.



E. Medical Recordkeeping

	Yes	No
1. To obtain a medical license, a physician's handwriting must be illegible.	<input type="checkbox"/>	<input type="checkbox"/>
2. My staff jokes about my handwriting.	<input type="checkbox"/>	<input type="checkbox"/>
3. Our office never makes alterations on a medical record.	<input type="checkbox"/>	<input type="checkbox"/>
4. Sometimes, when making record alterations, we use white-out.	<input type="checkbox"/>	<input type="checkbox"/>
5. We use standard abbreviations in our office and have a glossary for them.	<input type="checkbox"/>	<input type="checkbox"/>
6. We document all medical phone calls in a patient's chart.	<input type="checkbox"/>	<input type="checkbox"/>
7. We document both formal and informal consults with other physicians.	<input type="checkbox"/>	<input type="checkbox"/>
8. We document the patient's history and physical within 48 hours.	<input type="checkbox"/>	<input type="checkbox"/>
9. We document operation notes and consults within 24 hours.	<input type="checkbox"/>	<input type="checkbox"/>
10. We rarely record night calls in the chart.	<input type="checkbox"/>	<input type="checkbox"/>
11. We often use the abbreviations "PRN" as instructions to the patient.	<input type="checkbox"/>	<input type="checkbox"/>
12. The physician always signs and dates each progress note.	<input type="checkbox"/>	<input type="checkbox"/>
13. Others who make notes in the patient's chart include their signature, or initials, and date.	<input type="checkbox"/>	<input type="checkbox"/>
14. Lab and x-ray slips are not permanently attached in the medical records.	<input type="checkbox"/>	<input type="checkbox"/>
15. A "plan of management" is clearly written in our records.	<input type="checkbox"/>	<input type="checkbox"/>
16. We do not list patient no-shows in the medical record.	<input type="checkbox"/>	<input type="checkbox"/>
17. When the op note is either so full of errors or lost after transcription, I destroy the original and redo it.	<input type="checkbox"/>	<input type="checkbox"/>
18. Our office utilizes Electronic Medical Recordkeeping (EMRs).	<input type="checkbox"/>	<input type="checkbox"/>



PREFERRED ANSWERS

The purpose of the medical record is twofold: one, to provide accurate ongoing information about the patient for continuity of care; and two, to provide the physician with a legal defense should a malpractice lawsuit be filed. Areas of risk include illegibility, incomplete information, lack of documentation of phone calls, prescriptions, tests, consults, no-shows, improper alterations, and missing or destroyed information.

1. **NO.** Although the public jokes about the illegibility of physicians' handwriting, it is a big problem in defending a medical record when the physician's writing cannot be deciphered. A scribbled mess gives the impression the physician was inattentive to the patient. By contrast, neatly typed or handwritten notes give the impression that the physician cared about the patient and was medically attentive to the patient. A good medical record is a crucial part of a physician's avoiding and winning lawsuits. If your handwriting is a "joke" (see question #2), you have two options:
 - a. Hire a scribe to follow you around and write neatly in the chart.
 - b. Dictate your note and have it transcribed. Make certain you read, sign, and date each progress note.
2. **NO.** As discussed above, poor handwriting in a medical chart is no laughing matter, especially when this chart is used in the defense of a malpractice suit. The only thing worse than having a chart nobody can read is when physicians cannot read their own charts when on the witness stand.
3. **NO.** Alterations often do need to be made on a medical chart. However, it is not if alterations are made, but how alterations are made, that makes the difference. Corrections need to be made in such a way as to make it look like they are not "covering up" something else. Correct alterations can be made in a number of ways. One way is to put one line through the incorrect word, phrase or sentence, put the corrections above it, adding date and signature. Do not block out the erroneous area. Another way to make a correction is at the end of the chart. Put in the correct information, correctly dating it, and stating what in the record it is amending.
4. **NO.** Do not use white-out or any other means of correction which blocks out and obliterates the earlier wording. Such corrections look like a cover-up, which can be devastating to an otherwise defensible case!
5. **YES.** For any abbreviations used in your office, there should be a glossary for them. If you use nonstandard abbreviations, make certain you have an interoffice glossary for them also. If your records are ever challenged, you can indicate exactly what the abbreviation means so there can be no misinterpretation by attorneys or courts.
6. **YES.** It is vital that you document all medically related patient phone calls, including the reason for the call and the response given to the patient. The person taking the call and the person giving the response should indicate date, time, and signature. You can either put the telephone slip directly in the patient's chart or dictate its contents, including time and date, directly into the chart. Many lawsuits are lost because of discrepancies between what the patient said happened over the phone and what the doctor and staff remember. Therefore, it is important to document all medical phone calls in the chart.



