The Biggest Legal Mistakes Physicians Make—
And How to Avoid Them

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SEAK, Inc.
Falmouth, Massachusetts
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Finally, the editors would like to express their special thanks to Alex Babitsky, MBA; Nadine Donovan, Esq.; Joseph Burns; Paula Grant; Jon Cahill; and Dee Netzel for their invaluable assistance in the creation of what we hope will be an invaluable resource for physicians.
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Preface

Our company, SEAK, Inc., has been training physicians for 25 years. During that time, we have found legal issues to be an area of great interest to physicians. To help satisfy this need, we created a number of products. For example, our Law School for Physicians seminar, which has been running since 1997, is one of the best received and highly rated seminars we have ever produced. Our one-day training conferences on legal issues—such as those involving HIPAA, the ADA, the FMLA, and other legal matters—are consistently well attended. In 2003, we launched the National Directory of Physicians’ Counsel (at www.counselforphysicians.com). This unique resource allows physicians to quickly locate attorneys with specific experience in representing physicians and their unique problems.

The Biggest Legal Mistakes Physicians Make—And How to Avoid Them has been written to help physicians avoid common, and often very costly, legal mistakes. In this effort, we tapped into the expertise of more than 100 experienced attorneys nationwide.

This book is an easy-to-use reference. In each section, the “10 Biggest Mistakes” template conveys complicated legal information in a concise, need-to-know fashion. We have also included a detailed table of contents and index so that readers can find what they need quickly and efficiently.

Your feedback is always welcome.

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Prologue

The 10 Biggest Legal Mistakes Physicians Make by Failing to View Legal Issues Properly
By Steven I. Kern, Esq.

Executive Summary
The U.S. legal system is perhaps the most complex in the world. Over the past 20 years, health care has evolved into one of the most regulated and complicated areas of U.S. law. Each patient encounter involves myriad compliance issues. Most transactions implicate often obscure rules and regulations, and attorneys practicing health care law must devote hours each week just to keep up with the ever-changing laws affecting physicians and their practices. An attorney in general practice is no more qualified to handle physicians’ legal matters than a family practitioner is qualified to perform transplant surgery.

Mistake 1  Thinking: “I’m a Good Doctor—Nothing Bad Can Happen to Me”
Bad things can happen to good doctors. Malpractice cases often have little to do with malpractice and everything to do with the nature and extent of injury. Errors beyond the control of the physician can create dire problems. A recent transplant case at Duke University Medical Center, where organ procurement personnel failed to confirm the blood type of the donor, almost destroyed the career of a prominent transplant surgeon because he took responsibility for the care of the patient, though he had no direct responsibility to check tissue type. Innocent physicians have been repeatedly accused of sexual impropriety toward patients, who often misinterpret appropriate examination for sexual misconduct. A disgruntled employee can create enormous problems for the unwary physician. Having done nothing wrong is no guarantee that problems will not escalate.

Action Step  Physicians should take every complaint seriously. No matter how absurd it may seem, every complaint must be addressed in a timely, considered fashion. Serious allegations, no matter how absurd they may seem, must be addressed with great care.

Mistake 2  Thinking: “I Have an IQ of 160, Graduated Magna Cum Laude, and Know Better”
Physicians are, undoubtedly, among the best and the brightest members of society. Yet the skills and analytical tools that make physicians great at practicing medicine are very different from the skills and methods used effectively by a highly skilled attorney. Medicine is predominantly science based. Medical decisions are made in conformance with recognized standards and expected results. Legal analysis is far less evidence based. It is often far more dependent on nuance and shading than proven effect. The rules associated with the practice of law can appear Byzantine, convoluted, inefficient, and counterintuitive. Outcome is based on the subjective analysis of judge or jury rather than on predictable science.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

**Action Step** Physicians should accept the fact that the skill set associated with the practice of law is far different from the skill set associated with the practice of medicine. They should rely on the expertise of qualified legal counsel, and remember the adage, “He who represents himself often has a fool for a client.”

**Mistake 3  Choosing the Wrong Attorney**
Finding the right lawyer is as important as finding the right physician. The wrong lawyer can easily make matters worse. Health care law is now one of the most complex and complicated areas of law, and health care lawyers devote tremendous time and effort simply to keep current. Even attorneys who specialize in health care law cannot, individually, maintain the requisite knowledge to handle all aspects of health care practice. A good health care law firm must include health care lawyers who subspecialize in different areas of health care law, including health care regulation, administrative law, transactional and contract law, litigation, labor and tax law, and criminal law.

**Action Step** Physicians should be sure that their attorney devotes full time and attention to health care law and is part of a practice that is fully familiar with all aspects of health-care-related law.

**Mistake 4  Failing to Appreciate That Personal Activities Can Affect Professional Practice**
Even the most mundane legal problem can have a dramatic effect on a physician’s career. A conviction for driving under the influence of alcohol will almost certainly be reported to the physician’s licensing board, as will a domestic violence complaint. Licensing boards take these matters seriously. A civil suit by a patient, an employee, or a coworker accusing a physician of sexual harassment can have a devastating effect on a physician’s career. Settling a civil case or a criminal matter with an admission and a “slap on the wrist” instead of ending a problem can trigger greater problems, including loss of license, loss of hospital privileges, and removal from managed care panels. Even the most mundane legal problem can spin out of control. As a physician, every legal problem must be viewed from a career perspective, and should not be addressed without the input of competent health care counsel.

**Action Step** Whenever a physician’s actions or conduct is questioned, the physician should consult with health care counsel to confirm that there will be no effect on the physician’s professional practice.

**Mistake 5  Assuming That a Medical Malpractice Lawyer Is a Health Care Lawyer**
Lawyers who defend medical malpractice cases devote their time to litigating whether physicians deviated from recognized standards of medical care. These attorneys are, generally, highly skilled in presenting these questions to juries and understanding the legal and evidentiary laws required to prepare and try a civil case. They rarely, however, address
the myriad rules and regulations affecting the practice of medicine; generally do not appear regularly before state licensing boards or other administrative agencies, where legal and evidentiary laws are quite different; and do not routinely involve themselves in contractual and transactional matters.

**Action Step** Before deciding to use a medical malpractice attorney to handle other legal matters, physicians should be certain that the lawyer regularly appears before state licensing boards and other health care administrative agencies, knows the entire regulatory scheme (including the relevant state’s medical practice act, Medicare fraud and abuse regulations, the Health Insurance Portability and Accountability Act (HIPAA), and the Occupational Safety and Health Act), and is familiar with managed care contracting, state laws involving restrictive covenants, employment and tax laws, and other areas of health care law.

**Mistake 6** Thinking: “My Insurer-Appointed Lawyer Has No Interests Other Than Mine”

While an insurer-appointed lawyer is legally obligated to represent a physician’s interests, the reality can be quite different, since such lawyers are paid by the carrier. If the insurer becomes unhappy with the services of the lawyer, the lawyer can lose a significant portion, if not all, of his or her income. Thus, the lawyer’s actions will be dictated by the desires of the person paying the bills. Insurers are understandably concerned about the cost of litigation and the potential cost of any verdict. Therefore, an insurer’s decisions are driven by the insurer’s own economic analysis. If a case can be settled for less than the costs of litigation, the insurer may pressure counsel and the physician to settle the case. Concerned about costs, the insurer may also prohibit its lawyers from retaining the most qualified experts, hiring investigators, or aggressively pursuing discovery. Of course, any settlement will have significant repercussions for the physician. Settlements must be reported to the National Practitioner Data Bank, will increase costs of future malpractice premiums, and could interfere with managed care contracts, hospital privileges, and even licensure. Many states are now “profiling” physicians on their websites, so consumers will have instant access to physicians’ malpractice history. Therefore, the physician’s interest may be far better served by an aggressive defense through litigation than a pro forma defense in anticipation of settlement. This will create a conflict that places the insurer-appointed lawyer right in the middle.

**Action Step** If at any stage of litigation the physician suspects that the case is not being aggressively handled, necessary experts are not being retained, leads are not being pursued, or that the insurer-appointed attorney is pursuing settlement, the physician should obtain a second opinion from a health care attorney with malpractice litigation experience who is, preferably, not tied to any insurer.
Mistake 7    Failing to Appreciate the Needs of the Opponent
Whether negotiating a contract, entering into an employment agreement, or dealing with an investigation by state or federal regulators, it is critical to understand the needs, motivations, strengths, and weaknesses of the opponent. If a person takes a position that leaves the opponent with no alternatives, that person is likely to fail. If a person overestimates the opponent, that person will give more than is necessary. The following passage, quoted in *Internal Bleeding* by Robert Wachter, MD, and Kaveh Shojania, MD, illustrates the point.

U.S. Captain: “Please divert your course five degrees to the south to avoid collision.”
Canadian Radio Operator: “Recommend you divert your course fifteen degrees north to avoid collision.”
U.S. Captain: “This is the captain of a U.S. naval vessel. I say again, divert your course.”
Canadian Radio Operator: “No, sir. I say again, you divert your course.”
U.S. Captain: “This is the aircraft carrier U.S.S. Coral Sea. We are a large warship of the United States Navy. Divert your course now!!!”
Canadian Radio Operator: “This is a lighthouse. Your call.”

When entering into a new venture or relationship, considering bringing a lawsuit, defending a lawsuit, seeking to resolve litigation, recruiting a new employee, seeking employment, or engaging in any other activity involving another party, success will be directly related to one’s ability to size up the strengths and weaknesses, as well as the needs and motivations, of the opponent. Where the opponent’s needs and motivations parallel the physician’s, the physician should take advantage of those factors in framing his or her position and negotiating strategy.

Action Step    Physicians should fully evaluate the needs, expectations, and motivations of their opponent before addressing any problem. Their strategy is most likely to succeed when they can find common ground with their opponent or can exploit his or her weaknesses.

Mistake 8    Failing to Read the Fine Print
Contracts are rarely written in simple, understandable English. If the words aren’t completely understandable, chances are they may have a hidden meaning. Managed care contracts, for example, often include language requiring that physicians provide care to plan members as well as to members of other affiliated plans or groups. Termination provisions can be onerous, requiring physicians to continue to treat patients for long periods of time, even if the payor fails to pay the physician. Hold harmless and indemnification provisions can place the physician’s personal assets at risk.
PROLOGUE

Action Step  Physicians should not sign any contract in which they are not certain of the meaning of each and every term. They should read and understand every term of every contract or agreement before they sign it. If they find that the language is not clear and unambiguous, they should consult with qualified health care counsel before they sign.

Mistake 9  Volunteering Information
Meeting with an investigator, responding to an inquiry by a regulatory body, or speaking to a member of the media is always risky. If responding in writing, physicians should be certain to answer only the question asked and not to volunteer information beyond that requested. The more information the physician provides, the more avenues of inquiry he or she opens. When appearing in person, it is difficult for the physician to limit inquiries or keep the questioner from wandering into areas not anticipated in advance. A competent attorney will help limit the scope of inquiry and, in the process, deflect any of the questioner’s frustration from the physician to the attorney. Knowing what questions to answer and what questions to refuse to answer is an art, developed from years of experience.

Action Step  Physicians should not volunteer. They should never appear before an investigative body or speak with an investigator or a member of the media without experienced health care counsel present.

Mistake 10  Trusting the Wrong People
A hospital, an insurer, or even a colleague can be a good friend today and the worst enemy tomorrow. No one wants to take blame and no one wants to pay for his or her mistakes. When it comes down to who takes the blame, from any individual’s perspective, it should be the other guy! Anything a person says to others, even those whom that person trusts, can and will be used against that person if their interests diverge. Whether a codefendant in a malpractice case or a possible target of a criminal investigation, a physician’s words will be used against him or her. In many states, even a spouse can be subpoenaed to give testimony against his or her spouse. Unless the physician is speaking to his or her own attorney, there is rarely a privilege to prevent that communication from being used against the physician. While codefendants may seem to have the same interests as the physician’s, their interests can dramatically change over time.

Action Step  Physicians should always assume that their conversations about matters that could result in investigation or litigation will ultimately be used against them. If they do not want their conversation to become known to a potential adversary, they should not enter into the conversation. Today’s friend could become tomorrow’s nightmare.

Conclusion
Physicians who follow the action steps related to these mistakes are more likely to avoid unnecessary legal matters.

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Chapter 1 Antitrust

1.1 The 10 Biggest Legal Mistakes Physicians Make in Responding to Antitrust Complaints


Executive Summary
Physicians are often dismayed by both the application and complexity of the federal antitrust laws that apply to their practices and to the multiphysician organizations in which they participate. Unfortunately, many physicians believe that antitrust laws pertain only to large corporations, and they often do not take the opportunity to acquaint themselves with antitrust laws and the increasing relevance of these laws to modern American health care. This lack of understanding often leads to unfortunate consequences. Increasingly, physicians and physician practice groups, such as physician hospital organizations (PHOs) and independent practice associations (IPAs), are the target of enforcement actions brought by one of the two antitrust enforcement agencies--the Antitrust Division of the federal Department of Justice (DOJ) and the Federal Trade Commission (FTC)--as well as civil actions brought by private parties. In addition, antitrust issues are developing during negotiations between physicians and managed care organizations or other payers. The criminal nature of the antitrust offense, the heavy fines and sanctions that accompany conviction, and the possibility of treble damages for successful private litigants all suggest that physicians must pay careful attention to the antitrust laws and take any antitrust complaint seriously. The consequences of failing to do so are far too severe.

Mistake 1 Failing to Understand the Relevant Law
Although failing to understand the relevant law is a mistake that actually arises before the first antitrust complaint is received, it is important enough to mention. Avoiding the antitrust complaint is just as important as properly defending it when it arrives. Antitrust cases are some of the most complex and expensive to defend. Many antitrust defendants have settled cases that likely could have been won because of the cost of litigating them. Understanding the antitrust laws and their application to physicians, PHOs, and IPAs not only helps the physician avoid the conduct that spawns the antitrust complaint, but also helps him or her distinguish the winnable claims from those that should be settled.

Action Step Physicians should take affirmative steps to educate themselves regarding the antitrust laws, including the possible hiring of antitrust counsel to provide both training and periodic counseling. Physicians should also ensure that any IPAs and PHOs in which they participate have sought antitrust advice with respect to their activities.
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Mistake 2  **Failing to Have and Abide by an Appropriate Document Retention Program**

Failing to have and abide by an appropriate document retention program is a mistake that also can be made both before and after an antitrust complaint is received. After a complaint is received, there may be a natural reaction to want to search for and purge from physician files any incriminating or “bad” documents. This is not the time to undertake such an endeavor. In fact, when an antitrust complaint is received, an affirmative statement to employees is in order to the effect that no destruction of relevant documents should occur. A well-designed document retention program will include such guidelines. Furthermore, adherence to the document destruction schedule of a well-designed document retention program may prevent document destruction from looking as if it were part of a plan to hide relevant information from the government or a private plaintiff.

**Action Step**  Physicians should develop a document retention program and adhere to it. They should review this policy with relevant personnel upon receiving a complaint.

Mistake 3  **Failing to Take Complaints Seriously**

Because many physicians think of the antitrust laws as something for big companies to worry about, there may be a tendency to dismiss the severity of an antitrust complaint. Physicians must take antitrust complaints seriously, whether they are formal complaints filed in court or informal complaints brought to the physician’s attention by competitors, payers, or patients. If victorious, private antitrust plaintiffs stand to receive not just their proven damages, but three times their actual damages (known as “treble damages”). This concept provides the plaintiff with a windfall and gives the plaintiff tremendous incentive to pursue antitrust claims. In addition, the successful antitrust plaintiff also receives what may be an even bigger bounty in some instances: payment of his attorney’s fees by the losing defendant.

**Action Step**  Physicians should treat any antitrust complaint, formal or informal, as a “bet the practice” case.

Mistake 4  **Failing to Hire Antitrust Counsel in a Timely Manner**

Physicians may use the services of general legal practitioners to handle business and litigation matters. Such counsel may be fully prepared to respond to an antitrust complaint alone, just as they would any other complaint. However, if physician’s counsel has never handled antitrust claims, the failure of such counsel to associate co-counsel experienced with antitrust matters could be a serious disadvantage. The antitrust laws are complex and not always intuitive; therefore, experience is crucial.

**Action Step**  Physicians should consult with counsel as soon as possible upon receiving an antitrust complaint. If counsel is not experienced in dealing with antitrust matters, physicians should ask that he or she associate with special antitrust counsel.
Mistake 5  “Creatively” Reconstructing the Facts Involved
Remembering the specific details of previous meetings or the content of old documents is often difficult. Physicians, like most attorneys, remember past events in the most favorable light. However, this recollection may be inconsistent with discoverable documents or the testimony of multiple witnesses. Guessing at what happened or misleading investigators could create more significant problems than the initial antitrust investigation itself. Providing inaccurate information could subject the physician to charges of perjury and could cause the investigators to seek criminal penalties or move the investigation to a more serious stage. It may be embarrassing to confide damaging information to counsel or to an investigator. However, absolute honesty with a physician’s defense team is essential. Counsel needs to learn the incriminating information from the client first before the plaintiff or investigators present the information in a hostile environment. With prior knowledge of the problematic information, counsel can construct a defense and be ready to respond with exonerating documentation.

Action Step A physician must be completely candid with his or her counsel in responding to an antitrust complaint. Although on advice of counsel, a physician may refrain from answering questions, a physician should never mislead an investigator or a third party by creating a false explanation for past behavior or by fabricating rules or policies retroactively.

Mistake 6  Talking to Government Enforcement Agencies or Plaintiff’s Representatives without Counsel
In the event that either the FTC or the DOJ undertakes an investigation, these agencies will likely seek to gather information from the target of their investigation. While it is wise to be cooperative (see Mistake 7), it is also wise to have the benefit of counsel when speaking with the enforcement authorities. One must remember that enforcement agencies can and will use every statement that has been made to them. Off-hand comments about the relevant market (see Mistake 8), competitors, and other matters may carry more meaning than the physician would expect. Counsel should be able to assist the physician about the true meanings of some terms. These comments apply with equal force in the civil action setting when dealing with a plaintiff’s counsel.

Action Step If approached by representatives of the FTC or the DOJ, physicians should ask to have counsel present. Likewise, physicians should never talk with counsel or representatives for a plaintiff in an antitrust investigation unless their attorney is participating in the meeting.

Mistake 7  Being Uncooperative with Enforcement Agencies
While being cooperative with enforcement agencies is a point that may seem to be inconsistent with the previous suggestions to request the presence of counsel when speaking with the FTC or the DOJ, a physician should strive to be cooperative with enforcement
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authorities. The enforcement agencies often need information from the target physician(s) in order to determine if a complaint should be filed, or if already filed, whether it should be pursued. Counsel may be able to communicate with the agencies to determine exactly the type of information they require. The agencies can and will use subpoena powers to gain information if needed; however, the more cooperation that is shown to them, the more likely that the situation may be resolved in a reasonable time.

**Action Step**    Physicians should cooperate, under the guidance of counsel, to the fullest extent possible with enforcement agencies.

**Mistake 8   Relying on Unsophisticated Market Definitions**
Many physicians have proceeded to defend antitrust claims without an expert conversant with market definition in antitrust cases. In many but not all antitrust cases, whether brought by the enforcement agencies or by private parties, a necessary prerequisite will be proof of a proper relevant market, including a geographic component and a product or service component. The definition of the relevant market often is determinative. For example, market definition is most crucial in cases of claimed monopolization or attempted monopolization. If the market is defined too narrowly, it is far easier for a claimant to prove its case. Proper market definition often involves complex analysis that requires assistance from qualified economic experts and can be very expensive.

**Action Step**    Physicians should consult with counsel early after receiving an antitrust complaint to determine if an economist should be retained. If so, it should be an economist experienced in antitrust litigation.

**Mistake 9   Engaging in Misuse of or Overreliance on the Peer Review Process**
Many antitrust suits have been brought following a plaintiff physician’s loss of privileges through a peer review process. The peer review process itself, and participation in it, has been recognized as affording protection from antitrust suits when done properly. A problem often arises, however, if certain physicians set about to disparage the target physician outside the peer review process. Obviously, the peer review process is a valued tool used to ensure high-quality medical care, but to protect oneself from suits stemming from a loss of privileges, all statements about the subject physician’s qualifications and practice should be maintained within the bounds of a properly run peer review process.

**Action Step**    If asked to participate in a peer review process, a physician should consider retaining independent counsel. He or she should also ask if the relevant hospital has its own counsel involved as well as adequate insurance coverage for the peer review process.
Mistake 10  **Asserting a Defense Based on Policy Arguments That Physician’s Conduct Is Acceptable**

Selective prosecution arguments rarely redirect the investigator or prosecutor. In fact, they may encourage these individuals to devote additional resources to the area and to make an example of the physician or group they are pursuing. Policy arguments can often be used by government investigators to reconstruct the alleged intent behind the physician’s activities. If physicians indicate they must “band together” to obtain better reimbursement and to increase their leverage with managed care organizations, government officials may have the outline of the anticompetitive argument they are seeking in their case or investigation. Moreover, the investigator will probably indicate that he or she is not a policymaker and that such arguments are irrelevant to his or her investigation.

**Action Step**  Physicians should refrain from making policy arguments to government representatives or plaintiff’s counsel. Likewise, physicians should avoid the temptation to point out potentially anticompetitive conduct by their colleagues at another hospital or in another geographic region.

**Conclusion**
Antitrust complaints are serious matters that deserve the attention of a physician and his or her qualified antitrust counsel. Government antitrust investigators or plaintiff’s counsel are often seeking to discredit the physician, the PHO, or the IPA that is the subject of the complaint, and will seek significant damages, attorney’s fees, and/or criminal penalties. A physician should provide honest, reasoned responses to the inquiries of such investigators or plaintiff’s counsel after receiving advice from his or her counsel. All physicians, particularly those involved in multiphysician contracting organizations, must seek to understand the fundamentals of antitrust law before and during a response to any antitrust complaint.

**Additional Resources**
- Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care, [http://www.ftc.gov/reports/hlth3s.htm](http://www.ftc.gov/reports/hlth3s.htm)

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1.2 The 10 Biggest Legal Mistakes Physicians Make with Antitrust Laws
By Neil B. Caesar, Esq., and Kelly R. Pickens, Esq.

Executive Summary
Physicians generally dislike thinking about antitrust laws: They’re rife with areas of gray, rarely a doctor’s favorite color. But for the physician thinking about joining or forming a network or for the medical group considering a merger or alliance, antitrust issues can be critical. While physicians must be wary of running afoul of the rules, it is equally important that they understand what activities the antitrust rules permit. Physicians often need to grow and affiliate safely and have a clear understanding of appropriate and inappropriate actions. Antitrust law is complex and often counterintuitive. Generalizations are difficult, and, depending on the facts to which they may be applied, inherently dangerous. Caution is the byword when antitrust law is implicated.

