

Your practice, your patients and you:
Risk reduction strategies from MIEC



MIEC

Owned by the policyholders we protect.

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As an MIEC policyholder, you have an ally in risk management: the MIEC Loss Prevention Department. Our team of loss prevention specialists is here to answer your questions and to provide reassurance, advice, and resources. We have many tools and publications to assist you in reducing your liability, but we understand that you might not have time to go over everything in detail or perhaps you simply don't know where to begin. We have created this summary of topics we suggest you consider, whether you are new to practice or a seasoned practitioner. Each section links to more detailed information on the MIEC web site: www.miec.com. Please feel free to call us with any questions. Be sure to pass along our web site and phone number to your office manager.

We look forward to being of assistance to you.

Claudia Dobbs Loss Prevention Manager	Katie Theodorakis Senior Loss Prevention Representative
Kathy Kenady Loss Prevention Representative	Dorothy Dukes Senior Loss Prevention Representative

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“ Our department is pleased to offer you 75 years of collective experience in the field of liability prevention.”



Claudia Dobbs
Loss Prevention Manager

Staff

An engaged, loyal, caring staff can be a physician's greatest asset. Your staff is an extension of you; staff members' competence and congeniality, or lack thereof, reflects on your level of commitment to the safety and satisfaction of your patients. Staff members can also be your eyes and ears on the front lines, identifying areas for improvement in safety, efficiency, and patient relations. The importance of hiring the right people, training them effectively, and retaining valued employees should not be underestimated.

Hire the right people

Hire people who will represent your practice ideal. A candidate's attitude and personality are just as important as their work experience. Hire people who are friendly, convey warmth, have the desire to be helpful, the initiative to problem-solve, and are good at working as part of a team.

Orientation

Provide newly hired employees with an orientation to your practice. Welcome them to the team by providing introductions to each staff member and each physician. Familiarize them with your practice's mission statement and your Policies and Procedures manual. Give them an overview of your specialty, including common terms, procedures, and any ancillary services you provide.

Training

Each staff member must have enough training to be prepared, confident, and comfortable in his/her new role. Provide in-service and external training as necessary. Special topics can be covered during regular staff meetings, such as telephone etiquette, privacy, security and confidentiality issues, handling patient complaints (including irate, disruptive patients), Continuous Quality Improvement (CQI) projects, new laws and regulations, patient safety tips, and more. Provide staff with formal annual evaluations

to let them know how they are doing and if changes or improvements are expected in any area.

Team work

Staff members must work as a team by: planning, making decisions, managing workload and communicating. Cross-training can be particularly effective in combating the “that’s not my job” mentality and can keep things running smoothly if staff members must cover for one another.

Patient relations

Remind staff to treat your patients as they would want their friends or family members to be treated. Train staff to educate, anticipate, and reassure. See the Patient Relations section (page 3) for more tips.

Retain good staff

Foster an atmosphere of camaraderie

Employees are more likely to work well with each other and with their employers when they get to know each other in a congenial setting outside of the stresses, responsibilities, and professional hierarchy of the typical work day. Holiday parties, fun outings such as softball games, and team-building exercises are all effective ways to build collegiality. Our experience visiting thousands of practices has taught us that those that have photos posted in the breakroom of staff and employers enjoying such activities together always seem to have competent, contented staff members who work harmoniously together.

Let staff know their voice is important

- Have an open-door policy
- Encourage staff to ask questions, offer suggestions and participate in problem-solving and quality assurance programs
- Keep staff informed
- Have regular staff meetings
- Invite staff to tell you when there is a problem and what they suggest to resolve it

Foster professionalism

- Provide time and/or fees for professional association memberships and continuing education

Praise and discipline

- Be even-handed with praise, discipline, vacation requests, etc.
- Make criticism constructive, private, respectful, specific and timely
- Provide an occasional unexpected benefit
- Compliment and reward exemplary work
- Acknowledge employees’ efforts

Scope-of-practice and supervisory requirements

Make sure that staff members practice within the limits of their training,

certification and/or licensure. Be aware of physician supervisory requirements for allied health practitioners such as physician assistants and nurse practitioners.

