RISK MANAGEMENT AND PREVENTION

The **Department of Insurance and Claims Management** was established to administer the UAMS physician's liability program. The primary responsibility of the Department of Insurance and Claims Management is to reduce the risk of claims and lawsuits involving UAMS faculty and staff. In reality, there is no way to totally eliminate the possibility of a suit but there are many things you can do which will substantially improve the chance of successful defense in the event you are sued. Your cooperation and support is essential for a successful risk management program.

It is impossible to provide a complete discussion on any given topic contained in this manual but this guide will provide you with a handy reference to many issues associated with our program and your practice of medicine. The Insurance and Claims Management staff is available for consultation on any of the issues contained in this guide. In addition, the staff is available to give presentations on any issue that may be of interest to you or your department.

Our office hours are 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is 614-2082 and there is voicemail service in the event we are out of the office or you call after normal office hours. In addition, most of the faculty members have our cell phone number in the event the situation demands immediate attention at times other than during normal office hours.

Risk Management

Risk management is an effort designed to reduce the potential of malpractice claims while maintaining the provision of high quality patient care. Risk management differs from defensive medicine in that it is not just a set of strategies for preventing claims; it works in the best interest of the patient and the provider. Risk management stresses good rapport and communication between the provider and the patient, good documentation of the communication, obtaining informed consent, and reporting problems to the Insurance and Claims Management Department.

You have the responsibility of reviewing and following your own department's policies, procedures, and protocols as well as those of the University Medical Center. Unfamiliarity with these policies can create liability situations and is not an excuse for failure to comply with the approved policies of the department or institution.

Risk identification and analysis is performed through patient complaints, sentinel events, medical record and request reviews, and reports from clinical departments. Loss prevention involves continuous educational and orientation programs for medical staff, residents, students and nursing; policy review and development; compliance with local, state and federal regulatory risk management requirements and Joint Commission risk management related standards; support to Corporate Compliance Officer; participation in committees; development of mechanisms to assist patient and families following an adverse event; response to patient/family complaints and support to the medical staff.

COMMUNICATON

An open line of communication between the patient and health care provider is a key factor in reducing lawsuits. Studies have shown that patients who have good rapport with their physicians file fewer lawsuits. The basic premise is that people generally do not sue friends or those who they trust and respect.

The health care provider who communicates effectively with his/her patient is less likely to produce the kind of surprise that sparks most lawsuits. A patient is inclined to forgive mistakes made by someone who clearly demonstrates an earnest concern for their well-being. In addition to effective verbal communication with the patient, the physician must also document effectively. What the physician communicates into the medical records will stand as testimony if his/her actions are later contested.

From a risk management standpoint, one way to think of "care and treatment" is that medical *treatment* is what the physician does for a disease…medical *care* is what the physician does for the patient. A major step toward the prevention of malpractice suits begins with the realization that a patient expects care, not just treatment…and care requires communication.

CONFIDENTIALITY

The information disclosed to a physician during the course of the relationship between the patient and the physician should be held confidential to the greatest extent possible. The physician should never reveal confidential communications or records without the express consent of the patient. Confidentiality is a term we usually use to express protection of information or records but it means so much more.

Examinations must be humane, discreet, reasonable, and decent, exposing only the body parts under examination. If sensitive areas of the patient's body need to be examined, it is suggested that you explain to the patient the purpose and extent of your examination and have a chaperone present during such examinations. Access to a patient's body or medical information must be limited to the primary health care team involved in the care and treatment of the patient. This information or access may be granted to others, such as consultants, medical students, and chaplains, with the patient's express consent.

Practices such as examining patients in the presence of unidentified students and others and/or discussing the care and treatment of a patient with parties not directly involved in the care and treatment of the patient should not be permitted unless the patient has been informed and consent obtained.

