Risk Resource Guidelines

This manual is not intended to provide legal advice. We recommend that you consult with a qualified attorney for specific legal advice as it pertains to your situation.

ProAssurance®
Treated Fairly

Foreword

To Our Physician Policyholders:

Helping you adapt to the changing medical environment and increasing the control you experience is a top priority of ProAssurance's Risk Resource department. That is why we developed *Risk Resource Guidelines*. These guidelines make it easier for physicians and medical offices to help:

- improve patient safety
- reduce liability exposure; and
- implement practices and procedures that support a strong defense in the event of litigation.

In its generic form, risk management refers to identifying, assessing, and prioritizing risk. At ProAssurance, we go beyond simply managing risk by providing assistance and resources that help enhance your ability to provide quality patient care *and* run a successful medical practice.

While the vast majority of medical professional liability lawsuits result in no payment to the plaintiff, there often are considerable defense costs incurred. ProAssurance is committed to providing an unparalleled defense where environments allow. The lengthy process of a lawsuit can take an emotional toll; reviewing these guidelines can help you reduce your exposure to medical professional liability and its costs—both economic and non-economic.

This manual takes a medical/legal approach to reducing risk, with suggestions that are a natural accompaniment to the practice of good medicine. However, the information presented may not apply to all practice situations. We encourage you to consider our suggestions and determine whether they apply to your circumstances.

Risk Resource Guidelines exemplifies our Company's ability to blend physician knowledge and insurance expertise. You can contact our Risk Resource Advisors for personal assistance with your questions and concerns at 844-223-9648 or email RiskAdvisor@ProAssurance.com. We are committed to ensuring you are treated fairly.

Thank you for choosing ProAssurance.

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Using Your *Guidelines*

Your *Risk Resource Guidelines* is a first-stop resource for your risk questions. This handbook can help make it easier for you to meet day-to-day challenges and facilitate implementation of long-range loss prevention strategies.

While relevant for all physician offices, these *Guidelines* are not comprehensive. They are a starting point in researching risk solutions in conjunction with—not as a replacement for—personal assistance from your ProAssurance Risk Resource Advisor.

You can access an online version of these *Guidelines* at ProAssurance.com.

Please contact a ProAssurance Risk Resource Advisor for assistance with risk questions and concerns at 844-223-9648 (toll free) or email RiskAdvisor@ProAssurance.com.

NOTE:

These *Guidelines* are provided to ProAssurance clients in a number of states. Laws vary from state-to-state in their language, interpretation, application, and enforcement. The material contained in these *Guidelines* is general in nature and, while useful for all clients, specific modifications may be necessary to conform to state and local requirements.

These *Guidelines* are NOT a substitute for specific legal advice from your corporate or litigation defense attorney. Information in these *Guidelines* is not intended to be applied directly in every situation; consult your attorney for specific legal advice for your individual circumstances.

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Incident/Claim Reporting

Claims Reporting Telephone Number and Email

Please call our Claims Intake Hotline toll-free at 877-778-2524 or email ClaimsIntake@ProAssurance.com.

Having the following information and documents ready will help save you time:

- Patient or claimant name and date of birth
- Documents outlining the allegations, dates of alleged negligence, request for appearance, or subpoena
- Date the documents were received by the insured and how they were received
- A copy of the patient's medical records, if available
- The name and address of a contact person at your practice, and the best time to reach that individual

When to Contact Us

Time is of the essence. Reporting a claim or incident as soon as possible allows us the opportunity to investigate the situation while the facts are still clear. This is also in line with our proactive defense strategy. Whether you are faced with an actual legal action or suspect a claim may arise from a specific incident, notify us promptly.

Contact us immediately if:

- You receive legal papers naming you as a defendant or potential defendant;
- A patient or patient's relative demands compensation for medical services you provided;
- A patient or patient's relative makes a verbal or written threat to pursue legal action as a result of treatment you provided;
- An attorney contacts you about the care and treatment provided to a patient; or
- You receive a request for a patient's medical record from an attorney or the hospital notifies you of an attorney's request for the hospital chart on a patient you treated.

Watch for Warning Signs

Notify us of any medical incident that could potentially lead to legal proceedings or complaints. If we are aware of the incident, we can provide guidance on how best to handle the situation. We also will have a better opportunity to investigate the facts and build a solid defense for you, if necessary.

Contact us as soon as possible if:

- A patient experiences a significant or unexpected adverse outcome, even in the absence of any indication that the patient or a family member might contemplate legal action;
- You have reason to believe an act or omission in providing medical services to one of your patients may result in a claim or legal action in the future;
- A patient expresses dissatisfaction with your care and treatment or the results of the care and treatment you provided;
- An unfavorable result or complication arises from your care and treatment, whether anticipated or not;
- Another healthcare provider is involved in a legal action with one of your current or previous patients;
- You receive notice of an investigation or proceeding against you by your state licensing board; or
- A member of your staff informs you of a potential problem in treating a patient.

Communication

Good communication is integral to quality healthcare. Poor communication can occur between physician and patient, physician and staff, or physician and physician. You may have excellent clinical skills and a state-of-the-art practice; however, if communication is not a priority, you increase your risk of incurring a professional liability lawsuit.

Here are strategies to reduce your risk of litigation:

- **Be sensitive to each patient's level of knowledge.** Don't use complex terminology or oversimplify to the point of being condescending.
- **Apologize to patients who have been kept waiting.** Acknowledge your patients' time is valuable.
- **Do not avoid patients you have unintentionally angered.**
- **Do not reprimand staff in a patient's presence.**
- **Avoid criticizing current or former aspects of a patient's care in front of the patient.**
- **Project a caring and concerned attitude toward patients.**
- **Take the time to listen attentively to patients, colleagues, and staff.** Try to elicit what people are trying to tell you.
- **Concentrate and focus on the patient who is speaking to you.** Avoid negative nonverbal cues like using electronic devices or writing in the medical record while the patient is talking. If a patient feels you are not listening, they may stop providing information that could be critical.
- **Do not interrupt when patients are talking.** Even if you quickly formulate a diagnosis, wait for the patient to finish. Patients often do not start by describing their primary concern. If you interrupt early, you might miss the real reason for their visit.
- **Use written materials for better communication.** Patients may not remember everything you tell them. Provide educational materials and written instructions to reduce misunderstandings and errors. Always document in the medical record when and what type of educational materials you gave to the patient.
- **Explain your decision-making.** As much as possible, involve patients in choosing treatment options and encourage them to take responsibility. Patients who see themselves as part of their treatment team are less likely to resort to litigation when the result is not what they expect.

Communication Skills Checklist:

Use the following checklist to help ensure good communication with your patients.

Initial Contact:

- ☐ Introduce yourself by name.
- ☐ Make eye contact.
- ☐ Make physical contact (shake hand, touch arm).
- ☐ Ask the patient how they would like to be addressed. Record their preference in their chart.
- ☐ Explain what you will be doing.
- ☐ Ask the patient if he or she has any questions.
- ☐ Listen to and look at the patient. Nod your head to indicate you are actively listening if continuing to record information in the medical record.

Questioning:

- ☐ Use open-ended questions whenever possible.
- ☐ Ask questions one at a time.
- ☐ Allow the patient to respond in their own terms.

Facilitation:

- ☐ Encourage patients to continue, using phrases such as "go on."
- ☐ Use nonverbal clues to demonstrate interest, such as nodding your head.
- ☐ Paraphrase or restate what the patient has said for clarification.
- ☐ Do not interrupt the patient.
- ☐ Acknowledge and empathize with your patient's feelings: "You seem worried" or "I sense you are concerned."
- ☐ Avoid paternalistic or authoritarian statements, such as "Don't worry; you don't need to understand what this is all about."
- ☐ Use understandable lay language, avoiding technical medical terms.

Summarize:

- ☐ Conclude by summarizing what occurred during the visit.
- ☐ Tell the patient when you will expect to receive test results, if applicable.
- ☐ Verify the patient understands treatment plans or instructions.
- ☐ Develop a plan with the patient for future care, if appropriate.

Patient Complaints

Encourage patients to voice their complaints about your practice as part of your commitment to provide excellent care and service. Provide patients with a written statement that explains your commitment to exemplary service and how they may file complaints.