Resources:

Medical Assistants: An Update on the Scope and Limits of Training (CA only)

<http://www.miec.com/Portals/0/SpecialReportClaimsAlert/SpecialReportClaimsAlert32A.pdf>

Use of Nonphysician Clinicians in a Medical Practice

<http://www.miec.com/Portals/0/SpecialReportClaimsAlert/SpecialReportClaimsAlert25A.pdf>

Patient relations

Patients want to be treated with kindness and respect and to have confidence in you and your staff's ability to manage their healthcare with diligence and tact. They want a meaningful response to their questions and concerns. Keeping your patients happy makes good business sense, but it also has a profound impact on whether or not a patient will make a claim of medical negligence against you or make a complaint to the Medical Board. Patients who take such action are often angry about some aspect of their interactions with the medical practice before, or in conjunction with, their medical complaints.

There are many things you and your staff can do to foster patient satisfaction. MIEC recommends:

Provide patients with a brochure and/or website with information about your practice

Include:

- Introductions to you and, space permitting, your staff
- A description of your specialty and the services typically provided by a doctor with your type of training
- Specific services offered in your practice
- Financial policies
- Office hours, location, directions and contact information
- How to obtain assistance after-hours
- Patient responsibilities, (e.g., refill policy, failed appointments, etc.)
- If you employ nurse practitioners or physician assistants, a description of their training and scope of practice

Resources:

Your doctor and you (sample patient information brochure)

<http://www.miec.com/Portals/0/WordTemplates/Dear%20Patient.doc>

“ I understand our policyholders have many demands on their time. That’s why I am happy to help them with unparalleled service.”



Solicit feedback with a simple patient satisfaction survey

Ask patients:

- What three things do you like best about our practice?
- What three things do you like least?
- Do you have any suggestions for us?

Thank patients and let them know if you implement a change based on their suggestions. Use patient feedback to give staff kudos or to hone in on areas for improvement.

Be prepared to handle disgruntled patients

Studies show that people complain or sue doctors when they do not get a timely or credible explanation of unexpected complications, or answers to questions about their own or a relative’s treatment. The leading reasons for patient complaints include: delayed receipt of test results; long waits for an appointment; being kept waiting too long to see the doctor; staff rudeness or a doctor’s poor “bedside manner;” and billing errors. Anticipating problems and responding promptly to complaints can prevent an unhappy patient from hiring an attorney or threatening to sue.

- Develop a prompt resolution policy
- Train staff to calmly and politely handle disgruntled patients; role-playing may be a useful exercise
- The office administrator may address complaints about billing issues or interactions with staff, but all medical complaints should be addressed by the provider
- When in doubt, do not hesitate to ask MIEC for advice
- Document the date the complaint is brought to your attention and how it is resolved in a designated “complaints” file

Kelly Libert

Senior Underwriter

Resources:

Patient complaints: How to stop them before they start
<http://www.miec.com/Portals/0/ManagingYourPractice/MYP3.pdf>



Scheduling

Patient satisfaction surveys find that few things anger patients more than a long, unexplained wait to see their physician. Such waiting periods are perceived by patients as disrespectful of their time constraints and have a negative impact on the physician-patient relationship.

- Leave appointment slots available for urgent needs
- Be prepared to handle requests for interpreters for hearing-impaired or limited-English-proficient patients
- Advise patients if the doctor is running late and offer the option to continue waiting or reschedule for another day
- Offer simple courtesies to patients kept waiting, such as an apology, a glass of water or use of a phone (if they do not have a cell phone)
- If the doctor is delayed for a legitimate reason beyond his or her control, such as being called to a hospitalized patient's bedside for an emergent condition, inform patients of this

Resources:

Efficient scheduling: Reduce delays, increase patient satisfaction, and improve reimbursement

<http://www.miec.com/Portals/0/ManagingYourPractice/MYP15.pdf>

Money matters

When patients fail or refuse to pay for medical services, there are liability issues to be aware of. One of the most common questions Loss Prevention is asked is whether a physician must continue to provide care for a patient who can not pay at the time of the appointment or who has an outstanding balance. The answer is that you are not obligated to provide care for free. However, as long as there is a doctor/patient relationship, you cannot turn patients away due to their inability to pay.