Mistake 1 Misunderstanding the Scope of Antitrust Laws
Doctors probably know of antitrust laws in connection with physician/hospital organizations and other alliance activities. But the laws also apply to nonalliance functions performed routinely (e.g., medical staffing, joint purchasing, information exchange, and managed care contract negotiation) and to sizable mergers and acquisitions. For all of these tasks, ignorance of antitrust law can present real risks to physicians. In addition, the government is not the only party that may initiate antitrust scrutiny; private persons also may bring antitrust actions against allegedly offending physicians. It is thus important for physicians to watch alliances, acquisitions, and mergers with an eye toward aggrieved competitors that may seek to challenge the relationship.
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**Action Step** Physicians should identify which practice activities may implicate antitrust laws, and apply caution when pursuing those activities.

**Mistake 2** **Forgetting That Most Antitrust Costs Result from Scrutiny, Not a Guilty Verdict**

The risk of scrutiny often is as important as is the outcome of an antitrust case. Regardless of the outcome, scrutiny can harm reputations and require enormous amounts of time and money to withstand. Antitrust cases are very fact specific, with complicated rules about market share and the like. Consequently, it takes a lot of time and money to defend against an antitrust allegation.

**Action Step** Physicians should seek to avoid an investigation or challenge in the first place, by learning some of the red flags that can set off antitrust alarms.

**Mistake 3** **Not Learning the Rules Affecting Fee and Pricing Discussions**

Perhaps the biggest antitrust danger physicians face is “price fixing,” because no one has to show market power, or even prove damages. Price-fixing is defined as any agreement (oral or written) that has the purpose or effect of raising, depressing, or fixing prices. If physicians agree to it, they are breaking the law. Period. For example, if a physician asks colleagues (not part of the physician’s group practice) what they are paid by a managed care plan and then the physician holds out for the same pricing, the physician may be vulnerable to charges of price fixing. When discussing whether to form an alliance or how to deal with the perceived threat of competition, physicians must not discuss individual information about their fees or other financial details. If a physician winds up in the presence of this type of information exchange, the physician must insist that the talk stops and leave the meeting if it does not.

So, when may physicians have pricing discussions? There are at least two “safe” opportunities. First, when physicians form a contracting alliance that contains substantial financial and clinical integration (credentialing, risk-sharing, benchmarking, etc.), they may have effectively created a new competitor in the market. When this happens, the antitrust laws permit that financially and clinically integrated competitor to set its own fees. The physician owners then have the right to determine the fee to be charged by the new integrated alliance because they are no longer engaged in price-fixing activities. Rather they are owners deciding what their new company should charge. The degree of financial or clinical integration in a network will thus affect the price-fixing challenge. The degree of clinical integration is also important, as is the ability to bring something new to the market (e.g., specialization diversity). Each integration analysis is very fact specific, and it is a mistake to assume financial or clinical integration without the advice of experienced antitrust counsel. (Mistakes 5 and 6 contain additional discussion on contracting networks.)
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Second, physicians are generally permitted to share fee-related information with purchasers (e.g., patients, employers, and managed care organizations). They are also permitted to share certain fiscal information among themselves if specific conditions are fulfilled. The U.S. Department of Justice (DOJ) and the U.S. Federal Trade Commission (FTC) jointly announced a “safety zone” in 1994 concerning the circumstances under which fee information may be shared by a physician with purchasers or with other physicians. This safety zone has several requirements:

- Collection of fee-related data must be managed by a third party, not by one of the physicians. A purchaser, health care consultant, or trade association, for example, are viewed as appropriate information collectors.
- The pricing information must be at least three months old. (But there is certainly nothing wrong if the old information is still valid, as long as that fact is not shared.) More current fee-related information may not be shared among the physicians, although it may be made available to purchasers.
- Any information shared must reflect a data compilation from at least five providers for each reported summary conclusion or statistic. If the database has fewer than five contributors, the information may be provided only to purchasers to prevent inappropriate discussion among physicians concerning individual pricing.
- No individual physician’s data may comprise more than 25% of that particular statistic.
- Such information must be aggregated so that recipients cannot utilize the information to identify prices charged by any individual provider.

Action Step  
Physicians should avoid discussing individual pricing information, but should learn the rules about sharing generalized pricing information with purchasers or other physicians when specific safeguards are imposed.

Mistake 4  Not Realizing That Non-pricing-related Information May Usually Be Shared without Raising Antitrust Concerns

The DOJ and FTC created another safety zone that applies to sharing nonreimbursement or fee-related information. This safety zone protects physicians from challenge when they supply data that relate to the mode, quality, or efficiency of treatment. For example, a physician alliance may provide information about procedures that its physicians advocate without raising antitrust concerns. A network may suggest practice protocols without antitrust implications. The government seems to believe that such standards for clinical decisions generally provide pro-competitive benefits, by highlighting increased quality and enhancing efficiency. On the other hand, the safety zone expressly excludes the collective provision of information by physicians if there is any coercive element to it. So a network may not suggest, for example, that it will deal only with managed care plans that embrace its clinical protocols. The scope of what constitutes “nonprice” terms, however, is often not as broad as
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“any term except the fee schedule,” and again, this definition requires the advice of experienced antitrust counsel.

**Action Step** Physicians should assess whether they may benefit by sharing non-pricing-related information.

**Mistake 5 Ignoring the Dangers of “Boycotting”**
Boycotting is another common antitrust concern for affiliating physicians. Boycotting occurs when, for example, physicians on a hospital’s medical staff agree not to refer patients to a new physician (say, a “square peg who isn’t one of us”). Another example is if competitor physicians collectively agree not to bargain with a managed care organization outside of agreed parameters.

Boycott charges are a particular risk in forming alliances. If a venture involves a high proportion of an area’s physicians, there is antitrust risk if the participants coordinate a refusal to participate in managed care outside of the alliance. Again, the degree of financial and clinical integration among the physicians is relevant because by definition a boycott requires more than one party. The more the alliance can show integrated clinical activity or financial risk-sharing by its members, the more safely the members of a physician alliance may decide to act in concert. (Mistake 6 contains additional discussion of alliances.)

Boycott questions also arise when physicians are excluded from an alliance opportunity. To demonstrate that the exclusion reflected an inappropriate group boycott, the physician must make two points: that the other doctors denied the physician access for anticompetitive reasons, and that this denial kept the excluded doctor from earning an adequate living in the market.

It is quite difficult to meet this two-part burden. Cases that have prevailed on these arguments have shown, for example, that a decision ostensibly made by the plan was actually a smokescreen for actions of competitor physician/members because they were involved in the exclusionary decision or unduly influenced the allegedly “independent” plan’s decisionmaking. Even when an excluded physician is able to prove this sort of anticompetitive behavior, it is quite difficult to show as well that the physician was unable to earn a living in the market. In other words, if the excluded physician has other effective employment or revenue opportunities, antitrust relief will be unlikely. This is the gist of the concept of “market power” under antitrust law, which essentially means the power to influence competition and price significantly. Quite simply, in most instances, in the absence of precise language in a state “any willing provider” statute, a network or alliance is not required to admit every physician who wishes to join.
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As a general rule, a physician should not ask a colleague if he or she should join a managed care plan. If the physicians then decide not to join, this could be construed as a conspiracy to boycott. It is better for physicians to ask their colleagues about their experience with a particular MCO, and then gather enough information to make their own decisions. Best of all, physicians should avoid the word “let’s” when discussing managed care plans or other venture opportunities.

**Action Step** Physicians should avoid joint decisions to blacklist a MCO, a colleague, or another provider.

**Mistake 6 Not Understanding the Rules about Physician Network Joint Ventures**

There are two basic ways physicians may form network joint ventures for effective contracting and shared services. First, physicians may join together in an entity that imposes significant shared financial risks on the physicians (e.g., capitated payments, risk pools, and withholds) or provides substantial clinical integration (e.g., coordinated recordkeeping, utilization review, and credentialing). Second, physicians may form a looser network without integration, which is primarily limited to facilitating the efficient and coordinated flow of information for contracting purposes between the physicians and other payers or providers (the so-called messenger model).

Networks with sufficient financial risk-sharing or clinical integration survive antitrust scrutiny because they effectively create a new competitor in the marketplace, a physician entity that offers something new to other payers or providers. Unfortunately, many alliances forget that the legality of their formation was conditioned on these risk- or clinical-based activities. For every group that is truly sharing financial risk or managing outcomes, monitoring credentialing, improving performance, etc., there are probably 10 alliances that have said they will do so, but have not yet begun or started operations in antitrust compliance, but over time, have lost their way. Courts have had little tolerance for protracted promises about future intent, and the same is true for the FTC and the DOJ, which enforce the antitrust laws.

The FTC and DOJ have created several safety zones for joint activities, including safety zones focused on physician network joint ventures. These agencies will not challenge (unless extraordinary circumstances exist) a nonexclusive physician network joint venture whose participants share substantial financial risk or have substantial clinical integration if the physicians comprise 30% or less of the physicians in each specialty with active hospital staff privileges who practice in the relevant geographic market. Further, the agencies will not challenge an exclusive physician network joint venture (where the physicians may not seek contract opportunities that the network is also pursuing) if the participants constitute 20% or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market. If the level of participation exceeds these safety
zones, the relationship will not necessarily violate the antitrust law. Rather it will be subject to analysis under the “rule of reason,” which examines all of the venture’s pro-competitive and anticompetitive factors.

On the other hand, affiliations that comply with the antitrust rules under the messenger model technically are not even joint pricing agreements. The messenger model uses a third party (e.g., noncompetitor physicians or an IPA administrator in a multiprovider network) to tell the payer what price(s) the network participants are willing to accept. There is still antitrust risk, however, if the messenger influences individual provider or medical group responses, tells other members about a physician’s views, or acts as an agent for binding negotiation of the pricing agreement. There are some important limits to the messenger model, because it is primarily a vehicle for facilitating communication. It is not intended to present a unified voice for the physicians. Nonetheless the model can be an effective structure for improved contracting opportunities.

In the mid-1990s, the government negotiated a consent decree with a network that violated the messenger model. This consent decree gave important insight as to appropriate messenger model operations. According to the consent decree, a messenger model network:

- May convey to the physicians objective information about contract terms, including other payers’ terms.
- May solicit clarifications from a payer.
- May engage in discussions regarding contract terms other than prices and other than competitive terms and conditions; however, the messenger model network must tell the purchaser that it may refuse to respond to the network or may terminate discussions at any time.
- May not communicate to the physicians any information about the purchaser’s refusal to clarify or entertain further discussions.
- May convey to the physicians the purchaser’s responses, and may, at the request of a purchaser, communicate the individual views of each physician.
- May convey to the purchaser the acceptance or rejection by a physician of any contract offer.
- May refuse to communicate information only under limited circumstances, where the information is insufficient, lacks material terms, or is irrelevant to the physicians’ needs.

**Action Step** Physicians should determine whether their network joint venture will be integrated (financially or clinically) or will operate under the messenger model, and should work with competent counsel to follow the rules for the chosen structure.
Mistake 7  **Inappropriately Worrying about Monopolies and Restraint of Trade**

Restrainment of trade and monopoly charges are very difficult to prove. Although federal law states that every contract, combination, or conspiracy to restrain trade or commerce among parties is subject to the antitrust laws, any such allegation must prove a number of facts, including that there was agreement among the alleged conspirators to attempt to restrain trade, and that the agreement had (or would likely have) a negative impact on competition in the relevant market. This is quite difficult to prove.

Monopolistic activity is also difficult to prove. It must be shown in such a case that the defendant has substantial monopoly power, and that it was obtained willfully and inappropriately. (For example, antitrust law welcomes growth if it is due to a superior product and great customer loyalty.)

Monopoly power is often defined in terms of market share, but there is more to it than that. Technological superiority, relative size of competitors, barriers to entry, and pricing trends in the absence of diversity are also relevant to whether monopoly power exists. Further, monopoly power is not an antitrust violation in itself. It must be obtained by exclusionary, anticompetitive, or predatory conduct. There must also be a specific intent to monopolize, as well as to control prices and exclude competition. As a general rule, market shares of 30% or less are safe from scrutiny.

Often, the test of whether an affiliation is legal under antitrust laws is whether the restriction of competition that results from the activity is inherent in that activity. For example, physician networks may not deny qualified candidates the opportunity to join if the core purpose for the denial is to restrict access to the network’s market (i.e., to protect turf). On the other hand, physicians who are deselected or locked out because they failed to meet credentialing requirements would not be able to mount an antitrust case, nor would deselected physicians who retain the ability to compete effectively in the market, albeit outside of the network.

**Action Step** Physicians should avoid joint decisions designed to restrict access to competitors, but such decisions are not antitrust violations unless the physicians control enough of the market so as to make it difficult for other physicians to earn a living in the market.

Mistake 8  **Not Realizing That Mergers Are Usually Safe, but Size Matters**

One important element under restraint of trade and monopoly analysis is whether an affiliation—a merger or alliance—substantially lessens competition. This analysis is complicated, but there are guidelines. If the merger is between noncompetitors, such as a cardiology group and a gastroenterology group, there is not likely to be an antitrust issue because competitors are not removed from the market. If large groups merge, however, they must identify their product market (e.g., diagnostic cardiology services) and the geographic
market involved, and calculate the market share of the merging practices and of their
competition. This analysis requires physicians to look at the market from which they draw
patients, then look at alternative resources those patients have (including physicians in nearby
markets), then assess their market share from that expanded geography. This is a complicated
analysis. A rule of thumb for mergers is that if merging practices have more than 35% of the
market before a merger, or if the four largest competitors have 50% of the market before the
merger, antitrust issues may arise.

If the merged groups would capture a high portion of the market share, there are other
variables that can affect a case. These include the reasons for the merger (community need is
a valuable fact), the efficiencies generated by the merger, whether any of the parties would
fail financially if the merger did not occur, and how difficult it is for new participants to come
into the market. The harder it is for someone to enter a market, the more likely it is that a
merger will be challenged. If there are few radiologists in town, for example, a merger of
these practitioners will be more vulnerable to scrutiny.

**Action Step** Physicians should address antitrust law concerns for mergers or alliances
only when the consolidation would capture a significant portion of the relevant geographical
and product markets, making it difficult for others to compete.

**Mistake 9 Ignoring State Laws When Forming Networks or Merging Practices**
It is important to consider state laws as well as the federal antitrust law when considering
mergers or alliance formation. State laws vary greatly and provide various safe harbors from
federal antitrust scrutiny. (In Maine, for example, a list of advantages for joint ventures is
considered before state approval of a venture is granted.) For the most part, these state laws
have not yet withstood federal challenge and thus may not eliminate federal antitrust risk.
Also, other state laws (fair trade laws, tortious interference and consumer protection laws,
etc.) may come into play as well.

**Action Step** Physicians should review state law when forming mergers or alliances.

**Mistake 10 Waiting Too Long to Consult Competent Counsel When Establishing
Physician Alliances, Acquisitions, or Mergers**
Because the antitrust laws can be so onerous, it is imperative that physicians utilize
competent counsel to help assess risks and structure compliant solutions whenever seeking to
form an alliance or pursue an acquisition or merger. It is wise to bring counsel into the
discussions early on, so that structural alternatives may be assessed before structural and
operational decisions are finalized. Early utilization of counsel can also minimize the costs
and hassles when an alliance, acquisition, or merger is challenged under antitrust principles.
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**Action Step**  Physicians should consult competent counsel early when seeking to form an alliance or pursue an acquisition or merger.

**Conclusion**
Penalties for violating federal or state antitrust rules, and the danger of scrutiny when alliances, acquisitions, or mergers are operated casually or carelessly, make it imperative that physicians protect themselves by knowing enough about antitrust law to avoid risky behavior. Conversely, the demonizing of antitrust law should be avoided, as many opportunities for alliances, information sharing, and so on are permitted.

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Chapter 2 Asset Protection

2.1 The 10 Biggest Legal Mistakes Physicians Make Involving Asset Protection
By Daniel S. Rubin, Esq.

Executive Summary
All signs indicate that the prevalence of litigation against physicians is in a continuing upward spiral across the United States. Although some claims are meritorious, far too many are not. In such an atmosphere, every physician with even a modicum of wealth is subject to an unacceptable level of risk. Aggravating this problem is the fact that even in instances in which liability might, unfortunately, be clear, the extent of the injury and, by extension, the dollar amount of the damages, often remains subjective and can therefore be grossly inflated by an overzealous judge or jury. Timely and professional “asset protection” planning, free of the most common mistakes physicians often make, can help a physician to weather this litigation storm.

Mistake 1 Consulting Counsel Too Late
Once a claim has arisen, it is generally too late for a physician to protect his or her assets. This is because a transfer made with the intent to hinder, delay, or defraud a creditor will be held to be a “fraudulent transfer” and will be undone by a court. Moreover, the law of some states, such as New York, holds that a transfer made after a lawsuit has been brought is automatically deemed to have been made with the intent to hinder, delay, or defraud creditors. However, even transfers made prior to a lawsuit are at risk of being undone if the alleged act of malpractice has already occurred.

Action Step Physicians should consult with counsel to assess their asset protection options before those options are foreclosed by the existence of a claim.

Mistake 2 Hiring Inexperienced Counsel
For the same reasons that one should not rely on one’s internist for medical issues that require a specialist’s expertise, physicians should not expect every attorney to have the same level of asset protection planning skill. Asset protection planning, in particular, requires an in-depth understanding of the law that spans a number of legal disciplines, including trust law, real and personal property law, family law, bankruptcy law, and debtor-creditor law, as well as state and federal income, gift, estate, and generation-skipping transfer tax laws. Moreover, since asset protection often attempts to “cherry pick” the most favorable laws of domestic and even offshore jurisdictions, asset protection planning counsel should have a breadth of knowledge that goes beyond any one state or country.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

**Action Step** Physicians should do their own due diligence before engaging counsel for asset protection planning advice. The attorney who assisted in establishing the physician’s business practice is likely not the right choice to assist in establishing an asset protection plan. Physicians with asset protection plans already in place should consider obtaining a second opinion of the plan from independent counsel.

**Mistake 3 Attempting to Protect Too Much**
Courts will undo transfers made with the intent to “hinder, delay, or defraud creditors.” Since few, if any, defendants will admit to such intent in creating a trust, transferring property to a spouse, or taking some other action that might protect assets from creditors, courts are forced to look for extrinsic evidence of such intent. To the extent that a physician has attempted to protect all of his or her assets, the courts will almost certainly find a fraudulent intent.

**Action Step** Physicians should remember the old adage, “Pigs get fat while hogs get slaughtered,” and be satisfied with having obtained a reasonable level of asset protection. This concept is termed “nest egg” planning.

**Mistake 4 Failing to Consider Life Insurance and Annuities**
Although the issue is one of state law and therefore depends on a physician’s residence, life insurance and annuities are two of a very limited class of investments that are generally protected against creditor claims. The public policy underlying such protection is grounded in the understanding that life insurance and annuities are essential for the debtor and his or her family to maintain at least a minimum level of financial well-being and thereby avoid becoming a burden to the state. The manner in which most state law is written, however, does not limit these protections to subsistence levels and even large dollar amounts can potentially be exempted from creditor claims.

**Action Step** Physicians should assess their asset holdings and determine whether life insurance and/or annuities should be integrated into their portfolios. Physicians are cautioned, however, to consult with planners who have experience in asset protection planning to ensure that the investment is properly structured to maximize its potential asset protection benefit.

**Mistake 5 Failing to Update the Plan and/or to Get a Second Opinion**
Asset protection is a moving target. Every year new statutes are enacted and new cases are decided that affect the planning environment in some manner. In addition, a physician’s personal circumstances change over time in myriad ways that will affect the planning environment. To remain protected, it is incumbent upon the physician to remain abreast of changes that affect his or her asset protection plan.

**Action Step** Physicians should review their asset protection plan with counsel on a regular basis. Physician’s counsel should endeavor to keep the physician informed as to legal
Mistake 6  **Retaining Too Much Control**

It is simple human nature to desire to control one’s wealth, even after that wealth is “given away” for asset protection purposes. In asset protection planning, however, there exists an inverse relationship between the amount of control retained and the level of protection afforded. For example, a revocable living trust provides no asset protection because it is revocable by the settlor. Even irrevocable trusts can be successfully attacked, however, if excessive control is retained. A physician who establishes irrevocable trusts for asset protection purposes should strongly consider naming independent trustees and protectors, and should forego the option of funding the trust with any limited partnership, limited liability company, or corporation controlled by the physician. This is particularly true for “self-settled” asset protection trusts in which the settlor is also a trust beneficiary.

**Action Step**  With regard to any self-settled asset protection trusts that the physician has created, the physician should resign as trustee and protector and should liquidate into the trust any underlying entity that the physician controls. Moreover, to the extent that a close friend or family member has been named in any of these capacities, he or she should be asked to resign in favor of an independent third party.

Mistake 7  **Relying Too Much on the “Charging Order” Remedy**

Family limited partnerships and family limited liability companies are often touted as sufficient to protect a physician’s assets from creditors. The legal basis for such assertions is the “charging order” remedy, which provides that an owner’s creditors cannot take the owner’s interest in the entity, but instead are relegated to accepting distributions from the entity if and when distributions are made. To the extent that a family member or close friend is running the company, distributions are likely to cease until the claim is settled on terms favorable to the debtor.

Few state statutes provide that the charging order is an exclusive remedy, however, thereby making foreclosure of the physician’s interest in the entity a real possibility. Moreover, even where the charging order is an exclusive remedy, most state laws require a “business purpose” for a valid limited partnership or limited liability company to exist, and pure “asset protection” might not be deemed a valid business purpose.

**Action Step**  Physicians who have family limited partnerships or limited liability companies should review them to determine the state law under which they were established. If established under the law of the physician’s residence, the physician should question whether his or her state coincidentally happens to have the best legislation in this regard or
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whether the physician obtained inadequate legal advice. In the latter case, the physician should consider relocating the entity to a more favorable jurisdiction.

Mistake 8  Owning Real Estate Improperly
Residential real estate is exempted from the claims of most types of creditors if owned by a husband and wife in a form of joint tenancy called a “tenancy by the entireties.” The basis for the protection is that one spouse’s interest in the property should not be subject to creditor claims attributable solely to the acts of the other spouse. This protection can, however, be lost in the event of the death of the nondebtor spouse or in the event of a divorce, or where the creditor is a joint creditor of the husband and of the wife.

Commercial real estate should be owned within a limited liability company (an LLC). Like a corporation, an LLC insulates the owners of the company from liabilities arising out of the company’s business (i.e., the rental of real estate), but is better than a corporation for several reasons. First, unlike a corporation, an ownership interest in an LLC is arguably subject to charging order protection and, therefore, an owner’s creditor are not automatically entitled to control or liquidate the company. Second, unlike a corporation, there are few administrative formalities required of an LLC. Finally, unlike certain types of corporations, LLCs pass through all incidents of taxation to their owners, thereby avoiding significant tax complexity and the potential for a second level of taxation.

Action Step  Married physicians should review the deed to any residential real estate to ensure that the deed reflects ownership by the physician and the physician’s spouse as tenants by the entirety. Physicians should ensure that any commercial real estate that they own be transferred to a properly structured LLC; where the commercial real estate is currently owned by a corporation or a partnership, the physician should consider converting the entity to an LLC.