There are situations in which medical information and records are released to non-health care providers without the necessity of obtaining the patient's authorization. This includes release to government agencies, the health department, and insurance companies who pay for services rendered. If there is any doubt about whether or not to release information or medical records, you should contact the Insurance and Claims Management Department or the Medical Records Department prior to releasing the information in question.

One final note on confidentiality focuses on a situation somewhat unique to teaching facilities. In most hospitals, a patient has one primary treating physicians, the various nurses, and perhaps a consultant or two. At UAMS, the patient not only has the primary treating physician and the nurses but also has a host of residents and medical students involved to some extent. It is part of the training process for physicians, residents, and students to discuss the patient's condition and treatment options, however, many times these discussions take place in hospital corridors, elevators, and other public places. Every health care provider must remain alert to their surroundings and avoid breaching confidentiality inadvertently in public places. Hallways, elevators and cafeterias are not the best place to discuss a patient's condition, course of treatment, prognosis, test results, etc.

DOCUMENTATION

The patient's medical record always becomes a focal point anytime there is a question regarding the care and treatment rendered. It is important that the medical record be kept accurately and timely.

The medical record serves three primary purposes: 1) to insure quality patient care; 2) to provide documentary evidence of the patient's course of illness and treatment; and 3) to facilitate review.

One often thinks of the medical record as a means of protecting the hospital or providing a defense in a medical malpractice action. However, the purpose of the medical record is not to protect or to provide a defense. The purpose of the medical record, as it pertains to risk management, is to *preserve the truth.* In reality, a complete and accurate medical record will protect the legal interests of the patient, the hospital, and the responsible practitioner. The medical record will provide a justifiable defense if one exists or will indict the responsible party if there is no justifiable defense. A properly kept medical record can serve as the physician's best friend while an improperly maintained record may well prove to be the physician's worst enemy.

What Should Be Documented in the Medical Record?

There are no clearly defined guidelines as to what should or should not be documented in the medical record, however, for guidance with documentation, you should review UAMS Medical Center policy ML.2.07. There are, however, certain minimum requirements on what generic information should be documented. These include:

1. identification data
2. medical history
3. physical examinations
4. diagnostic and therapeutic orders
5. appropriate consent
6. clinical observations
7. reports of procedures
8. results of tests
9. conclusions at the termination of care

It is recommended that in addition to these minimum requirements, other significant items should become part of the medical record. Keep in mind the old adage "If it hasn't been documented, it hasn't been done." With this in mind, anything related to the care and treatment of a patient or the patient's conditions that the physician considers or does during the course of treatment should be documented. It should be pointed out that the obligation to document the treatment rendered and the patient's response to the treatment is a positive one rather than a negative one. In other words, only acts of commission should be documented, not acts of omission.

For example, if a unit is understaffed on a given day and appropriate care could not be rendered to all patients, it would be inappropriate to record "All primary care was not rendered due to 1:12 nurse ratio." The absence of documented care would establish what was and was not done and there is no need to highlight what was not done by making a blatant entry.

Often, a patient's degree of mobility, appetite, orientation, mental attitude, and degree of independence will influence the scope of care being rendered. For this reason, it is important that the physician record what he or she *sees, hears, smells, and feels.*

Examples:

1. Sees- bleeding, pallor, deformities, drainage, urine color, etc.
2. Hears- patient complaints, moaning, breath sounds, etc.
3. Smells- alcohol on patient's breath, malodorous drainage, fecal odor, vomitus, acetone breath, etc.
4. Feels- motion at fracture site, firm, hot, area of induration, crepitus of subcutaneous emphysema, etc.

Inappropriate Entries

As stated above, items specifically related to the care and treatment of the patient should be documented. The corollary to this is that items not related to the care and treatment of the patient should not be included in the patient's medical record. Some examples include "editorial comments" that are inappropriate for the patient's chart including the treating physician's personal feelings about the patient. Criticisms, witticisms, and derogatory or indiscreet remarks should never be placed in the medical record.