7. **YES.** Formal consults which include letters or phone calls from other physicians must go directly into the chart and become a permanent record of it. Do not overlook the informal consult made in coffee shops, in the hallway of the hospital, in the elevators, or anywhere else. These are very important to your defense and should be clearly shown in the medical record.
8. **YES.** Patient history and physicals should be made a part of the chart within 48 hours.
9. **YES.** Op notes and consults should be made part of the chart within 24 hours. A very serious problem can develop if the physician waits too long to dictate these notes. In cases where months or years go by, it is very difficult for the physician to remember all the facts accurately. If, in the meantime, a lawsuit or threat of a lawsuit has occurred, the physician may be tempted to adjust the notes. It is vital that these notes be made objectively and put into the chart as soon as practicable. An acceptable standard is 24 hours.
10. **NO.** Night calls need to be documented in the chart as well as daytime calls. Many physicians have difficulty remembering the content of a night call and have no provision for recording it. Some physicians have solved this problem by putting a dictation machine right next to the phone, or by calling their office and leaving a message for the staff regarding the call. Again, it is very difficult to defend a case where the patient's memory differs from the physician's.
11. **NO.** Instructions such as "PRN" are not instructional enough to give to the patient regarding when to return. The chart should indicate that the patient was told to return when his temperature rises to 102°, pain moves to lower-right quadrant, shortness of breath returns, pain persists for two more hours, etc. "Follow-up PRN" gives too much responsibility to the patient and is not clear enough as to what instructions were given.
12. **YES.** The physician should sign and date every progress note in the chart. This means the progress note should be reviewed before the chart is put back in the file and appropriate alterations or additions made at that time.
13. **YES.** All others who put information in the chart also need to sign and date it. Some offices have found it helpful to have a master card on file which shows all staff names, signatures, and initials so the signing party can be identified years later, should the need arise.
14. **NO.** Lab and x-ray slips should be permanently attached in the medical record. If they are loose and fall out, it might appear tests were ordered but never happened, and subsequent follow up would also be difficult to prove. In fact, all pieces of paper should be permanently attached in the chart so they cannot fall out. Sections should be clearly marked so information can be found quickly by anyone who needs it.
15. **YES.** It is important that the plan of management be clearly written in the records. It should state what the patient was told regarding treatment, drugs, and follow-up visits .
16. **NO.** Patient no-shows need to be clearly marked in the medical record. It is important that your office have a system for following patients who need to have continued care, especially if they do not show up. You might make it standard office procedure to call the patient three times and then follow up with a note or letter sent both registered and regular mail. These attempts should be clearly marked in the file. You may consider discharging from your practice patients in need of care who consistently do not come in for follow-up. They may become too much of a liability for you.



17. **NO.** This is a very dangerous practice. There are a number of copies that go out on each op note and will be in evidence along with your subsequent note. It is extremely difficult to defend a case where multiple records regarding the same procedure are in evidence, especially if they differ.
18. **Yes or No.** There is growing use of EMRs in physicians' offices. The American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-005, 123 Stat. 115 (2009), which contains the Health Information Technology for Economic and Clinical Health Act, encourages health care providers to adopt electronic medical records. Electronic medical recordkeeping might soon become the standard of care and failure to utilize them might be considered a deviation from the standard.

If the EMR could possibly have avoided a maloccurrence, plaintiff lawyers might use that to their advantage. EMR systems can reduce the incidence of medication errors and adverse interactions and can track test results and patient follow-ups, avoiding "fall-through-the-crack" incidents. In addition, a variety of physicians can access the records remotely, giving them timely and accurate information.

Advantages for the physician and patient: The EMR provides immediate patient information which is readable, clear, complete, and gives guidelines for diagnosis and treatment plans. It can reduce errors through drug alerts and test tracking flags. Physicians can access information readily and remotely, including allergies and treatment history, can read the reports of other providers, and can review x-ray and other test reports and images. They can help defend physicians should a malpractice case be filed, as they contain all pertinent patient information, time and date information, including phone messages, informed consents, patient education forms, missed or cancelled appointments.

Disadvantages: There is some question about the privacy of the records and some concern about the use of formalized templates. Templates should be used carefully and customized for particular patients or conditions. Installing EMRs can be expensive and disruptive. It takes time to customize a system to fit your particular practice needs and time for the transition. Staff need to be trained and mistakes corrected and evaluated.



F. Termination of Physician/Patient Relationship

	Yes	No
1. Patient care is never terminated when it would leave the patient in a medically unstable condition (abandonment).	<input type="checkbox"/>	<input type="checkbox"/>
2. Reasons for terminating care of patients in our office include noncompliance, disruption, threatened (or actual) litigation, and nonpayment.	<input type="checkbox"/>	<input type="checkbox"/>
3. Our termination letter is patient-friendly and objective.	<input type="checkbox"/>	<input type="checkbox"/>
4. Our termination letter is sent both certified mail and regular mail.	<input type="checkbox"/>	<input type="checkbox"/>
5. Our office usually gives patients 30 days to find another physician, during which time we will continue to see the patient.	<input type="checkbox"/>	<input type="checkbox"/>
6. Entire staff is aware of when patients are being “referred on” and are prepared to handle patient calls in the interim.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

1. **YES.** You can terminate the care of a patient, but it must be done at an appropriate time not when the patient is medically unstable, which is called “abandonment.”
2. **YES.** You can legally and morally terminate a patient’s care for those reasons.
3. **YES.** Good. Your patient termination letter should simply tell the patient your office will no longer be treating them and includes instructions on how to find a new provider and get their records.
4. **YES.** That is the way to do it. Courts have generally held that mail sent through the USPS reach the destination. If you receive the certified letter returned, do not open it. Rather, put it unopened into the patient’s chart.
5. **YES.** That’s standard and a fairly safe way to handle the time frame.
6. **YES.** Inform every one of the terminated patients and have a protocol for handling them if they call or come to your office, especially those who become angry or disruptive.