Key elements for handling complaints include:

- Listen. Do not interrupt or get defensive.
- Show empathy. Accept and acknowledge the patient's feelings.
- Ask questions to clarify the problem and to understand what the patient wants.
- Discuss solutions.
- Take action. Implement a solution and make it clear the patient's decision to lodge a complaint will not compromise their care.
- Keep the patient informed of your progress toward a solution.
- Provide the name and number of a person the patient can contact if they have further questions or concerns.
- Follow-up to ensure patient satisfaction.
- Document the complaint according to your practice's policy.
- If appropriate, make changes in your practice's operations to avoid future patient dissatisfaction.

It may be helpful to distribute periodic patient satisfaction surveys. Take action based on the results of those surveys as necessary.

Please see our Patient Complaint Sample Form at ProAssurance.com/SampleForms.

Disclosure of Adverse Outcomes

If an adverse event or unanticipated outcome occurs in your practice, take great care when you disclose what occurred to the patient and/or the patient's family. You want to ensure there is open, sincere, and effective communication with the patient and their family—not only to avoid a potential claim or lawsuit, but also to comply with any mandatory state disclosure laws.

When an adverse event occurs, arrange to communicate with the patient and family as soon as possible. Do not delay.

It is imperative you contact our Claims Intake Hotline as soon as an adverse event or unanticipated outcome occurs; we can then assist you in disclosure and communication with the patient and family. Call our Claims Intake Hotline toll-free at 877-778-2524 or email ClaimsIntake@ProAssurance.com.

Disclosure is a complicated medical/legal matter. Many states have "apology laws"—laws of evidence that prevent statements of apology or sympathy from being used against physicians in a lawsuit. When discussing an adverse event with a patient or family member, it may be appropriate to apologize for the fact that the incident occurred.

Do not apologize for your role in the incident or accept responsibility without first consulting ProAssurance. We can assist in conducting a complex legal analysis of your specific situation in light of your state's "apology" law and provide information for the best course of action.

A patient's request to forgive a bill as a result of an adverse event may later develop into a claim. Consult your ProAssurance Claims Specialist before granting the request; it may affect the potential defense of a medical professional liability claim.

When discussing adverse outcomes, it is important to remember today's technology makes it easy to record conversations with the push of a button on a phone, tablet, or other electronic device.

Because a recording device can be concealed in a purse or pocket, you may not know you are being recorded. Some states require the consent of only one party to record a conversation; however, a few states require consent of all involved parties. Since your consent may not be required, you should assume your disclosure conversation is being recorded. It is important to remember these recordings may be used as evidence in professional liability litigation. *Contact a ProAssurance Risk Resource Advisor (844-223-9648, option 1 or RiskAdvisor@ProAssurance.com) for questions regarding your state's recording laws.*

When communicating with the patient and family after an adverse event, follow these general guidelines:

- Plan what you intend to say and review your plan with a ProAssurance Claims Specialist, if possible.
- Consider having a fact witness present during the discussion, perhaps your nurse or one of your partners.
- Spend plenty of time with the patient and family members. Listen to their questions and answer them to the best of your ability.
- Focus on the patient, not on yourself.
- Sincerely acknowledge the patient's and/or family's suffering. Do not belittle a complication. Do not point fingers or blame other physicians or staff members.
- Do not overwhelm the patient and family with information. In complicated cases, it is best to schedule multiple conversations so they can better digest your information.
- Discuss the patient's current condition and continued treatment, as well as the event's definitive medical consequences on the patient's health (if known).
- If you do not know what happened, admit this. Then tell the patient and family you are investigating the situation and will let them know as soon as you have answers.
- Provide the patient and family with your contact information, including your cell and home phone numbers.
- Consider sending a sympathy card or flowers as appropriate.
- Remain available.

Document the discussions, but do so with care, including:

- The date, time, and location of the discussion.
- The parties and relationships of those present.
- The fact that an unanticipated outcome occurred.
- The questions asked and requests for help made by the patient and family.
- Your responses to their questions and requests.
- Your commitment to share additional information as it becomes available and to assist the patient and family.

Do not make any admissions of liability or statements of blame. Do not make any references to the cause of the outcome or any future peer review proceedings.

Hearing-Impaired, Limited English Proficiency, and Minimally Literate Patients

Effective physician-patient communication is essential to quality healthcare and preventing allegations of malpractice. Communication becomes a greater challenge, though, when a patient is hearing impaired, has limited or no English language skills, or is illiterate. Federal laws mandate physicians make reasonable accommodation for hearing-impaired and Limited English Proficiency (LEP) patients.

Perhaps more importantly, failure to accommodate these patients could have drastic consequences and lead to medical professional liability lawsuits. This section provides suggestions to help mitigate liability risks related to miscommunication with hearing-impaired, LEP, and illiterate patients.

Hearing Impaired Patients

The Americans with Disabilities Act (ADA) prohibits discrimination against hearing-impaired individuals in places of public accommodation. Under Title III of the Act, a physician's office is a place of public accommodation. Therefore, physicians must make reasonable accommodations for hearing-impaired patients.

What constitutes reasonable accommodations for a hearing-impaired patient will vary depending on the circumstances of each case. It may be different from one hearing-impaired patient to the next—ranging from something as simple as passing handwritten notes to hiring a qualified sign language interpreter.

When treating a hearing-impaired patient, it is recommended to determine the best method of communication prior to the visit if possible. There are numerous options for communicating with hearing-impaired patients, including:

- Qualified interpreters
- Note takers
- Computer-aided transcription services
- Written materials
- Drawings or pictures
- Telephone handset amplifiers
- Assistive listening systems and devices
- Telephones compatible with hearing aids
- Open and closed captioning
- Telecommunications devices for deaf persons
- Videotext displays

If your practice serves a large number of deaf patients, consider both setting aside specific blocks of time to see them and hiring an interpreter.

Ensure the methods you and your hearing-impaired patients choose for communication are accurate, effectively convey medical terminology, and maintain confidentiality. Include documentation in the medical record stating the agreed upon method of communication.

Limited English Proficiency Patients

Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, or national origin. As a result, physicians must ensure that non-English-speaking patients receive equal access to healthcare.

Take reasonable steps to ensure LEP patients have meaningful access to your medical care. The meaningful access requirement has some flexibility in how these resources are provided and depends on factors articulated by both the U.S. Department of Justice and the Department of Health and Human Services (DHHS) Office for Civil Rights. To help determine your obligations to provide meaningful access, consult the DHHS website at HHS.gov for guidelines and answers to frequently asked questions.

After establishing the need for language services, select a service, or combination of services, that best meets your office's needs and resources. There are numerous options available, including:

- **Hiring bilingual staff**
- **Using telephone or videoconference interpreting services**
- **Sharing costs of resources or services with other practices**
- **Hiring or contracting for onsite, qualified interpreters**
- **Using community volunteers**
- **Using written transcription and translation services**
- **Referring the patient to a physician better suited to communicate with them.** This option should not be your sole method of accommodating LEP patients, but it can be a good option in some cases. For example, two physicians practice in the same field and routinely make referrals to one another. If one physician has a Vietnamese-speaking assistant and the other has a Spanish-speaking assistant, they may refer Spanish-speaking and Vietnamese-speaking patients to each other to provide greater language services for patients.
- **Allowing the patient to use, but not depend solely on, family or friends to translate.** It is not uncommon for physicians to rely on patients' friends or family—including minor children—to act as ad hoc translators. While many LEP patients prefer, and may even insist on, using a friend or family member to translate for them, physicians are still responsible for ensuring effective patient communication.

  In the case of a minor child translating, he or she may lack the education or maturity level to effectively convey critical information. An adult friend or family member may be uncomfortable relaying certain information, and the patient may be less forthcoming with critical information, as well. This could lead to inaccurate or incomplete information being relayed and possibly inaccurate diagnoses or treatment.

  We encourage physicians to consider carefully the complexity of the situation. It is important for physicians to assess whether the friend or family member can understand the English and medical terminology used and that it is sufficient to convey the content of the conversation.

Again, regardless of the solution you and your LEP patients choose, you are responsible for ensuring that method:

- is accurate and effectively conveys medical terminology;
- maintains confidentiality;
- includes any necessary business associate agreements; and
- is documented in the medical record as the method used for communication.