When situations arise that may give concern about the quality of care or risk management issues, the physician is encouraged to contact the Insurance and Claims Management Department; the Office of General Counsel, or the Patient Safety Department to discuss events that give rise to a concern. However, such contacts with the Insurance and Claims Management Department, legal counsel, hospital administration, or others should never be noted in the patient's medical record. If the physician feels compelled to document such contact, the note should be made somewhere other than in the patient's medical record.

Documenting Complications or Mishaps

Medication errors, conflicts with doctors' orders, unexpected outcomes, and complications occur from time to time even with efforts to provide the best of care. It is important that these events be documented and addressed in the medical record.

Entries in the medical record that address these types of events should be made in a factual manner without being judgmental or placing blame. Keep the entry objective and describe the event, the evaluation of the patient following the event, and whether or not the event resulted in any injury to the patient. If there was some injury to the patient, the documentation should describe the injury and what course of treatment will be followed to address the injury. The complication or injury should be addressed in subsequent notes until it is resolved. If the event did not result in an injury to the patient, this should also be included in the note. Again, the physician should be careful not to contribute their own judgmental comments, witticisms, or other prejudicial remarks.

Late Entries or Addendum

The patient's medical history, clinical record, order sheet, and discharge summary are usually accomplished in a sequential manner. These notes should contain relevant observations and information regarding the patient's condition and course of treatment.

The contemporaneous entry of information in the medical record is important. In some situations, such as the emergency room, time data may be entered after the fact and could vary several minutes from the actual time of the occurrence. This is, perhaps, unavoidable in the ER but for most physicians, there is opportunity to document contemporaneously. The greater the delay between the procedure itself and the dictation of the report or entry of the note, the greater the risk that the lapse of time will adversely effect the credibility of the report. Every effort should be made to avoid "late" entries of this nature.

Upon occasion, however, the physician may feel that he or she does not have adequate time, while on the job, to write a thorough and detailed note as to all that took place in reference to the care and treatment of a patient during a specific visit. If time does not permit complete documentation contemporaneous with the event or treatment, the physician should write a supplement to the medical record as soon as possible and attach it to the original record rather than maintaining personal notes.

If a late entry or addendum to an entry must be developed, it is important to note the entry as "Late Entry" or "Addendum". The note should be dated and timed and, as noted, indicate that the note is a late entry or addendum to an earlier note.

When an event occurs that the physician feels may give rise to some legal exposure, he or she is inclined to maintain his or her own personal notes which elaborate upon the medical record. Since malpractice cases are often initiated and pursued after many months or years have passed from the time the care and treatment was rendered, personal notes are invaluable to refresh memories but it should also be recognized that the need for personal notes belie the completeness of the medical record. Personal notes are not protected from discovery and may have to be turned over to the plaintiff attorney upon request. Keep the note factual and objective. Do not impose your personal judgment or lay blame. Simply write enough to refresh your memory in the event you are asked to recall details.

Errors in the Medical Record

Errors inevitably occur in any medical record. They may be minor errors in transcription, inadvertently omitted test results, physicians' orders, other information omitted, or deliberate falsifications.

Deliberate falsifications must be avoided at all costs. Deliberate falsifications lead to allegations of a cover up which will, at best, create a prima facie case of negligence and have severe negative impact on the healthcare provider's credibility.

Effort should be made to avoid other types of errors. However, in the event an error occurs, they can be corrected legally by following the following procedure:

1. the person who made the incorrect entry should make the correction and initial the correction;
2. the person making the change should enter the date and time of the correction; and
3. *the original entry should not be deleted, obliterated or erased.*

As you document, keep in mind that the only thing that belongs in the medical record is information about the condition and the care and treatment of the patient. Any letter to or from attorneys, variance reports, communications with Quality Assurance, General Counsel, Patient Safety or Insurance and Claims Management have nothing to do with the care and treatment of the patient and do not, therefore, need to become a part of the patient's chart.