G. Informed Consent

	Yes	No
1. Nevada has a law regarding informed consent for medical procedures.	<input type="checkbox"/>	<input type="checkbox"/>
2. I obtain informed consent for all invasive procedures.	<input type="checkbox"/>	<input type="checkbox"/>
3. Our office nurse generally obtains the informed consent.	<input type="checkbox"/>	<input type="checkbox"/>
4. Informed consents are never obtained in my office – only at the hospital by hospital staff.	<input type="checkbox"/>	<input type="checkbox"/>
5. If I told my patients the risks of the procedure, most would decline necessary treatment.	<input type="checkbox"/>	<input type="checkbox"/>
6. I have a preprinted form for informed consent and the patient gets a copy of it.	<input type="checkbox"/>	<input type="checkbox"/>
7. Both the patient and the physician sign informed consent forms in my practice.	<input type="checkbox"/>	<input type="checkbox"/>
8. Informed consent law is an offshoot of the law of “battery.”	<input type="checkbox"/>	<input type="checkbox"/>
9. I do not use informed consent because of the time involved.	<input type="checkbox"/>	<input type="checkbox"/>
10. There has never been a lawsuit alleging lack of informed consent.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

1. **YES.** Chapter 41A of the Nevada Revised Statutes, Actions for Medical or Dental Malpractice, reads in pertinent part:

NRS 41A.110 Consent of patient: When conclusively established. A physician licensed to practice medicine under the provisions of chapter 630 of NRS, or a dentist licensed to practice dentistry under the provisions of chapter 631 of NRS, has conclusively obtained the consent of a patient for a medical, surgical or dental procedure, as appropriate, if he has done the following:

1. *Explained to the patient in general terms, without specific details, the procedure to be undertaken;*
2. *Explained to the patient alternative methods of treatment, if any, and their general nature;*
3. *Explained to the patient that there may be risks, together with the general nature and extent of the risks involved, without enumerating such risks; and*
4. *Obtained the signature of the patient to a statement containing an explanation of the procedure, alternative methods of treatment and risks involved, as provided in this section.*

(Added to NRS by 1975, 408; A 1997, 1219; 1999, 5; 2007, 273)

NRS 41A.120 Consent of patient: When implied. In addition to the provisions of chapter 129 of NRS and any other instances in which a consent is implied or excused by law, a consent to any medical, surgical or dental procedure will be implied if:

1. *In competent medical judgment, the proposed medical, surgical or dental procedure is reasonably necessary and any delay in performing such a procedure could reasonably be expected to result in death, disfigurement, impairment of faculties or serious bodily harm; and*
2. *A person authorized to consent is not readily available.*

(Added to NRS by 1975, 408; A 1997, 1220; 1999, 5)



2. **YES.** Informed consent is a growing area of responsibility for physicians.
3. **NO.** Informed consent should always be obtained by the physician. Nurses, receptionists, or bookkeepers are not the appropriate people to obtain informed consent because they cannot adequately answer the questions involved and are not the ones performing the procedure.
4. **NO.** There is a big confusion regarding informed consent and consent-to-treat. Hospitals generally have only “Consent to Treat” forms for patients. These protect only the hospital against any claim of battery. Some of these consents now contain a statement that the patient has had the risks of the treatment discussed by the physician. However, these consent forms do not in any way protect the physician, who needs to obtain and document their own informed consent form from the patient.
5. **NO.** Research has indicated that although many physicians feel patients are afraid of procedures once they hear the risks, quite the opposite is true. Patients who learn of the risks still agree to the treatment and are better prepared for adverse outcomes.
6. **YES.** This is a very helpful way to handle informed consent. Some are put on NCR paper. The original, after being signed and dated, goes into the patient’s chart, and a copy is given to the patient to be discussed with the family. Although some of the copies may later be found elsewhere, it at least shows the physician did everything possible to disseminate appropriate information to the patient and family.
7. **YES.** It is important for both the patient and the physician to sign the informed consent form when it is discussed. Some forms include a place for a witness to sign it and all must date it. Informed consent should be obtained as close to the time it is first discussed as possible, thus giving the patient time to digest the information and ask questions.
8. **YES.** Informed consent law is an offshoot of the law of battery. If patients do not give it, they can allege battery was committed against them. This also occurs if an unsuspected secondary condition appears during the surgery and the physician deals with it without the patient’s prior knowledge. Some informed consent forms actually include the statement that additional procedures may be necessary at the time of the surgery and will be handled.
9. **NO.** Of course, it is true that informed consent takes time, but it is time well spent. The more the patient and family are told regarding the risks, alternatives and possible expectations, the better the outcome and the less time involved in defending yourself in a non-meritorious claim later on.
10. **NO.** There are a growing number of lawsuits alleging only lack of informed consent. Please be certain to protect yourself from this by obtaining informed consent for all invasive procedures and drug therapies, making certain that the form is written in clear, non-medical jargon, conducted in the doctor’s office whenever possible, signed and dated by the physician, patient and witness if available, and the original is placed in the medical record. There should also be a statement in the progress report that informed consent was obtained, that the patient is aware of the risks and alternatives, and that the patient is requesting treatment. This, along with the original of the informed consent form, should help the physician defend any case involving unrealistic expectations or unanticipated outcomes.