Mistake 9  Underfunding Pension Plans and Individual Retirement Accounts
Pension plans that are “qualified” plans under the Employee Retirement Income Security Act of 1979 (ERISA) have been held by the U.S. Supreme Court to be protected from creditor claims. Individual retirement accounts (IRAs) are protected from creditor claims under the laws of some, but by no means all, states. Moreover, even those states that exempt IRAs from creditor claims may not exempt Roth IRAs, since Roth IRAs are created under a different section of the Internal Revenue Code. Physicians should, therefore, be careful when deciding whether to “roll out” a pension plan into an IRA, since doing so may negate the asset’s innate protection.

Action Step  Physicians should ensure that they are fully funding their pension plans, as well as their IRAs, since such assets likely provide protection from creditor claims (as well as a significant financial benefit due to the ability to obtain tax-deferred growth).
Mistake 10  **Relying on “I Love You” Wills**

When a person dies survived by a spouse, no estate tax will be due. This is because an unlimited deduction exists for property that is left to a surviving spouse whether outright or in trust. Due to the perceived complexity of trusts, an individual who is ill advised will often choose an outright disposition of his or her estate to the spouse, and vice versa. Individuals who are well advised will always choose to use a trust; not for any tax benefit, but because creditors are barred from satisfying their claims against monies left in trust. This is true even though the surviving spouse might have broad access to the trust fund.

This planning is especially important for physicians, since they often employ “poor man’s asset protection planning” by titling assets in the name of their spouse. In such a case, if the spouse should die first, that type of planning is undone, since the assets will come back to the physician unless a trust is used.

**Action Step**  Physicians should review their last will and testament and that of their spouse. If it provides that any portion of the estate passes to the surviving spouse outright, it should be redrafted to include a qualified terminable interest property (QTIP) trust.

**Conclusion**

Physicians need not remain at risk to the possibility of a devastating malpractice claim. Timely asset protection planning, with the assistance of competent counsel and which is regularly reviewed, can reduce a physician’s risk to a manageable level.

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2.2 The 10 Biggest Legal Mistakes Physicians Make When Titling Their Assets Among Their Spouse, Children, and Other Family Members

By Patricia Donlevy-Rosen, Esq.
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Executive Summary
Many physicians attempt to implement asset protection on their own by titling assets among their spouse, children, and other family members. Often in doing so, rather than protect the assets from the physician’s creditor, the assets are exposed to additional creditors, which causes family conflicts and raises gift and estate tax issues. Physicians should proceed with caution and seek experienced counsel when obtaining new assets or transferring title to existing assets.

Mistake 1 Not Getting Advice of Experienced Counsel
Physicians sometimes transfer assets in the manner they believe will best protect them without first conferring with legal counsel. As a result, they may expose their assets to more liabilities than anticipated and receive less protection from third-party claims than could otherwise be obtained. In addition, titling assets among spouse, children, and other family members often has gift and estate tax ramifications that are problematic to undo later. Obtaining competent legal counsel should result in greater protection of assets with less exposure to liabilities and headaches, as well as provide a workable estate plan.

Action Step Physicians should consult with experienced counsel before they start to title assets.

Mistake 2 Making Fraudulent Transfers/Conveyances
Physicians who have been notified of a possible claim often gift or sell assets to protect those assets from creditors. In most states, a creditor who is unable to collect on a judgment will be able to challenge gifts and other transfers made within four years of the time the action on which the judgment is made arose. If successful, a court will undo the transfer (i.e., put the property back in the physician’s hands, thus making it available to the physician’s creditors). Any sale made for less than fair market value or any gift made, including one to a spouse, within the period provided by the state’s fraudulent transfer laws may result in a creditor getting a court to undo the transfer.

Action Step Before a claim is even threatened, physicians should have experienced counsel review their assets to ascertain whether the assets are titled in a manner that provides the physicians with the ultimate legal protection.
Mistake 3  **Assuming That Transfer of Title to a Spouse Will Protect the Asset**
Physicians transfer their assets to spouses who are not also physicians thinking that the assets will be protected from the physicians’ malpractice claims. Doing so assumes that the spouse does not work, or have an interest, in the physician’s practice. More important, it assumes that the nonphysician spouse will never be liable to anyone for any reason (such as credit card debts, medical bills, intentional torts, or accidents) and that the spouse will never divorce the physician or die before the physician does and leave the assets to the physician. When a physician titles assets in the spouse, there may be estate tax ramifications that will cause more estate taxes to be paid on the second death than need to be paid with proper planning. The Internal Revenue Code permits U.S. citizen spouses to transfer title back and forth between themselves with no immediate gift tax consequences, but if a recipient spouse is a not a U.S. citizen, there will be gift taxes on transfers in excess of $112,000 per year. Finally, a physician’s creditor may be able to undo the transfer to the spouse if a court finds the transfer to be a fraudulent transfer/conveyance.

**Action Step** Physicians should consult with experienced counsel before they start to transfer assets to a spouse.

Mistake 4  **Assuming That Tenancy by the Entirety Provides Adequate Protection**
Tenancy by the entirety (TBE) is a form of ownership recognized under common law that can be created and exist only during marriage. Traditionally, once property is put in TBE one spouse cannot transfer or mortgage it without the other spouse’s written consent (although statutes in certain states have changed this practice). Married physicians living in states that recognize traditional TBE (such as Delaware, Florida, Pennsylvania, Michigan, and Rhode Island) may believe their assets held as TBE to be completely protected. Although a creditor of one spouse generally cannot reach traditional TBE property in states recognizing TBE, bankruptcy courts have found ways to reach the debtor spouse’s interest by partition, foreclosure, or otherwise. There are no gift tax concerns to creating the TBE if the donee spouse is a U.S. citizen. Moreover, death and divorce both end any TBE protection.

**Action Step** Before placing any property in TBE, physicians need to consult with experienced counsel to determine whether the benefits of doing so outweigh the negative effects related to life circumstances and gift and estate tax ramifications.

Mistake 5  **Giving Up Ownership or Control Unnecessarily**
Physicians take property they own outright and retitle it with another family member as tenants in common or as joint tenants with right of survivorship. A tenancy in common is one in which the interests are unilaterally severable (i.e., one owner can transfer his or her interest without the consent of the other). Since the family member may transfer his or her interest without the physician’s consent, the creditor of the family member may reach the family member’s interest in the property. The death of the family member would not, absent a
provision in the family member’s will (or under state intestate successor law), return the property interest to the physician. Creditors (including spouses) of the estate of the family member would be able to reach the deceased family member’s interest in the property held as tenants in common. Thus, the physician could end up with an unwanted and uncooperative “partner” (creditor of the family member).

A joint tenancy with the right of survivorship is similar to a tenancy in common in that it is also unilaterally severable; the family member may transfer his or her interest without the physician’s consent. Thus, while the family member is alive, his or her creditors (including spouses) may reach the family member’s interest in the property. The joint tenancy with the right of survivorship differs from a tenancy in common only upon the death of one of the co-owners. Conversely, if the physician dies first, the physician’s creditors would have no recourse, since the entire property interest would belong to the family member. If the family member dies first, the entire property interest would vest in the physician, providing no protection from the physician’s creditors.

Both tenancy in common and tenancy with right of survivorship are subject to partition or severance by a court.

**Action Step** Physicians should discuss the pros and cons of making title transfers with competent counsel before doing so.

**Mistake 6 Assumption That Transferring Title to Children or Other Family Members Will Protect Assets**

Physicians transfer their assets to their children or other family members assuming that the assets will be protected from malpractice claims (sometimes with the expectation that the asset will be returned at some future date). Doing so assumes that the child or family member does not work, or have an interest, in the physician’s practice. More important, it assumes that the child or family member will never be liable to anyone for any reason (such as alimony or child support, credit card debts, medical bills, intentional torts, or accidents) and that the child or family member will make the asset available to the physician at a later date or when asked. It also assumes that the child’s or family member’s estate will return the asset to or distribute it according to the physician’s wishes. But what if the child/transferee dies first? His or her spouse may have different thoughts about returning the asset. When a physician titles an asset in the name of a child or family member, there may be gift tax ramifications causing the physician to owe gift taxes in that year, or estate tax ramifications that will cause more estate taxes to be paid on the second death than need to be paid with proper planning. Finally, a physician’s creditor may be able to undo the transfer if a court finds it to be a fraudulent transfer/conveyance (generally, a four-year window).
ASSET PROTECTION: TITLING ASSETS AMONG FAMILY

**Action Step** Physicians should not rely on the willingness or ability of children or other family members to give back assets. Physicians should consult with experienced counsel before starting to transfer assets to a child or family member.

**Mistake 7** **Assuming That Children or Other Family Members Will Be Willing and Able to Transfer Assets Back and Forgetting That They Can Have Their Own Liabilities**

Physicians faced with malpractice threats sometimes transfer title of assets to children or other family members expecting that when the threat is over (or when the physician so desires), the assets will be given back. Assuming that the transfer is a true gift (no strings attached), the physician is counting on the goodwill of the recipient to give it back, as well as the recipient being alive and not having subjected the asset to his or her own creditors. For example, if a doctor transfers rental property to his unmarried cousin, who later marries, has a son, and then divorces his wife, that rental property may end up being transferred by a court to the cousin’s spouse as part of the divorce settlement (or its rental income could be garnished for child support). Thus, despite the cousin’s intentions, the physician may have no recourse. In another example, a doctor gives his stamp collection to his elderly retired aunt, who seemingly isn’t likely to incur liabilities. Unbeknownst to the physician, his aunt has cosigned a loan for her ne’er-do-well nephew, and the lender turns to her to pay the debt. When her liquid assets are insufficient to pay the creditor, the lender takes the stamp collection.

**Action Step** Physicians shouldn’t rely on the willingness or ability of family members to return assets at a later time, and must remember that the assets could be exposed to a new set of creditors—that of the transferee.

**Mistake 8** **Assuming That Children or Other Family Members Will Be Alive to Give Back Assets**

Physicians transfer title of assets to their children or other family members expecting that when the threat is over (or the physician so desires), the assets will be returned. The first assumption is that the child or family member who received the property will be alive at the time the physician wants the asset back. If not, the family member’s estate would have no reason to return the property; that is, unless the child or other family member provided for its return in his or her will or trust. If the property is not returned by the family member’s will or trust, the physician is out of luck. If the will or trust does return it to the physician, the return may be at a time when the very creditor the physician sought to avoid is ready to attach the property. A properly implemented asset protection trust would ensure the physician that the property will always be available for the physician’s benefit and enjoyment while the physician is alive, and available for the physician’s chosen beneficiaries upon the physician’s demise.
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Action Step  Physicians should assume that once they make a gift it is forever gone. Instead of making gifts for asset protection, physicians should consider the use of properly structured asset protection trusts, so that the assets will be available for the benefit of the physician during the physician’s lifetime.

Mistake 9  **Neglecting the Gift Tax Ramifications of Transferring Assets to Children or Other Family Members**

Physicians make gifts to their children or other family members without regard to the gift tax ramifications. While a transfer may protect the asset from the physician’s creditors, it may also use up the physician’s annual gift tax exclusion (currently $11,000 per donee per year) and use up the lifetime unified credit ($1.5 million for gifts made for years through 2004).

Action Step  Before making a gift or transferring assets for less than fair market value, physicians should consult with a qualified professional to ascertain the gift tax ramifications.

Mistake 10  **Neglecting the Estate Tax Ramifications of Transferring Assets to Anyone Else (Including the Spouse)**

Physicians transferring title by gift (including “sales” for less than fair market value) often do so without regard to the effect the transfer has on their estate, including the estate tax ramifications. Improper titling of assets may cause additional estate taxes to be incurred. For example, if a physician places title of all the family’s assets in the name of the nonphysician spouse (or as tenancy by the entirety or joint tenancy with right of survivorship), when the second spouse dies all the assets will be subject to estate tax and only one unified credit will be used, rather than two (one for each spouse). If gifts are made in excess of the annual gift tax exclusion in any year, the excess will eat up the one-time unified-credit amount and may cause additional estate taxes to be due on death. With proper planning, the estate taxes can be minimized, if not avoided entirely. In addition, “temporary” gifts to select family members may result in the physician’s estate being distributed in a manner that the physician had not anticipated and cause unnecessary strife among family members (such as when one or more family members inadvertently receive more than their “fair share”).

Action Step  Before making a gift or transferring assets for less than fair market value, physicians should consult with a qualified professional to ascertain the estate tax ramifications.

Conclusion

Physicians seeking to protect their assets who are mindful of these mistakes and take steps to avoid them will be most likely to achieve the desired protection for their assets.
ASSET PROTECTION: STATE EXEMPTION LAWS

Additional Resources
- www.ProtectYou.com (website authored and maintained by Donlevy-Rosen & Rosen, PA, a law firm in Coral Gables (Miami), Fla.)

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2.3 The 10 Biggest Legal Mistakes Physicians Make When Attempting to Use State Exemption Laws to Shield Assets

By Patricia Donlevy-Rosen, Esq.
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Executive Summary
All states provide some degree of asset protection through their state exemption laws. Many physicians attempt to implement asset protection on their own by using state exemption laws that shield certain types of assets, such as a homestead, wages, annuities, life insurance, and retirement funds. In doing so, physicians often invest in assets that provide neither the maximum return nor the optimum asset protection. In addition, investments in exempt assets are often made without proper estate tax considerations. Therefore, physicians need to proceed with caution and seek experienced advice before attempting to utilize state exemption laws.

Mistake 1 Not Getting Advice of Experienced Counsel Before Attempting to Use a State Exemption
Physicians often attempt to use the creditor exemption laws of the state in which they reside in a way that does not always provide the desired exemption. As a result, they may expose their assets to more liabilities than anticipated, and they may receive no or less protection.
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from third-party claims than could otherwise be obtained. In addition, using state exemptions sometimes causes physicians to forgo other investment opportunities with greater appreciation potential. Obtaining competent legal counsel will result in greater protection of assets with less exposure to liabilities and headaches, as well as provide flexible estate planning.

**Action Step** Physicians should consult with legal counsel who has knowledge of the exemption laws and the options available in using them.

**Mistake 2** Not Knowing the Exemption Laws That Apply to the State of Current Residence

Some assertions should not be taken as gospel, such as a statement about the protection afforded by putting assets in a spouse’s name or by titling assets jointly with a spouse. The state in which a physician resides (or the state in which a physician’s real property is located) may not afford the same protection as the protection afforded by other states. A physician needs to know which state is his or her primary residence for purposes of litigation (it may not be the same as the state in which the physician has an office). In addition, a physician needs to know what exemptions are available for residents of the state and to what extent those exemptions are available to the physician given the specific circumstances. For example, Massachusetts provides generous homestead protection to people over a certain age or with a disability. Since real property is governed by the laws of the state in which it is located, if the physician (or a trust) owns property outside his or her state of residence, the physician will need to know what if any protections are available in that state for the real property. However, the physician must also remember that when real property is owned by an entity (e.g., a limited partnership, a limited liability company, or a corporation), other laws may apply, and homestead exemptions may not be available.

**Action Step** Physicians need to have a qualified professional periodically review their assets to ensure those assets are held in a manner providing the best protection for the physicians.

**Mistake 3** Attempting to Convert a Nonexempt Asset into an Exempt Asset at the Wrong Time

Physicians sometimes attempt to protect their assets after the threat of a claim occurs by converting nonexempt assets into exempt assets. An exemption from attachment, garnishment, or legal process provided by a state’s statute would not be effective if the physician fraudulently transferred or converted the asset. Any conversion by the physician that results in the proceeds of the asset becoming exempt by state law from the claims of a creditor of the physician may be a fraudulent asset conversion as to the creditor—whether the creditor’s claim arose before or after the conversion of the asset—if the debtor-physician made the conversion with the intent to hinder, delay, or defeat the claim of the creditor. In
other words, a court can order the transfer/conversion to be undone, and thus make the asset available to the creditor.

**Action Step**  Asset protection planning should be undertaken (and completed) before there is any claim against the physician.

**Mistake 4  Moving One’s Principal Residence from One State to Another**
People often relocate from one state to another. After they move, they often forget to have their wills redone and their asset holdings reviewed in light of the laws of their new state of residence. For example, a physician moving to Florida from Delaware (which has no homestead protection) may fail to take advantage of the generous homestead (unlimited value) protection afforded in Florida for a physician’s primary residence. Conversely, moving may cause the loss of protection. For example, Florida provides a 100% wage exemption for the head of a family, whereas Georgia limits it to 75%. Thus, a physician who is the head of a family and moves his practice from northern Florida to Georgia may not realize that his wages have lost substantial protection. Primary residence is also relevant when IRAs, SEP/IRAs, and 509 plans are involved. Plans that are not “ERISA qualified plans” are protected by statute in some states (such as Florida, Kansas, New York, and Wisconsin). Whether and to what extent a physician’s non-ERISA plan is protected must be determined by reviewing the applicable state law. Physicians who move from a state that protects IRAs to a state that does not lose the protection for their IRAs.

**Action Step**  Before they move their residence to another state, physicians should seek counsel from an attorney familiar with the exemption laws of the intended state of residence.

**Mistake 5  Losing the Exemption by Titling the Asset Improperly**
Just because a physician owns an asset that is eligible for exemption under state law does not make the asset automatically exempt; it must be titled in the specific manner to allow the physician to claim the exemption. For example, state law may provide a homestead exemption that makes all or part of the physician’s primary residence in the state exempt from the physician’s creditors. Generally, only a natural person (i.e., a human being) may claim homestead protection, and that natural person must have legal title to the property. Thus, if the physician’s principal residence is owned by a limited liability company, a limited partnership, a corporation, or a trust, the physician may lose the exemption. For example, a physician’s home in Florida would be 100% exempt from the claims of his or her creditors. If the physician places the home in a family limited partnership, the homestead protection would be lost and a creditor may have a way to reach the otherwise exempt asset.

**Action Step**  Physicians should have the manner in which their assets are titled reviewed by competent counsel to ensure that they are receiving the maximum protection from available exemptions.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

Mistake 6  Relying on a State Exemption When Other Investment Properties or Vehicles Would Better Suit Physicians’ Goals for Asset Protection, Estate Planning, and Investing

Physicians residing in states that provide a generous homestead protection from creditors often invest a substantial portion of their wealth in a residence. Often, they do not realize that the state statute protects only the actual primary residence in the state in which they reside such that their second home is fully exposed to creditor claims. Also, homestead exemptions typically cover the actual residence, not the contents, such as furnishings. In Florida, for example, a physician may have unlimited value protection for the actual residence (assuming that it is on one-half acre or less in a municipality), but only $1,000 of the physician’s furnishings are protected. Also, putting an inordinate proportion of one’s net worth in a primary residence results in the loss of other investment opportunities. The real estate market is not always the best investment vehicle.

Action Step  Before taking advantage of an exemption, physicians should have an experienced professional clearly explain the drawbacks and limitations of the exemption.

Mistake 7  Using Life Insurance or Annuity Contracts As a Primary Investment or an Asset Protection Vehicle

In states providing life insurance or annuity exemptions, physicians often place a disproportionate amount of their net worth in such vehicles. Life insurance policies and annuity contracts are often marketed as a method of investing assets with protection from creditors. Physicians do not weigh and are often unaware of the hidden costs of such vehicles in terms of built-in commissions, termination fees, and limited investment offerings (usually restricted to a limited number of mutual funds), as well as their inflexibility when compared with other protective vehicles, such as properly implemented asset protection trusts or properly implemented asset protection trusts in combination with limited liability companies. In addition, any investment or premium payment made once the threat of a claim exists is subject to attack on fraudulent transfer grounds and may be undone by a court.

The availability and the extent of the exemption with respect to the cash value of life insurance during a physician’s life vary widely among the states; the exemption is limited to $4,000 of cash value in bankruptcy where the federal exemptions apply. Although some states (e.g., Florida, New Jersey, and New York) provide a more generous exemption, further protection for the insurance may be available by transferring ownership of the insurance to an irrevocable insurance trust, a limited partnership, or a limited liability company. Each provides additional impediments to creditors, such as spendthrift clauses and charging order limitations, which can usually be used for estate planning purposes as a means of removing the assets from the physician’s estate. If, however, a life insurance trust is used, it should be in place (in other words, fully executed) before the policy is acquired, and the policy should
ASSET PROTECTION: STATE EXEMPTION LAWS

be acquired by the trust directly. Also, if premiums are paid after a claim is asserted, the creditor may be able to recover the premiums paid.

**Action Step**  
Before physicians commit a substantial portion of their assets to an annuity or life insurance trust, they should consult an experienced asset protection professional.

**Mistake 8**  
**Placing Title to a Physician’s Life Insurance Policy in a Spouse, Children, or Other Family Members**

Physicians often attempt to protect their family members by purchasing life insurance and making the spouse, a child, or other family member the owner of the policy. In states where life insurance is exempt, it is generally exempt from the creditors of the insured not the creditors of the owner. Thus, placing policy ownership in the name of the spouse, a child, or another family member exposes the policy to the claims of such family member’s creditors. In addition, transferring title raises gift and estate tax issues. Instead, if the physician has a life insurance trust purchase the policy initially or own it for three years before the death of the insured (physician), the insurance death benefit will not be included in the physician’s estate and the death benefit will escape estate taxes.

**Action Step**  
Physicians should not transfer ownership of their life insurance policies to their spouse, children, or other family members; rather they should have their attorney prepare a life insurance trust to purchase the life insurance policy (or to hold existing life insurance policies).

**Mistake 9**  
**Purchasing or Owning a Life Insurance Policy on One’s Own Life and Making One’s Estate the Beneficiary**

A state exemption law may protect only the death proceeds of a life insurance policy that are not payable to the physician’s estate (or a trust obligated for the deceased physician’s debts) from the creditors of the insured. A few states also protect the proceeds from the creditors of the beneficiaries. If the physician’s estate is the beneficiary of his or her life insurance policy, the policy proceeds will be available to the creditors of the physician’s estate and be included in the physician’s estate for the purpose of determining the gross taxable estate for estate tax purposes. On the other hand, if the physician has his or her life insurance trust purchase a life insurance policy on the physician’s life and makes the trust the beneficiary, then the death proceeds would not be included in the estate and would not be reachable by the creditors of the physician’s estate. If the physician already owns a life insurance policy on his or her life and transfers ownership to a life insurance trust (and does not have the estate named as the beneficiary), the physician must survive three years from the transfer for the death benefit to be excluded from his or her estate for estate tax purposes.
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**Action Step** A physician must be sure not to purchase or own life insurance directly. Life insurance policies should be purchased and owned by a life insurance trust and a physician’s estate should never be a beneficiary of the policy.