INFORMED CONSENT

As the name implies, the purpose of the doctrine of informed consent is to give the patient sufficient information so that the patient can make a knowledgeable and informed decision about the proposed treatment or procedure. Because the doctrine of informed consent is based on the law of negligence, the physician's duty is greater than simply speaking at the patient's request or responding to patient's questions. The physician has a duty to volunteer the information needed by the patient that will allow the patient to make an informed decision.

Health care providers have a legal duty to abide by the treatment decisions made by their patients unless a compelling state interest exists. If a patient's consent is to be considered informed, it must adequately address information, competency, and voluntariness. Each of these elements must be adequately met or the consent given will not be valid.

Loosely defined, consent is permission, agreement, and acceptance as to opinion or course of action. It is an act of reason, accompanied with deliberation, the mind weighing as in a balance the good or evil on each side. It is an act unclouded by fraud, duress, or sometimes even a mistake. There are several different kinds of consent. There is implied consent, consent in an emergency, express consent, etc. We will focus on express consent since this is usually the type of consent we refer to when we discuss *informed* consent.

Who Can Consent

Competent Adults: A competent adult may give, withhold, or revoke consent for himself. *Any patient may refuse to give consent to treatment for himself or herself.* A spouse may not give, withhold, or revoke consent for the competent patient unless legally authorized to act on behalf of the patient.

Incompetent Adults: An incompetent adult may not give consent for himself. There are exceptions to this general rule but the exceptions are so rare that they will not be discussed in this manual. Insurance and Claims Management or the Office of General Counsel should be consulted prior to proceeding with care and treatment on a patient of unsound mind when substituted consent from one legally authorized to give such consent is unable to be obtained.

Minors: In Arkansas, a minor is a person under the age of eighteen (18) years. A minor may not give, withhold, or revoke consent for himself *except under certain circumstances.* As a general rule, a physician must obtain consent of a parent or guardian before proceeding with non-emergency treatment.

There are, however, certain circumstances under which a minor may consent to treatment without parental consent. A minor may consent to treatment for himself/herself if:

1. the minor is married (this does not include divorced or widowed minors if they are living with their parents); or

2. the minor is emancipated (for purposes of consent, an emancipated minor is one who does not live with or receive financial support from their parents); or
3. the minor is seeking treatment for a venereal disease or birth control; or
4. the minor is seeking treatment in connection with pregnancy or childbirth (this does not include the unnatural interruption of the pregnancy); or
5. the minor is incarcerated in the Department of Correction or the Department of Community Punishment; or
6. the minor is unemancipated but is deemed by the physician to be of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedure.

As a general rule, the following may consent for themselves:

1. Any adult, for himself for herself;
2. Any parent, whether an adult or minor, for his or her minor child
3. Any married person, whether an adult or minor, for himself for herself
4. Any person standing in loco parentis
5. Any emancipated minor for himself or herself

Substituted Consent

In the event the patient is unable to consent to treatment for himself or herself, whether due to their age, physical, or mental state, consent for treatment may be obtained from another who is legally authorized or empowered to give such consent. For purposes of this section, substituted consent is used in those cases where the patient is "of unsound mind". *Of unsound mind*, for purposes of this section, means and includes the inability to perceive all relevant facts related to one's condition and proposed treatment so as to make an intelligent decision based thereon, regardless of whether the inability is only temporary or has existed for an extended period of time or is due to natural state, age, shock or anxiety, illness, injury, drugs or sedation, intoxication, or other cause of whatever nature. It is important to understand that "of unsound mind" as used in this section does not require an adjudication of incompetency.