Check with your specialty college for availability of consent forms. These would be specific to your practice and procedures.



H. Billings and Collections

	Yes	No
1. We always try to explain to our patients in advance when there will be additional charges beyond ours: e.g., for radiology, pathology, anesthesiology and hospital charges.	<input type="checkbox"/>	<input type="checkbox"/>
2. I personally never discuss fees with my patients; that is left to our financial person.	<input type="checkbox"/>	<input type="checkbox"/>
3. We provide a private location to discuss patient's financial arrangements.	<input type="checkbox"/>	<input type="checkbox"/>
4. When I treat a patient for "no charge," I let the rest of the staff know immediately.	<input type="checkbox"/>	<input type="checkbox"/>
5. We have patients sign a contract to pay for services which are not covered by insurance.	<input type="checkbox"/>	<input type="checkbox"/>
6. Our collection and billing procedures are clearly outlined to patients in a patient information booklet.	<input type="checkbox"/>	<input type="checkbox"/>
7. We never cancel any patient's bills after a maloccurrence because we fear it may be considered an "admission of guilt."	<input type="checkbox"/>	<input type="checkbox"/>
8. I review all accounts before they are turned over to collection.	<input type="checkbox"/>	<input type="checkbox"/>
9. The in-house collection people are in compliance with federal guidelines when contacting people for their overdue bills.	<input type="checkbox"/>	<input type="checkbox"/>
10. We discharge patients from our practice when we turn them over to collection.	<input type="checkbox"/>	<input type="checkbox"/>
11. All accounts over 120 days old are automatically turned over to collection.	<input type="checkbox"/>	<input type="checkbox"/>
12. Our office system is to send friendly reminders at 30, 60, 90, and 120 days.	<input type="checkbox"/>	<input type="checkbox"/>
13. Sometimes during the holidays, our office cancels small debts of patients.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

Many claims of malpractice are brought on by anger over harsh collection practices or unanticipated bills. Therefore, the billings and collections area is an extremely sensitive one. Many people are as sensitive about their financial condition as their health condition. Few people have any idea how expensive it is to get sick in our country and need to be prepared.

1. **YES.** Many patients still believe the doctor's office is a one-stop deal. They become confused, frustrated, and angry when they receive additional charges for radiology, pathology, anesthesiology, assistant surgeons, hospital charges, and others. Please prepare your patients for these charges by telling them whom to expect the bills from and approximately what they will be. Many offices keep lists of these charges so they can be fairly accurate.
2. **YES or NO.** Okay either way. Many physicians are uncomfortable discussing the financial aspects of treatment. If this is the case, please make certain the person explaining the charges to your patient can do so in a warm, caring way. However, many patients say they appreciate it when the doctor describes the charges and even shows a little empathy by saying, "It's amazing how expensive these things can be sometimes."



3. **YES.** It is very important to have privacy to discuss patients' financial arrangements. Patients do not want others to overhear the intimate nature of their finances; it is a very personal area.
4. **YES.** Patients often complain that their doctor charged them nothing for the visit; yet, they were sent a bill. This creates bad feelings among the patient, the staff, and the physician. Please be certain to clearly indicate to your staff when a patient has not been charged.
5. **YES.** Patients who help draw up and sign their own contract to pay for services are more inclined to pay than those who do not. Again, please have the financial person show warmth and consideration for the patient and be as cooperative as possible in making these arrangements.
6. **YES.** Lawyers and accountants strongly suggest your billing and collection procedures be outlined in a patient information booklet. That way, patients can see in writing what the expectations are. If fees are to be paid at time of service, this should be so indicated. Whether you do or do not bill Medicare and accept assignment should also be clearly described in your brochure.
7. **NO.** Formerly, it was considered an "admission of guilt" for a physician to cancel the bill of a patient where a maloccurrence has occurred. However, recent thinking has changed. If you consider the patient's financial hardship, then the bill can be cancelled. Feel free to call your attorney for advice and guidance in just how to handle these particular bills.
8. **YES.** The physician should always review accounts before they are turned over to collection. Any accounts for which there is some concern about the medical outcome should probably not be turned over to collection. Also, if you suspect a patient is particularly litigious, you may not want to turn the account over to collection. Many malpractice suits are brought on by harsh collection practices. Please be certain yours are fair and individualized.
9. **YES.** Please make certain that your collection people follow federal guidelines concerning when they can call people at work, how many times, and so forth. If you have questions about what the federal guidelines are, please contact your collection agency and have them send you a copy.
10. **YES.** Patients you turn over to collections should be discharged from your practice. Patients who do not pay their bills are a detriment and a risk to your practice.
11. **NO.** Please do not automatically turn any accounts over to collection. Review all of them and then consider the costs of collection versus the bad will sometimes created.
12. **YES.** Good idea. Patients need to be reminded about their overdue bills. Any type of reminder is helpful and should be done consistently.
13. **YES or NO.** Some do. Some physicians actually cancel the small debts of their patients during the holidays as a goodwill gesture. Many offices find that the cost of carrying these accounts and sending out reminders exceeds the amount of the remaining bill. Something to think about.