**Mistake 10** Relying on Tax-Qualified Retirement Vehicles in Order to Be Protected from the Claims of Creditors

Lower courts have chipped away at guaranteed protection, creating exceptions and limitations to the protection of tax-qualified retirement plans. One court has even stated that it was not bound by the fact that the IRS had determined a plan to be qualified and that the court could take a hindsight look at qualification. The pension benefits of physicians who work for a large entity and do not own a controlling interest in it are probably protected. However, the pension benefits of physicians who are owners of, or partners or shareholders in, a practice may not be protected. Physicians should take matters into their own hands. Following the asset protection rule of “removing the ability of any U.S. court to disrupt the physician’s planning,” protecting retirement plan assets can be accomplished by causing the retirement plan to establish a single-member offshore limited liability company (an LLC) governed by properly structured documents containing special protective provisions. The retirement plan contributes (transfers) all of its assets to the LLC in exchange for a 100% ownership interest (member interest) in the LLC, leaving the plan directly holding only a member interest in the offshore LLC. As long as no significant litigation threat exists, the LLC assets can continue to be held at the same U.S. financial institutions in which they previously resided, managed by the same investment adviser, and the trustee of the pension plan (probably the physician) can be the LLC co-manager and have direct signature control over the cash and securities as before. If a creditor seeks to reach the retirement plan assets, the offshore co-manager of the LLC would, pursuant to the LLC operating agreement, remove the U.S. co-manager and relocate the LLC assets to a suitable offshore financial institution, identified beforehand with the assistance of experienced counsel. At this point, the retirement plan assets would be held at an offshore financial institution, but they would remain invested in the same securities and managed by the same investment adviser as they were before. A U.S. court could not force the LLC owner (the retirement plan) to turn over the LLC assets because the offshore LLC manager (now in control of the assets) is permitted to act only when the LLC owner (the retirement plan) is giving directions voluntarily—without any U.S. court interference.

**Action Step** To be certain that their qualified retirement plan assets will be available for retirement enjoyment, physicians should not depend on a U.S. court to follow the letter of the law. Rather, they should get competent, experienced counsel and protect their assets.

**Conclusion**

Physicians seeking to protect their assets who are mindful of these mistakes and take steps to avoid them will be most likely to achieve the desired protection for their assets.
2.4 The 10 Biggest Legal Mistakes Physicians Make When Using Offshore Trusts

By Patricia Donlevy-Rosen, Esq.

Executive Summary

Many physicians, due to lack of information or misinformation, do not take advantage of the full spectrum of asset protection legally available to them. As a result, rather than effectively protecting their assets from creditors, they leave their assets exposed and incur unnecessary expenses, legal and otherwise. Therefore, physicians should proceed with caution and use experienced counsel when considering how to best protect their assets or use offshore trusts.

Mistake 1    Not Getting Advice of Experienced U.S. Counsel

Physicians sometimes set up offshore trusts with the help of offshore companies or onshore
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

persons that they believe will help them for bargain prices or because the physicians hope to achieve income tax savings. As a result, physicians may expose their assets to more liabilities than anticipated, and they may receive less protection from third-party claims than could otherwise be obtained. In addition, transferring assets to an offshore trust may have gift and estate tax ramifications. Although local counsel may be familiar with gift and estate tax issues, they may lack the knowledge and experience needed to optimize the protection afforded by offshore trust legislation. Obtaining competent legal counsel will result in greater protection of assets with less exposure to liabilities and headaches, as well as provide a workable estate plan.

**Action Step** Physicians should consult with experienced asset protection counsel before they execute, or start to title assets in the name of, offshore trusts.

**Mistake 2 Making Erroneous Assumptions about What an Offshore Trust Entails**
Physicians often recoil at the suggestion of offshore trust asset protection planning because they mistakenly assume that such planning entails the immediate loss of control over their assets. However, an offshore asset protection trust (OAPT) plan may be structured so that the liquid assets (e.g., cash, securities, and bonds) of the physician are held in a limited liability company (LLC) which, in turn, is wholly owned by the offshore trust (the trust with the LLC). If the physician is named manager of the LLC, the physician would retain day-to-day control over the assets. Only at the point that the physician faces a serious threat from a third party (the critical time) would the physician’s day-to-day control be terminated, and the determination of the critical time would always be by the physician.

Also, just as a physician may have financial accounts anywhere, so may the physician’s OAPT or his or her trust with the LLC. Only at the critical time would the accounts need to be totally offshore, in a financial institution with no U.S. branch. Even at the critical time, the physician would be able to have his or her chosen asset manager continue to manage the assets (i.e., direct the buying and selling of securities).

**Action Step** Before dismissing the idea of using an OAPT, a physician should discuss the physician’s concerns with an experienced professional who regularly deals with offshore trusts.

**Mistake 3 Assuming That All Offshore Trust Documents Provide Equivalent Protection**
All offshore trust documents are not created equal. Many offshore trust companies offer trust forms, and these are often used by U.S. lawyers who are not well versed in offshore asset protection planning. If the particular offshore legislation permits, these forms will provide protective provisions, such as a “flight clause” and a “duress clause”; however, such form language will fail to provide for the effective execution of the clauses. For example, most
flight clauses provide that the trust may “move” to another jurisdiction, if appropriate, without providing a mechanism to be certain that the flight clause can be affected under all circumstances (e.g., even if an injunction has been issued). Also, most form “duress clauses” nullify the attempted exercise of any power unless exercised by the power holder of his or her own free will, again, without providing a mechanism by which the trustee can be certain that a power is being freely exercised. Usually it is only counsel with extensive experience in offshore trusts who have thought out and provided for all contingencies.

Some physicians have OAPTs drafted by non-U.S. lawyers or other professionals located in the offshore jurisdiction. Although they may address protective clause issues, they will uniformly fail to draft a trust document providing for the optimum legal tax and estate planning under U.S. laws. For example, they rarely provide for the marital deduction or credit shelter trusts, thus possibly resulting in gift taxes and higher than necessary estate taxes.

**Action Step** Physicians should consult with U.S. counsel knowledgeable about offshore trusts, and if counsel doesn’t satisfactorily address all of their concerns, go elsewhere for counsel.

**Mistake 4 Assuming That All Offshore Trust Jurisdictions and All Trust Companies Are Equivalent**

Physicians often choose their offshore jurisdiction based on “curb appeal,” which is the most enticing place to visit (e.g., Bermuda, the Bahamas, or the Cayman Islands). This selection process is akin to a layperson picking a medical specialist based on the specialist’s proximity to a five-star restaurant. Those knowledgeable in the field of offshore asset protection have ascertained the best jurisdictions for registering a trust based on the following factors: the jurisdiction’s legal system (common law, rather than civil law), its enacted protective legislation applicable to offshore trusts (i.e., statutes of limitation, burdens of proof, consequences of fraudulent transfers, all of which vary significantly among the jurisdictions), its economic health and political/social stability, its primary language (English), and most important, its track record in applying its protective legislation to the trusts that have been attacked by creditors. Physicians often fail to realize that some offshore jurisdictions have legislation that provides less protection than that afforded by the physician’s home state. For example, the statute of limitations for attacking trusts is longer in the Cayman Islands than the four years applicable in most states.

In choosing a trust company, a physician should depend on counsel experienced with entities in the offshore jurisdiction, since all trust companies do not provide equivalent service. A physician should compare not only fees, but also ease of communication, expertise of staff, and track record in defending trusts.
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**Action Step** Physicians should ask counsel how the proposed offshore jurisdiction and offshore trust company compares with others, and if counsel isn’t knowledgeable, go elsewhere for counsel.

**Mistake 5 Making the Physician or the Physician’s Spouse a Trustee or a Protector**
In the usual OAPT, there will be a trust protector (provided the applicable legislation allows one). Regarding the OAPT, the protector is the most powerful role in that the protector may veto any discretionary act of the trustee and remove and replace any trustee with or without cause. The initial protector is often a friend, a relative, or a company chosen by the physician settlor, but should never be the physician settlor or the physician settlor’s spouse. Also, a properly drafted OAPT will preclude the settlor and the settlor’s spouse from being trustees. A beneficiary should also be precluded from acting as a sole trustee and from participating in the exercise of any discretionary powers that might inure to the beneficiary’s benefit. Otherwise, a U.S. court could order the use of those powers so as to allow the creditors of the physician settlor, the physician settlor’s spouse, or other beneficiary to reach the trust assets.

**Action Step** A physician should ascertain that the trust document itself prohibits the physician or the physician’s spouse from being a protector or a trustee, and prohibits a beneficiary from being the sole trustee.

**Mistake 6 Failing to Transfer or Receive OAPT Assets Properly**
Physicians often execute OAPT documents, but fail to take the important step of funding the structure with assets. As soon as the trust (and holding entity) documents have been executed and filed, assets should be retitled in the name of the trust (or holding entities). Each transfer, initial and subsequent, to a trust (domestic or offshore) is subject to fraudulent transfer and solvency scrutiny. If a physician makes transfers after a claim has been made, that transfer may not have the ultimate protection, since the creditor will have a basis to attack the transfer. In addition, an asset loses the protection afforded by the trust and its jurisdiction once it is distributed to any beneficiary outside of the OAPT structure. However, the trustee in a properly drafted offshore trust structure will have discretion as to the manner of the distribution, and should be able to, among other things: directly pay expenses of a beneficiary, including the physician; permit the beneficiary, including the physician, to reside in a dwelling or other improved real estate owned by the OAPT (see Mistake 8); accumulate income; and/or purchase an asset exempt under the laws of the recipient beneficiary’s state, and then transfer that exempt asset to that beneficiary.

**Action Step** The physician should transfer eligible assets into the OAPT structure as soon as it is effective, and not have significant assets distributed without discussion with counsel. Such discussion should include a thorough review of any pending or threatened litigation or judgments.
Mistake 7  **Failing to Understand How Distributions/Benefits Can Be Received**
The purpose of an OAPT is to enable a physician to be able to enjoy assets without the assets being vulnerable to creditor seizure. A properly drafted OAPT should give the trustee(s) the discretion to make distributions of income and/or principal to or for the benefit of its beneficiaries, which would normally include the physician. However, just as having the most effective medication in one’s possession is useless without the knowledge of how to properly administer it, a well-structured asset protection plan is less than optimally effective if the physician is not clear as to how it works. The physician should understand whether and to what extent assets can be distributed, both when there is no claim against the physician, and most important, when there is a serious claim or judgment against the physician.

**Action Step** Before executing and funding an OAPT, a physician should be sure to understand how it operates, and if counsel cannot adequately and clearly explain its operation, the physician should go elsewhere for counsel.

Mistake 8  **Assuming That Transfer of an Immovable Asset’s Title to an OAPT Will Provide Protection**
Physicians may be told that transferring title of their assets to OAPTs will protect the assets from malpractice claims. This protection is true if the asset itself can be moved offshore by the trustee at the critical time, so that no U.S. court will have jurisdiction over it. However, certain assets, such as equipment, real estate (including a home or office building), and accounts receivable (“immovable assets”) cannot be moved offshore. Therefore, if a physician titles his or her immovable assets in the name of an OAPT and is sued, the fact that the immovable asset is still located in the United States makes it vulnerable to the claims of the physician’s creditor. For example, a court may disregard the transfer, especially if there is a fraudulent transfer issue, and have the property reedded or retitled in the name of the creditor. The only way to make an immovable asset unattractive to a creditor is to remove its value. Removing value, by a mortgage or lien, and placing that value (proceeds of the mortgage or loan) into the OAPT in effect protects the immovable asset from the claims of creditors.

**Action Step** Physicians should consult with experienced counsel before they start to transfer title to a trust. They should also inquire about removing value from immovable assets, such as equipment, real estate, and accounts receivable.

Mistake 9  **Purchasing Annuities or Life Insurance Contracts Instead of Implementing an OAPT with a Loan Structure**
Physicians often borrow against their immovable assets to purchase annuity or life insurance contracts, believing they are taking advantage of their state’s limited exemption from creditors applicable to annuity or life insurance contracts. In most cases, the contract is distributed to the owners of the business (i.e., medical practice) as “nontaxable” deferred
compensation (nontaxable because the continued ownership of the contract by the business owner is allegedly subject to a “substantial risk of forfeiture” if the owner leaves the business or loses his or her professional license). Such contracts are risky from two perspectives: First, it is almost certain that the “tax-free” distribution of the contract will not be tax free (because the Internal Revenue Service will not respect the contrived “risk of forfeiture” for a closely held business) and the ultimate protection depends on a U.S. court upholding the referenced exemption (which can and has been successfully attacked several times). Second, the interest paid on the loan incurred to purchase life insurance or annuity contracts will not be deductible (adding to the cost of the plan). Alternatively, a closely held medical practice can accomplish asset protection for its immovable assets by forming its own OAPT, and implementing a loan structure similar to the one described in Mistake 8.

Action Plan  Medical practices should compare the benefits of an OAPT with a loan structure to the benefits of purchasing annuity or life insurance contracts.

Mistake 10  **Assuming That OAPTs Provide Income, Gift, or Estate Tax Advantages**

Contrary to what promoters often tout to U.S. citizens or residents, OAPTs cannot legitimately result in:

- A reduction or elimination of income subject to tax;
- Deductions for personal expenses paid by the trust;
- Depreciation deductions for a physician owner’s personal residence and furnishings;
- A stepped-up basis for property transferred to the trust;
- The reduction or elimination of self-employment taxes; or
- The reduction or elimination of gift and estate taxes.

Benefits like these are inconsistent with the tax rules applicable to trusts and the other entities that may be involved. The IRS has targeted these schemes, and attempts to avoid income tax may subject the physician taxpayer to civil or criminal penalties, or both.

Schemes often consist of convoluted, multitiered structures, typically involving more than one trust (and other entities as well), each holding different assets of the physician taxpayer (e.g., the business can be owned by one entity, the business equipment by a second entity, a home by a third, and an automobile by a fourth), as well as interests in other trusts. Funds may flow from one trust to another trust by way of rental agreements, fees for services, purchase and sale agreements, and distributions. Some trusts purport to involve charitable purposes. A common factor in each of these trusts is that the original owner of the assets that are nominally subject to the trust effectively retains authority to cause the financial benefits of the trust to be directly or indirectly returned or made available to the owner. For example, the trustee may be the promoter or a relative or friend of the owner who simply carries out the directions of the owner whether or not permitted by the terms of the trust. Often, the trustee
ASSET PROTECTION: OFFSHORE TRUSTS

gives the owner checks that are presigned by the trustee, checks that are accompanied by a rubber stamp of the trustee’s signature, or a credit card or a debit card with the intention of permitting the owner to obtain cash from the trust or otherwise to use the assets of the trust for the owner’s benefit. Promoters often advise potential physician clients not to contact their own tax attorney or accountant because the formal education undertaken by those professionals will somehow preclude their understanding of the scheme. These schemes may be known by a variety of names, including the common law trust, the pure trust, the pure equity contract trust, and the contract trust.

An OAPT is gift- and estate-tax neutral. Similar to conventional estate planning, using a properly drafted domestic inter vivos trust, the OAPT will, upon the physician’s death, avoid probate and the associated expenditure of money and time, thus offering similar advantages regarding the administration and distribution of the physician’s estate. Additionally, the OAPT structure limits the exposure to contests by beneficiaries and heirs-at-law, since it is not bound by state laws regarding the rights of spouses, children, and other heirs-at-law. Therefore, assuming that the OAPT is governed by a jurisdiction that does not recognize forced heirship rights (which typically refers to the civil law rules in Latin American countries that are similar to U.S. elective share rules), the physician’s wishes will govern distributions at his or her death.

At the physician’s death, the value of the assets in the OAPT will be included in the physician’s gross estate (unless there was a completed gift or sale to the trust). In order to take full advantage of all the estate planning techniques available, the OAPT should contain the provisions that otherwise would be found in the physician’s will or domestic inter vivos trust covering the unified credit, the marital deduction, and the generation-skipping transfer tax exemption.

Action Step   Physicians should not use OAPTs to avoid paying income taxes, but they should be sure that the optimum gift and estate planning has been accomplished.

Conclusion   Physicians seeking to protect their assets who are mindful of these mistakes and take steps to avoid them will be most likely to achieve the desired protection for their assets.

Additional Resources

- www.ProtectYou.com (a website authored and maintained by the law firm of Donlevy-Rosen & Rosen PA, Coral Gables (Miami), Fla.)
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

Executive Summary
It is a common misconception that it is illegal for a U.S. citizen to hold assets offshore. Although moving assets offshore to hide income from the Internal Revenue Service in order to evade taxes is prohibited, the use of an offshore account to protect one’s assets from creditors is perfectly acceptable under U.S. law and is a common practice. Establishing an
ASSET PROTECTION: MOVING ASSETS OFFSHORE

offshore account, however, requires care, and there are some common errors physicians make when moving their assets offshore.

Mistake 1 Not Considering the Option of Moving Assets Offshore
Physicians are often subject to lawsuits. A judgment or an out-of-court settlement for an amount larger than the physician’s malpractice coverage can mean personal and business assets will be seized to satisfy the remaining liability. Proper structuring of the physician’s business practice may reduce this risk, but many times that is not enough. In order to reduce the risk of assets being seized to satisfy a judgment, all physicians should consider moving their assets into an offshore account.

Action Step Physicians should talk to an experienced professional about setting up an offshore account to protect both their business and personal assets.

Mistake 2 Not Planning Ahead
The best time to plan and move assets offshore is before a lawsuit is threatened or filed in court. Once a suit is pending, a physician may still transfer his or her assets offshore, but it is best to do so prior to a suit. If the assets are moved before a suit, they cannot be reached, especially if they are placed in a country that does not recognize the judgments of U.S. courts.

Action Step Physicians should consult with an experienced professional as soon as possible to discuss the benefits of moving assets offshore before it is too late.

Mistake 3 Failing to Disclose and Pay Taxes on Offshore Assets
Physicians are one of the targeted groups for offshore tax schemes, according to the Internal Revenue Service. Every year, new “foolproof” ways to avoid paying taxes are marketed to unsuspecting physicians. Ignorance of the tax law is no excuse, however, and physicians who fail to disclose income and do not pay their taxes are subject to steep civil fines and criminal penalties, including jail time.

Action Step Physicians should know that something that sounds too good to be true usually is. They should not fall prey to abusive tax schemes. U.S. citizens are subject to tax on their worldwide income, and they should disclose all income and pay the tax on it. When in doubt, physicians should consult a qualified tax professional.

Mistake 4 Expecting to Save Taxes by Moving Offshore
Physicians are deluged with information on how to avoid paying taxes on their income. Any reputable attorney will know that most offshore schemes will not reduce tax liability. Physicians who want to reduce their tax liability should talk to an experienced professional about how to do so legitimately.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

**Action Step** Physicians should not rely on offshore accounts to reduce their income tax responsibility. They should talk to an experienced professional about ways to legally reduce any expected tax liability.

**Mistake 5 Using an Unqualified Professional**
Physicians should not consult unqualified professionals when moving assets offshore. A licensed, qualified professional will have been practicing for years and will know the law in the United States and multiple offshore jurisdictions. An unlicensed, unqualified professional will not be trained in moving assets offshore. The consequences of using such a professional can range from minor ones (such as an increase in taxes due) to severe (such as mishandled funds or poorly structured transactions). In a worst-case scenario, a physician could lose all of his or her money to poor investments or illegitimate transactions. An improperly structured offshore account could result in assets being seized by creditors.

**Action Step** Physicians should consult a licensed professional attorney or certified public accountant who has experience setting up offshore accounts. Physicians should ask for recommendations and references from people whom they trust.

**Mistake 6 Not Using an Established Jurisdiction**
Physicians who want to move assets to offshore accounts should be sure to establish their accounts in a jurisdiction that has a reputation for honesty and security in business transactions. Countries that have steady governments and stable economies are recommended for offshore transactions. A licensed professional will be able to recommend the jurisdiction or jurisdictions that are most appropriate for each physician’s individual situation. Moving assets to an unstable or insecure jurisdiction may result in the assets being temporarily unreachable or sometimes permanently lost. Jurisdictions that are often recommended for moving assets offshore include the Bahamas, the Cayman Islands, Panama, the Cook Islands, and Bermuda.

**Action Step** Physicians should be sure to establish their offshore accounts in countries that have good reputations for such transactions.

**Mistake 7 Using a Disreputable Offshore Company**
Physicians who want to evade creditors can go to one of many disreputable offshore firms and establish an account, and their name is not placed anywhere on the account. This account is great because, in name, the money is no longer theirs and cannot be linked to them by creditors or the Internal Revenue Service. This account is also a problem because, in name, the money is no longer theirs and cannot be linked to them. Such firms have been known to steal these funds from many an unwary physician, knowing the defrauded physician has nowhere to turn: since they removed their names from the account, they have no way of proving the money is theirs and the U.S. government has no power in another country.
ASSET PROTECTION: MOVING ASSETS OFFSHORE

Action Step  Physicians should use established investment and banking firms to set up their offshore accounts, and keep their names somewhere on the account.

Mistake 8  Failing to Protect All Exposed Assets
Physicians are often wary of moving all of their assets offshore. Physicians who leave exposed assets onshore and within the reach of creditors risk losing those assets if a lawsuit is ever brought against them. All of a physician’s assets do not have to be moved offshore, but eventually they should all be removed from the reach of creditors. A physician who is cautious about moving all of his or her assets offshore should consult a professional about alternative asset protection arrangements.

Action Step  For the best protection, physicians should be sure to protect all of their assets. Those who choose to move only some assets offshore should be sure to protect their other assets through alternative methods.

Mistake 9  Trying to Do It Alone
Physicians should not try to move assets offshore without the advice and assistance of a licensed professional. If done improperly, the assets will not be protected from the reach of creditors. Experienced asset protection planners are trained in moving assets offshore. They know how to structure transactions legitimately so that once the assets are moved offshore, creditors cannot touch them. Attempting to move assets offshore without the help of a licensed professional may result in exposed assets that creditors can seize.

Action Step  Physicians should visit a qualified professional as soon as possible rather than attempting to move assets offshore by themselves. Spending a little today might save a lot in the future.

Mistake 10  Leaving a Paper or Money Trail
To ensure complete privacy and to protect assets from being detected by creditors, physicians should not set up offshore businesses and then record their own name as officer or owner. Most reputable offshore companies allow investors to keep their name undisclosed and to use a nominee as the officer or owner. Some companies may even provide a name of a nominee for the customer to represent to the public as the owner or officer of the business.

Action Step  Physicians should appoint nominee officers to protect their privacy and disguise from creditors those who truly own and control the assets.

Conclusion
Physicians who avoid these mistakes when moving assets offshore will have protected assets that will never be reached by creditors.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

Additional Resources
- W. Reed, *Bulletproof Asset Protection* (Five Corners Publications, 2000)
- Asset Protection Corporation, www.assetprotectioncorp.com
- Offshore News Online, www.offshoreon.com

About the Author
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2.6 The 10 Biggest Legal Mistakes Physicians Make When Dealing with Asset Protection Professionals
By James J. Everett, Esq.

Executive Summary
Every practicing physician faces the risk of a lawsuit. Although many physicians mistakenly believe that they will never be sued, thousands of physicians are served with medical malpractice claims each year. To minimize the risk of personal and business assets being seized in the event of an adverse monetary judgment or settlement, physicians should consult an asset protection professional about protecting their assets. In doing so, they should avoid making the following common errors when dealing with asset protection professionals.

Mistake 1  Not Considering Asset Protection Planning
Physicians often do not realize how significant the threat of a lawsuit is. An adverse judgment or an out of court settlement can mean that personal and business assets may be seized to satisfy a liability. A high monetary judgment may result in the loss of everything the physician owns, including his or her house and life savings. An asset protection professional can advise physicians of the best way to organize their affairs before a lawsuit is threatened. Physicians should have an asset protection plan in place before their assets are in danger of being seized.
ASSET PROTECTION: DEALING WITH PROFESSIONALS

**Action Step** Physicians should consult with an asset protection professional as soon as possible to institute an asset protection plan.