When seeking substituted consent, the following should be considered:

1. Any parent, whether an adult or minor, for his minor child or for his adult child of unsound mind whether the child is of the parent's blood, is an adopted child, is a step child, or is a foster child; provided, however, the father of an illegitimate child cannot consent for the child solely on the basis of parenthood;
2. Any married person, for a spouse of unsound mind;
3. Any person standing in *loco parentis* may consent for the child;
4. Any adult, for his minor sibling or adult sibling of unsound mind;
5. In the absence of a parent, any maternal grandparent and, if the father is so authorized and empowered, any paternal grandparent for his minor grandchild or his adult grandchild of unsound mind;
6. Any adult child, for his/her mother or father of unsound mind.

A word of warning…sterilization procedures fall into a special category and only a court can authorize sterilization of a person who is not capable of speaking for themselves. For example, a female patient with a mental disorder is brought to the clinic by her mother because the mother feels the child may be sexually active and is worried about a possible pregnancy. The mother explains that although her daughter is over the age of 18, she is not capable of making decisions for herself and the mother has been designated the legal guardian and, as such, is requesting a tubal ligation be performed in order to prevent a pregnancy. The physician would have to explain to the mother that he/she is prohibited by law from performing a sterilization procedure on the daughter without a court order. It would be the mother's obligation to pursue such a court order, not the physician's.

Surrogate Decision Maker

If the patient is unable or unwilling to make decisions for himself or herself, it may be necessary to designate a surrogate decision maker for the patient. A surrogate decision maker may make healthcare decisions for a patient who is an adult or emancipated minor only if:

1. The patient has been determined by the attending physician to lack capacity; and
2. An agent or guardian has not been appointed or the agent or guardian is not readily available.

The attending healthcare provider shall designate a surrogate for the patient and shall document the appointment in the medical record. The appointment of a surrogate shall be made if:

1. The patient lacks capacity;
2. The patient has not appointed an agent or the agent is not readily available;
3. The patent has not designated a surrogate or the surrogate is not readily available; and
4. The patient does not have a guardian or the guardian is not readily available.

The surrogate shall be an adult who:

1. Has exhibited special care and concern for the patient;
2. Is familiar with the patient's personal values;
3. Is reasonably available; and
4. Is willing to serve.

In designating the person best qualified to serve as the surrogate for the patient, the attending physician shall consider the proposed surrogate's:

1. Ability to make decisions either in accordance with the known wishes of the patient or in accordance with the patient's best interests;
2. Frequency of contact with the patient before and during the incapacitating illness;
3. Demonstrated care and concern;
4. Availability to visit the patient during the illness; and
5. Availability to engage in face-to-face contact with healthcare providers for the purpose of fully participating in the decision-making process.

Consideration may be given in order of descending preference for service as a surrogate to:

1. The patient's spouse, unless legally separated;
2. The patient's adult child;
3. The patient's parent;
4. The patient's adult sibling; or
5. Any other adult relative of the patient.

If none of the individuals eligible to act as a surrogate are reasonably available, the attending physician may make healthcare decisions after the attending physician:

1. Consults with and obtains the recommendations of the institution's ethics officers; or
2. Obtains concurrence from a second physician who is:

    a. Not directly involved in the patient's care;
    b. Does not serve in a capacity of decision-making, influence, or responsibility over the designated attending physician; and
    c. Does not serve in a capacity under the authority of the attending physician's decision-making, influence, or responsibility.

In the event of a challenge to the designation of the surrogate, it is presumed the selection was valid. Please contact the Insurance and Claims Management Department or the Office of General Counsel if there is any question regarding the designation of a surrogate decision-maker.

Consent in an Emergency

An emergency, for purposes of this section, is defined as a situation wherein, in competent medical judgment, the proposed surgical or medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain consent would reasonably be expected to jeopardize the life, health, or safety of the person affected or would reasonably be expected to result in disfigurement or impaired faculties.

In the event of an emergency as defined above and the patient is unable to give, withhold or revoke consent, and there is no one immediately available authorized to give consent, medical or surgical care can be instituted without consent. Documentation should explain why care and treatment was implemented without substituted consent or consent from one legally authorized to grant consent.