I. Employee Matters/Vicarious Liability

	Yes	No
1. I am mindful of the vicarious liability risks arising from my employees, particularly those who have medical contact with my patients.	<input type="checkbox"/>	<input type="checkbox"/>
2. Our office tries to hire and retain the best employees for each position and we pay them well.	<input type="checkbox"/>	<input type="checkbox"/>
3. The physician monitors and keeps control over physician extenders, including PA's, nurses, nurse practitioners, and technicians.	<input type="checkbox"/>	<input type="checkbox"/>
4. Our office standards and expectations are clearly communicated to our employees.	<input type="checkbox"/>	<input type="checkbox"/>
5. Employees who overstep their bounds are disciplined, monitored, and sometimes fired.	<input type="checkbox"/>	<input type="checkbox"/>
6. Our office has regular meetings to share information and to continue to upgrade our skills and abilities.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

- YES.** Please do. In order to accommodate more patients within a more cost-effective system, there will be more physician extenders utilized. However you, the physician, still have the ultimate responsibility for those you employ, direct, supervise, or monitor. You need to provide ongoing training, monitoring and evaluation of their patient involvement. Hire the best, pay them appropriately, remain accessible to answer their questions, and set clear medical guidelines.
- YES.** You should. Your employees represent you, both legally and from a public relations perspective. Make time to find the best and pay them well. It is money well spent, so you are not constantly looking for and training new employees.
- YES.** As "Captain of the Ship," you are ultimately responsible for the actions of all your employees.
- YES.** Employees should be given a simple, yet complete employee handbook outlining all your rules and expectations as well as procedures for discipline.
- YES.** See #3. Keep a paper trail of your employee's misdeeds and the progressive discipline you have utilized. This will also help if you fire the employee and are sued for unlawful termination or some other cause.
- YES.** Schedule regular staff meetings, including an agenda, to improve communication, discuss important issues, and provide on-going training. Well-trained employees are generally happier and more likely to treat your patients as you would like.



J. Handling the Maloccurrence

	Yes	No
1. When a patient has a bad or unexpected outcome, I stop communicating with the patient for fear I will incriminate myself.	<input type="checkbox"/>	<input type="checkbox"/>
2. I direct my staff to stop communicating with the patient also for fear they will say something incriminating.	<input type="checkbox"/>	<input type="checkbox"/>
3. Dealing with patients' families is so disruptive, I communicate only with the patient whenever possible.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

1. **NO.** Stopping communication is the worst thing to do! When patients have a bad or unexpected outcome, they look to you for explanation and comfort. You must speak to them and their family members immediately, telling them the truth in objective terms and outlining a plan for the future. You must make time to spend with the patient showing you care and that there are things that can be done on their behalf. Although it is possible a bad result or unexpected outcome will result in a malpractice lawsuit, that is not always the case. Many patients who feel their physicians care about them decide just to get on with their lives and not involve themselves in the legal process. What you do and say immediately after the bad result or unexpected outcome can make a big difference.
2. **NO.** Please don't. Your staff can go a long way in also showing patients how much you care for them. Patients want your care as much as they want your cure, and the staff are in a good position to augment your caring efforts.
3. **NO.** Bad idea. Many lawsuits are instigated by patients' families who do not have the same positive relationship with the physician that the patient has. If the family members are too disruptive, have them appoint a spokesperson with whom you communicate openly and frequently. It is important to keep the family informed and involved as much as possible.



K. Communicating with Patients

Hippocrates: *“For where there is love of man, there is love of art. For some patients, though conscious that their position is perilous, recover their health simply through contentment with the physician.”*

The patient’s relationship with the physician and staff is a very important component in the medical treatment. The better the communication among all, the more likely there is to be patient and physician satisfaction.

Many malpractice lawsuits result from a perceived lack of caring by the medical professionals. Good communication helps improve patient care and physician defendability. Ethical and caring communication between physician and patient requires honesty, accountability, and trust. It avoids defensiveness, blame, and argument.