**Mistake 2  Trying to Do It Alone**
Physicians should not try to structure asset protection transactions without the assistance of a qualified professional. The law regarding asset protection is complicated and easily misunderstood, and the rules relating to asset protection are different for various jurisdictions. If an asset protection plan does not comply with all of the intricacies of the law, the assets will be exposed and may be reached by creditors, leaving the physician with nothing.

**Action Step** Physicians should consult an experienced professional when they are ready to implement a plan for asset protection to ensure complete protection from creditors.

**Mistake 3  Relying on the Internet or Do-It-Yourself Books for Advice**
Many Internet websites and books on asset protection are not written by attorneys with experience in asset protection, but rather by laypersons who have not been trained to read and understand the law. Many of these websites and books downplay the importance of professionals in asset protection. In addition, the advice on personal and professional asset protection that can be found on the Internet and in books is often incorrect. Erroneous advice will lead to the use of an improper structure when developing an asset protection plan and can result in no protection at all from creditors.

**Action Step** Physicians should hire a qualified professional to structure their asset protection plans rather than rely on the Internet or do-it-yourself books.

**Mistake 4  Using an Unlicensed or Unqualified Professional**
Physicians who use an unlicensed or unqualified professional will get the same result as they would if they tried to develop an asset protection plan themselves. The law is complex and the risks are enormous if the asset protection plan is found to be illegitimate. An asset protection plan that is disregarded will result in assets being reachable by creditors. To minimize the risk of using an unlicensed or unqualified professional, physicians should ask for referrals from friends or colleagues.

**Action Step** Physicians should not follow the advice of an unlicensed, unqualified person when protecting their assets. They should consult a licensed professional.

**Mistake 5  Not Following the Professional’s Advice**
Professionals, such as attorneys, are trained to be knowledgeable in the area of asset protection. They are taught to read and interpret the law correctly. Physicians who seek qualified professionals for advice on asset protection will get the best recommendations...
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

available for their particular situation. Ignoring or not following that advice can result in assets being exposed to and seized by creditors.

**Action Step** Physicians who are willing to spend the time and money to get the best advice possible should be prepared to follow it.

**Mistake 6 Not Disclosing All Assets**
Physicians should disclose the existence of all their assets when consulting a professional about the best asset protection plan for their situation. Omitting an asset may result in an incomplete or ineffective structure, and the omitted assets will not be protected from creditors. Assets that should be included in an asset protection plan to avoid exposure to creditors include
- Business equipment, bank accounts, and vehicles
- Personal homes, bank accounts, and vehicles
- Antiques and collectibles
- Real estate
- Recreational vehicles, boats, and planes
- Securities and other financial instruments
- Royalties, patents, and copyrights

**Action Step** For the best asset protection plan, physicians should disclose all their assets to the professional they hire to structure their asset protection plan.

**Mistake 7 Failing to Disclose a Lawsuit, Threatened or Actual**
Physicians should disclose all potential and actual lawsuits to their asset protection professional. It is still possible to protect assets after a lawsuit has been instituted. By disclosing all actual or threatened lawsuits, the physician will give the asset protection professional a chance to assess all options regarding asset protection and institute the appropriate plan under the circumstances. By failing to disclose actual or threatened lawsuits, the plan put into place by the asset protection professional may end up being ineffective. An ineffective asset protection plan may result in exposed assets being seized by creditors.

**Action Step** Physicians should disclose all potential and actual lawsuits to their asset protection professional before the development of an asset protection plan.

**Mistake 8 Waiting Until It’s Too Late**
Physicians should not wait until the court has entered a judgment or a creditor has secured a garnishment on their assets. At that point, it may be too late to protect assets from being seized. To prevent the loss of assets to creditors, physicians should consult with a professional before any action is taken by creditors to seize assets.
ASSET PROTECTION: DEALING WITH PROFESSIONALS

Action Step Physicians should consult an asset protection professional as soon as possible to develop an asset protection plan.

Mistake 9  **Expecting to Save Taxes**
Physicians may expect that a benefit of asset protection is to save taxes. While there are legitimate ways to save taxes and insulate assets simultaneously, the main goal of an asset protection plan is to shield assets from the reach of creditors. Physicians should talk to an experienced tax professional about how to validly reduce their tax liability.

Action Step Physicians should not rely on asset protection structures to necessarily reduce their tax liability. They should talk to an experienced professional today about ways to protect their assets and concurrently reduce any potential tax liability.

Mistake 10  **Not Keeping the Asset Protection Plan Current**
Physicians who use an experienced professional to implement their initial asset protection plan will ensure that their plan conforms at the outset to U.S. law. Laws change, however, and a strategy that was effective when executed may become obsolete, exposing assets to creditors. Some plans may need to be updated occasionally to guarantee continued compliance with the law and to ensure the most effective asset protection possible. As a physician’s financial and personal situation changes, it is necessary to keep the asset protection professional apprised of the changes so that modifications to the asset protection plan can be instituted, as necessary.

Action Step Physicians should consult periodically with their qualified asset protection professional to ensure that their asset protection plan is up to date.

Conclusion Physicians who consult an asset protection professional to avoid these mistakes will have an asset protection plan that fully protects their assets from creditors.

Additional Resources
- W. Reed, *Bulletproof Asset Protection* (Five Corners Publications, 2000)

About the Author
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2.7 The 10 Biggest Legal Mistakes Physicians Make in Protecting Their Personal Assets
By Philip A. Goldblum, Esq.

Executive Summary
The goal of asset protection planning is to protect and preserve assets from being adversely affected by events such as a lawsuit, divorce, illness, death, business failure, or even a change in taxation or other government action. Physicians, who rely heavily on their practice income and who have significant professional exposure, should be acutely aware of asset protection and preservation issues, yet they often fail to plan. With proper planning, physicians can take many steps to protect and preserve their assets, which they have accumulated through their efforts.

Mistake 1 Failing to Consult with Legal and Financial Professionals
Physicians must understand that their practices expose them to many legal, business, and financial risks, which must be thoroughly planned for. Before a practice is established and while it is ongoing, physicians should consult with counsel and financial advisers to properly address these planning issues. This consultation should be continuous as personal assets are accumulated. Physicians should not be intimidated and must make the time to consult with the appropriate professionals in order to take the necessary steps to minimize their risks and protect and preserve their wealth.

Action Step Physicians should not hesitate to consult with professionals to identify and address these protection concerns. This consultation should be continuous as assets are accumulated or as new ventures are contemplated. A team approach, among professionals, should be established.

Mistake 2 Failing to Be Properly Insured
One of the most basic steps physicians can take to protect their assets is to practice risk management in the form of risk shifting. The first step physicians should take toward asset protection is to make certain that they carry adequate liability insurance, including not only professional liability and other business insurance, but adequate automobile and homeowners coverage as well. Physicians should consult with their commercial brokers regarding appropriate coverage limits and deductibles. Also, they should consider having the policies
reviewed by an attorney who specializes in insurance law. If the physician has accumulated assets in excess of limits, then an increase in the limits might be in order. It may also make sense to purchase an umbrella policy if additional coverage is needed.

**Action Step** Physicians should consult with a commercial insurance agent who can clearly discuss with them options and strategies that meet their insurance needs.

**Mistake 3  Failing to Properly Insure for Death or Disability**
Like many individuals, physicians often fail to protect against some of life’s curve balls, such as premature death or disability. No discussion of asset protection planning would be complete without mentioning the protection of the physician's most valuable asset: the physician himself or herself. Physicians need to make certain they carry adequate life insurance and disability insurance coverage. They should also consider purchasing long-term care insurance to preserve their assets in the event that they or their spouse require this type of care. There are many misconceptions regarding long-term care insurance, so physicians need to educate themselves about this type of insurance protection. They should consult with professionals about appropriate coverage and tax consequences. Without appropriate coverage, the physician and his or her family could be forced to spend down their life’s savings.

**Action Step** Physicians should consult with advisers and professionals about appropriate insurance to meet their needs. Coordination with a tax adviser is also important.

**Mistake 4  Failing to Consider How Assets Are Titled**
Physicians should pay attention to how their assets are titled, especially if they are married. Married physicians may own assets in their name only (as may their spouses) or the physicians and their spouses may own assets jointly. In some instances, the law protects jointly owned property of a husband and wife from creditors of either spouse. As with any rule, however, there are always exceptions. Physicians also need to think about protection from divorce. In addition, owning assets jointly is not a bulletproof solution because husband and wife may have joint obligations or the judgment-less spouse may die first and thus a judgment creditor could then seize assets of the spouse whom it had obtained the judgment against.

**Action Step** Physicians should consult with counsel about how their various accounts should be titled. As additional assets are accumulated or as new ventures are considered, they should be sure to continue to consult with their advisers.

**Mistake 5  Failing to Consider Placing More Assets into Protected Classes of Assets**
Certain assets enjoy enhanced protection under the law. This enhanced protection can vary from state to state. As a result of the Enron tragedy, many people have become aware that
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one’s principal residence may be a protected asset in certain states and lavish homes are often built in those states. In most states, life insurance and pension plan assets are protected asset categories. It is not unusual for physicians to own large whole life policies and enhanced pension and profit sharing plans.

Action Step Consulting with legal and financial advisers regarding these issues is a critical part of insulating and protecting personal assets. Building value and separate “nest eggs” is always a smart approach to protecting and preserving assets. Therefore, physicians should consult with professionals about planning issues and about creating diversified pools of assets, some of which have enhanced protection under the law.

Mistake 6 Failing to Check Social Security Statements
The Social Security Administration has begun sending statements containing earnings records to everyone who has ever paid Social Security taxes. A physician may not recall what he or she earned 10 or 15 years ago, but if the earnings for a particular year do not make sense (perhaps they were very low, or even zero), then it is worth an inquiry. One’s earnings records will determine the Social Security benefits that he or she may receive. Unreported earnings could result in a decrease in benefits, which means having to spend more of one’s own assets (another form of asset erosion that is worth protecting against). The Social Security statement also contains instructions on how to keep one’s earnings record accurate.

Action Step Physicians should check their Social Security statements for accuracy. If they don’t understand the statements, they should consult with their financial adviser.

Mistake 7 Failing to Implement Sophisticated Planning Strategies on a Timely Basis
Generally, the goals of the more sophisticated strategies—that is, those dealing with off-shore trusts and other legal entities specifically created to provide asset protection—are to deter litigation and provide incentives for early and cost-effective settlements by enhancing one’s bargaining position. These strategies are not a means to defraud creditors or hide assets. Candidates for asset protection include physicians who wish to shelter personal assets from liability and who wish to diversify their investment portfolios into direct overseas investments. Before one enters into any of these strategies, one must be familiar with the structure of asset protection (by being able to afford to lock up assets), and be in a financial position that lends itself to asset protection planning.

One of these strategies, family limited partnerships (FLPs), is attractive as an asset protection tool because of the limited remedies available to creditors when attempting to reach assets transferred to an FLP. In forming an FLP, one transfers ownership of a particular asset or
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assets to the FLP in return for an ownership interest in the FLP itself. So, instead of owning 100 shares of a stock or a piece of real estate, one owns (as a “partner”) an interest in an FLP that owns the stock or real estate.

Generally, a judgment creditor may obtain only a “charging order” against distributions received by the debtor partner from the FLP. The creditor is treated as an assignee of the FLP interest. As an assignee of an FLP partnership interest, the creditor may be treated as the owner of the interest for federal income tax purposes and be subject to tax on the pro rata undistributed income of the FLP. Creditors do not like reporting income without receiving cash distributions to pay the associated tax. This, therefore, discourages creditors from looking to FLP interests to satisfy a debt. However, it is still possible that creditors in egregious circumstances could argue that fraudulent conveyances should result in remedies other than merely a charging order, such as a sale of the debtor’s FLP interest or even liquidation of the FLP. This may be a particular danger if the creation of the FLP lacks any apparent purpose other than asset protection. Often, the impetus for discussing an FLP is triggered by an event or circumstance that raises liability exposure and the client is hoping that establishing an FLP will provide some defense against an anticipated onslaught of creditors. This is obviously a dangerous perspective, as it immediately raises fraudulent conveyance issues (i.e., transfers made in order to defraud creditors). Clients must be cognizant of the limits of what can and cannot be accomplished in this area, and the compromises a client must be willing to accept to achieve his or her goals and objectives. Transferring assets to an FLP will result in a shield, although not an invulnerable shield, to protect assets from creditors.

When asset protection planning is a paramount concern of the client, the safest structure from an asset protection perspective is to have the limited partner of the FLP be an offshore trust and to have substantially all the assets of the partnership located outside the jurisdiction of the U.S. courts. By moving both the limited partner as well as the partnership’s assets outside the jurisdiction of the U.S. courts, the client has forced the potential creditor to physically go to the foreign jurisdiction where the trust has its situs and attempt to persuade a local court that the creation of the trust and the original transfer were fraudulent. Obviously, this structure exponentially increases the complexity and cost of planning, as well as increases the filing requirements.

Domestic Delaware and Alaska trusts have become more popular as an asset protection tool, but these trusts are relatively new and thus not yet as tested as a planning tool.

**Action Step** Physicians should consult with counsel to determine if more sophisticated planning techniques are required to meet their needs, which may be because of the size of their estate or their enhanced exposure.
Mistake 8  **Failing to Conduct Estate Planning Properly**

By far the biggest and most widespread mistake that physicians make is simply failing to plan their estates properly. Some may not be aware of the existence or magnitude of death taxes. Others may just assume that their estates are not large enough to be taxed, or that the taxes won’t exist when they die. Others still are just too busy to focus on the process and get it done. As the old saying goes: “You can only be certain of two things—death and taxes.” Failing to plan properly for the occurrence of the two can be financially catastrophic for a physician’s family.

**Action Step** Consultation with professionals regarding estate planning is imperative, no matter what the size of the estate.

Mistake 9  **Failing to Properly Consider Whether to Form an Entity and What Type**

The initial consideration a physician faces is whether to form a legal entity to conduct the medical practice and if so, the type of entity to form. The choices include partnerships, limited liability companies, and corporations (S corporations, C corporations, and professional corporations). Each has different legal characteristics, tax attributes, and asset protection features.

The unique features of a corporation are its perpetual existence (i.e., the death of an individual does not terminate the existence of the corporation) and its ability to provide limited liability to its officers, directors, and shareholders (whereas physicians who participate as sole proprietorships or general partnerships have unlimited personal liability).

The problem for physicians is that personal liability for malpractice cannot be limited by using a corporation. Although a corporation won’t shield them from claims brought by patients they treat, it can be used to defend against the negligence of a physician partner. If the practice is structured as a general partnership, the physician is legally responsible for any injury caused by the other partners. Moreover, a partner could bind other partners and the practice to other contractual obligations, which also might create liability exposure.

Except for professional malpractice cases, when the source of the claim arises outside of the physician-patient relationship, the corporation can be an effective device to shield the physician from liability. Thus, with respect to the other injuries that occur at the practice location, employee-related issues, or issues with landlords or other customers or suppliers, the corporation will provide a useful shield against personal liability, thus protecting the physician’s personal assets.

**Action Step** Physicians should consult with professionals to determine the type of legal entity that best suits their medical practice.
Mistake 10  Failing to Use Multiple Corporations
If the practice or corporation can be divided into separate businesses, assets can be further protected by the use of multiple entities. For example, a single corporation may own and operate five medical clinics in different locations. If something happens at one of these clinics that gives rise to liability or business failure, the assets of the other successful clinics must be isolated from these claims. A logical approach would be for each office location to be separately incorporated, thus if one location falters, it would not have an effect on the others. A judgment creditor of one corporation would not be able to reach the assets of the other successful companies. Also, consideration should be given as to the legal structure of any new ventures.

Action Step  As a physician’s practice grows and as he or she enters new ventures, consideration of the structure and ownership of business assets and operations is critical in any attempt to protect and preserve the physician’s assets. Physicians should consult with their advisers to develop a proper plan.

Conclusion
Physicians face many challenges and potential risks. With proper planning, these risks can be minimized and assets can be protected and preserved. Consultation with a team of advisers who specialize in these matters is critical.

About the Author
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Chapter 3  Bankruptcy

3.1 The 10 Biggest Legal Mistakes Physicians Make in Bankruptcy Matters
By Steven B. Ramsdell, Esq.

Executive Summary
The bankruptcy process consists of intertwined procedural and substantive rules that must be carefully observed if one is to maximize the probability of achieving his or her objectives, whether as debtor or as creditor. Although physicians, thanks to their potential for achieving significant wealth, are not disproportionately represented in the bankruptcy process as debtors, for whom the objective is generally to be released from preexisting debt and to obtain a fresh start going forward, it is nevertheless not uncommon that a physician, like any business person, is compelled to seek bankruptcy relief. The routine events that might lead a physician to contemplate bankruptcy include the following:

- An inability to pay back student loan obligations pursuant to the terms of the notes;
- The failure, either because of inattention or cash-flow difficulties, to sufficiently remit estimated tax payments to the government, resulting in accumulated income and self-employment taxes, interest, and penalties, beyond the physician’s ready ability to pay;
- Cash flow in a start-up medical practice that is insufficient to service the debts incurred to finance such start-up through, for example, business loans or credit card borrowing;
- Downsizing a practice in which the physician is personally liable for future rent on a long-term lease; and
- Investing in real estate, where the market falls out and the value of the real estate falls below the amount of the encumbering mortgage obligations.

With the potential to generate high incomes and to acquire significant assets and investments comes the potential to incur correspondingly high business and personal expenses and to incur extraordinary amounts of debt. Therefore, where bankruptcy is implicated for the physician, such a case is likely to be more involved than the routine consumer bankruptcy. As a result, it is incumbent on the physician, more so than on an average debtor, to approach bankruptcy with the resolve to become educated as to the rights and obligations that accompany the bankruptcy and to scrupulously observe its requirements.

Additionally, physicians are often in a financial position to extend credit to others. For example, a physician owning a small business complex might sublease various units to tenants. Another might develop real estate and take back a second mortgage for investment income when such real estate is sold. In these contexts over long periods of time, a physician is likely to be confronted with the occasional borrower who defaults on rent or mortgage obligations.
payments and then files bankruptcy, leaving the physician subject to the creditors’ rights provisions of the Bankruptcy Code.

This section enumerates some of the bankruptcy mistakes that must be avoided by a physician as debtor or creditor in confronting the bankruptcy process. Some of these mistakes can thwart not only the legitimate expectations that the physician sought to vindicate in the bankruptcy process, but can also have catastrophic economic ramifications for the physician.

**Mistake 1  Failing to Precisely Disclose Information Required by Bankruptcy Schedules and Forms**

Failing to precisely disclose assets and other financial information required by the bankruptcy schedules and forms can result in a denial of discharge of debts, which is the primary objective in filing bankruptcy. Moreover, it prevents the debtor’s attorney from accurately exempting all of the physician’s assets that may be entitled to protection from creditors in the case. Finally, oversights in the required financial disclosures raise questions as to the credibility and accuracy of other information on the forms and might thereby invite additional scrutiny where none was warranted, causing additional anxiety and legal costs in completing the process.

**Action Step**  Physicians should not take lightly their obligation to disclose their assets and financial background information. Bankruptcy provides the potential for a drastic benefit in the form of a discharge of debts, but with the benefit comes the obligation to present comprehensive disclosures of assets and other financial background transactions and information.

**Mistake 2  Failing to Carefully Determine the Ability to Exempt Certain Assets**

Physicians may fail to carefully determine the exemptability of all their assets, both to preserve as many assets as possible for themselves and their family and to avoid an unpleasant surprise in bankruptcy upon learning that an asset once thought to be exempt must now be turned over to the creditors. For example, retirement plans present a number of complexities depending on their type and structure. Many a debtor is informed that a retirement vehicle is exempt from creditors only to learn in bankruptcy that the particular retirement vehicle at issue is an exception to the rules. Similarly, real estate that is owned as tenants by the entireties with a spouse is exempt from non-joint creditors in many states, and one would not want to miss out on this benefit where it is applicable.

**Action Step**  Physicians should work carefully with competent bankruptcy counsel to ensure that counsel is aware of all of their assets, such as the titling and governing documents of those assets, including deeds to real estate, certificates of title for vehicles and bank accounts, and plan documents for trusts and retirement plans.
Mistake 3  Assuming Old Tax Debts Will Be Discharged Under Chapter 7 or Chapter 11

It is safest to assume that tax obligations are generally not dischargeable under chapter 7 or chapter 11 of the Bankruptcy Code. There are numerous exceptions interspersed throughout the Bankruptcy Code that work to exclude various taxes from discharge. Nevertheless, depending on such issues as the age of the taxes, the dates of the filing of the tax returns, the pendency of any prior offers in compromise, the existence of any prior bankruptcies, and other issues, there are taxes that are eligible to be discharged. In those cases where the criteria for discharge are satisfied, obtaining a bankruptcy discharge of taxes can provide a significant economic benefit to a debtor.

Action Step  Advance preparation is the key to ensuring that prepetition taxes are eligible for discharge in bankruptcy. Physicians should work carefully and closely with their tax adviser and bankruptcy attorney to ensure that their bankruptcy attorney has the applicable facts concerning the nature of the tax liabilities, including the type, year, date the returns were filed, and the dates of assessment by the taxing authority, along with any other relevant circumstances or facts requested by the attorney.

Mistake 4  Failing to Consider Chapter 13 As a Method for Resolving Tax Debts

Under chapter 13, unlike the other available bankruptcy chapters, taxes can be repaid without interest and potentially over a longer period of time (five years from the bankruptcy filing rather than six years from the date of assessment of the tax).

Action Step  Physicians who are consulting with an attorney over potential bankruptcy options for their tax problems should remind the attorney to consider whether they are eligible for chapter 13 and cooperate with the attorney in determining whether chapter 13 presents the optimum approach.

Mistake 5  Violating the Automatic Stay

Once a bankruptcy case is commenced by filing a petition with the bankruptcy court, a stay of all collection actions automatically takes effect to preclude creditors from taking any further steps toward collecting what they are owed. After the bankruptcy filing, the automatic stay precludes the creditor from, for example, filing a lawsuit to collect a debt, continuing a suit that has already begun, collecting on a judgment that has previously been entered on a suit, repossessing collateral, foreclosing a mortgage, or even contacting the debtor for payment.

Action Step  After receiving a court notice or otherwise becoming advised that a debtor is in bankruptcy, a creditor should immediately cease all collection efforts and seek counsel to determine the scope of the stay and to obtain relief from the automatic stay from the bankruptcy court, if appropriate.
Mistake 6  **Failing to File a Proof of Claim**

Generally, in order to share in the payment distributions that are made to creditors in a bankruptcy case, it is mandatory to file a proof of claim with the bankruptcy court setting forth the amount that is owed. Filing a proof of claim beyond the due date will lower a claim’s priority level, making it unlikely that any payment will be received at all. Even in chapter 11 cases where it may not be mandatory to file a proof of claim, the safest practice is to file one anyway, since the amount set forth in a filed proof of claim will supersede the amount set forth in the debtor’s schedules and such proof of claim will be deemed filed in any bankruptcy chapters to which the chapter 11 case might be subsequently converted.