Many physicians and office managers are tempted to tell patients that

they can't receive further medical care until their balance is paid. If the patient becomes injured as a result, they can claim that their physician "abandoned" them during their time of need. A jury is not likely to be sympathetic to a doctor who turns away sick patients. Even if the patient is motivated by this tactic to bring his or her account current (and has the means to do so), this can sour the relationship between the patient and the practice, sowing the seeds of future discord.

We recommend that billing personnel work with patients to keep accounts current by politely offering to arrange a payment plan. It can be particularly effective for the physician to send a kindly-worded letter to patients offering to work out some kind of payment arrangement. If this doesn't do the trick, you have the option to send the account to collections and/or formally withdraw from the patient's care, thereby terminating the doctor-patient relationship and releasing you from the duty to provide further care for the patient (page 7). It is our opinion that once you reach the point of sending the patient to collections, the rapport necessary to foster a productive doctor-patient relationship has likely been compromised, and withdrawing from care is likely the prudent course of action.

Write-offs and complaints

Some patients may ask that their bill be reduced or eliminated as recompense for dissatisfaction with the medical care they received. We recommend that you speak with an MIEC Claims Representative before agreeing to take such action, as it could appear as an admission on your part that the care rendered was substandard.

Patient education, informed consent and informed refusal

Malpractice liability experts, risk managers, and an increasing number of physicians, nurses and other health professionals acknowledge that patient and family education has become an essential component of health care. Studies repeatedly find that patients want more information than they currently receive from their caregivers. Patients want to be involved in decisions affecting their care and treatment. They desire enough information to enable them to make informed decisions about treatment options, medications, invasive procedures, and tests that have risks of injury or adverse outcome.

When a patient sustains an injury which is not the physician's fault, but is related to something the patient did or failed to do because he or she was inadequately informed by the doctor, the patient may blame the physician and a malpractice suit may follow. Providing patient education and obtaining informed consent are effective methods for avoiding such problems.

Informed consent is a process, not a form. The signed consent form is not a substitute for an oral discussion. Even in states in which a signed consent form is regarded as evidence that the patient did give an informed consent, malpractice defense attorneys have considerable difficulty refuting a plaintiff's claim that he or she signed a consent form, but did not understand its contents.

Informed refusal requires physicians to disclose material information a patient needs to make an informed decision, such as the likely known consequences of a patient forgoing a test, medication, procedure or referral. How much to disclose depends on what a reasonable person in the patient's position would regard as significant.

MIEC recommends:

- Provide patients with oral and written patient education, and document that you have done so
- Discuss with patients the risks, benefits, and alternatives of treatment options and diagnostic tests; answer any questions they may have; document this discussion and whether the patient consents to the treatment/test
- When a patient refuses to undergo a recommended treatment or diagnostic test, advise patients of the risks of refusing and document this discussion

Resources:

Patient education improves care and reduces liability

<http://www.miec.com/Portals/0/ManagingYourPractice/MYP14.pdf>

Health literacy: A national dilemma

<http://www.miec.com/Portals/0/SpecialReportClaimsAlert/SpecialReportClaimsAlert41.pdf>

Informed consent revisited: What is expected of physicians

<http://www.miec.com/Portals/0/ClaimsAlert/clmalt17.pdf>

How to manage noncompliant patients

<http://www.miec.com/Portals/0/ManagingYourPractice/MYP6.pdf>

Ending the doctor-patient relationship

Physicians can sever a doctor-patient relationship for virtually any non-discriminatory reason, provided they give the patient proper notice and do not “abandon” a patient in the midst of an acute medical problem.

