How to Avoid being Sued – or – How to maximize your defense if you are

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Top 4 areas that impact physician liability

I. Poorly defined office policies and procedures
II. System failures
III. Communication breakdown
IV. Deficient documentation practices
I. Office Policies and Procedures

What increases physician liability?

A. Staff members who aren’t properly and sufficiently oriented to the practice. Train your staff:
   1) How to relay medical advice over the phone and document
   2) Renew medications and document to your authorization
   3) Document in a way that protects you
   4) Communicate with patients respectfully and courteously on the phone/in person
   5) How to be your “eyes and ears”

B. Offices without an emergency policy or whose staff has not been trained how to respond in case of an emergency.

C. Groups who fail to function as groups
   1) Group policies are not well defined
   2) Record-keeping practices vary among providers
   3) Billing practices vary among providers
   4) Group members fail to communicate with each other regularly
II. Avoid Systems Failures

- System failures that contribute to increased physician liability:
  - No follow-up on ordered diagnostic tests
  - No follow-up when patients fail appointments
  - No follow-up when patients are referred to specialists
  - No follow-up on telephone communication
Notification of Test results

• “No news is good news?”
• Design a follow-up system to ensure ordered tests are returned
• Insist on evidence of your review before report is filed or patient notified
• Document when and how patients are notified of test results

Failed appointments

• Schedule the patient’s next appointment before they leave
• Document failed appointments in charts, not appointment book or practice management system
• Have staff advise you when patients miss scheduled appointments for instructions re: action to be taken
• Patients with urgent conditions: set call policy and follow-up in writing
Referrals to specialists

- Request consultation in writing
- Schedule the appointment for the patient before they leave the office
- Have staff calendar when you can expect a written report from the consultant
- Prior to the patient’s next visit, ask your staff to 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

Telephone messages

- Document significant telephone calls in the chart, NOT the telephone log
  - Staff’s notes should include: Caller, date (mm/dd/yy), time, contents, staff initials
  - Document action to be taken or advice given
  - Non-medical staff responding on behalf of MD, document “Per Dr. XX, advised patient. . .”
On-call coverage

- On-call coverage: Document!
  - What the patient reported
  - What advice you gave
  - Date and time of call
  - When the patient refuses your advice
  - Patient understanding of your advice
  - Forward a copy to the patient’s PCP

III. Communication breakdown

How to reduce liability caused by communication breakdown:

- **Communicate** effectively with patients
  - Tell them who you are
  - Tell them what you expect of them
  - Be an active listener
  - Spend time educating them, orally and in writing (and document that you did so)
III. Communication breakdown

- **Communicate effectively with your staff**
  - Acknowledge their importance as your patient relations department
  - Rely on their feedback
  - Hire competent, courteous staff that promote a healthy physician-patient relationship

- **Communicate effectively with your colleagues**
  - Put referrals in writing and be specific
  - Report to referring physicians promptly and in writing
  - When returning patients to PCPs, do so in writing
  - Document telephone conversations when on-call
IV. Communication breakdown

- **Social media and networking**
  - Have a policy for staff and patients
  - Keep personal and professional networking separate
  - Don’t “Friend” or “Follow” your patients
  - Don’t respond to negative online comments about you or your practice.

IV. Documentation practices

Protective record-keeping habits should:

- Demonstrate the physician’s decision-making and judgment
- Justify the treatment rendered
- Justify the fees charged
- Differentiate between the patient’s and physician’s responsibilities
Documentation essentials

Your progress notes or consultative reports are the corner stones of your charts. Document:

– What the patient said
– What you saw
– What you diagnosed
– What you did and will do
– What you told the patient to do
– When you told the patient to return

• **Document** enough to distinguish between your responsibility and the patient’s responsibility
  – Allergies, medications, other doctors
  – Failed, cancelled, rescheduled appointments
  – Informed consent
  – Informed refusal and noncompliance
Informed consent

• It’s a process, not a form
• Know who can provide information and obtain consent
• Ensure patients have sufficient information to make an informed decision
• Document (in progress notes or H&P)
  – risks, benefits, and alternatives have been discussed
  – The patient’s questions have been answered, and
  – The patient wishes to proceed

Informed refusal

• Like consent, the documentation should include:
  – The risks, benefits and alternatives of failing to follow recommendations that have been discussed
  – The patient’s questions have been answered
  – The patient’s understanding of the risks and refuses to follow the advice
Documentation essentials: Medication

• Document medications so they are “trackable”
  – Medications from other physicians
  – Indications
  – Rx details and refills authorized
    • Name, dose, amount, directions, refills x n
  – Renewals and changes
  – Efficacy

Contact MIEC

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