**Action Step**  Physicians should consult with counsel for advice on the necessity for filing, the timing of filing, and the proper completion of a proof of claim form. Short of retaining counsel, physicians should, at a minimum, pay careful attention to all notices they receive from the bankruptcy court reflecting deadlines for filing proofs of claim so that the potential for recovering a bankruptcy distribution on amounts owed is not jeopardized.

Mistake 7  **Failing to Monitor Senior Mortgage Lenders**

Physicians sometimes fail to monitor senior mortgage lenders, who might obtain relief from the automatic stay from the bankruptcy court and proceed to foreclosure, thereby wiping out all junior lien interests against an asset. For those who hold a second- or third-priority mortgage against real estate, notwithstanding any payment terms that the debtor has committed to under any bankruptcy reorganization plan, such junior lien rights can be eliminated if a senior lienholder obtains relief from the automatic stay to exercise foreclosure rights against the real estate. Generally, a senior lienholder’s foreclosure sale eliminates all encumbrances that are junior to the foreclosing interest.

**Action Step**  A secured creditor in bankruptcy whose collateral is subject to senior liens must carefully monitor the progress of the bankruptcy case for any actions by such senior lienholders that seek to recover collateral to the detriment of the junior secured claim. In some cases, the junior secured creditor will want to preserve its own foreclosure rights through its own motion to lift the automatic stay or want to negotiate with the senior secured creditor over servicing its debt or even acquiring its senior position.

Mistake 8  **Failing to Observe Deadlines for Filing a Discharge or Dischargeability Complaint**

Individual debtors will obtain a discharge of most debts, unless a complaint is filed within a strict deadline for objecting to the dischargeability of a particular debt or objecting to the discharge of all debts. In chapter 7 cases, the deadline for filing such a complaint is 60 days after the first date set for the initial meeting of creditors. This deadline gives creditors precious little time to analyze the background facts, undertake discovery under the Federal Rules of Bankruptcy Procedure, if necessary, and prepare and file the complaint in time.
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Action Step  In appropriate circumstances, the deadline for filing a discharge or dischargeability complaint may be extended, but it is incumbent on a creditor to diligently pursue any discharge or dischargeability rights from the outset of the bankruptcy case in order to comply with the deadline for filing a complaint or to justify an extension of time for doing so, since an extension is much less likely to be granted if the creditor has not attempted to diligently construct its complaint.

Mistake 9  **Failing to Observe Deadlines for Opposing Confirmation of a Plan**
Similar to the proof of claim and discharge or dischargeability deadlines, it is of paramount importance that a creditor not waive its rights by failing to object to a reorganization plan. Once a reorganization plan is confirmed by the bankruptcy court, the creditor’s rights will have been largely fixed and determined with finality.

Action Step  Only through a careful review of a plan’s proposed treatment of a creditor’s claims and the exercise of its objection rights can a creditor ensure that a proposed plan complies with the applicable requirements for confirmation that are imposed by the Bankruptcy Code.

Mistake 10  **Failing to Treat Bankruptcy As Litigation**
Unlike certain other legal forums, bankruptcy is formal litigation. Adversary proceedings are separate lawsuits within a bankruptcy case. Contested matters are motions and other disputes within the general framework of the bankruptcy proceeding. In either type of litigation, the Federal Rules of Civil Procedure are generally incorporated through the Federal Rules of Bankruptcy Procedure. Additionally, the Federal Rules of Evidence apply. Although bankruptcy courts are often referred to as courts of equity, they are guided by the legal requirements of the Bankruptcy Code and the formal procedural rules previously discussed.

Action Step  Those who participate in the bankruptcy process as either debtor or creditor must approach it with the knowledge that it is governed by strict litigation rules. The bankruptcy court determines the rights of the parties after adversarial litigation in the traditional manner as other civil suits, based on the governing procedural rules and substantive law of the Bankruptcy Code and other legal principles.

Conclusion
Physicians who are aware of the various pitfalls in bankruptcy that are represented by these mistakes will maximize the chances that they obtain what they are legitimately entitled to, whether it be a discharge of debts or protection of a claim as creditor.

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3.2 The 10 Biggest Legal Mistakes Physicians Make in Dealing with Bankruptcy Counsel
By William J. McLeod, Esq.

Executive Summary
Unlike other legal matters, bankruptcy is a serious legal process that requires competent counsel. For the process to be a success, the debtor must cooperate with counsel to the fullest. A good bankruptcy attorney will carefully review the debtor’s financial information to spot problems. However, whether an attorney can fully assess those issues will ultimately depend on the debtor. Unfortunately, debtors often prove to be their own worst enemy.

Mistake 1 Not Providing Information on a Timely Basis
The decision to file for bankruptcy is rarely made hastily. Usually a debtor has exhausted other avenues to deal with oppressive debt before even contemplating bankruptcy. It can be an emotional and heart-wrenching process. Meeting with and retaining counsel are among the first steps in moving through that process. When counsel is retained, debtors still need to diligently work with their attorney in gathering crucial financial documents and information to properly prepare the petition and schedules that will be filed in the U.S. Bankruptcy Court. Simply retaining counsel does not relieve the debtor from adhering to the requirements of the Bankruptcy Code to prepare and file a complete and truthful petition. The time frame for the debtor to obtain that “fresh start” will ultimately be determined by the debtor.

Action Step Physicians should retain counsel and work diligently to gather documents and financial information so that the bankruptcy process can begin.

Mistake 2 Not Disclosing All Financial Information
Bankruptcy law is not practiced like criminal law. Since criminal defendants have the right not to incriminate themselves, a good criminal lawyer will usually advise the criminal
defendant to tell him or her only the information the lawyer needs to know. Bankruptcy is different. Bankruptcy counsel needs to know everything. When asked how much money the debtor has, the debtor must be honest. Saying “a few hundred, I guess” when the reality is that there are thousands of dollars in an account will not suffice. When asked how credit cards were used, the debtor must give as much accurate information as possible. Bankruptcy counsel cannot effectively represent the debtor unless the attorney knows everything about the debtor’s financial position. What the attorney does not know will likely end up hurting the debtor, not the attorney.

**Action Step**

Physicians should cooperate with counsel and disclose all financial information.

**Mistake 3**  
**Misunderstanding Counsel’s Role in the Bankruptcy**

Competent bankruptcy attorneys will, within the best of their abilities, prepare an accurate bankruptcy petition using the information obtained by the debtor. Sometimes the debtor forgets to give certain information to the attorney. Other times, the debtor discloses the information, but because this is ultimately a human system, the information does not make its way to the documents that will be filed in court. No debtor can claim that a petition is inaccurate because his or her attorney did not prepare it correctly. The petition and related documents are signed under penalty of perjury. Courts have rejected the “I thought my attorney put that information in” defense and have denied a discharge to debtors who have not read their petitions prior to filing.

**Action Step**

Physicians should carefully review the petition and schedules, and ensure that the documents are accurate and complete. The moment the debtor discovers that there is an error in the petition, even after it has been filed, counsel must be apprised immediately.

**Mistake 4**  
**Not Hiring an Expert**

As no physician can treat every ailment; no attorney can effectively represent a client on every legal matter. Bankruptcy is a specialized area of the law, with its own rules, courts, and judges. Hiring a friend or golf buddy can be problematic if issues arise that the attorney is not experienced enough to handle appropriately. While many office supply stores carry blank bankruptcy forms, the temptation to save a few bucks can be tempered by legal complications and fees that will arise later. In addition, the political climate has swayed against what are now referred to as the “easy bankruptcies” of the past. Debtors should have competent counsel to guide them through an increasingly difficult legal process.

**Action Step**

Physicians should search for a qualified and experienced bankruptcy attorney, feeling free to interview more than one.
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Mistake 5  **Using Credit to Pay Attorney’s Fees**
The Bankruptcy Code prohibits certain debts from discharge. Some debts are nondischargeable if they are incurred within a certain period of time prior to filing. Other debts are nondischargeable if they are incurred through fraud. Paying counsel’s fees with either a cash advance or a credit line is an invitation to trouble. If a debtor uses credit knowing it will never be paid back, it can be considered fraud and result in the debt being declared nondischargeable as well as higher costs and attorney’s fees. In some cases, it can even result in a discharge being denied or other legal problems.

**Action Step**  Debtors must pay attorney’s fees with their own money.

Mistake 6  **Being Obstinate about Monthly Expenses**
Simply stated, debtors filing bankruptcy are living beyond their means. There can be a plethora of reasons a debtor has been led to this point (such as divorce or health problems). The Bankruptcy Code allows debtors to exempt from their income necessary and reasonable monthly expenses. This includes food, transportation, housing, and other similar expenses. It does not include contributions to a Christmas club, a vacation fund, or an IRA. What a debtor can claim as a necessary monthly expense varies from case to case based on the individual needs of the debtor. Competent counsel will be able to spot problematic expenses and bring them to the debtor’s attention. When these issues are raised, debtors should listen to their counsel and not decry why they cannot spend their income the way they see fit. Debtors in bankruptcy do not have that option. Being obstinate about expenses when counsel advises that they are not necessary can result in legal complications in the bankruptcy, including a denial of discharge, a conversion from a Chapter 7 to a Chapter 13, or a higher monthly payment under a Chapter 13 plan.

**Action Step**  Debtors need to listen to counsel, and if so advised, be prepared to adjust how they spend their money.

Mistake 7  **Failing to Obtain a Recent Copy of Their Credit Report**
The credit report lists all outstanding obligations to creditors, including obligations that a debtor may have forgotten. If the debtor’s bankruptcy petition lists all creditors that are noted on the credit report, the bankruptcy information related to those debts will eventually be noted on the credit report. This is important because, in some cases, when a debt is not listed on the petition, it may not be considered discharged. This can prove problematic years after the discharge is received when the debtor is applying for a mortgage or an automobile loan and an outstanding debt still appears on the credit report.

**Action Step**  Debtors should obtain their credit report to assist their counsel. They should also obtain their report six months after receiving their discharge to ensure that the information in the report is accurate.
Mistake 8  
**Misrepresenting How Debtor Got into Financial Trouble**
A good bankruptcy attorney will ask at the earliest possible time why someone is seeking bankruptcy protection. There are many reasons people end up in bankruptcy: a lost job, a health problem, a divorce. All of these issues contribute to a diminution in income or an increase in expenses (or both) that ultimately interfere with the ability to make ends meet. There are also other factors that can contribute to a bankruptcy: substance abuse, gambling, overspending, and the like. Debtors should not be concerned that their attorney is going to pass judgment on how they arrived at the decision or the need to file for bankruptcy. Debtors should not be ashamed to tell counsel the truth about their personal problems that contributed to the filing. Knowing that information will enable counsel to provide the best advice and counsel.

**Action Step**  Debtors should tell their attorney everything, including how they got into financial distress, even if the reason is difficult to discuss with a stranger.

Mistake 9  
**Not Disclosing Lawsuits and Potential Lawsuits**
One of the biggest mistakes debtors make in dealing with their lawyers is not telling them about lawsuits they have, or may have. Lawsuits, or alternatively, the claims a debtor has against a particular person or entity, must be disclosed on the bankruptcy petition. The Bankruptcy Code determines whether the proceeds from a lawsuit can be used to pay creditors. If a debtor does not disclose the existence of the claim, the debtor loses it. Physicians should remember this rule: list it or lose it.

**Action Step**  List it or lose it. Physicians should tell bankruptcy counsel about all potential claims. Competent bankruptcy counsel can assist the debtor in determining whether bankruptcy is the best option in light of the existence of a claim.

Mistake 10  
**Not Disclosing the Embarrassing Things Counsel Does Not Specifically Question**
The important thing to remember in the bankruptcy process, and the most important thing to remember about working with counsel, is that before filing the petition, the debtor has all the control. If an issue is discovered prior to the filing, it can be dealt with appropriately. This might include not filing bankruptcy, delaying the filing, or perhaps seeking bankruptcy under a different chapter. The time for issues and problems to be disclosed is before the filing, when the debtor has all the control. But once the petition is filed, the debtor effectively relinquishes control to the Bankruptcy Court, from whom the debtor is seeking protection. Issues that arise after the filing can have legal consequences that may be unavoidable because there was no planning or disclosure prior to the filing of the petition. Any information about assets, debt and credit, and how debts were incurred should be disclosed, especially if there are concerns about fraud.
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Action Step When in doubt, physicians should disclose everything to their attorney before filing the petition.

Conclusion
The decision to seek bankruptcy is a difficult one, and the process is only made more difficult when physician-debtors do not heed the advice and counsel of their attorneys. This process can be ameliorated if physician debtors heed the recommendations in this section, as well as that of their attorneys.

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3.3 The 10 Biggest Legal Mistakes Physicians Make Before and During the Bankruptcy Process
By William J. McLeod, Esq.

Executive Summary
A debtor’s key to a successful bankruptcy process is, ultimately, honesty. Physicians need to be aware that even some seemingly benign actions can have serious legal consequences and, in some circumstances, be financially devastating.

Mistake 1 Transferring Assets
Simply stated, physicians contemplating bankruptcy cannot transfer assets. This includes interests in professional corporations and practice groups, accounts receivable, real estate, and other property. Transferring assets can include mortgaging, placing in trust, and/or selling property at fair market value. Transferring assets can result in the transferee being sued by a trustee, and the transferor being denied a discharge. Certain transfers can be set aside, even if they occur up to a year before the bankruptcy filing.

Action Step Physicians should not transfer any assets if they are contemplating bankruptcy.
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Mistake 2  Getting into More Debt
The temptation to get into more debt can be great, especially if there has been a cycle of using unsecured credit to pay down other creditors. Continued use of credit cards, once it is apparent that bankruptcy is inevitable, is only an invitation to trouble, higher legal fees, and a possible denial of discharge.

Action Step  Physicians should stop using unsecured credit, such as credit cards and credit lines.

Mistake 3  Paying off Certain Creditors
Often, physicians in financial distress borrow money from friends, family, and colleagues. The prospect of filing bankruptcy often leads debtors to shy away from having to tell their friends and family. They might even consider paying the debt prior to filing bankruptcy, so as to keep the debt out of the bankruptcy. In bankruptcy, all unsecured creditors are put on an even playing field, but friends and family are considered insiders. The Bankruptcy Code states that any payment to creditors within 90 days of the filing of a bankruptcy petition can be set aside by the trustee as a preferential payment. In other words, the physician debtor cannot “prefer” to pay one creditor over another, when it is presumed that the debtor will end up in bankruptcy. Insiders, however, are treated differently. Any payments to insiders within one year of filing can be set aside as a preferential transfer.

Action Step  Physicians should stop paying creditors and start the process of preparing to file.

Mistake 4  Not Reading the Petition and Schedules Before Signing
When a physician retains an attorney it does not mean that the physician need not be concerned with the accuracy of the petition itself. While an attorney will prepare the necessary paperwork, it is done based on the information provided by the physician debtor. When the debtor signs the petition, schedules, and the statement of financial affairs, that signature is under penalty of perjury. Debtors cannot merely say that they glanced at the petition and assumed that their attorney accurately set forth every item in the petition. Recently, a court ruled that debtors who maintained that they did not read their petition fully, and relied on their attorney being accurate, were denied a discharge. A good attorney will take steps to make sure that his or her client has had plenty of opportunity to review the petition, make changes, and ensure that it is accurate. Physician debtors should take advantage of those opportunities.

Action Step  Physicians should read the petition carefully, and if there are any changes to be made, or if any information is not accurate, inform their attorney immediately.
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Mistake 5  Not Retaining Competent Counsel
Bankruptcy is a complicated process, and has been made even more so by recent Civil Enforcement Program actions led by the U.S. Trustee’s office in an effort to detect fraud. The bankruptcy paperwork may highlight or trigger issues that can adversely affect a debtor in bankruptcy. A competent and experienced bankruptcy lawyer will be able to determine what issues the physician can expect to arise and who might be affected by those issues, which may include those who are not filing bankruptcy, such as business partners and spouses. The attorney retained should be experienced in bankruptcy matters, not merely someone who is doing the physician debtor a favor.

Action Step  Physicians should not represent themselves in a bankruptcy matter; they should retain competent counsel.

Mistake 6  Concealing Personal Property
Debtors are required to detail what property they own. While debtors are not (yet) required to itemize every kitchen utensil, they do have to list certain items (e.g., jewelry, automobiles, and stock holdings). Debtors should assume that the trustee already knows what the debtor owns, especially if that personal property was obtained with a credit card. A gold Rolex bought with an American Express card as a personal treat should be listed on the petition. Physicians who have concerns about having to surrender an item of personal property in a bankruptcy should consult with their lawyer. They should not try to hide the property or give it away.

Action Step  Physicians should disclose all personal property, and take no steps to conceal it or give it away.

Mistake 7  Reaffirming a Debt Against the Physician’s Interest
A debtor can reaffirm a debt in bankruptcy. This means that the debtor may pay the debt, thus taking the debt out of the bankruptcy itself and not subjecting it to a discharge. There are significant legal implications in reaffirming a debt, since it can no longer be discharged in any subsequent bankruptcy proceeding. Many debtors reaffirm secured debts on cars and homes. However, debtors seeking to reaffirm must assess whether they can actually afford the payments associated with reaffirmation. Debtors who already have precarious income and spending issues run the risk of additional financial dilemmas by reaffirming a debt they cannot afford to pay. To avoid this situation, debtors must seriously examine their current income and expenses, and whether their income or expenses are likely to change in such a way that making those payments might prove difficult. A competent attorney can help guide debtors in determining what is in their best interest.

Action Step  Physicians should listen to the advice of counsel before reaffirming any debt.
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Mistake 8  Obtaining Phony Appraisals and Valuations
Attorneys for debtors rarely retain appraisers to place value on their clients’ property, but rather advise the debtors to obtain valuations themselves. This could be something as simple as taking a diamond ring to a jeweler for an appraisal or getting an appraisal on the debtor’s home. Physicians should resist the temptation to get an appraisal that will end up defying credibility. No bankruptcy trustee will believe that a two-carat diamond ring is worth only $1,000, and no bankruptcy trustee will believe that a 2,500 square foot condominium in Boston’s historic Beacon Hill is worth only $100,000. Providing intentionally misleading information will result in a denial of discharge, and likely a referral to the U.S. Trustee and the U.S. Attorney for criminal prosecution.

Action Step  Physicians should get accurate appraisals and valuations for real and personal property if required by their counsel.

Mistake 9  Not Communicating with Business Partners
Debtors who have equitable interests in business entities, such as practice groups, should inform their partners of their intention to file for bankruptcy. It is not recommended to encourage partners to transfer assets or to engage in any activity that might be considered fraudulent. Partners who are aware of a debt-distressed partner’s intentions will have the ability and time to consult with their own counsel to determine their rights, obligations, and in some cases, options. If a business partner learns of a bankruptcy filing through the mail, and after the filing, the options for all partners may be limited. In addition to creating possible legal complications for nondebtor partners, it will likely result in bad personal feelings and animosity, which are not needed in an already stressful legal process.

Action Step  Physicians should consult with counsel and talk to their business partners. A debtor’s filing affects the debtor’s family, and business partners are, for the purposes of bankruptcy, as important as family.

Mistake 10  Not Accepting That It’s Time to File
Denial is easy to see in everyday life. Some debtors seek assistance as soon as it is apparent that the debt is not manageable. Others, such as a compulsive gambler who is waiting for the perfect roll of the dice or the perfect hand, will wait and hope. Ultimately, their waiting proves to be futile. By the time they find the motivation to take action, they are in a financially worse situation that, in many cases, presents additional legal concerns and complications. In fact, many debtors who delay filing end up in a position where bankruptcy will not provide a maximum benefit. The time to start dealing with oppressive debt is at the first moment that the debtor realizes that there is a problem in meeting both debt obligations and everyday expenses. This does not mean that debtors need to rush to the bankruptcy court upon realizing this, but certainly a careful, thoughtful, and informed evaluation of all
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available options should be considered. Doing nothing does not mean that the debt situation is
going away.

**Action Step**    Debtors need to take control, face the debt demon, and start the process of
going on with their lives.

**Conclusion**
Bankruptcy is difficult enough without making costly mistakes. All of these action steps
should be taken after consultation with counsel. Competent bankruptcy counsel can listen to
the unique facts of the debtor’s case and make appropriate recommendations to ensure that
the process of bankruptcy is as productive and painless as possible.

**Additional Resources**
- *Bankruptcy: Is It the Right Solution to Your Debt Problems?* 2nd ed. (Nolo Press
  2004)
  *Know Your Legal Rights, Recover From Mistakes and Start Over Successfully* (Sphinx Publishing 2002)

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Chapter 4 Business Planning and Structuring

4.1 The 10 Biggest Legal Mistakes Physicians Make When Dealing with Practice Support Agreements

By Roger N. Morris, Esq., and Jay M. Johnson, Esq.

Executive Summary
New physicians looking to start their practice face many challenges. The need to earn a living and the desire to pay off loans require more than just the ability to diagnose and treat patients. There is a business side to the practice that commands attention, and the first business decisions that most physicians make involve deciding where to work and for whom. Established practitioners also face career decisions. Many hospitals in medically underserved areas can make offers to new and established physicians that sound tempting on the surface. Indeed, recruitment offers include such practice support as collections guarantees, payment of student loans, the arrangement of employment with a local practice group, and other perks. With any such offer, strings are attached. Given the nature of these practice support agreements and the laws affecting recruitment arrangements, it is important for new physicians to understand their agreements and the legal constraints relating to them. Certainly, making mistakes with practice service agreements can have serious long-term effects on a physician’s career and finances.

Mistake 1 Failing to Involve Legal Counsel
Given the importance of practice support agreements, which can determine the course of a physician’s career for at least three years, it is important to involve legal counsel. Many contractual terms may be new to young physicians, and there is not a single term that can be left misunderstood. Moreover, given the consequences of violating applicable laws relating to recruitment and the complexity of those laws, involvement of counsel from the outset is vital.

Action Step Before initiating negotiation on a practice support agreement, and throughout the negotiation, physicians should consult legal counsel.

Mistake 2 Failing to Research Each Potential Employer
A recruiting hospital may arrange for the physician to meet with representatives of an existing practice in the hospital’s service area and negotiate employment. However, the physician need not become employed with a specific group and should consider multiple employment opportunities if they are available. Before agreeing to employment, the physician should research potential employers carefully, including credentials and reputations of personnel, quality of facilities, opportunities to become a partner, compensation and bonuses over time, turnover of physicians, malpractice claims, the appropriateness of the environment for the physician’s personality, and the employer’s commitment to adhering to applicable law.
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**Action Step** Physicians should conduct appropriate due diligence reviews on each practice under consideration before entering into an agreement.

**Mistake 3  Failing to Grasp the Ramifications of Certain Commitments**
A practice support agreement demands certain commitments from the physician. After all, the whole point of a recruitment benefits package is to obtain the services of a doctor for a given period of time, typically three years. A physician cannot enter into any such agreement lightly, since the failure to honor the commitment can lead to the forfeiture of any future benefits, as well as the requirement to repay amounts advanced to the physician for cash collection guarantees, malpractice insurance, living and moving expense stipends, license fees, and even loan repayments. If a physician decides that the employment situation is not a good one, the price of resigning and moving on can be very high.