Procedure for terminating the physician-patient relationship:

- Send a letter certified mail, return receipt requested, that includes:
 - The length of time for which emergency care will be available
 - ❖ Provide patients with a “reasonable” amount of time to find a new physician. Physicians typically give 15 – 30 days
 - An authorization for release of medical records
 - Referral to health plan or local medical society to find new physician
- Advise scheduling staff that a patient has been discharged from the practice and not to schedule appointments for the patient in the future
- File a copy of the letter in the patient's chart
 - If the return-receipt-requested letter is refused, file the returned letter in the chart and send a copy of the letter by regular mail

Resources:

How to discharge a patient from your medical practice

<http://www.miec.com/Portals/0/ManagingYourPractice/MYP2.pdf>

Privacy and confidentiality office policies

Common sense considerations:

The following are some common sense suggestions for honoring your patients' privacy:

- Provide patients with a drape should they be disrobed and required to wait for the physician in an examination room
- For examinations of a potentially sensitive nature, offer to have a chaperone present



“ Our goal is to help you decrease your liability without increasing your burdens ”

- Be aware of audible conversations (e.g., telephone calls, conversation between staff members)
- Do not discuss patients with your family members, friends, etc., unless the patient has authorized you to do so

Kathy Kenady

Loss Prevention Representative

Obtain information from patients regarding release of their health information at the time of registration and update this information periodically. Ask patients:

- Who can authorize treatment for minors? Who is responsible for payment? Who has custody?
- With whom in your family may we discuss your health condition?
- May we leave general messages on your voicemail (home, work, or cellular phone)?

Resources:

Protect your patient's right to privacy

<http://www.miec.com/Portals/0/ManagingYourPractice/MYP11.pdf>

“ I believe in the passion that drives our policyholders. That’s why I consider it my duty to serve physicians, so they can improve the world one patient at a time.”



Karen Tuttle
Senior Underwriter

Legal requirements:

The federal HIPAA regulations and various state laws mandate certain procedures to protect patient privacy and confidentiality.

HIPAA’s Privacy Act: A compliance primer for the solo and small group practice

<http://www.miec.com/Portals/0/SpecialReportClaimsAlert/SpecialReportClaimsAlert34.pdf>

California Confidentiality of Medical Information Act: Rules for privacy and release of medical information

<http://www.miec.com/Portals/0/SpecialReportClaimsAlert/SpecialReportClaimsAlert26A.pdf>

Access to medical records

Whether or not a physician should grant access to medical records varies depending on who is making the request, specifically what information is being requested and for what purpose, and if patient authorization has been properly executed, if it is required.

In general:

- Patients have a right to access their own records (a rare exception being certain psychiatric records)
- Under HIPAA, records can be shared without patient authorization for purposes of treatment, payment or operations
- Minors and their guardians may or may not have the right to access their records depending on the content of the records

MIEC recommends:

- Familiarize yourself with HIPAA and state laws that affect access to patient information
- Ask MIEC for advice if you are unsure what to do
- Flag “specially protected” information to ensure that it is not improperly disclosed:

- HIV/AIDS information
- Confidential correspondence from a family member about the patient
- Inpatient mental and behavioral health records
- Inpatient, federally-funded drug and alcohol abuse treatment
- Anything you are concerned the patient might not want released without his or her specific authorization

Resources:

When trouble comes knockin': What to do when legal papers arrive
<http://www.miec.com/Portals/0/SpecialReportClaimsAlert/SpecialReportClaimsAlert39.pdf>

Managing information

In modern medicine, one of the greatest challenges facing physicians is managing patient information from a variety of sources and coordinating patient care among staff, co-treaters, and patients themselves. Patients understand that sometimes even the most skilled, conscientious physicians may err in diagnosis or treatment. What is far more difficult to understand is how they or their loved one now face a dire prognosis because information – such as a lab value, an x-ray report, a medication allergy – simply “fell through the cracks” or because each physician in the care team assumed someone else was managing an aspect of the patient’s care. Physicians, their colleagues and staff must work together to develop meaningful systems for communicating, ordering diagnostic tests, referring patients to specialists, effectively managing information, and follow-up.