Minimally Literate Patients

Minimally literate patients are an often overlooked impediment to quality patient care. Patients with poor literacy skills have difficulty understanding clinical options and making informed choices. They often do not follow treatment plans because they never understood the physician's instructions in the first place. They may take prescribed medications inaccurately, sometimes resulting in hospitalizations. This communication barrier can result in grave danger to patients.

An estimated one third of U.S. residents has limited ability to comprehend medical information. Medical information can be highly technical and challenging to understand for many patients. For those who have limited literacy, it can be nearly impossible unless you make efforts to recognize and address their needs.

You may be able to identify patients with poor literacy skills during check-in. Look for these clues:

- An incomplete intake form or asking a staff member or companion to complete it;
- An adult who has not graduated from high school;
- Missed appointments;
- Mishandled medication or referencing medications by color and shape;
- Claims of poor eyesight or forgotten glasses; and
- Asking a companion to read written information to them.

If you notice these signs, you may be caring for an illiterate or minimally literate patient. It is then prudent to adjust your communication style to help ensure patient understanding.

When caring for a minimally literate patient, we suggest the following strategies:

- **Avoid "medicalese."** Assume all patients have difficulty understanding medical jargon.
- **Ask questions to clarify comprehension.** Use the "teach-back method." After covering critical points, ask the patient to repeat your instructions in their own words. Ask questions such as, "I want to make sure I explained everything. So tell me—what are you going to do when you get home?"
- **Use pictures or models.** Illustrations assist patient comprehension and recall.
- **Talk to family members, too.** Once you realize a patient has poor literacy skills, enlist the aid of family members.
- **Ask the person** if they have any questions.

Time spent clarifying patient comprehension can prevent follow-up phone calls and return visits, and improve patient health.

Special Note: Regulatory Compliance

Communication recommendations in these *Guidelines* are intended to help prevent medical professional liability lawsuits arising from miscommunications with hearing impaired, LEP, or minimally literate patients. Achieving full compliance with the ADA, Title VI, and related regulations—as well as any state or local laws—is a separate legal matter. Consult your attorney for regulatory compliance assistance with those matters.

Informed Consent

Informed consent is an important risk reduction tool and helps ensure patients have realistic expectations of a treatment or procedure. The allegation of lack of informed consent is included in many claims of malpractice. A properly executed and documented informed consent process provides powerful evidence to help defeat the informed consent aspect of a plaintiff's case and weaken the remaining aspects of the claim. It also can be a strong deterrent to frivolous claims based on communication errors, misunderstandings, or unrealistic expectations of risk-free outcomes.

Laws on informed consent vary from state to state. Some states have very specific statutory rules and requirements on informed consent. Please note these *Guidelines* are general in nature; ProAssurance strongly encourages you to familiarize yourself with your state's specific informed consent requirements. As always, please call your ProAssurance Claims Intake Specialist (877-778-2524) or Risk Resource Advisor (844-223-9648) should you require assistance.

From a risk perspective, it is prudent to obtain written informed consent from all patients undergoing treatments or procedures with a significant risk of complications. To assist you in mitigating risks related to informed consent, ProAssurance offers the following analysis and strategies.

Informed Consent Process

It is the physician's responsibility to educate the patient about the proposed course of treatment—including procedures—and to discuss the associated risks, benefits, and alternatives.

It is the patient's responsibility to weigh the information and make an informed decision. Informed consent is NOT a signed form but is a process that encompasses three elements:

1. Discussion
2. Decision
3. Documentation

Informed Consent Discussion

The purpose of an informed consent discussion is to encourage questions, dialogue, and understanding—allowing the patient to make an informed decision about whether to proceed with the physician's recommendations.

Conducting the informed consent discussion is the non-delegable duty of the treating or performing physician. Even when a trained patient educator or educational videotapes are used, the process is better when the physician is involved. Provide patients with enough information to reach an informed decision. Generally, the discussion should include:

- **Diagnosis—**Explain what is known, what is suspected, and what danger it may present to the patient if left untreated.
- **Recommended Treatment—**Describe the recommended treatment and/or procedure. Be specific in explaining what it will involve (e.g., the surgery, anesthesia, duration of the procedure, and any temporary effects the patient may experience). Discuss whether the procedure is new or experimental in nature.
- **Prognosis/Risks/Benefits—**Explain the likelihood for success and disclose material risks. Be realistic. Disclose a risk if its occurrence is serious and frequent enough to affect the patient's decision, and disclose the most serious risks even if they occur infrequently. In addition to explaining the possible complications specific to the proposed procedure, also discuss the general complications that may be encountered because of the patient's physical status. Advise the patient that an imperfect result is possible, with potential consequences.

- **Alternative Treatments—**Discuss other reasonable treatment options available to the patient. Present the nature of each, the potential for success, and reasons for recommending against them and selecting the recommended treatment. Also inform the patient of the risks of refusing treatment, and suggest the patient seek a second opinion. The practice of medicine is not an exact science; the patient should understand the procedure's results are not guaranteed.
- **Terminology and Timing—**Conduct informed consent discussions in easily understood lay terminology, with ample time for questions. It is important to facilitate and document the informed consent discussion well in advance (not on the day) of the procedure or treatment.

Documentation

Document the informed consent process in the patient's medical record. Sign, date, and time the note. If handouts are provided, including instructional or educational materials, note in the patient's chart what the patient received or viewed. Your documentation does not have to include the entire content of the discussion; however, it should record that:

- An informed consent discussion occurred and included the associated risks, benefits, and alternatives;
- The patient had the opportunity to ask questions; and
- The patient understood the information provided, the possible risks, and agreed to proceed.

Why the Informed Consent Process is Necessary

The process is necessary because it is the physician's ethical and legal obligation. The benefits of conducting effective and thorough informed consent practices include:

- Patients who are more compliant with medical advice;
- Patients who feel more like a part of the team, working to achieve a common goal and less like unwilling participants in a forced, undesirable process;
- Deterring non-meritorious claims that are based on unrealistic expectations or misunderstandings;
- Strengthened physician-patient relationships, good patient rapport, and increased patient confidence in their physician; and
- Fewer lawsuits.

Take the time, every time, to discuss and document informed consent thoroughly and correctly. The benefits will outweigh what may seem, at times, a burdensome task.

Consent Form

In addition to documenting the informed consent discussion, obtaining the patient's signature on a consent form provides evidence that an informed consent discussion occurred. Consent forms should include the same elements as the discussion, written in easily understood lay language. Include an introductory paragraph describing the informed consent process and its importance. Indicate in the introductory paragraph that the patient should sign only if he or she understands the risks, benefits, and alternatives of the proposed procedure or treatment.

In some jurisdictions, state law dictates provisions that must be included in informed consent forms. Be sure to comply with your state's requirements.

Consider using procedure-specific forms that identify the most common risks and complications. However, it is helpful to provide space to list additional risks and alternatives, depending on the patient's condition. Whether procedure-specific or generic forms are used, complete the forms in their entirety. The physician should consider personally signing the consent form. Give the patient a copy of the signed and dated form, and retain a copy in the medical record. You can access sample consent forms at ProAssurance.com/SampleForms.

Informed Refusal

If a patient refuses treatment, discuss the potential consequences of their refusal. Document that you advised the patient of the risks involved in refusing treatment and note the patient's reasons for refusing treatment. Consider having the patient sign an informed refusal form; this form should indicate the treatment/procedure was explained, the risks of refusing treatment were discussed, and the patient elected to refuse. Give the patient a copy of the form. When a patient refuses treatment, encourage them to obtain a second opinion and document this discussion.

Informed Consent for Minors

Consent for treatment of a minor is generally obtained from a parent, legal guardian, or person empowered to act on the minor's behalf. This may be complicated when parents are divorced, the minor is in foster care, the minor is emancipated, or a state statute governs consent for a minor's specific treatment.

Divorced parents generally retain the right to consent for treatment of their children unless a court order denies that right. If it is unclear which divorced parent can legally consent to a minor's treatment, request a copy of the court order and maintain a copy in the minor's medical record. If a minor is in foster care, the relevant court order should cover who has the authority to consent for the minor's treatment.

Many states have laws defining minors who are competent to consent for treatment. Most states also have provisions in which competent minors may arrange for their own care involving contraceptives, pregnancy, abortion, sexually transmitted diseases, drug and alcohol abuse, psychiatric disorders, and/or HIV testing and treatment.