**Action Step** When negotiating a practice support agreement, physicians should understand their legal and business obligations and all costs associated with the failure to honor the obligations of the agreement.

**Mistake 4  Accepting Boilerplate Language in Contracts**
Often, a hospital or a physician group will put a “standard” contract in front of a physician and ask for a signature. But not all practice support arrangements are created equal. A practice support agreement should fit the physician’s situation, reflecting the actual deal negotiated. The compensation and benefits should be appropriate for the demand for the physician’s services. The descriptions of the physician’s duties and of the benefits should address any nuance in the particular physician’s situation.

**Action Step** Physicians should not accept boilerplate language as necessarily appropriate for their situation. They should negotiate and make the agreement fit the circumstances contemplated. Again, consulting legal counsel in this situation is imperative, because a skilled lawyer will be able to help the physician understand the consequences of accepting boilerplate language.

**Mistake 5  Being Fearful of Negotiation**
Young physicians may feel that they will lose a deal if they try to negotiate. However, there is nothing wrong with asking for something they want. This is business, and the physician will have to live with the terms of the agreement, so it should reflect a fully negotiated deal. The party on the other side of any deal will not hesitate to seek commitments and concessions; accordingly, physicians should not hesitate either.

**Action Step** Physicians should not be afraid to ask for additional benefits or concessions. They should go into the negotiations knowing what they want, understanding that there is an ideal result as well as lesser acceptable results.
Mistake 6  Failing to Negotiate the Details
A young physician may have an idea about how a deal will work, but may be disappointed with reality. Only if the details are ironed out in the written agreement, both with the hospital and with the physician’s employer, can there be real confidence that the experience will turn out as envisioned. Does the agreement require publicity upon the physician’s arrival? If so, it should be specified what that publicity will entail and when it will take place, otherwise the physician should be ready for “publicity” to feature only an ad in the yellow pages. Will the new office have room for the newly hired physician? The contract should discuss office space and equipment, or the physician could find himself or herself sharing space in a storage room. Will there be business cards and a pager waiting on the physician’s start date? These factors should be spelled out in the employment agreement. If the practice support benefits are to be assigned to the physician’s new group practice, have there been promises made regarding, for example, the hiring of new support personnel? If so, they should be included in the agreement.

Action Step  Physicians should consider every term in the agreement and make sure that all issues are resolved such that they are understood and operate to the physicians’ satisfaction.

Mistake 7  Failing to Understand Antikickback Constraints
The federal antikickback law (42 U.S.C. Section 1320a-7b(b)) makes it a crime to knowingly and willfully offer, pay, solicit, or receive remuneration to induce referrals of items or services reimbursable by a federal health care program. Parties on both sides of a transaction involving payment for referrals can be liable under the law. Penalties include fines, imprisonment, and exclusion from federal programs. On its face, an arrangement whereby a hospital pays recruitment benefits to a physician, including entering into a practice support agreement, would violate the antikickback law if the benefits were paid in exchange for future referrals. However, the law provides for certain “safe harbors” that protect specified activity from prosecution (if certain behavior falls outside the exact requirements of a safe harbor, liability is not automatic but depends on the circumstances and the likelihood that the behavior will lead to abuse). There is a safe harbor (42 C.F.R. Section 1001.952(n)) for physician recruitment activities that attract a physician to a health practitioner shortage area (HPSA), but the safe harbor will apply only if the arrangement meets certain criteria:

- The physician cannot be required to make or influence referrals in exchange for the benefits, although the hospital may require that the physician maintain staff privileges.
- The physician may not be restricted from establishing privileges at, or referring patients to, other hospitals.
- The value of benefits provided may not be tied to the amount or volume of referrals made to the hospital.
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- The payment or exchange of value may not directly or indirectly benefit any person (other than the physician being recruited) or entity in a position to make or influence referrals to the hospital.
- There is a written agreement, with a term of no more than three years, and there can be no renegotiation within the three-year term.
- If the physician leaves an established practice, 75% of the revenue of the new practice must be from new patients.
- At least 75% of the revenue of the new practice must be generated from patients who are living in an HPSA or a medically underserved area or who are part of a medically underserved population.
- The physician agrees to treat federal health care program beneficiaries in a nondiscriminatory manner.
- If a recruitment arrangement involving a practice support agreement does not fit squarely in the safe harbor, it could still pass muster if there is little danger of health care program fraud or abuse. The major factors considered are as follows:
  - Whether there is documented evidence of an objective need for the practitioner’s services (The government has made clear that recruitment into an area that is not designated an HPSA is not dispositive, and it will consider other evidence that indicates an area is deficient with respect to a particular specialty.)
  - Whether the physician has an existing stream of referrals within the hospital’s service area
  - Whether the benefit does not exceed what is reasonably necessary to recruit a practitioner
  - Whether the remuneration directly or indirectly benefits other referral sources (There is greater scrutiny when a hospital makes payments directly to a group practice when the practice recruits a physician.)

**Action Step** Physicians should be aware of the limitations on recruitment activities and practice support agreements as set forth in the federal antikickback statute. Legal counsel will be of significant help in this regard. Physicians should not sign an agreement that requires referrals to the hospital, bases benefits on the value of referrals, or prohibits acquiring staff privileges at competing hospitals. If necessary, a physician should acquire from the hospital documentary evidence demonstrating a need for the physician’s services.

**Mistake 8** **Failing to Understand Stark Law Constraints**
The Stark law (42 U.S.C. Section 1395nn) is designed to prevent abusive self-referrals of patients whose treatment is covered by government health care programs. In other words, a physician may not refer such patients for certain “designated health services” to an entity in which the physician has a financial interest. Civil fines as well as exclusion from participation in government-funded programs can be imposed for violation of the Stark law. Compensation
arrangements to physicians are covered by the law, and “designated health services” include hospital services. Consequently, a physician’s referral of patients to a hospital that pays the physician compensation is subject to the Stark law, absent an exception. An exception exists for recruitment arrangements that include practice support agreements. Requirements for meeting the exception include the physician not being required to refer patients to the hospital, and not being paid based on the volume or value of referrals.

**Action Step** Physicians should be aware of the limitations on recruitment activities and practice support agreements as set forth in the Stark law. Legal counsel that has significant health law training will be of help in this regard.

**Mistake 9 Failing to Understand the Stark Law’s Effect on Joining a Group Practice**

When a practice support agreement involves the recruited physician joining a group practice, the Stark law imposes specific requirements as set forth in recently promulgated regulations (effective July 24, 2004):

- If payments are made by the hospital directly to the medical practice, the written agreement regarding recruitment benefits is signed by the group practice as well as the physician.
- Benefits must be passed directly through to the physician except for actual costs incurred by the practice.
- If the hospital provides a collections guarantee, costs allocated by the medical practice to the physician are limited to the actual additional incremental costs attributable to the physician.
- If benefits are paid directly to the medical practice, the benefits cannot be determined based on the volume or value of any actual or anticipated referrals by the practice.
- The medical practice cannot impose any additional restrictions, such as a covenant not to compete, on the recruited physician (other than restrictions based on quality of care).

**Action Step** In contemplating working with a group practice, physicians should consult legal counsel and be aware of the Stark law requirements. They should inquire as to the practice’s understanding of these requirements, and insist on compliance.

**Mistake 10 Failing to Understand IRS Constraints on Benefits**

Effective negotiation requires knowledge, and it is important to know that limits may exist on benefits. Nonprofit entities (such as hospitals) are constrained by the Internal Revenue Service as to the benefits that can be paid. Possibly acceptable incentives include income guarantees, moving expenses, payment of malpractice premiums, below-market rent, and a
mortgage guarantee on a personal residence. The amounts are not specifically defined, but must be “reasonable,” taking into account the location of the hospital, its patient populations, etc.

**Action Step** Physicians should be aware that although IRS constraints on benefits exist, they are not specific. Alternative structures of benefit packages, with varying benefit types available, and varying payback schedules, can be of assistance in overcoming this issue.

**Conclusion** Physicians who are being recruited and are considering a practice support agreement should take into account applicable legal restrictions and avoid these common negotiating mistakes in order to avoid future problems and achieve the best possible situation.

**Additional Resources**
- Internal Revenue Service, *Revenue Ruling 97-21*
- U.S. Department of Health and Human Services, Office of Inspector General, *OIG Advisory Opinion 01-4*

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Executive Summary
Every year, thousands of physicians retire, sell or move their practices, or they quit their jobs for more lucrative opportunities. In doing so, they usually focus on the new position that seems more exciting or satisfying. However, it is a mistake to neglect the details of closing the existing practice or otherwise exiting the old position. Many physicians make serious mistakes when closing practices or leaving jobs, mistakes that can affect them for years to come.

Mistake 1 Abandoning Patients
Once a physician has established a physician-patient relationship, the physician must not “abandon” the patient. Abandonment is a problem when a physician terminates a relationship with an individual patient, but can also be a problem when a physician closes a practice, thereby terminating all relationships with all patients. Abandonment is a particular problem if a physician abruptly closes a medical practice without prior notice to patients, or fails to properly notify some segment of the patient population (e.g., where a physician closes the practice but fails to notify nursing home patients).

Abandonment is often defined as “the unilateral severance of the professional relationship...without reasonable notice at a time when there is still the necessity of continuing medical attention” [Lee v Dewbre, 362 SW2d 900, 902 (Tex. Civ. App.-Amarillo 1962, no writ)]. To prove abandonment, a physician must fail to provide “an adequate medical attendant” and also fail to give adequate notice. Finally, as in any negligence action, the plaintiff must prove he or she suffered injuries or damages that were caused by the physician’s conduct.

Action Step Physicians should give the entire active patient load reasonable notice before closing the office doors and leaving the area. The length of notice depends on the types of patients in the practice, their aggregate need for continuing care, and the difficulty of finding replacement care. A surgeon, whose typical involvement with patients is of fairly short duration, might find a short notice period acceptable, whereas a family physician or a physician in another specialty in which physician-patient relationships are of long duration might not consider a short notice period acceptable. A hospital-based physician might have an easier time with the notice period if another physician, such as a radiologist, is ready to begin work the day after the physician departs.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

In addition, physicians should check the laws of their particular state. Texas, for example, has a rule requiring physicians to post a sign in their offices, publish a notice in two newspapers, send letters to all patients seen within the last two years, and furnish evidence thereof to the medical board.

Mistake 2  Violating Noncompete Clauses
A noncompetition clause (also called a “covenant not to compete”) prohibits the departing physician from competing with either an existing practice or the purchaser of a practice, for a specific time and in a specific area. Physicians often overlook these clauses when they leave jobs with other practices, and sometimes find themselves on the receiving end of injunctions and lawsuits.

Action Step  Physicians should consult counsel. In some states, judicial doctrines prohibit enforcement as between persons of a “common calling” in an employment setting. Most states require that noncompetition clauses have reasonable limitations as to time, geographical area, and the scope of activity to be restrained. It may well be that the physician has signed a contract containing an arguably unenforceable clause because it is not reasonable. Some states require that noncompetition clauses have mandatory buyout provisions. Texas law, for example, requires that physicians not be denied access to a list of patients who they had seen or had treated within one year of termination and that they be given access to the medical records of their patients upon authorization of those patients. On the other hand, noncompetition clauses are most typically enforced strictly where the sale of a business is concerned, so competing with the buyer of a medical practice is a bad idea.

Mistake 3  Insisting on Accounts Receivable When There Is No Right to Them
Insisting on accounts receivable when there is no right to them occurs often in separation from employment situations. If there are services rendered but not billed, or billed but not yet collected as of separation, it is tempting to lay claim to them if they are substantial. However, when one is an employee, the payment of salary is usually full compensation for services rendered.

Action Step  Physicians should read the employment contract carefully. Some contracts are contradictory, having the usual provision that employees are not entitled to accounts receivable, but are entitled to them if they are also a member or a shareholder, and this provision may provide some leverage. If there is a dispute over whether one has become a member or a shareholder, however, laying a strong claim is doubtful. Making an aggressive claim in which legal entitlement is shaky is a great way to “burn bridges behind you.”

Mistake 4  Not Understanding the Tail Coverage Obligation
Departing physicians generally want their former employers to pay for extended reporting, or “tail coverage,” when they leave a practice.
BUSINESS STRUCTURING: CLOSING OR LEAVING A PRACTICE

**Action Step**  Again, physicians must read the employment contract carefully. The obligation to pay tail coverage, if any, must be clearly spelled out in the employment contract if a physician wants to make a strong claim for it. Often the employer’s obligation to pay is conditioned on the employee’s having fulfilled certain conditions, such as giving notice of intent to depart for a certain period. However, physicians should not let coverage lapse because of a dispute over payment.

**Mistake 5  Failing to Make Proper Arrangements for Medical Records**
When a physician relocates a practice to a new area, it is tempting to leave the records with another physician under some kind of informal agreement. This can backfire. What happens if the other physician discards the records because the patients don’t like him or her? Or what happens if the other physician gets tired of storing the records? Or what happens if the other physician closes his or her practice and access cannot be gained?

**Action Step**  Physicians should have a very clear understanding of what it means to be a medical records custodian. Even if no money changes hands, they should have a contract that clearly delineates responsibilities to store records (including protection from destruction), release them in response to subpoenas, retain them for required periods, and provide access in case there is a need to respond to a suit, audit, complaint, or so forth.

**Mistake 6  Failing to Provide Adequate Contact Information**
When physicians leave a practice situation they are dissatisfied with, there is a temptation to make it difficult for that practice to contact them, such as by leaving a forwarding address that is a post office box, a telephone number that is an answering service, and so forth.

**Action Step**  Even when leaving a position under less-than-ideal circumstances, physicians should leave adequate forwarding information. Patients may need to contact them. Payors may need to contact them as well, especially where audits and adjustments are concerned that are the responsibility of the departing physician. If the practice has to say that it doesn’t know where the departing physician is, complaints to the medical board are a certainty. And a physician doesn’t want a complaint when he or she is trying to get licensed in another state.

**Mistake 7  Violating Fraud Laws When Selling a Practice**
The federal government believes that some practice sales are the source of illegal kickbacks. It could work like this: The selling doctor is in a position to make referrals of Medicare and Medicaid patients to the buyer, and the purchase price of the practice could be considered a payment for those referrals. This is a particularly sensitive issue where a physician sells his or her practice to a hospital, then goes to work there as an employee, or where an ophthalmologist purchases the practice of an optometrist to ensure a steady referral stream.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

**Action Step** There is a safe harbor to protect practice sales from allegations of illegal kickbacks so long as the sale has been completed no more than one year from the date of the agreement pertaining to the sale, and the selling physician will not be in a position to make Medicare or Medicaid referrals to, or otherwise generate business for, the purchasing physician after one year from the date of the agreement pertaining to the sale. This means that the payout of the purchase price must last no more than one year, which could be a problem depending on the valuation method used. It should be noted that a percentage of revenue over the one year is not a prohibited means of payment.

**Mistake 8 Not Notifying Appropriate Third Parties**
Sometimes physicians are so anxious to retire or leave a job that they don’t make appropriate notifications beyond their patients. This can lead to problems after retirement, often not major, but annoying nonetheless, and usually entirely preventable.

**Action Step** Hospital medical staff bylaws may have an honorary membership classification if a certain notice period is observed. Payer contracts typically have voluntary no-fault termination provisions; again, if a certain notice period is observed. A notification of retired status (or change of office address) is required for federal Drug Enforcement Administration registration. And it may be advantageous to time the retirement date with the renewal date for professional liability insurance, so that the physician would pay only for a tail policy. If a practice is closed due to catastrophic illness, surviving family members may not be aware of all that needs to be done, especially if they have not been involved in the management, so physicians should seek competent assistance.

**Mistake 9 Prescribing for Family after Retirement**
When physicians retire but keep their license active, there is always the temptation to prescribe drugs for themselves and family members. Doing so can lead to allegations of failing to keep adequate medical records, nontherapeutic prescribing, and worse. Medical boards are afraid that retired physicians will try to rely too much on their experience and not keep up with new drug information.

**Action Step** Treating one’s own family members is a bad idea when one is in active practice. After retirement is no better.

**Mistake 10 Assuming All Legal Obligations End on Retirement**
Many physicians assume that, because they have retired, they no longer need to respond to subpoenas, answer complaints filed with the medical board, or do the other things they had to do while practicing. For example, if a retired physician receives a subpoena for medical records, the physician must respond to it, for there is no “retired person” exception to the rules of discovery in lawsuits.
BUSINESS STRUCTURING: NEGOTIATING BUYOUTS

**Action Step**  
Physicians should consult counsel. They should know how long they have to keep medical records if they choose to keep the records after they retire. Physicians who are likely to get subpoenas should consider having a third party respond for them under a medical records custodianship agreement. They should also consider putting their medical license on “retired” or “inactive” status, or consider letting it lapse altogether. The medical board doesn’t have jurisdiction over nonlicensees; however, a plaintiff can still sue a retired physician, so physicians should maintain tail coverage.

**Conclusion**  
Physicians contemplating retirement, selling, or leaving a medical practice for any reason should carefully plan their actions to avoid these mistakes. Ideally, competent assistance should be sought before making a firm decision to sell or make a move. In the case of a sudden, unforeseen event, such as a catastrophic illness, counsel should be consulted as soon as possible after medical conditions are stabilized, because the stress of the illness can lead to bad decisions. In any event, hasty decisions and actions, while expeditious at the time, can lead to problems later that can be avoided with proper planning.

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4.3 The 10 Biggest Legal Mistakes Physicians Make When Negotiating Buyouts—the Remaining Partners’ Perspective  
By Neil B. Caesar, Esq., and Kelly R. Pickens, Esq.

**Executive Summary**  
It is important for medical groups to decide in advance what to pay a member upon his or her departure from the group. These arrangements should be established as part of a consistent strategy that begins with associate employment, continues through member buy-in, and ends with appropriate payout provisions.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

Mistake 1  Failing to Address Payout Provisions When Buy-ins Are Established

Too many medical groups wait to address an appropriate formula for paying out a departing physician until it is time for the departure. There are different reasons for this reluctance, including not wanting to “rock the boat” or assuming that a physician who enjoyed the good fortune of being with the group will not be so crass as to seek economic fairness upon departure. Regardless, this approach usually leads to strife and extra costs. It makes better sense to assess payout issues when addressing the buy-in formula. Almost all medical groups have readily demonstrable value. It is only fair to recognize that value among its owners. Otherwise, physicians would be penalized for having practiced in a group setting. It would be financially better to withdraw from the group, set up a solo practice, and then sell it for a value upon retirement.

Action Step  Physicians should establish a fair and consistent payout approach before it is needed.

Mistake 2  Not Putting the Group’s Interests Foremost When Establishing Payout Arrangements

Fair payout arrangements should be premised, first and foremost, on protecting the ongoing group practice. The group’s welfare must be more important than maximizing the benefit to any individual physician. Excessive generosity will threaten the continuing well-being of the group, a sure pathway to trouble both for the continuing physicians and, often, for the departed physician whose installment payments may become threatened if the group becomes overextended.

Action Step  Physicians should protect the group’s welfare when establishing payout arrangements.

Mistake 3  Establishing Different Payout Terms Based on the Reason for the Member’s Departure

Practices often believe they should vary the payout formula according to whether a physician’s departure is due to death, retirement, or disability, or if a physician retires “too young.” These approaches are often ill conceived. It is only fair to reward fully a departing partner who has participated in the group’s growth long enough to deserve a full payout, regardless of the reasons for the departure; after all, the physician is leaving behind essentially the same tangible and intangible values. An ongoing practice will almost always have the same patient loyalty and forecast for success, regardless of whether the departing physician dies, relocates, or retires.

Such variations usually intend to penalize “inappropriate” departures to discourage partners from withdrawing voluntarily. But a medical practice’s success is usually tied inherently to the collegial, if not synergistic, interdependence of its physician members. Someone who no
BUSINESS STRUCTURING: NEGOTIATING BUYOUTS

longer wishes to be in the group but who stays because of economic coercion will provide a negative influence on the continuing group practice. (Exceptions, such as when a physician departs to compete with the group or harms the group with early notice, are discussed in Mistake 5.)

Action Step Physicians should establish a formula that ignores the motivations for departure.

Mistake 4 Funding a Payout with Life or Disability Insurance
Medical groups that obtain life and/or disability insurance on all or some of their members in amounts sufficient to fund buyout proceeds usually waste their money. It may be comforting to know that departures may have little economic effect on the remaining physicians, but this emotional comfort is often expensive and misplaced.

First, even when the insurance is funded collectively by the group, a departing member will wind up paying for an allocated portion of his or her own insurance, which then benefits the group. The accounts receivable generated by that physician remain with the group. Thus, the doctor subsidizes his or her own insurance and provides a gift back to the remaining colleagues of the receivables and other intangible values he or she generated. Second, the practice’s receipt of insurance proceeds may trigger the alternative minimum tax under federal tax law, making this arrangement far less attractive. If the physicians try to avoid the agreement with a “cross-purchase” arrangement (by which the shareholders individually purchase policies on each other), this is a complicated process at best, and unwieldy when the group has more than two or three physicians. Third, insurance funds a departure only under certain circumstances. A life insurance policy will not fund a payout due to disability, nor will a disability policy fund a death payout. Neither will fund a retirement. The group may have to fund a payout regardless of insurance, so why not just structure the payout to be affordable and eliminate the insurance?

On the other hand, sometimes a medical group has a physician whose drawing power, reputation, or influence is so great compared with that of the other physicians that the group is unsure whether it can survive that physician’s death or disability. In that case, insurance may be justified, to provide cash flow that would not necessarily be sustainable otherwise.

Action Step Physicians should avoid purchasing insurance to fund payouts, except in unusual circumstances.

Mistake 5 Ignoring the Goodwill Values Involved in a Group Practice Payout
As with a physician partner’s buy-in, all three types of assets that affect a medical practice’s worth should be addressed during the payout of a departing physician: the group’s hard assets, its accounts receivable, and its goodwill. Most groups embrace the first two categories,
but some groups ignore or undervalue the practice’s goodwill. This approach is often unfair economically to the departing physician.

Most groups enjoy a fairly strong market for medical practice sales and significant value has been attributed to practice intangibles. Primary care practices are typically sold with goodwill values equal to 10% to 60% of annual revenue; specialties often command 10% to 80% goodwill values. Even hospital-based practices frequently have goodwill values of 5% to 25% or more. If a successful internal medicine practice can command a sale price equal to 40% to 50% of its annual pretax gross income, then logic suggests that it is unfair to deny at least some of those values to a departing physician.

In addition, most departures that ignore goodwill result in a windfall profit to the continuing partners. Upon the member’s departure, the group will likely hire a replacement physician who is much less senior than the departed physician and who commands a much reduced compensation package. Yet the earnings of the group will likely be comparable to what the group earned before the member’s departure, precisely because of the practice’s goodwill value (which includes its ongoing vitality). While this windfall is greatest during the first year after the physician’s departure, it will continue while the replacement physician phases up to full-member entitlement.