Develop a “tickler” system

The system can be as simple as a hard copy log, an Excel spreadsheet, or a more technically advanced EMR system. Responsibility for tracking the information can be delegated to staff. The purpose of the tickler system is to ensure that:

- The patient obtained the diagnostic test or referral as advised; and
- The diagnostic test results or consultation report has been received and routed to the physician for review and further instructions. If results have not been received in a timely fashion, staff can follow up with the lab or specialist to obtain this information.

Ensure physician review

Initial all incoming lab reports, consultation reports, and pre-operative clearance documentation as evidence of your review and instruct staff not to file such information without evidence of your review, even if it’s in your “out” box. Alternatively, summarize your review of the information in the progress notes.

Notify patients of results

Notify patients of diagnostic test results, either by phone, in writing, or by having them make an appointment to discuss results. Document that patients have been notified of the results and any follow-up instructions.

Don't fall into these traps:

Do not tell patients that “no news is good news” with respect to their lab results. Rather, enlist patients as active participants in their care by instructing them to call in for results within a specified time-frame if they have not heard from your office.

Do not file diagnostic test results in a patient's chart without review even if you anticipate reviewing and discussing the results at the patient's next visit. There could be information in the report that requires attention before the date of the next visit. In the event that the patient fails to come in for his/her appointment as instructed, vital information could be overlooked.

Failed appointments

Although patients bear some responsibility for an injury that results from failure to return as directed, doctors also retain responsibility in this situation. Juries may decide that you, as a medical expert, have superior knowledge than the patient and therefore have a greater understanding of the degree of urgency with which the follow-up appointment is required.

MIEC recommends:

- Have staff schedule patients' next appointments before they leave
- Document failed appointments in charts, not just the appointment book
- Have staff advise you when patients miss an appointment so that you may evaluate the urgency with which the patient should be pursued, and instruct staff accordingly
- Have staff document their efforts to have the patient return to care. In instances of particular concern, it may be appropriate for you to notify the patient in writing of the importance of obtaining care, and the risk to the patient if he/she fails to do so.

Referrals to specialists

MIEC recommends:

- Request consultations in writing
- Ask staff to schedule the appointment for the patient before they leave the office
- Calendar when you can expect a written report from the consultant
- Prior to the patient's next visit, ensure that a report was received from the consultant. If not:
 - Contact the patient (Did you see the specialist?)
 - Contact the consultant (Please forward your report)
 - Document conversations with patients and specialists

Resources:

A log to track referrals and test results

<http://www.miec.com/Portals/0/WordTemplates/A%20Log%20to%20Track%20Referrals%20and%20Test%20Results.doc>

Did-not-keep-appointment (DNKA) Template

<http://www.miec.com/Portals/0/WordTemplates/DNKA.doc>



Medication management

MIEC has defended approximately 1600 medication-related claims or suits since 1975. Most of the cases fall into two main categories: failure to manage medications and negligent prescription of medication resulting in severe side effect or complication. Other claims have arisen from injuries caused by overlooked allergies, dosing errors, pharmacy or staff errors, mismanagement of pain medications, and failure to obtain informed consent when prescribing medications that could cause significant injury. Seventy-one percent (71%) of MIEC's medication-related claims arise from events in physician offices, while 28% occur in a hospital setting, and one percent in surgery centers and skilled nursing facilities.