The use of this type of consent requires a judgment call by the physician. For example, a minor child presents to the emergency room after sustaining a fall. The child is diagnosed with a fractured femur that will require surgical intervention. The parents are not available nor is anyone authorized and empowered to give consent. In this hypothetical, at the time of the initial presentation, there is not immediate threat to life or limb so an emergency does not currently exist. Treatment is delayed in an effort to obtain consent. Time may well become a factor. The physician must remain aware of the patient's status and, if consent cannot be obtained in a timely manner, the situation may develop into an emergency requiring surgical intervention before consent can be obtained. The physician must exercise their judgment to decide when an emergency exists and when they must act immediately whether or not consent has been obtained.

Elements of Informed Consent

The courts are eminently clear that the responsibility to obtain informed consent from a patient clearly remains with the physician and this responsibility cannot be delegated. The task of obtaining informed consent from the patient can be delegated but the responsibility cannot. Within our institution, it is strongly recommended that the physician who is going to perform the procedure obtain informed consent.

The physician obtaining consent from the patient should explain the nature of the procedure, treatment, or disease. The patient should be informed about the expectations of the recommended treatment and the likelihood of success. This is not to imply any guarantee of success be given to the patient but some indication of the likelihood of the expected outcome. The patient should be informed about the particular *known inherent risks* and possible complications that are *material* to the informed decision. Finally, the patient should be informed about reasonable alternatives that are available and what the probable outcome would be with one of the alternatives or in the absence of treatment.

The mere signing of the consent form constitutes only some evidence of a valid consent. The best evidence that informed consent was obtained is by a properly completed and signed consent form *and* an accurate narrative by the attending physician in the patient's chart.

The corollary to the doctrine of informed consent is "informed refusal". When a patient (or the surrogate) rejects proposed treatment, he should be advised in a discreet, professional manner of the consequences of the refusal. Keep in mind, however, that it is the patient's right to refuse treatment even if the physician believes the decision is irrational. Consent obtained by fraud or under duress is not valid consent. In the event the patient rejects treatment, the physician must honor the refusal of consent. Again, appropriate documentation is essential in this situation.

Court Ordered Consent

Consent may be given by the court where an emergency exists, there has been a protest or refusal of consent by a person authorized and empowered to do so, and there is no other person immediately available who is authorized, empowered, and capable of consent.

The court may grant consent provided the patient is:

1. a pregnant female in the last trimester of pregnancy;
2. a person of insufficient age or mental capacity to understand and appreciate the nature of the proposed treatment and the probable consequences of refusal;
3. a parent of a minor child, provided the court finds that the life and health of the parent is essential to the child's financial support or physical or emotional well-being.

In the event there has been refusal of consent and the physician feels action should be taken, the physician should contact the hospital administrator on duty or the Office of General Counsel. The decision of whether or not a court order should be sought will be made by University Medical Center Administration.

Police Orders

Upon occasion, a physician may be in a situation where the police bring in a person and request tests or procedures be performed. There is no case law on this subject in Arkansas at this time. However, the physician should be advised that many procedures or tests require consent from "one authorized and empowered to do so" and the police are not on the list of those authorized to give substituted consent. The decision to allow tests or procedures remains with the patient or, if the patient is unable for whatever reason, the decision remains with one authorized and empowered to give consent on behalf of the patient. In other words, the police have no authority to consent on behalf of a patient and the policy on obtaining consent must be followed.

There are very limited areas in which a law enforcement officer may request certain tests be performed on someone in their custody. When in doubt, contact the Office of General Counsel for guidance.

Areas Not Discussed

The area of informed consent and refusal to consent is much too broad to be discussed in its entirety here. There are special consent issues surrounding some religious groups (i.e. Jehovah's Witness), there are special situations in which the patient may have prepared a living will or advanced directive which could take precedence over next-of-kin consent if the patient is unable to consent or refuse to consent for himself; there are situations in which the patient may have refused to consent but the medical situation has changed significantly since the refusal. If time allows, assistance is available through the Department of Insurance and Claims Management, hospital administration, or the General Counsel's Office.