It is prudent to follow these guidelines regarding minors and informed consent:

- In most situations, state law requires physicians obtain parental consent.
- When parents consent to treatment, physicians should solicit the minor patient's assent (when developmentally appropriate).
- Physicians who wish to accommodate minors not accompanied by a parent or guardian may have the parent or guardian sign a written authorization that consents to treatment for a certain period of time for a specific diagnosis.
- When a minor has a serious medical emergency and the physician cannot locate a parent or legal guardian, the physician may choose to render emergency treatment immediately, and then continue to search for a parent or legal guardian.
- When a minor is legally emancipated or permitted by state law to consent to medical treatment—and there is a risk the minor will not receive care if the physician notifies a parent or legal guardian—informed consent may be obtained directly from the minor patient.
- Develop written informed consent policies and procedures for consent by minors.
- Establish a written policy and procedure for obtaining informed consent via telephone. Include a provision that two witnesses listen to the informed consent discussion, and obtain the signatures of both witnesses.
- State law may govern a minor patient's right to consent to testing or treatment. Before agreeing to test a minor without the minor's consent (e.g., when a parent or legal guardian requests drug testing), it is important to determine whether any state-specific laws apply. If a minor patient has the right to consent without the additional consent of a parent or guardian, the minor patient may need to be informed and be provided the ability to consent before any tests are performed.

Please see our Informed Consent Form and Informed Consent Checklist at ProAssurance.com/SampleForms.

Medical Records

The primary purpose of a medical record is to provide a complete and accurate description of a patient's medical history. This includes medical conditions, diagnoses, the care and treatment you provide, and the results of such treatment. A well-documented medical record reflects all clinically relevant aspects of the patient's health and serves as an effective communication vehicle about the patient's health.

The medical record also has a very important secondary function: it is the most important piece of evidence in the successful defense of a medical professional liability claim. For this reason, it is also your most vital risk reduction tool.

You can help promote good patient care and enhance the defensibility of a medical professional liability claim with the following risk tips.

Storage and Organization

- **Store medical records in an orderly fashion.** You and your staff need to be able to access patient records easily and in a timely manner. Keep all active medical records in your office. You may store inactive charts in a secure, off-site storage facility.
- **Take all necessary precautions to protect medical records—or the devices on which they are electronically stored—from damage or loss due to fire, flood, and theft.** Only remove a patient's original chart from your office or copy it to a mobile storage device when it is necessary. If the record is stolen or damaged, contact a ProAssurance Risk Resource Advisor for advice on how best to proceed (call 844-223-9648 or email RiskAdvisor@ProAssurance.com).

  With electronic medical records (EMR), patient information must be protected from unauthorized access. Determine who will have access to your EMR system and to what extent. For example, will the level of access be driven by job function? Can physicians access the records off-site? In choosing and implementing an electronic system, consult information technology specialists and legal counsel to ensure that your EMR system security complies with state and federal laws.
- **Ensure the contents of medical records are properly organized and professional in appearance.** Tabs can divide paper records as follows, with records in each category filed in chronological order: progress notes/office visits, lab reports/diagnostic test results, consultations, correspondence, hospital records, prescriptions/medications, etc. It is important to securely attach each document to the medical record.

Documentation

Good medical record documentation helps improve the quality of patient care and influences positive patient outcomes. It may prevent a lawsuit when a patient experiences a poor outcome. It also is—by far—your best defense tool when a claim is filed.

Legible, Timely, Chronological, Accurate, Thorough, Objective

Good medical documentation is:

- **Legible**, first and foremost. If you use paper records, be sure to write legibly. Printing is always acceptable. If you cannot write legibly, then dictate. Also, if you scan information into an electronic medical record system, review the information once it has been scanned for quality, including legibility. For electronic medical records, confirm that all staff members who may eventually need to interpret any part of the record are familiar with the printed format. A printout of a patient's chart may look different from the electronic version. Does the hard copy tell a logical story to a potential jury? If not, find a system that does.
- **Timely**. Contemporaneously document the care and treatment you provide. Note the date and time of every medical record you create and every entry you make in a patient's chart, understanding if and how electronic records automate this need. Authenticate each entry with your signature or initials.
- **Chronological**. Your documentation will be more easily understood when it is both sequential by date and logical in process. Use the **SOAP format** to record the patient's **Subjective** complaints, your **Objective** observations, your **Assessment**, and treatment **Plan**. Ask yourself this question: Is there a logical process presented in the record for coming to this treatment decision?
- **Accurate**. Inaccuracies can lead to miscommunication between you and the patient, you and your staff, or you and another physician, and could be problematic if you must defend your care in court.
- **Thorough**. Document everything that is meaningful to the patient's medical history and current condition, as well as your assessment and treatment plan. A good rule of thumb is the medical record contains all the information another physician would need to reconstruct the patient's pertinent medical history, gain an understanding of the patient's medical conditions, and provide further treatment.

  Many EMR systems use pick lists and drop down boxes. These convenient, time-saving features may create the temptation to cut corners instead of completing thorough medical record documentation. Ensure your system has a "free text" area to accommodate a patient's complaints, symptoms, and diagnoses that may not match choices available on your lists.
- **Specific and objective**. First, document what you see and observe in a specific and objective fashion; then add your subjective interpretations. For example, if a skin lesion is one centimeter in diameter, document that it is "one centimeter in diameter"—and not that it is a "small" skin lesion. It also is appropriate to document that, in your opinion, the lesion is "small," but it is best to include objective documentation that supports your interpretation.

Use standardized abbreviations instead of personal ones. If you are unsure whether an abbreviation is standard, consult a medical abbreviations manual. Nonstandard medication abbreviations can lead to prescription errors. A good online resource for proper medication abbreviations is available from the Institute for Safe Medication Practices at ISMP.org/Recommendations/Error-Prone-Abbreviations-List.

Document all diagnostic tests, the order date, the date you receive and interpret the results, the date you notify the patient of the results, and any follow-up needed. Initial and date all diagnostic test results when you receive and review them before they are added to the patient's medical record. Many EMR systems have built-in tracking systems for preventive health maintenance and routine reminders, as well as the ability to track the results of labs, x-rays, and other diagnostic tests. Avoid EMR systems that lack comprehensive, built-in tracking systems.

Also plan to document:

- Noncompliance with your medical advice or a prescribed treatment plan.
- Noncompliance with medications and failure to follow instructions.
- Verbal or written instructions and printed educational materials you provide.
- Food, drug, latex, and other environmental allergies. Ask patients about allergies during their initial visit and at every subsequent visit to keep information current. It is important to document patient allergies in a prominent and conspicuous place in the medical record.

Routinely update medication and problem lists at each patient visit. Keep these lists in a prominent place in the medical record for easy access and routine review.

Do not editorialize, rationalize, or make excuses. Be tactful in your choice of words. Personal remarks about a patient or a family member, self-serving statements, defensive notes, and derogatory comments about other physicians or nurses do not belong in the medical record. Similarly, do not include billing and/or collection information in a patient's medical record.

Keep billing records separate from medical records.

Corrections, Addendums, and Alterations

Take extreme caution in correcting, amending, or adding to a medical record after it has been created. Also, understand the difference between a correction, amendment, or addition and an *alteration*. Corrections, amendments, or additions involve amending or clarifying records in order to fix inaccuracies for proper patient care purposes. Alterations, however, involve modifying accurate information for selfish or fraudulent reasons. **Never alter a medical record.** Such conduct will destroy your credibility and the entire medical record's legitimacy.

Corrections

If you discover a typographical error or inaccuracy in a paper medical record, correct it by simply drawing a single line through the incorrect entry—taking care not to render the original entry unreadable—then make the correct entry next to or above it. Never write over an original entry. Never use correction fluid or tabs, or otherwise erase or render an original entry unreadable. Date, time, and initial the correction.

If you make an entry in the wrong patient's chart, draw an "X" through the misplaced note, write "entered in wrong chart," and sign and date the change.

If you discover that a page in a medical record is damaged and difficult or impossible to read, it is acceptable to create a clean copy; do keep the original in the record, however.

If you discover a typographical error or inaccuracy in an electronic medical record, make sure the system tracks the author, date, and time of the correction. If it does not, consider describing and authenticating the correction in a separate note.