MIEC recommends:

- Document prescriptions and refills legibly and completely, including the drug name, dose, amount, instructions, and number of authorized refills
- Document patients' current medications (prescribed, OTC, and CAM) at each visit
- Ask about "recreational" drugs
- Document medication allergies in a consistent location within the chart;
- Do not authorize "standing orders"
- When the initial number of authorized refills has been exhausted



Dorothy Duker
Senior Loss Prevention
Representative

and the pharmacy requests a renewal of the prescription on behalf of the patient, staff should document that the renewal is authorized per the doctor’s instructions

- Monitor adverse drug reactions (and near-misses) as part of your quality improvement program
- Use a Medication Control Record (MCR) to provide you with an at-a-glance summary of the patient’s current and past medications
- Follow up on ordered laboratory tests to measure therapeutic levels
- Encourage staff to question any medication orders that appear to be out of the ordinary (e.g., doses are too high, calculations appear to be incorrect, refill intervals indicate improper use, etc.)
- Discuss even “remote” medication complications if the risks or side effects are “significant” or “material” and could result in permanent injury or even death. Obtain patient’s informed consent (or refusal) and document the discussion

Considerations for pain management

- For patients suffering from chronic pain, document the efficacy of medications and effect on functioning and quality of life over time
- Justify increases or decreases in dosage and other changes to the medication regimen
- Have patients sign a medication management agreement
- Adhere to your state’s guidelines for prescribing, monitoring, and documenting controlled substances
- Physicians in Alaska, California and Idaho have access to patients’ medication histories through statewide databases, a useful tool in discovering if a patient is obtaining prescriptions from multiple sources and potentially abusing or diverting narcotics

Resources:

Sample Medication Management Agreement

<http://www.miec.com/Portals/0/Templates/Medication%20Management%20New.doc>

Alaska Administrative Code, prescribing controlled substances (page 39):

<http://www.dced.state.ak.us/occ/pub/MedicalStatutes.pdf>

Alaska State Board of Pharmacy Statutes and Regulations, Article 4A, Controlled Substance Prescription Database

<http://www.dced.state.ak.us/occ/pub/PharmacyStatutes.pdf>

Medical Board of California: Guidelines for Prescribing Controlled Substances for Pain

http://www.medbd.ca.gov/pain_guidelines.html

The California Department of Justice, Bureau of Narcotic Enforcement, CURES (Controlled Substance Utilization Review and Evaluation System) Prescription Drug Monitoring Program (PDMP) system:

<http://ag.ca.gov/bne/cures.php>

Hawaii Board of Medical Examiners Pain Management Guidelines

http://hawaii.gov/dcca/pvl/news-releases/medical_announcements/pain_management_guidelines.pdf/view

Idaho State Board of Medicine: Policy for the Use of Controlled Substances for the Treatment of Pain

<http://www.bom.state.id.us/licensees/opioids.html>

Idaho Board of Pharmacy: call (208) 334-2356 to receive forms and applications for information on a patient's controlled substance medication history.

On-call considerations

Physicians who are on-call after hours for their own patients or for their colleagues' patients need an effective method for documenting patient contacts.

Document phone calls when on-call

Documenting discussions with patients while on-call may be a hassle, but the bottom line is that documentation can prevent a credibility battle in the event that an injured patient later avers that you did not advise them as you say you did. Whose recollection will a jury believe? The physician who sees hundreds of patients and did not document this discussion? Or the patient and family members who are experiencing a medical crisis that is most likely unique in their lives?

Some physicians dictate calls received, have them transcribed, and file the transcription in their charts or mail/fax to the colleague for whom they are on-call. Others keep a notepad in their pockets or on their nightstands to document calls and bring them to the office for inclusion in the chart.

Leaving messages in office voicemail for staff to transcribe is another means of memorializing phone calls, as is using the “memo” function on cell phones, PDAs, etc.

