

# 8-Point Practice-Saving CHECKLIST

***What Every Physician Needs To Know About Protecting Themselves From A Lawsuit***

We'd all like to believe that lawsuits only arise from major mistakes ... gross examples of negligence or incompetence. But malpractice statistics paint a much different picture. The truth is: medical malpractice cases often stem from simple oversights and common errors.

Now you can quickly pinpoint your practice's malpractice weaknesses with this convenient "Practice-Saving Checklist." It's an easy guideline to help you evaluate your current procedures ... and implement simple solutions to dramatically lower your risk of a lawsuit.

**1 Do you have a standard procedure for evaluating new patients?...**  YES  NO **ACTION REQUIRED**

The simple step of having standardized forms helps you avoid the potential risk of missing information when you begin treating any new patient. It's important to obtain critical health history details and capture the findings from your physical examination on your intake and evaluation forms. It's also important to keep financial records and clinical information separate in your patient folder.

**2 Do you use written letters of notification when deciding not to treat a patient?.....**  YES  NO **ACTION REQUIRED**

If you decide not to treat a new patient or to discontinue treatment of a current patient, proper documentation of your decision can reduce your risk of later claims, alleging a doctor-patient relationship still existed. Your notification letter to the former patient should outline the reasons why you will no longer be involved in that person's care. In addition, any health care concerns should be highlighted while clearly stating that you will not be responsible for treatment of that patient after the reasonable time frame suggested in your letter. The letter should be sent by certified mail with return receipt.

**3 Do you consistently create patient records *at the time* of treatment?.....**  YES  NO **ACTION REQUIRED**

Experts generally point to patient records as one of the most common weaknesses in today's busy practices. Failure to consistently document patient visits can become a red flag during a malpractice proceeding. Patient paperwork should be considered an integral part of patient care with time set aside to complete the task at the time of treatment. The same attention to detail should be demonstrated in your records and patient visits.

**4 Do you review patient records before treatment?.....**  YES  NO **ACTION REQUIRED**

Providing quality care to your patients includes being "up to speed" on past care and exam findings. Patient records should contain subjective statements regarding whether a patient is getting better or worse, new complaints and any contraindications of further treatment. Reviewing this information BEFORE every patient visit helps you provide top quality care for your patients.

**5 Do you regularly use informed consent forms?.....**  YES  NO **ACTION REQUIRED**

Informed consent is more than getting a patient's signature on a form. It's a process of educating your patient. Before any treatment protocol is implemented, your patient should always understand the following: (1) the nature of the treatment, (2) all material risks for the treatment, (3) the possibility of risk, (4) alternative treatments available and associated risks, and (5) consequences of going untreated. Your patient's signature on an informed consent form simply serves as documentation that you've done a thorough job of educating your patient.

**6 Are new procedures closely monitored when implemented in your practice? .....**  YES  NO **ACTION REQUIRED**

It's crucial for all members of your practice to approach the use of new procedures carefully. Many times, practitioners learn new procedures at a seminar and then try that new procedure on a patient shortly after returning to work. Extreme caution should be used until each new procedure has been validated or is taught in accredited colleges or post graduate continuing education.

**7 Does your bedside manner put patients at ease?.....**  YES  NO **ACTION REQUIRED**

Bedside manner counts – even to the point that doctors who are considered “warm” and “friendly” may be less likely than their aloof counterparts to face lawsuits. Simply put, if a person likes you, that person is less likely to sue you. It's much easier to initiate legal action against someone you don't like or don't really know. Many malpractice suits stem from patient dissatisfaction and breakdowns in communication.

**8 Do you have a standard procedure for billing – including standardized collection letters?.....**  YES  NO **ACTION REQUIRED**

Many malpractice experts point to direct or indirect disagreements over billing practices as a major source of malpractice claims. Effective billing and collection procedures can help you avoid the risk of this type of claim – while also avoiding patient misunderstandings that can sour valuable relationships.

**What if a patient sues you?**

Your reaction in the event you're served a summons or receive some other notice of a pending lawsuit or potential claim can make a big difference in the success of your defense. Most importantly, notify your malpractice company immediately. Their malpractice experts should assume responsibility for handling your case and can help advise you of your next steps.

It's also important to keep the following rules of thumb in mind:

- **Do not change or alter medical records in any way.** When facing a potential claim, it can be tempting to add information and document items you originally omitted. Do not make changes or additions to the record. First, changing records is illegal in many states. Secondly, experts could later scrutinize records to determine which notes existed originally and which were added at a later date. Finally, if it's determined that your records were altered, a jury will probably question your honesty and integrity – regardless of your good intentions. **It's always better to have an incomplete record than to alter your records and violate a jury's trust.**
- **Do not offer to pay expenses.** Many times, offering payment is misread as admitting wrongdoing.
- **Do not have “off the record” discussions with allegedly injured patients.** These conversations generally end negatively. In fact, an “off the record” discussion can easily be taken out of context and be used against you during a lawsuit.
- **Do not admit wrongdoing or negligence.** If a patient voices a complaint about treatment, listen compassionately and exercise good bedside manners – but under no circumstances admit to causing an injury. It's important to contact your malpractice company immediately before discussions like this.

*The “8-Point Practice-Saving Checklist: What Every Physician Needs To Know About Protecting Themselves From A Lawsuit” was created at the request of the PSIG Malpractice Program. The accompanying text is offered solely for general information and educational purposes. It is not offered as, nor does it constitute, legal advice or opinion. You should not act or rely upon this information without seeking the advice of an attorney.*