When listening to the patient, physicians and their staff should ask open-ended questions, not interrupt, and acknowledge the emotional impact on the patient by expressing compassion and empathy. You should use supportive nonverbal communication with the patient by leaning forward, equalizing height, and avoiding the appearance of being rushed or distracted.

Your staff play an integral role in making your patients feel cared about. They should use the same good communication skills you do and also be available to your patients and their families physically and emotionally.

In your practice, you should engage in practice sessions to discuss some of the most troubling communication situations. These include your office’s plan to handle the following difficult situations:

1. Patients who are angry about long waits before they can see the physician. What is your office’s plan for handling these patients?
2. Patients refuse necessary treatment or testing for a variety of reasons – financial, fear, lack of understanding, and/or other. How do you convince the patient to get the needed treatment or test – and what if they still decline?
3. A patient, who is an ER referral, calls requesting medical advice or medication. You have not yet seen the patient. How should your staff handle this?
4. A patient has been discharged for either medical or financial noncompliance. He is sent a discharge letter by both regular mail and certified mail. At a later date he calls and demands to be seen. He states that he did not receive the letter. How will your office handle this?
5. During the course of a conversation, an irate patient will “mention” his attorney. He does not state that he is going to contact him or why he would contact the attorney. How should you handle this?
6. How do you handle calls from spouses, parents, or others requesting prescriptions or medical advice for patients who are at work, school, out of town, etc.?



7. Your office requires annual demographic and medical information updates. Unfortunately, some patients hate paperwork and there are those who refuse. How does your office staff accomplish this task?
8. All doctors are in surgery for the rest of the day. A patient calls with what he perceives as a serious problem. The nurse speaks with him and determines that it is not an emergency. He attempts to explain the situation and offer advice. The patient wants to “speak to a doctor.” The on-call physician is there for emergencies. What should the nurse do now?
9. You have been advised by the patient’s insurance company that they will not pay for a service and that it is the patient’s financial obligation. You have exhausted the appeals process. The patient demands that you “do something.” How will you handle this?
10. The patient returns several months after a serious test and when you open the chart you see that the patient was not informed of the positive results. How do you handle this?

No matter what the situation, the following behaviors will help make the patient feel listened to and cared about:

- Take time to listen to the patient
- Make extra time if there is a problem or untoward outcome
- Involve family members when appropriate
- Look the patient right in the eye when speaking
- Avoid looking at clocks, phones, charts or other distractions
- Tell patients that you understand their anger, fear, disappointment
- Let the patient vent without interrupting
- If the patient goes on for too long, gently redirect to the current topic
- Apologize appropriately for errors and mistakes
- Fix the problem, if you can
- Tell the patients what your plan of action is, which will help them to move forward
- Be honest yet hopeful



II. LOSS MITIGATION – “AFTER THE LOSS ...”

L. Attorney Contacts

	Yes	No
1. When an attorney calls me about a patient’s care, I am very helpful and give full information.	<input type="checkbox"/>	<input type="checkbox"/>
2. My staff have protocols for how to deal with calls from attorneys.	<input type="checkbox"/>	<input type="checkbox"/>
3. When an attorney calls and asks about another physician, I tell him as much as I know.	<input type="checkbox"/>	<input type="checkbox"/>
4. When a physician I do not know calls me from another state, I freely discuss a patient’s care with him.	<input type="checkbox"/>	<input type="checkbox"/>
5. My office staff knows what a Summons and Complaint look like and they get it to me right away.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

1. **NO.** Be very careful. Be polite, but firm, with the attorney and tell him you will consider giving information once you have a letter outlining exactly what he wants. Once you receive the letter from the attorney, refer it to your attorney or insurance carrier to handle. If you wish to respond in writing, make certain language is objective and that you give as little information as possible. Have your attorney or insurance carrier review the letter. This is a very serious and important first step in litigation. You do not want to do something which will anger a plaintiff unnecessarily or get yourself in trouble.
2. **YES.** They should. Make certain your staff knows to be polite to the attorney and to refer the call to you. They should give absolutely no patient information to an attorney or anyone else without authorization. Make certain they are aware of confidentiality matters as well.
3. **NO.** Do not get caught by this tricky maneuver. Often plaintiff attorneys go on “fishing expeditions” to see what they can discover by rattling one physician and making him think he is off the hook if he gives information about another physician. The attorney is probably also contacting the other physician for information about you.
4. **NO.** Unless the patient has given you authorization to speak to another physician, do not assume the other physician is who he says he is. Some plaintiff attorneys pretend to be physicians to entice you to disclose patient information. Another trick.
5. **YES.** Make certain everyone on the staff knows what one looks like and that it needs to be given to you immediately. If a copy of the records is requested, make a copy of the original chart, lock the original in a safe, and send the copy to the attorney after you have looked it over. Do not make any changes in the record at this time!