Establish policies and procedures with your call group

- Develop a system to note calls and to report patient contacts to off-call colleagues
- Establish a prescription refill policy and avoid refilling narcotics or authorize only enough to cover patients until their primary care physician is available to assume care
- Make certain your on-call colleagues have professional liability coverage and that you have staff privileges at the same hospitals

Resources:

Telephone communication: Did you hear what I heard?

http://www.miec.com/Portals/0/WriteOn/Writeon1_online_02.07.pdf

On-Call Physician’s Report Form:

<http://www.miec.com/Portals/0/WordTemplates/Oncall%20Report.doc>.

Documentation

Medical records often are the most important objective evidence physicians can offer in their defense against a malpractice claim. When jurors, arbitrators, pre-litigation screening panels or other triers of the facts must choose between conflicting versions of events told by opposing parties, contemporaneous documentation is a defendant’s most decisive confirmation that he or she met accepted standards of medical practice. Weak medical records make it difficult to determine whether an adverse outcome resulted from factors beyond the physician’s control or from negligent medical care that invariably handicaps litigation defense. Documentation should be detailed enough to justify care, justify fees, and distinguish between doctor and patient responsibilities. We strongly recommend that you review our handbook dedicated to this subject.

Resources:

Medical record documentation for patient safety and physician defensibility: A handbook for physicians and medical office staff

<http://www.mymiec.com/portals/0/pubs/MedicalRec.pdf>

Electronic medical records: A supplement to medical record documentation

<http://www.mymiec.com/portals/0/pubs/ElectronicRec.pdf>

How long to keep medical records

There are two things to consider: 1) the legal requirements in your state, and; 2) the course of action that will be most protective of you.

Many malpractice defense attorneys advise physicians to “keep medical records forever,” because the records may be needed in the physician’s defense in a malpractice action, or patients and their subsequent treating

***“ As your MIEC Claims Representative,
I will serve your professional liability
needs with both steadfast advocacy and
compassionate support.”***



***Michael Anderson
Senior Claims Representative***

physicians may need them for ongoing care. Although state laws limit the amount of time an adult patient has to initiate a legal action (the statute of limitations), for various reasons courts do permit lawsuits to be filed years after the statute of limitations has expired. Without the medical records to corroborate the physician’s treatment years before the suit was filed, the doctor’s defense could be compromised.

For many physicians, keeping medical records forever is not practical or physically possible. MIEC’s defense attorneys recommend that physicians retain most medical records for at least eight to ten years after the patient’s last medical treatment. Some records ought to be retained for as long as 25 years, such as in cases in which the patient:

- Suffered significant complications of treatment or surgery
- Had traumatic injuries that could or did result in a major disability
- Was being followed for a pregnancy
- Was a minor at the time of the alleged injury

Legal requirements

Please view the grid in our newsletter, as requirements differ from state to state:

Resources:

How long do we have to keep medical records?

<http://www.miec.com/Portals/0/ManagingYourPractice/MYP1B.pdf>

Be aware that most states require that minors’ records be retained for many years beyond what is required of adults’ records. If you treat a combination of minor and adult patients, it is a good idea to flag minors’ charts in some way so that you do not inadvertently destroy them too soon, nor do you have to devote staff time to combing through records to determine the patient’s age when it’s time for a purge.



Premises issues

Ostensible agency

Many physicians enter into overhead-sharing arrangements with other physicians. The physicians are independent entities, but share office space and perhaps staff and phone lines. Such arrangements make good business sense, but physicians should be aware of the concept of “ostensible agency” and related liability issues. If the physicians in a cost-sharing arrangement appear to be in practice together as partners or a group, and if a patient makes a complaint of medical negligence, all of the physicians will likely be named in the complaint. MIEC would likely be able to extricate the physician who has no relationship with the patient, but such a process can be costly and time-consuming.

It is impossible to say with certainty whether a jury will find that the appearance of agency has been created in any particular case. The basic question is to what extent a reasonable patient would believe the physicians involved are practicing together.