Never make a correction to a medical record after a claim or lawsuit has been filed or after receiving notice that a claim or lawsuit might be filed. Correcting the record at that point will be viewed as self-serving and will severely undermine your defense.

Addendums/Additions

Occasionally, you may need to make an addendum or addition to the record to add inadvertently omitted but pertinent information, correct an inaccuracy, or clarify a previous record. If this happens, clearly note the current date and time in the next available space in the record, reference the entry as a "late entry" or as an "addendum" to the prior record, and then document the appropriate information. Do not attempt to squeeze a "late note" into the margins or into the space between the original entries.

When making an addendum in an EMR, make sure the system tracks the author, date, and time of the addendum.

Never Alter a Medical Record

Altering a medical record will destroy your credibility, cast doubt on the trustworthiness of every record and note in the chart, and severely damage your defense in the event of a medical professional liability lawsuit. Furthermore, such conduct could place your professional liability coverage at risk. **You will be caught.** It is important to emphasize that plaintiffs' attorneys use sophisticated tools, such as ink dating and handwriting analysis, to discover alterations in a paper chart; metadata allows discovery of an alteration in an electronic medical record.

In some circumstances, the difference between *correcting* an error or *clarifying* an inaccuracy and *altering* a record will be a very thin line. If you ever contemplate making a correction or clarification to a medical record and have even the slightest concern it might be perceived as an attempt to alter the record, call a ProAssurance Risk Resource Advisor (844-223-9648) or Claims Intake Specialist (877-778-2524) for guidance.

ProAssurance does not recommend or endorse EMR vendors. However, the Office of the National Coordinator for Health Information Technology's (ONC's) website, HealthIT.gov is the leading national resource on health information technology. HealthIT.gov maintains several useful resources:

- Providers can use a certification research tool, Certified HealthIT Product List at chpl.healthit.gov, to search for and compare EMR products, review certification requirements, and see which products are certified. More specifically, you can see what certification criteria and quality measures a certain product has met.
- Resources specific to EMR implementation, benefits, privacy, security, incentives, and certifications are available in the "How do I?" Providers section at HealthIT.gov/how-do-i/providers.
- ONC's SAFER Guides—a set of evidence-based guides and self-assessment tools to ensure EMR readiness and IT safety—is also available at HealthIT.gov/topic/safety/safer-guides.

Accessing EMRs on Mobile Devices

Prior to using mobile devices to access electronic medical records, it is important to:

- Decide whether mobile devices may be used to access patient information at your practice and understand the risks of doing so;
- Develop and train everyone in your organization on the policies and procedures that apply;
- Consider implementing passwords, encryption, and the ability to remotely wipe all data if a device is lost or stolen; and
- Caution employees to avoid public Wi-Fi networks, and establish a policy for proper disposal of old devices so protected health information (PHI) is not discoverable.

Some EMR companies offer a mobile device application that allows an individual to use a smartphone or tablet to connect to patient records from home. These applications often require the user to enter passwords and can track access just as the EMR does at the clinic or hospital. Check with your vendor to determine whether your mobile application—when properly used—adequately protects information.

Keep Legal Communications Separate from Patient Records

If you are involved in a claim, communications with your insurance carrier or defense attorney may be legally privileged. Those communications may not be subject to discovery in litigation. Keep these communications separate from the patient's medical record.

Retention and Destruction

A good document retention policy will help ensure patient records are readily available for the patient's treatment and use. It will also provide you with ready access in the event of a lawsuit, since the medical record will provide critical evidence in your defense.

When you are developing a document retention policy, it is important to comply with all state and federal legal, regulatory, and accreditation requirements. Specify how long your patients' medical records should be retained, where they should be stored, when and by whom they may be destroyed, and under what circumstances a particular medical record should be retained indefinitely. Address each type of record your practice generates, including medical records, billing records, appointment books, patient sign-in sheets, phone logs, etc.

Some states have statutes or regulations specifying the amount of time for medical record retention. Consult your local or state medical society for this information. In the absence of such a statute or regulation, you may wish to retain medical records for at least the period of time specified by your state's statute of limitations for medical professional liability cases (i.e., the period of time within which a patient must file a claim after the incident giving rise to the claim occurred). **A longer retention period is almost always prudent, however. In many states it may not always be clear** when the statute of limitations begins to run, and in some circumstances, it may not commence until several years after the initial incident occurred.

Following are basic record-retention guidelines:

- **For adult patients**—retain medical records for a minimum of 10 years after the last date of service;
- **For minor patients**—keep medical records until minors reach the age of majority (usually age 18) plus the period of time specified by your state's statute of limitations, or a minimum of 10 years since the last date of service (whichever is longer); and
- **Store the medical record indefinitely if**—a claim or lawsuit is actually filed, you receive notice that a claim might be filed in the future, or there was a significant or unexpected adverse outcome.

If onsite storage space becomes an issue, you can store inactive patients' records in an offsite storage facility. In addition, you can transfer inactive patients' records to electronic storage or transfer all but the last five years of information to electronic storage for active patients who have voluminous records. There also are vendors that offer electronic storage of records.

Please consider potential issues with protected health information (PHI) being stored on electronic equipment (such as copiers and fax machines) that is used in the office prior to that equipment's destruction or removal from use.

For additional references, see the American Health Information Management Association website at AHIMA.org.

Tracking Systems

Lapses in patient care or follow-up can lead to dire consequences. Substantial malpractice settlements and verdicts have been paid due to "lost" diagnostic reports and physicians' failure to review reports. When a patient misses or cancels an appointment, his or her medical condition may remain undetected or untreated. If the patient later experiences an illness or injury, he or she may attempt to hold you responsible for circumstances resulting from their inaction. Furthermore, continuity of patient care may be threatened when a patient misses or cancels a referral appointment. To prevent such lapses, and the corresponding malpractice risk they create, develop written follow-up policies and procedures that track:

- Lab and diagnostic tests
- Cancellations and no-shows
- Consultations and referrals

Lab and Diagnostic Tests

Establish a tracking system to document and follow-up on patients referred for diagnostic, imaging, or laboratory studies. An effective system will verify the:

- Test is actually performed;
- Results are reported to the office;
- Physician reviews the results;
- Physician communicates the results to the patient;
- Results are properly acted upon; and
- Results are properly filed.

Maintain the tracking system in the same manner as patient medical records, but in a central location apart from the records and accessible to all involved in the patient's care.

It is important for the physician to review, sign, and date all diagnostic test results as soon as they are available—and *before* they are filed in the record. When a patient's test results are abnormal, it is important to communicate the results and need for follow-up to the patient.

If the patient does not follow through as advised, it is prudent to make repeated efforts to encourage the patient to return—while documenting those efforts. (The number of repeated efforts will be dependent upon the seriousness of the test results.)

An effective tracking system will include a mechanism to help ensure patients return for needed follow-up appointments. It will also document that the practice took necessary action to encourage the patient to return.

It is important to follow up in a timely manner when lab results require immediate attention. Physician notification systems that alert physicians when "panic value" test results are received can help ensure timely follow-up.

Documenting all communication with patients regarding test results and any needed follow-up is also important. File copies of all correspondence regarding patient tests in the medical record and clearly document all follow-up efforts.

Cancellations and No-shows

Tracking missed or cancelled appointments will help you improve patient care and reduce liability risk. When patients miss or cancel appointments, attempt to reschedule the appointments and document your efforts. If the patient informs your office of the reason for the no-show or cancellation, document this as well. Enter all of this documentation into the patient's medical record.

Do not erase or delete an appointment when the patient cancels. Instead, indicate its cancellation by the patient.

It is prudent for the physician or allied healthcare professional (e.g., nurse practitioner or physician assistant) to review all missed or cancelled appointments. The physician's review dictates any indicated follow-up measures. Patients with more urgent conditions may require more aggressive efforts. You may wish to send a certified letter to the patient and keep a copy of the letter and the return receipt. Document all follow-up efforts in the medical record.

Consultations/Referrals

It is important to have an effective system in place to identify and track patients scheduled for referrals or consultations. When the physician recommends that a patient see a specialist for consultation or continued care, document the referral in the patient's medical record.

When the physician refers a patient for treatment or consultation, it is essential the medical record reflect the results of the referral or consultation. Include any letters or other communications between physicians in the medical record. Document any discussions with the referring or consulting physician in the medical record.