M. Reporting Claims and Incidents

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. I do not report serious incidents to my insurance company for fear they will cancel my policy. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I wait until a maloccurrence becomes a filed claim or lawsuit before I report it to my insurance company. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If I have a claim filed against me, I should speak to no one about it, except my lawyer and insurance company. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. When I or my chart is subpoenaed for a case, I go immediately to the records and make all necessary corrections. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. The defense attorney hired by the insurance company is their attorney, not mine. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. I know how to contact IND. | <input type="checkbox"/> | <input type="checkbox"/> |

PREFERRED ANSWERS

1. **NO.** It is very important to let the insurance company know of any serious incident immediately. There are many things they can do to begin your defense and perhaps stop a claim before it happens. Insurance companies rarely cancel a policy after one bad incident or case as the decision to cancel an insured's policy is a very serious matter. Open communication with your insurance company is very important.
2. **NO.** Do not wait. Many times a maloccurrence can be handled by the insurance company in such a way as to forestall a claim from being filed. Report the claim and let the company do its job.
3. **YES.** For the most part. Be very careful whom you speak to about a claim, especially other physicians and experts who may later become involved in the case. By all means do not speak to the press even if stories appear in the news. Your talking to the press could affect where the trial is held, necessitating a change of venue, and may create a public situation which becomes difficult for you to defend against.
4. **NO.** Do not touch the chart. Put the original in a safe after making a copy. You and your attorney can make necessary changes on the copy which can explain any discrepancies later.
5. **NO.** The defense attorney hired by the insurance company is your attorney. All communication between you and your attorney is confidential and protected. If you do not feel your representation is adequate, contact the insurance company to request a different attorney.
6. Contact IND to report any claim, incident, or question. Phone number (702) 697- 6400 (local) or (866) 940 - 6526 (toll free) or (702) 697- 6401 (fax).



N. Nevada Statute of Limitations

	Yes	No
1. I have read the Statute of Limitations law for Nevada.	<input type="checkbox"/>	<input type="checkbox"/>
2. I understand that Nevada's Statute of Limitations law is in a transitional phase.	<input type="checkbox"/>	<input type="checkbox"/>
3. Children in Nevada have an extremely long statute of limitations.	<input type="checkbox"/>	<input type="checkbox"/>
4. Nevada law states that medical records must be kept for five years.	<input type="checkbox"/>	<input type="checkbox"/>
5. The statute of limitations is tolled if the physician has actively concealed any act, error or omission regarding the case.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

- YES.** Please do. There are many misunderstandings about the statute of limitations in Nevada and it is helpful to review the actual provisions. Chapter 41A of the Nevada Revised Statutes, Actions for Medical or Dental Malpractice, reads in pertinent part:

NRS 41A.097 Limitation of actions; tolling of limitation.

- Except as otherwise provided in subsection 3, an action for injury or death against a provider of health care may not be commenced more than 4 years after the date of injury or 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:*
 - Injury to or the wrongful death of a person occurring before October 1, 2002, based upon alleged professional negligence of the provider of health care;*
 - Injury to or the wrongful death of a person occurring before October 1, 2002, from professional services rendered without consent; or*
 - Injury to or the wrongful death of a person occurring before October 1, 2002, from error or omission in practice by the provider of health care.*
- Except as otherwise provided in subsection 3, an action for injury or death against a provider of health care may not be commenced more than 3 years after the date of injury or 1 year after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:*
 - Injury to or the wrongful death of a person occurring on or after October 1, 2002, based upon alleged professional negligence of the provider of health care;*
 - Injury to or the wrongful death of a person occurring on or after October 1, 2002, from professional services rendered without consent; or*
 - Injury to or the wrongful death of a person occurring on or after October 1, 2002, from error or omission in practice by the provider of health care.*



3. *This time limitation is tolled for any period during which the provider of health care has concealed any act, error or omission upon which the action is based and which is known or through the use of reasonable diligence should have been known to him.*
4. *For the purposes of this section, the parent, guardian or legal custodian of any minor child is responsible for exercising reasonable judgment in determining whether to prosecute any cause of action limited by subsection 1 or 2. If the parent, guardian or custodian fails to commence an action on behalf of that child within the prescribed period of limitations, the child may not bring an action based on the same alleged injury against any provider of health care upon the removal of his disability, except that in the case of:*
 - (a) *Brain damage or birth defect, the period of limitation is extended until the child attains 10 years of age.*
 - (b) *Sterility, the period of limitation is extended until 2 years after the child discovers the injury.*
(Added to NRS by 1971, 366; A 1975, 407; 1977, 857, 954, 1082; 1985, 2011; 1989, 424; 1991, 1131; 1993, 2224; 1995, 2350; 1999, 5; 2001, 1107; 2002 Special Session, 8; 2004 initiative petition, Ballot Question No. 3)
2. **YES.** Due to recent tort changes in Nevada, the statute of limitations applicable to medical care is in transition depending upon when medical care was provided. The statute of limitations ultimately may be as short as three years (3) after the date of injury or one (1) year after the date the patient should have known about the injury.
3. **YES or NO.** Children in Nevada have an extended statute of limitations for the following:
 - a. For brain damage or birth defect, the period of limitation is extended until the child attains 10 years of age.
 - b. For sterility, the period of limitation is extended until two years after the child discovers the injury. Therefore, there is a common misconception that claims involving children have a long statute of limitation for all injuries. This is not true.
4. **YES.** Although Nevada law states medical records should be kept for five years, there are many situations for which you will want to keep your records longer. These include cases where an allegation of malpractice can be made and others which include brain damage, birth defects, or sterility. These should be kept much longer, possibly forever. Identify the medical record with: "Do Not Destroy," and consider keeping it in a scanned, electronic form.
5. **YES.** This means that if there is active concealment on the part of the physician, the statute of limitations does not run and the case can be filed at any time.