MIEC recommends:

- Explain in your patient information brochure, web site, and/or new patient orientation materials that although you share space with another physician, you are sole practitioners. Explain the circumstances in which (if any) the other physician(s) in the space might establish a medical relationship with your patients
- Use separate and distinct letterhead stationary
- Refer to yourself as “sole practitioner” on signage
- Advertise individually
- If feasible in your situation, you may also consider employing separate staff members and having separate phone lines and patient check-in windows

Develop a premises safety and security policy

Physicians and their staff can be held liable for failing to exercise ordinary or reasonable care to prevent personal injuries to patients and those who accompany them to the office. The law defines ordinary or reasonable care as “care which persons of ordinary prudence would use in order to avoid injury to themselves or others.”

MIEC recommends:

- Adhere to OSHA regulations
- Dispose of biomedical waste per state and local laws
- Do not leave dangerous objects (needles, etc.) out in the open
- Ensure that children are supervised at all times
- Do not leave patients unattended in an exam room for a long period of time
- Lock up medications and prescription pads
- Have emergency plans for natural disasters and other crises and run periodic practice drills
- You are not required to have a “crash cart” on site, but if you do have any emergency equipment on the premises, make certain that:
 - Equipment is accessible
 - Equipment is maintained and operable
 - Authorized staff is trained in use of the equipment

Resources:

Patient safety in a medical office practice

<http://www.miec.com/Portals/0/ManagingYourPractice/MYP13.pdf>

Partnership and employment agreements

We receive many calls from physicians who are embroiled in acrimonious practice “divorces.” Many of the difficulties these physicians face could have been avoided had there been clear employment or partnership agreements in place, with a separation plan outlining how certain issues will be handled should the business arrangement be dissolved.

From a liability perspective, continuity of patient care should be the priority of all parties involved. Among the issues the parties ought to agree upon in advance:

- Whether patients who one doctor sees are considered patients of the group or patients of the individual physician
- Whether a departing physician will have access to a list of his or her patients to notify them of the departure and offer them an opportunity to continue their care at the doctor’s new location
 - If patients are considered patients of the group, rather than of an individual physician, the group itself should notify patients that a doctor has left the practice; otherwise, the individual physician should notify his or her patients
 - Be aware that nobody “owns” a patient, and patients may

- regard an existing relationship as a relationship with a physician, not a group
- Who owns the records (group or individual doctors)? Consider:
 - How records or copies of records will be transferred when current patients choose to leave the group practice and continue their care with the departing physician
 - Who will make the copies
 - How much to charge for the copies
 - Whether original charts (if owned by the group) will be transferred to the departing physician, who then becomes custodian of those charts
- What type of announcement will be made to the departing physician's patients; ideally, an announcement letter co-signed by the group and the departing physician should be sent to each patient
- How phone calls for the departing physician will be handled

Remain professional when the relationship ends on less-than-pleasant terms. For patients' sakes, keep the transition as cordial as possible. If patients request that a copy of their records be sent to the other physician, or request contact information for the other physician, comply graciously with these requests. Keep patients' needs in mind above your own feelings of anger or desire to retaliate against a former colleague.

Continuous Quality Improvement (CQI)

"CQI" is usually defined as a method of evaluating structure, processes, systems, and outcomes to identify problems and/or their causes; intervening to reduce or eliminate these problems; and continually correcting the process and improving outcomes. A CQI program in an office practice helps physicians maintain and improve the quality of the care and treatment they provide to patients and helps to ensure that physicians have the documentation that is essential to their defense in a medical malpractice lawsuit.

There are several different directions you could pursue as part of your CQI program. For example:

- Create and maintain a current and evolving Policies and Procedures Manual
- Conduct clinical reviews to maintain uniformly high standards of quality care among practice providers
- Use a Documentation Review/Self-Assessment form to evaluate the quality of patient charts
- Establish and maintain a meaningful, ongoing employee training and evaluation process to ensure a skilled and cooperative staff that is attentive to CQI in your practice

Resources:

Why, why, why do CQI?!

<http://www.miec.com/Portals/0/SpecialReportClaimsAlert/SpecialReportClaimsAlert40.pdf>

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