The referring physician's review of all referral and consulting physicians' correspondence is also critical. It is important this information is reviewed and signed or initialed by the referring physician before it is filed in the medical record. Note the date that the referral or consultation letters are received in writing or with a date stamp.

Document a patient's noncompliance or refusal to see the consulted physician.

Types of Tracking Systems

Tracking systems do not have to be complex or expensive; they just have to work. Many physicians use very simple and inexpensive methods, such as logbooks, card files, and appointment books. The most common tracking system is a manual logbook. Some practices—due to increasing patient volumes—implement electronic tracking systems. Further, some practices have electronic medical records systems with the capability to provide tracking.

You can access a sample tracking log at ProAssurance.com/SampleForms or by contacting a Risk Resource Advisor (844-223-9648 or RiskAdvisor@ProAssurance.com).

Additionally, there are numerous commercially available tracking systems. You can research available options through an online search using a phrase such as "physician office lab tracking systems."

Please see our Tracking and Follow-Up Log at ProAssurance.com/SampleForms.

Policy and Procedure Manual

A policy and procedure manual is an important tool for defining a practice's operations. When there are numerous procedures performed in a practice that may vary from physician to physician or between staff members, a comprehensive policy and procedure manual helps to alleviate confusion and possible errors from occurring.

It is important for staff to review and initial that they have read and are aware of the policies and procedures. It is recommended the physician (or a committee of physicians and staff members) review policies and procedures annually.

The following is a list of policies and procedures for medical office practices. This list is not all-inclusive; edit and supplement this list to suit your unique practice:

1. Clinical Protocols/Patient Care

- Telephone triage
- Medications
- Nursing assessment and documentation
- Patient education
- Informed consent
- Follow-up of diagnostic testing and referrals
- Emergency care
- Genetic testing/counseling

2. Patient Relations and Confidentiality

- Termination of care/physician-patient relationship
- Patient complaints

3. Health Information Management (Medical Records)

- Records security
- Retention, storage, and destruction of records
- Release of information/privacy of records
- Back-up and contingency plans for records
- Use of fax/email/Internet

4. Laboratory

- Specimen handling
- Panic values
- Quality controls

5. Radiology

- Use of contrast media
- Pregnancy precautions
- Radiation safety
- Release of imaging materials

6. Appointment Scheduling

- No-shows
- Cancellations
- Referrals to specialists
- Appointment reminders
- Follow-up appointments

7. Infection Control

- Autoclave use and spore testing
- Cleaning, disinfecting, and sterilizing medical equipment and devices
- OSHA Training
- Universal precautions

8. Human Resources

- Employment policies/employee handbook
- Cell phone/internet use
- Social media
- Job descriptions
- Confidentiality agreement

9. Practice Operations

- Purchasing
- Accounts receivable/payable
- Billing and collections
- Corporate compliance
- ADA
- HIPAA/HITECH

10. Special Procedures

- IV sedation
- Use of anesthesia, including local anesthesia
- Monitoring and managing patients during and after procedures

11. Safety

- Fire safety
- Emergency preparedness
- Hazardous materials

Medical Emergencies

Acute medical emergencies can occur in any setting. In an emergency, it is important to stabilize the patient and quickly arrange for further intervention. Effective emergency response involves more than just a crash cart—it requires **equipment**, **training**, and a **plan**.

Equipment

It is important to have the capability of basic life support (BLS) to respond to emergencies such as cardiac or respiratory arrest or anaphylactic shock. Equipment may include oxygen, an oxygen mask, a bag resuscitator, oral airways, and other essential equipment and drugs. If you treat children, pediatric-sized equipment and medication doses are necessary.

Several factors affect your level of response: patient demographics, location, the types of services rendered in the practice, the availability of medical resources nearby, and the level of emergency medical services in the community.

Some physicians' offices maintain advanced life support (ALS) or advanced cardiovascular life support (ACLS) equipment, which can vary from drug kits to full crash carts with defibrillation and intubation capabilities. This equipment is only as good as the skills of the staff who use it. It is important for physicians and staff who use ALS or ACLS equipment be properly trained. If pediatric ALS or ACLS equipment is in your practice, proper PALS training for physicians and staff is recommended.

If you choose to keep BLS, ALS, or ACLS equipment in your practice, check the equipment regularly to monitor accessibility, functionality, and each medication's expiration date. Maintain a log of these regular checks.

Training

BLS, ALS, or ACLS training is available from numerous sources, including most hospitals. It is prudent for all clinical staff to have at least BLS training with periodic recertification. Document training and certification in each employee's personnel file.

Emergency Plan

It is important to develop written emergency response procedures that identify basic requirements for handling an office emergency. A well-developed emergency response plan includes the following actions:

- Post a list of emergency telephone numbers by telephones and at the nurses' station.
- Educate staff on their individual responsibilities when an emergency occurs.
- Provide annual in-services from the fire department regarding fire safety principles.
- Maintain safety-related equipment, such as flashlights for power failure and visible overhead exit signs for evacuation.

Ensure staff understands when to call for local emergency assistance. In the case of a medical emergency, designate appropriate staff to begin BLS—as well as who will call 911 as soon as possible.

Conduct routine staff education on individual responsibilities when an emergency occurs; document both education and the emergency drills conducted.

Confidentiality

Written policies and procedures will help avoid the risk of a breach in patient confidentiality. To preserve patient confidentiality, it is important for all staff members to:

- Never discuss cases or patients where conversations may be overheard.
- Never leave case files, consulting reports, or any other written material regarding patients in areas where other people may inadvertently see them.
- Limit who may take medical records from a facility and under what conditions.
- Keep all patient information confidential.
- Sign a confidentiality statement as a condition of employment and annually at the time of their performance evaluations.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

In general, the HIPAA Privacy Rule ("Rule") prevents physicians and other healthcare providers from using or disclosing any protected health information unless they have obtained permission from the patient or unless the Rule allows disclosure without the patient's permission. HIPAA rules are voluminous, complex, and can be revised yearly; it is recommended that practices consult their corporate attorney to help ensure HIPAA compliance. Following is a very brief overview of HIPAA with regard to release of patient information.

Patient authorizations grant permission to release patient health information. To be considered valid, an authorization must be in plain language and include the following elements:

- Description of the information to be released;
- Name of the person or organization authorized to release the information (e.g., Dr. John Smith, Smallville Cardiology Clinic);
- Name of the person or organization to receive the information (e.g., the patient's attorney, the patient's employer);
- Purpose of the disclosure* (e.g., "at the request of the patient" is sufficient when the patient initiates the authorization);
- Expiration date or event (e.g., "end of the research study," or "at the conclusion of the subject litigation" is sufficient);
- Statement of the patient's right to revoke the authorization in writing;
- Description of how the patient may revoke the authorization and exceptions to the right to revoke;
- Statement that the physician may not condition treatment on whether the patient signs the authorizations;
- Statement acknowledging that the information may be re-disclosed by the recipient and no longer protected by the Rule;
- Signature by the patient and the date; and
- If the authorization is signed by a personal representative, a description of the representative's authority to act for the patient.

Patients can revoke authorizations at any time except when they have already been acted upon. Keep authorizations for at least six years in the event a patient requests an accounting of any disclosure of their protected health information.

**This may be prohibited by state statute.*

Access to Protected Health Information

With a few exceptions, HIPAA gives patients the right to inspect and make a copy of information maintained in their record. Practices must act on a patient's request for access within 30 days of the request (60 days if the records are kept off-site).

A reasonable, cost-based fee is allowed for copy requests. This fee may only include the costs of copying (supplies and labor) and postage. Many states have rules limiting the amount a practice may charge for copying a medical record. Be sure to review your state's rules regularly as some are adjusted annually.

When an attorney makes a request for records, have the physician review the request and the patient's records, so they can take appropriate action, including notifying a ProAssurance Claims Specialist. Establish a screening process to help ensure the physician is notified of requests for records from attorneys.

Resources

The United States Department of Health and Human Services Office for Civil Rights enforces HIPAA. Its website provides helpful HIPAA compliance information and a "frequently asked questions" page on HIPAA Privacy regulations. Access the website at HHS.gov/HIPAA/index.html.