O. Depositions

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. When summoned to give a deposition about one of my patients, I go to the attorney's office alone. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If a request is made for a deposition to be given at my office, I readily agree. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. A deposition might be a plaintiff attorney's "fishing expedition," so I will go and give enough information to be dropped from the suit. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I do not need to prepare for depositions, because my lawyer will help me through any rough spots. | <input type="checkbox"/> | <input type="checkbox"/> |

PREFERRED ANSWERS

1. **NO.** Your insurance company will provide an attorney for you to help you through the deposition process. Never go alone!
2. **NO.** You do not want attorneys looking around in your office. Many put your deposition on video and scan the rooms for additional information. Also, you are likely to be distracted by the goings on in your own office, which will not help your concentration. Agree to meet in the attorney's office or in some neutral spot.
3. **NO.** Be very careful. Your conduct at a deposition will differ based on whether you are being deposed as a party to the action or as a treating physician. Do not go alone, and listen to your lawyer's advice about how much information to give. Yes, it is a "fishing expedition" and the more information you give the plaintiff's attorney, the more fish can be caught. Defense attorneys usually want you to give short answers which make the plaintiff's attorney work for information. A short "yes" or "no" answer is the best in a deposition setting.
4. **NO.** Do not count on it. Your defense attorney can do little during a deposition unless things become way out of line. Plan to spend time with your attorney going over your testimony in advance of the deposition. Additionally, be extremely familiar with your chart and all the lab, x-ray, and consultation reports contained therein. The deposition is a very important part of the litigation process. Attorneys not only want to hear your answers to questions, but they want to assess you for your trial impact as well. Dress conservatively, be polite, and refuse to become angry or rattled during any of the proceedings. Keep to yourself any disgust you might feel about the process. A good deposition can make a plaintiff's attorney think twice about pursuing a case.



P. Courtroom Testimony

	Yes	No
1. I will encourage my insurer to try my case because physician defendants usually prevail.	<input type="checkbox"/>	<input type="checkbox"/>
2. I intend to spend minimal time preparing for trial since my attorney does all the work.	<input type="checkbox"/>	<input type="checkbox"/>
3. I look forward to testifying; once the jury hears my side of the case, it will exonerate me.	<input type="checkbox"/>	<input type="checkbox"/>
4. If the other attorney pushes me too far during my testimony, I will "let him have it!"	<input type="checkbox"/>	<input type="checkbox"/>
5. If a plaintiff's attorney files a frivolous lawsuit against me, I will sue him in retaliation.	<input type="checkbox"/>	<input type="checkbox"/>
6. I have a support group of people who will help me survive the emotional trauma of a malpractice lawsuit, should one occur.	<input type="checkbox"/>	<input type="checkbox"/>

PREFERRED ANSWERS

- YES or NO.** Be careful. Although it is true that most physician defendants do prevail when they go to trial, those who do not can lose substantial sums. The decision to settle or go to court is always a difficult one and a number of factors need to be considered, including the question of negligence, the quality of the medical record, your demeanor as the defendant physician (your likability and believability), the extent of damages in the case, the emotional appeal of the case, and the composition of the jury.
- NO.** Do not count on it. A trial is a drama of immense proportions for which all players need to know their parts in order to provide a competent, confident defense. Be prepared to spend many hours preparing for a trial and allocate a week or two (or more) away from your practice.
- YES or NO.** As described in question #1 above, juries consider many factors when deliberating. One is, of course, your likability and believability as the defendant. However, the quality of the experts, the plaintiff's case, the extent of damages, and other sympathy factors must be considered.
- NO.** Do not allow yourself to be taunted into losing control. If the other attorney pushes you too far, they may be trying to let the jury see another side of you. It may be he is uncomfortable with the technical areas of the case and wants the jury to focus on you and your personality. Always be polite, in control, and willing to educate the jury about the case, but never let the other attorney or the judge "have it."
- YES or NO.** You can, but the results over the years are miniscule and discouraging. Better to spend your efforts on getting on with your life and taking care of your patients, your family, and yourself.
- YES.** A medical malpractice lawsuit can be traumatic for a physician. Going through it alone may sound noble, but it can wreak havoc on one's personal and professional life. Find people you can talk to and be open to counseling sessions for yourself, your spouse, and other family members, if necessary. Being sued is not a shame; letting it destroy you and your family is.