MALPRACTICE INSURANCE

Medical malpractice (medical professional liability coverage) insurance is provided to all faculty members and house staff members involved in the clinical care of patients. The coverage afforded the faculty and house staff at UAMS is written on a claims-made basis.

Under a *standard* claims-made policy, coverage begins on the date the individual physician is initially insured under the policy and coverage ends the day the policy is canceled. In other words, the policy will respond in the event a claim or lawsuit is made only if the policy is in force. If the policy (or coverage) is terminated, and a claim or lawsuit is made after the termination date, the policy will not respond even though the event occurred while the policy was in force. It should be noted, however, that with a standard claims-made policy, the insured has the option of purchasing what is known as "indefinite reporting period coverage" or "tail" at the time the policy or coverage is canceled. By purchasing "tail", the physician has the right to report claims or lawsuits that are brought after the policy was canceled but that stemmed from events occurring while the policy was in force.

The policy under which the physicians at UAMS are covered acts a little differently than the standard claims-made policy. Under our policy, if an individual insured physician (faculty or house staff) leaves UAMS, the "tail" is provided at no cost to the individual physician. The individual physician still has the right to report claims or lawsuits that may be brought due to events that occurred while employed by UAMS.

The coverage afforded to faculty and house staff is for <u>UAMS approved activities only</u>. The policy is not intended to and will not respond for "moonlighting" activities. If there is a question about whether or not a particular activity is UAMS approved, the question should be directed to the department chairperson.

Claims brought under the policy may be settled out of court prior to the initiation of a lawsuit, or lawsuits may be settled prior to trial but <u>only</u> with the written consent of the insured or, upon rare occasions, as directed by the UAMS Executive Committee.

Reporting Procedures

The Insurance and Claims Management Department encourages any physician to freely communicate any concerns regarding the care and treatment of a patient including unexpected outcomes, errors, or any medical/legal event. If you have reason to believe a malpractice claim might occur due to some event, **REPORT IT**. The phone number for the Insurance and Claims Management Department is **614-2077** or **614-2082**. Information you should have available includes the name of the patient, the medical record number, physicians involved, and the nature of the event causing concern.

In the event you receive a letter threatening suit or suit papers, you should contact the Insurance and Claims Management Department *immediately.* In the event you are served with suit papers, you will have only limited time in which to have an Answer filed with the court. Hence, time is of the essence.

Subpoenas, Claims, and Suits

Physicians find themselves involved in the legal arena for a variety of reasons not all of which are medical malpractice. Contact could be made in a variety of ways. The physician might be contacted by an attorney who simply wants to "discuss" the care and treatment rendered. Do not enter into conversations with attorneys regarding patient care matters without first checking with the Insurance and Claims Management Department or the Office of General Counsel. Revealing sensitive patient information to unknown individuals, regardless of who they say they are, can constitute a breach of patient confidentiality. In addition, answering an attorney's questions out of context can work against your interest.

If you receive a subpoena demanding your presence for a deposition or trial testimony, you should notify the Insurance and Claims Management Department or the Office of General Counsel immediately. Most depositions can be conducted at a time and place convenient to you and we can help guide you through the process. In addition, if there is need to retain an attorney for you, the Insurance and Claims Management Department can make those arrangements.

If you receive suit papers, it is imperative that you contact the Insurance and Claims Management Department immediately so that an attorney can be retained and an Answer filed within the allotted time period as described in Arkansas law. Failure to file an answer timely subjects the defendant to a default verdict.

For any questions or when in doubt, contact the Insurance and Claims Management Department or the Office of General Counsel.

Kemal Kutait, Director, Insurance and Claims Management - 614-2082 or 614-2077

Office of General Counsel – 686-7608