State Patient Confidentiality Laws

HIPAA preempts state laws that are less stringent than HIPAA, but states may enact laws that are *more* stringent than HIPAA. Consult your corporate attorney to ensure compliance with HIPAA and any applicable state confidentiality laws.

Please see our Confidentiality Agreement and Patient Authorization to Release Medical Information Sample Forms at ProAssurance.com/SampleForms.

Ending the Physician-Patient Relationship

Physicians may end the physician-patient relationship for any number of reasons. Valid reasons may include (but are not limited to):

- persistent noncompliance with medical advice;
- repeated failure to keep appointments;
- combative and threatening behavior; or
- delinquent account status.

When terminating a patient from your practice, take care to avoid charges of patient abandonment. An abandonment claim is a legal action in which a patient claims the physician discharged him or her without proper advance notice and, while trying to find another physician, the patient's condition worsened, resulting in injury or death.

State laws on patient abandonment vary, and some states' laws are more specific than others. Contact a ProAssurance Risk Resource Advisor (844-223-9648 or RiskAdvisor@ProAssurance.com) for guidance on properly ending a physician-patient relationship.

Tips to avoid claims of patient abandonment include:

- Evaluate the patient's condition and render stabilizing care. Ideally, you don't want to discharge a patient who is undergoing a course of treatment for an acute condition until the treatment is finished or the condition is resolved. Before a discharge, ask yourself, "If we discharge the patient now, is it likely the patient's condition will worsen before he or she can find another physician?"
- When possible, discuss the termination and your reasons for termination with the patient. You may conduct this conversation in person or by phone. A staff member may conduct this conversation with the patient, if necessary. Document the discussion in the patient's medical record.
- Send a written confirmation of the termination to the patient via regular mail and certified mail with return receipt requested. The letter may be brief and include:
    1. a specified period of time during which you will continue to provide care. The American Medical Association generally suggests 30 days. However, you may need to provide more (or less) time depending on the circumstances and the availability in your area of another physician in your same specialty;
    2. a reminder that the patient's medical condition requires care and the patient should find another physician immediately;
    3. contact information for a medical referral service. Many state and local medical societies have such services; and
    4. how the patient may obtain a copy of his or her medical record.
- Personally sign the termination letter and place a copy in the patient's medical record. You can access sample letters at ProAssurance.com/SampleForms, or contact a Risk Resource Advisor (844-223-9648 or RiskAdvisor@ProAssurance.com).

Additional Considerations

Consult your third party payor and managed care contracts before terminating a patient to determine if there are additional requirements for discharging covered patients. Take extreme care when terminating a patient with a disability. Ensure your stated reason for terminating a disabled patient is "disability neutral," (i.e., the reason for ending the relationship cannot be due to the patient's disability).

If the patient terminates the relationship, consider writing a termination letter to the patient to acknowledge the decision made by the patient.

Please see our Withdrawal of Care or Termination Letter at ProAssurance.com/SampleForms.

Closing/Selling a Practice, Changing Practice Locations, and Retirement

There are several risk issues that arise when you sell a practice, change practice locations, or retire. From a malpractice standpoint, your most important responsibilities are to:

- **Notify** your patients in advance to help ensure continuity of care and avoid potential abandonment claims.
- **Safeguard** the integrity of your medical records and the confidentiality of your patients' health information by making appropriate arrangements for custodianship of their medical records.

The risk tips below can help make your transition as seamless as possible. The extent to which you address each issue below will depend on the nature of your practice.

Notify Your Patients

Provide at least 60 to 90 days written notice by mail to each active patient's last known address. You do not have to notify inactive patients, patients properly discharged from the practice, patients who have moved from the community or transferred their care to another physician, or those you have not seen for several years. Some states have statutory requirements dictating notification requirements for a physician closing a practice or retiring.

If you are leaving or retiring from group practice, the remaining physicians in the practice will probably assume the care of most or all of your patients. Tell your patients they can remain with the same practice and simply switch to another physician in the group. In addition, tell patients they are free to establish a new physician relationship outside of the group and encourage them to do this as soon as possible if they so desire.

If you are retiring and selling a solo practice to another physician who will assume care of your patients, tell your patients the name of the new physician who is willing to continue their care. Similarly, if you are retiring and closing a solo practice and have arranged for another physician in the area to assume care of your patients, tell your patients the physician's name and location. Again, advise patients they are free to choose a different physician if they wish and encourage them to do so as soon as possible.

Finally, if you are moving, closing, or retiring from a solo practice and have not arranged for another physician in your area to assume care of your patients, encourage patients to establish a new physician relationship as soon as possible. You may refer patients to the local or state medical society for a listing of qualified physicians in the area.

Explain to patients how the custody of their medical records is being handled. Encourage them to contact you or your office immediately if they wish to make different arrangements. Do not release an original chart to a patient; offer to provide a copy of their records, instead.

Include a statement in your written notice that upon receipt of proper authorization from the patient (or the patient's legally authorized representative), your office will provide a copy of the patient's medical record to the physician of the patient's choice. Consider enclosing an authorization with your notice to the patient.

Finally, retain a list of patients who have been notified and the date of notification.

You can access the Closing a Practice Toolkit at ProAssurance.com, or contact a Risk Resource Advisor (844-223-9648 or RiskAdvisor@ProAssurance.com) for assistance.

Provide for Proper Custody of Your Patients' Medical Records

As the treating physician, you are the custodian of your patients' medical records. You are responsible for maintaining the medical records in a safe, secure, and confidential manner. These obligations do not cease when you close or retire from practice. You may maintain records in one of several ways, including:

- If you are moving or retiring from a group practice, leave your patients' charts in the custody of the practice;
- If you are selling a practice to another physician, transfer patients' charts to the purchasing physician's custody;
- If you are closing or retiring from a solo practice, arrange with another physician to assume care of your patients and their charts; or
- Maintain custody of your patients' charts yourself and/or with the assistance of a records storage service.

Before making any of the above arrangements, obtain legal and risk reduction advice for your specific situation. In addition, consult your state licensing board or medical association for specific requirements.

The American Health Information Management Association's website, AHIMA.org, also provides excellent resources.

Please see our Closing a Practice Toolkit at ProAssurance.com/SampleForms.

Office Staff

Your staff is a critical component in reducing your risk for malpractice claims. Properly trained and educated staff members are strong protection against a medical professional liability claim and contribute greatly to the success of a practice. This section includes risk tips for office staff issues.

- Prepare written job descriptions for all staff. Ensure each staff member reviews their job description, and address the job description at each annual performance evaluation.
- Make certain each staff member works within the boundaries of state laws regarding appropriate job functions.
- Provide staff clear instructions on the amount and type of advice they may relay to patients and limitations on such advice.
- Establish a formal orientation period for new employees. Include a review of administrative practices, emergency medical procedures, and clinical skills and responsibilities.
- Develop procedures to ensure professional staff are credentialed and re-credentialed.
- Educate employees on patient confidentiality and security for protected health information (PHI), including the need to protect ePHI from cyberattacks.
- Employees should sign a confidentiality agreement upon hire and annually.
- Document employee training to include clinical competency, credentialing, performance evaluations, and annual reviews in employees' personnel files.
- Hold regular staff meetings with designated agendas.
- Sign in sheets may help document attendance where necessary.
- Provide frequent feedback (both positive and negative) to staff.
- Ensure tasks are delegated to staff with the appropriate education, training, and experience to perform the task.

Please see our Employee (Unlicensed) Skills Checklist and Employee (Licensed) Competency Skills Checklist at ProAssurance.com/SampleForms.

Telephone Procedures

Your office telephone is a powerful form of communication. It is important that friendly staff who are competent are available to address callers' requests.

Try not to keep callers on hold for more than one minute. If a lengthier wait is unavoidable, it is common courtesy for your receptionist to ask the caller if they are willing to continue holding.

Faulty telephone procedures can lead to professional liability risk. Information provided over the phone, but not documented, can be used against you by a plaintiff's attorney. If telephone conversations regarding patient care and treatment go undocumented, this may create problems or even errors when other healthcare professionals review the medical records for subsequent care and treatment purposes. Additionally, many medical professional liability lawsuits have occurred due to a failure to review the patient's medical record prior to providing advice over the telephone.

Your practice's telephone procedures are an important risk reduction tool. Consider the following when establishing telephone procedures:

- Document all medically relevant telephone conversations, including after-hours calls. At a minimum, document the following in the patient's medical record:
  - the date and time of the call;
  - the person handling the call;
  - the patient's complaint and symptoms;
  - any medical advice given, including final disposition; and
  - any medications prescribed or refilled.
- If you use an answering service, obtain a list of all calls from the service and promptly document the calls in patients' medical records.
- Develop written telephone triage protocols that address frequently asked questions. Describe complaints that require immediate attention and parameters to determine if an office visit or other action is necessary.
- Develop written protocols for the renewal of prescriptions via telephone. Specify which drugs may be renewed and the number of prescription refills allowed before the patient needs a follow-up evaluation.
- Prior to providing any medical advice over the telephone, have the physician or healthcare professional review the patient's medical record.
- Thoroughly document telephone calls between physicians regarding patient care.

Periodic review of turnaround times for phone calls as a quality improvement component is advised. Patient complaints regarding call backs may be reduced or eliminated, improving patient satisfaction scores.

Please see our Telephone Triage Guidelines at ProAssurance.com/SampleForms.

Texting, Emailing, and Social Media Communications

Electronic communications pose specific challenges. Ideally, you ensure communications containing protected health information (PHI) meet HIPAA's security and privacy requirements. The careful healthcare provider also documents in the patient's medical record any treatment decision for which transmitted information was used. From a practical standpoint, getting data from a mobile device into the medical record can be difficult.

From a risk perspective, it is important for all communications with PHI to comply with HIPAA's privacy and security requirements. Document information that is used to make treatment decisions in the patient's chart, regardless of how it was received.

Alternatively, you may decide to reduce risk by prohibiting the use of email and texting services in providing patient care.

Texting, Emailing, and Social Media

Communicating via text and email is a trickier topic, as plain texting and emailing are unsecured communications. These messages travel through servers over which healthcare providers have no control. Texts and email can be hacked or seen by a party who, innocently or not, looks at a provider's phone or tablet.

Therefore, take precautions before PHI is texted or emailed—including when accessing your EMR system through a special application (app) installed on mobile devices. Using a secure app associated with your EMR is likely the safest and easiest way to ensure your texts and email remain private and secure and reach the appropriate patient's medical record.

Social media can be a useful marketing tool. Physicians should create guidelines to ensure HIPAA privacy to educate staff members on other professional liability risks associated with social media.

The use of cameras on personal electronic devices and the ease of uploading the images to social media have increased the risks of inappropriate picture taking. Establish policies for storage and retention of photographs and other images in the patient's medical record. Ensure that policies address camera use by patients, employees, and medical staff.

The Problem of Documentation

Some EMRs do not offer text or email apps and, therefore, some providers use apps that are separate from their medical record system. When considering whether to use such an application, keep in mind that documenting the communication in the patient record will be more difficult if the app does not automatically interact with the EMR. The practice will have to develop a policy and system to ensure that texted communications that would ordinarily be made part of the chart are documented and do not slip through the cracks.

Telemedicine and Professional Liability

Telemedicine is generally defined as the delivery of healthcare at a distance, while telehealth refers to the delivery of health related education using technology. Knowing your state's specific definitions will help you comply with applicable law. In determining best practices, ensure your methods measure technical capacity, diagnostic accuracy, and evaluate therapeutic impact. Establishing guidelines safeguard patient well-being and help reduce risk while delivering care.

Telemedicine Guidelines

- Embrace privacy and confidentiality, help maintain quality safeguards, and apply parameters including limitations posed by the technology used.
- Develop processes to coordinate with other telemedicine professionals to allow for the best possible care.
- Instruct healthcare professionals to chronicle all medical advice and decisions within the medical record.

Liability Considerations

- Review your insurance policy before assuming you have telemedicine coverage.
- Some states allow the practice of telemedicine across state lines without additional licensure, but some consider this practicing medicine without a license. Remain up-to-date on the laws of your home state and those of your patient's state.
- Technology can interrupt the continuity of care. If your treatment of the patient will be limited in nature, consider how you will share information concerning your treatment of the patient with the patient's primary care physician.
- Consolidate all communications in a unified patient record.
- Time lapses in documentation increase risk; therefore, update the medical record in a timely fashion.
- If a physical examination of the patient is required to meet the standard of care, decline to treat the patient remotely.
- Develop informed consent guidelines specific to telemedicine.

Please see our Telemedicine and Professional Liability Video Series at ProAssurance.com/Telemed.

Billing and Collection

Fee disputes and collection actions can be prime triggering mechanisms for dissatisfied patients to file a medical professional liability claim.

Sometimes when patients complain about their bill, they are actually angry or dissatisfied with the physician. It is helpful for employees who handle billing questions to receive training in responding to upset or angry patients. Such training will help ensure they are sensitive to patients' potential underlying dissatisfaction, respond accordingly, and have appropriate tools for documenting patient complaints. Develop procedures to help ensure any complaints regarding a physician are brought to the physician's attention.

Following are tips for billing and collection practices:

- Discuss fees with patients in advance of treatment to deter disputes and misunderstandings.
- When unusual circumstances occur, involve the physician in billing and collection decisions.
- Have the physician review patient records before they are sent to a collection agency.
- Do not place correspondence regarding billing and collection in the patient's medical record.

Physicians often forgive bills when patients experience unanticipated results or unsatisfactory outcomes or treatments. Some patients will refrain from bringing a malpractice action once their bills are waived. However, there is no guarantee these patients will not bring claims. If they do, such refunds or waivers may be viewed as evidence of medical negligence. For these reasons, it is important that you *contact your ProAssurance Claims Specialist (877-778-2524 or ClaimsIntake@ProAssurance.com) before granting any refunds, fee reductions, or waivers for patients who are dissatisfied with medical care.*

Scheduling

Lengthy waiting times can cause patient frustration and may lead to deterioration of the physician-patient relationship.

When the physician is running late, inform patients and give them an opportunity to reschedule (when appropriate). Apologize to patients if they have been kept waiting—this shows you respect your patients' time.

Periodic review of scheduling practices as a component of quality improvement is suggested. Trends may be identified sooner thus avoiding patient complaints and improving patient satisfaction.

Medications

Prescriptions require authorization by a physician or another properly licensed and duly authorized practitioner. The responsibility for the prescription remains with the treating physician when staff phone in prescriptions. It is important to safeguard medications and prescription pads, taking care to ensure they are not accessible to unauthorized individuals.

Medication reconciliation is a safety strategy that compares the list your practice prescribes with the list of medications the patient is currently taking prescribed by other physicians. This process is important to avoid medication errors such as omissions, duplication, dosing, and drug interactions. Physicians should also assess for the use of herbal preparations, vitamins, nutritional supplements, and over-the-counter drugs. Document the discussion of potential side effects of the medication(s) with your patient.

Following are tips to help limit medical professional liability risks related to medications and prescriptions:

- Develop written protocols for staff when ordering or refilling medications.
- Create a standing physician order authorizing the drugs that may be renewed by nurses if your state regulations allow nurses to authorize routine maintenance medication without a direct physician order. Standing orders should list the drugs by name, dosage, frequency, and number of refills allowed.
- Document all prescription refills in the medical record. Include the date, drug name, dosage, amount, and number of refills, followed by the signature of the individual authorizing the refill.
- Keep prescription pads in a locked drawer or other safe area not visible to patients.
- Do not presign prescription pads.
- Keep drug samples and other in-house medications in a central, secure area.
- Provide written instructions to patients receiving sample medications, and document these instructions.
- Document in the medical record when patients receive sample medication(s).
- Document any alternative therapies, such as exercise, physical and behavioral therapy, and response to therapy for patients with chronic pain.
- The Centers for Disease Control and Prevention (CDC) provide guidance to physicians for safe prescribing of opioids. These measures include prescribing the lowest effective dose for the shortest time period, avoiding or delaying prescribing opioids for chronic pain, scheduling regular follow-up, and establishing an opioid agreement/contract. The patient also has responsibilities as part of the agreement, such as seeing only one physician, using only one pharmacy, and submitting to periodic urine screens and pill counts. Document in the medical record that any violation of agreement terms may prompt termination of opioid therapy.

Please see our Medication Education Form for Patients, Medication Refill Guidelines, and Medication Refill Log at ProAssurance.com/SampleForms.

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