**Action Step** Physicians should craft a payout formula that acknowledges their practice’s full value.

**Mistake 6 Not Taking Advantage of Deferred Compensation Tax Rules**

Payout arrangements should use “deferred compensation” to pay for accounts receivable and goodwill values to the departing physician. Deferred compensation is treated as “wages” to the departing physician (taxed as ordinary income) and is tax deductible by the group practice. However, because deferred compensation payments are paid for past services, there should be no FICA (Social Security) or related FUTA (federal unemployment) taxes for the group practice or the departing physician. This is because unfunded deferred compensation is subject to FICA and FUTA taxes in the *later* of the year the services are performed or when there is no “substantial risk of forfeiture” of the payment. When properly structured, deferred compensation is not subject to forfeiture (except, perhaps, for circumstances within the control of the departing member, such as competition). Thus, the deferred compensation was subject to FICA and FUTA taxes earlier, when the services were performed; but at that time the physician probably already paid the maximum FICA and FUTA taxes. Therefore, no further FICA or FUTA should be due.

For tax purposes, it usually makes sense to define the deferred compensation entitlement in terms of salary—eight months of the average monthly salary from the past three years, for example. (An acceptable alternative is to state the deferred compensation as a fixed
percentage of the most recent year’s gross receipts.) If, instead, deferred compensation is stated as a percentage of accounts receivable and practice intangibles, the practice invites scrutiny by the Internal Revenue Service. The danger then is that the deferred compensation will be recharacterized as an asset repurchase by the group, thereby eliminating the tax deductibility of the payments.

**Action Step**  Physicians should consider tax rules carefully when assessing whether to use deferred compensation for the payout formula.

**Mistake 7  Failing to “Phase Up” Separation Pay Entitlements to Junior Partners**

Payout arrangements should reflect the flipside of the group’s approach toward practice buy-ins. Typically, a physician phases up to full parity over some period of time to reflect the difference between the group’s overall vitality and the young partner’s individual contribution toward that vitality. The payout formula should reflect the same approach toward this “phase-in” to acknowledge that a junior partner leaves less value behind than does a senior partner (particularly the goodwill component).

Consistency suggests that the young physician’s equal right to payout should begin when the buy-in has been completed. However, many senior physicians are reluctant to provide a large payout to a young partner, regardless of economic valuation principles. Often, a group will phase up a young partner’s entitlement to a full payout more slowly than the buy-in term, so that the young partner may “pay his dues” through additional years of involvement. One example is a 10% to 20% phase-in each year, reaching full parity in 5 to 10 years. The group must remember to reduce the senior physician’s portion as the junior member approaches parity. If the junior member’s payout entitlement is artificially reduced because of “paying the dues,” then the senior physicians receive a greater entitlement by default. As that discrepancy is reduced, the group must ensure that its payout formula reduces the senior physicians’ entitlement proportionately.

**Action Step**  Physicians should assess how quickly a junior partner should achieve full entitlement to separation pay and make sure the senior physicians’ entitlements reflect this phase-in period.

**Mistake 8  Miscalculating the Appropriate Amount of and Timing for Deferred Compensation**

What amount of deferred compensation is appropriate depends on the group practice’s philosophy. First, if the departing physician was paid by productivity, should the physician receive an equal share of the practice’s payout values or a share tied to productivity? One argument suggests that the group owns its assets equally, and they should be shared equally with departing physicians. The alternative argument is that deferred compensation reflects the intangible values left behind by the physician, and those values relate to how hard that
physician worked (i.e., the physician’s productivity). Either approach is fair if it reflects the group’s overall philosophy, including “share and share alike” or “eat what you kill.”

Second, how will the practice handle cash flow problems? The deferred compensation obligation may be significant in value, because it is tied to both receivables (future revenue tied to past services) and goodwill. The group therefore must consider how quickly it is willing to pay the deferred compensation. At a minimum, the group should not pay more during a payment period (monthly, quarterly, or semi-annually) than would have been reflected in the accounts receivable collected from that physician’s work, minus the payments made to the replacement physician. Indeed, it makes sense for the group to pay only a fraction of this amount on a current basis.

On the other hand, if the payments are spread over too long a period, the departing physician loses the present value of those funds. Would the group be willing to increase deferred compensation to recognize the time value of money, perhaps with an interest component to the payments? The difference in value is perhaps insignificant for deferred compensation paid over one or two years, but it is a very real component of the overall package when payments extend three to five years. Further, most group practices reject the concept of paying interest on deferred compensation. Again, the answer should reflect the group’s overall philosophy.

Finally, the group must protect itself against unforeseen problems. Even the most carefully calculated payout formula may create hardship when cash flow takes an unexpectedly bad turn. This is particularly important when multiple members depart within a short time, or when a very high-earning physician (with substantial deferred compensation) leaves the group. This danger can be addressed by proposing a cap on the total deferred compensation paid by the group during a fiscal year. Typically, such a cap is 5% to 10% of the practice’s gross income for the year. When structuring this formula, the group must decide whether this ceiling will defer unpaid compensation or eliminate it. One theory suggests that the practice’s cash flow problems demonstrate that the values left behind by the departed physician were less than the agreed formula had expected. The alternative argument is that any cash problems reflect an aberration and should not penalize the departing member. This argument is especially persuasive when the cash problems are due to subsequent circumstances.

Regardless, if this approach is taken, the deferral should be limited to one or two years. Any continued cash problems should then result in a reduction of the payment. But physicians should talk to their tax adviser, as this approach arguably affects the payment of FICA and FUTA taxes.

**Action Step** Physicians should assess timing and productivity issues when crafting a deferred compensation formula.
Mistake 9  
**Forgetting to Limit Separation Pay When the Physician’s Actions Hurt the Group**

There are several circumstances in which this mistake can arise:

*Reduction Because of Competition.* When a withdrawing physician practices the same specialty within the group’s competitive market, the physician in effect takes back the goodwill value portion of his or her deferred payout. The group does not enjoy the value of that physician’s contribution to goodwill and should not pay for it. Indeed, a junior physician who leaves the group and competes may impose more harm than the physician’s contribution to goodwill can offset because the junior physician effectively removes more of the practice’s vitality than he or she contributed. It is thus important that payouts be reduced when a former member competes in any manner while the payments are being made. The group must value the reduction appropriately, since many courts will knock down a noncompete formula if it is perceived to punish the competing physician. A reduction tied to goodwill should be safe. But physicians should consult with competent health care counsel before implementing a reduction that includes any portions tied to accounts receivable or hard asset values.

*Reduction for Sick Pay.* A departing physician’s payout should be tied to values left behind by the physician. If a physician has drawn a salary before the departure, yet has been absent from work too often or for too long a period, the physician has already drawn down on those same values to fund his or her salary payments during the absences. It seems fair to reduce the deferred compensation by any sick pay received prior to retirement or death, unless the physician had returned to work long enough to generate sufficient additional revenues, thereby “replenishing the pot,” in effect.

*Reduction for Insufficient Notice.* A medical group needs time to minimize the losses from a physician’s departure, to reallocate workload, recruit additional physician assistance, and so forth. To discourage a member from resigning on short notice, physicians should consider adding a “penalty” provision to the deferred compensation arrangement. For example, if a six-month notice is normally required (absent death or disability), a physician who gives a four-month notice might have his or her deferred compensation reduced by one third. Under this approach, the departing physician retains freedom to decide whether to pay the penalty in exchange for a quicker departure.

*Reduction for Upcoming or Prepaid Expenses.* Groups sometimes pay expenses far in advance to achieve cost savings or for other reasons. If a group has just paid a year’s worth of malpractice insurance, a departing physician should be responsible for paying for that portion of the insurance that may accrue to the physician’s benefit in the future. This is unnecessary if a portion of the payment can be refunded.
A related issue affects insurance “tail premiums.” Malpractice coverage that is claims-based often requires a substantial tail premium to cover claims asserted after the physician’s departure. The risk covered by this insurance accrues both to the departing physician and to the remaining group practice. The group’s documents should make clear who is responsible to pay the tail premium. A common solution is to split the costs, since both parties benefit from the coverage.

**Reduction for Future Liabilities.** Finally, physicians should assess whether to seek recompense from a departed physician for any liabilities that affect the group because of the physician. Examples include a Medicare challenge for alleged billing errors made by the departed physician, or a malpractice claim potentially in excess of insurance limits. One solution may be to seek recompense in some amount for as long as the physician is still receiving deferred compensation, but then to reduce or forgo payback after the payout has concluded. Regardless, this decision should reflect the group’s overall philosophy and should be carefully drafted by competent counsel.

**Action Step** Physicians should identify those actions by the departing member that may affect the payout entitlement.

**Mistake 10  Forgetting to Consider State Law When Crafting Separation Pay**
State laws often affect separation pay issues. Some states, for example, prohibit garnishing an employee’s “wages,” which may be defined to include deferred compensation. This would affect any of the penalty provisions or reductions discussed in this section. Or, the state’s tax rules may vary from the federal rules and affect the tax ramifications of deferred compensation. Therefore, the group’s attorney should carefully consider separation pay provisions to assure compliance with state as well as federal law.

**Action Step** Physicians should consider state law when crafting a payout formula.

**Conclusion**
The overriding theme when crafting separation pay is mutual fairness. From the medical group’s perspective, this means that separation pay should be consistent with the group’s philosophy and should never be allowed to harm the ongoing vitality of the practice. This goal usually can be accomplished while still paying fair compensation to the departing physician.

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BUSINESS STRUCTURING: DECISIONAL GRIDLOCK AND INFIGHTING

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4.4 The 10 Biggest Legal Mistakes Physicians Make That May Result in Decisional Gridlock or Self-Destructive Partner Infighting
By Mark A. Coel, Esq.

Executive Summary
It has become difficult enough for physicians to navigate the legal, regulatory, clinical, liability, and economic issues that confront most medical practices. Intertwining all of these issues in an unhappy relationship among medical practice partners invariably results in total gridlock.

Mistake 1 Getting Together for the Wrong Reasons
The state and federal self-referral laws provide a number of exceptions and some distinct advantages to properly structured physician group practices. The desire to join forces in an effort to capture ancillary service revenue has, unfortunately, resulted in the merger or consolidation of physician practices when the physicians involved simply do not belong together or the physicians are from specialties that have little or no synergy from a patient care perspective. This lack of synergy, other than with respect to one particular source of revenue, can be completely destructive and, in many cases, a nonstarter for many groups.

Action Step Physicians should not enter into mergers or an acquisition simply because they are trying to increase cash flow. There should be some other levels of synergy as well.

Mistake 2 Not Meeting with Experienced Counsel Early in the Process
It’s a story that unfortunately plays itself out time and time again when two or more physicians decide they want to associate with one another: One will say, “Don’t worry, I know someone who can set up the corporation for us cheaply,” or “I’ll just go online and file the organizational documents myself.” The failure to use experienced counsel (whether an attorney, an accountant, or a practice management consultant) can often be the biggest mistake a practice can make.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

**Action Step** Physicians should use experienced counsel who can guide them through the organizational process, point out pitfalls, provide options and, most important, start a dialogue that will either lead to a meeting of the minds (which can then be documented) or expose gulfs that may never be gapped.

**Mistake 3  Not Entering into Written Agreements or Not Updating Existing Agreements**
Organizing a medical practice can be a daunting task that involves at least negotiating leases and third-party payer contracts, setting up billing systems, and hiring personnel. While all of these steps are critical, an organization that lacks a proper foundation—reflected in its organizational documents, shareholders agreement, and employment agreements—will likely find itself in trouble at the first sign of friction.

**Action Step** Organizational documents, shareholders agreement, and employment agreements should be put in place early and revisited periodically or as the organization’s constituency changes.

**Mistake 4  Not Creating a Governance Structure and Failing to Centralize Management**
An organization that fails to centralize its management is unlikely to succeed. Without a consensus, without common goals, and with various individuals moving in different directions, infighting is inevitable.

**Action Step** Any group practice, no matter how large or how small, needs to create a decision-making process and employ centralized management with a chain of command. Doing so includes establishing a board of directors or other governing body that makes policies and oversees major business decisions and assigning one more individuals to be responsible for implementing and administering these policies and decisions.

**Mistake 5  Not Meeting on a Regular Basis**
Aside from the many issues that confront any business, medical practices face a host of other challenges. Whether the challenge comes from laws and regulations at the state and federal level, liability issues (including difficulties obtaining malpractice coverage), or being at the mercy of third-party payers, a practice’s fortunes can change virtually overnight. Physicians in medical practices that deal with these issues infrequently and casually will invariably face uphill and costly battles (and disagreements among each other).

**Action Step** Physicians in practices who meet on a regular and formal basis and gather and consider opinions from their advisers are more likely to anticipate potential problems and address them before those problems swing out of control.
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Mistake 6 Creating a Voting Structure That Is Too Divisive or Can Result in Deadlock
Perhaps one of the greatest challenges in creating a governance structure for any business is preserving the voice of the minority without allowing the minority to put a stranglehold on the business. Partners in a medical practice who are outvoted at every turn are unlikely to be around for very long.

Action Step In seeking to circumvent this mistake, some practices create “major decision” provisions whereby a higher voting threshold is established for certain enumerated decisions. Practices must be careful when establishing the voting structure to avoid setting this threshold too high; for example, to the extent unanimity is required with respect to a particular decision, the vote of one individual could potentially result in a deadlock.

Mistake 7 Not Having a Vehicle to Resolve Disputes
In some states, a voting deadlock may allow a physician shareholder to petition a court to force the dissolution of the practice. This action can yield unexpected and disastrous results, particularly where there is no written agreement regarding the specifics of the breakup. A court can decide which of the owners ultimately will get the various assets of the practice, including telephone numbers, contracts (including, potentially, the lease for the practice’s office space), and other key assets.

Action Step In scenarios in which there is a potential for a deadlock (50/50 ownership or where unanimity is required for certain decisions), the operative documents should include some mechanism for either resolving a dispute or creating an orderly mechanism for a dissolution. Such mechanisms include:
- Mediation or arbitration provisions
- Empowerment of one individual to cast a “tie-breaking” vote
- Waiver of the statutory right to seek judicial dissolution
- Use of blind options (also referred to as double shotgun) whereby, in the event of a dispute, an owner extends an offer to buy and an offer to sell to other owners along with the corresponding right on the part of the other owners to either sell or purchase in accordance with the offer extended
- Clear identification of the manner in which the assets of the practice will be distributed in the event of a dissolution.

Mistake 8 Implementing a Compensation Plan That Creates Too Much Competition
On the continuum of choices for compensating owners of a medical practice, the options range from an equal sharing of all revenue to an “eat what you kill” approach, whereby physicians are compensated based on their own production. While for many practices some
element of productivity-based compensation is desirable (rewarding physicians who work harder), a compensation formula that is too heavily weighted toward the productivity element can potentially create unhealthy competition among physicians within a practice and lead to infighting over certain issues, such as scheduling, allocation of patients by payer class, and types of procedures.

**Action Step** While it is desirable to have some element of productivity-based compensation to reward the harder working physicians, it is also desirable to have some portion of the practice’s revenue shared on an equal basis to create a unity of ownership among the physicians.

**Mistake 9  Not Agreeing on How the Expenses of the Practice Will Be Shared**
Just as destructive as the issues surrounding the sharing of revenue, if not more, are disputes over the manner in which the expenses of a practice are shared. Typically, these disputes arise in practices in which some physicians use greater resources of the practice than others. For example, some physicians use more equipment, space, and personnel compared with other physicians, who may see more patients off-site, such as in hospitals and other facilities. While some practices attempt to track every penny that may be attributable to a particular provider (which can create infighting in and of itself), others take a simpler path and simply divide the overhead equally among the physicians within the practice.

**Action Step** Physicians in a practice should have a clear understanding of how the overhead and expenses of the practice will be shared. Such an understanding should involve identifying expenses that are true direct expenses of each physician (such as insurance, retirement plan contributions and other benefits and expenses for continuing education, entertainment, and automobiles among other costs), as well as expenses that are common to all of the physicians in the practice (such as rent and related expenses, personnel costs, and consultant fees). In the end, to the extent one or more physicians within a practice use more of the practice’s resources, physicians should give some consideration to allocating a greater portion of the practice’s overhead to such physicians. In lieu of attempting to track each expense to a particular physician, the practice may be better served by allocating overhead using a formula similar to that suggested in Mistake 8 (that is, allocating a portion of the overhead equally and another portion based on relative production).

**Mistake 10  Not Treating Partners Equally**
Many physicians who join existing medical practices with the understanding that they ultimately will be brought in as equity holders often discover that what they are ultimately offered falls well short of their expectations. This result is typically the fault of both parties: the practice not fully disclosing what it means to be a “partner” and the incoming physician not asking the right questions. Too often, physicians are offered equity interests that carry with them rights inferior to those of the other owners (ranging from the percentage interest
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offered, unequal treatment in terms of compensation, benefits, time-off, call obligations, differences in severance packages and post-termination restrictive covenants).

**Action Step** New physicians should ask exactly how they will be treated so that they can eliminate any misunderstandings before they begin work.

**Conclusion** Many of the disputes in which physicians in group practices find themselves can be avoided if issues are discussed in advance and properly documented. Moreover, costly legal battles can often be avoided through open communication and the establishment of a means for resolving disputes.

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### 4.5 The 10 Biggest Legal Mistakes Older Physicians Make in Retirement Arrangements

**By James M. Daniel, Jr., Esq., and Kimberly H. Gillespie, Esq.**

**Executive Summary** Each year thousands of physicians retire after long and successful careers. While retirement should be a time of relaxation, if proper precautions are not taken, a physician’s retirement can become a legal nightmare. To ensure the type of retirement that so many physicians have worked for, it is imperative that they plan thoroughly and address meticulously the many financial, legal, and human resource issues that can arise. This section highlights 10 of the most serious mistakes physicians can make when planning to retire, close their medical practice, or both.

**Mistake 1** **Failing to Timely Review and Assess Contractual Obligations** Most physicians are party to a number of contracts that impose myriad contractual obligations. Such agreements can include medical office leases, maintenance and service contracts, insurance contracts, utility agreements, and personal service agreements (i.e., medical directorships). One of the physician’s first steps toward retirement should be to gather and review all of these contracts as soon as possible, but at least one year prior to the targeted retirement. Doing so will provide adequate time to assess notice and termination
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provisions and to determine how the physician’s rights, obligations, or both may be affected if any agreement needs to be prematurely terminated. It is important that the physician clearly and accurately understand and then execute the steps necessary to effectuate a proper termination under each agreement.

**Action Step**  At least one year prior to retirement, physicians should identify and compile a copy of all their current contracts, including any personal services agreements under which they are personally obligated to perform, as well as other types of contracts affecting their practice (e.g., office leases, service contracts, and insurance policies). If necessary, physicians should ask their attorney to assist in the review and assessment of their contractual rights and obligations.

**Mistake 2   Allowing a Lapse in the Physician’s Professional Liability Insurance Coverage**

Physicians generally have either occurrence-based or claims-made malpractice coverage. A claims-made policy covers the physician for claims made during the time in which the insurance is maintained. Therefore, physicians who retire and allow their claims-made policy to expire will not be protected if a claim is filed after the expiration of the policy. It is vitally important that physicians who have a claims-made policy arrange for a reporting endorsement, commonly referred to as “tail” coverage.

**Action Step**  Physicians should review their current medical malpractice coverage and determine if it is an occurrence-based or a claims-made policy. If necessary, they should contact their medical malpractice insurer for assistance. Physicians may find the carrier is willing to provide them with tail coverage and to offer them a credit for prepaid premiums, discounts, or both.

**Mistake 3   Failing to Timely and Adequately Advise Patients of Impending Retirement**

To avoid a claim of patient abandonment, it is important that physicians properly terminate their “relationship” with each patient prior to retirement. While it is likely that state law will outline specific notification requirements, when it does not, a physician should provide patients at least 60 days advance written notice of the impending retirement. Such notification must be in writing and can be provided by mailing a letter to each patient informing him or her of the physician’s retirement, closing date, or both; and the patient’s rights with respect to his or her medical records. It is a good idea for physicians to have their attorney review this notification letter to ensure that it meets state requirements.

It will likely be impractical to send a notice to every patient the physician has formed a relationship with over the years. When that is the case, experts recommend that the physician notify patients seen within the last three years, being careful to identify the high-risk patients
currently under the physician’s care and for whom continuing care will be vital. It is often suggested that the physician send notice to these individuals via certified mail with a return receipt in addition to the physician’s general notification letter. Such documentation should then be filed in the patient’s records.

**Action Step** Physicians should research their state’s law requirements concerning patient notification. If necessary, they should consult an experienced health care attorney for assistance. They should ensure that they are able to identify every patient they have seen over the most recent three years, being careful to identity high-risk patients. If applicable, the retiring physician should notify three to four other physicians with comparable qualifications to whom he or she may recommend patients.

**Mistake 4** **Failing to Make Adequate Arrangements for Records Storage and Retention**

Proper storage of patient records is of critical importance. State law may stipulate how long patient records must be retained, how they must be stored, and the degree to which patients (and others) must be granted access to their records. In addition to ensuring access by patients and state and federal authorities, the physician’s medical malpractice insurer also may have particular record retention and storage requirements.

While it is important to research state-imposed requirements concerning record retention and storage, it is equally important to identify the outside statutory time limits within which a patient (or others) can initiate a legal claim against the physician. Usually, maintaining records for seven to 10 years is a sufficient amount of time, but there are exceptions. For example, a pediatric practice will need to maintain patient records much longer. It is not uncommon for states to extend the statute of limitations applicable to minors for several years after a patient reaches the legal age of majority.

Further, if the physician plans to transfer or sell his or her records to another physician, it is advisable that the physician consult with an experienced health care attorney to ensure that the arrangement complies with applicable state and federal laws. Such an agreement should specifically grant the physician a right to access his or her patient’s medical records in the future, to receive copies of material upon request, and to be notified if the physician receiving the records retires, or otherwise plans to dispose of the patient records.

**Action Step** Physicians should research state and federal legal requirements concerning patient record retention and storage, and follow them meticulously. Also, they should explore the possibility of retaining, in at least two different locations, multiple copies on microfiche or other electronic means.
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Mistake 5  Not Properly Addressing Employee Needs
When a physician has employees who will be affected by his or her retirement, assessing the employees’ needs early in the planning phase is wise. First, if the physician’s retirement also means the closing of the medical practice, the physician will want to ensure that the employees are provided with adequate notice. In addition to researching any legal requirements, it is imperative that the physician review his or her personnel manual and assess obligations with respect to compensation, accrued vacation and sick time, severance pay, insurance benefits, pension plans, and other benefits. The physician should plan on providing the employees with at least 30 days of notice; however, this may be driven by the physician’s notice requirements to his or her patients.

The physician should also anticipate that some employees will likely resign before the closing day. To address staffing shortages, experts advise physicians to interview temporary staffing companies in advance, select one or two that can adequately address the physician’s needs, and make arrangements to contact them if temporary help becomes necessary. Experts further recommend that the physician consider offering a bonus to key employees who remain on staff until closing.

Action Step  Retiring physicians should take inventory of their employees to determine who should be offered a “retention bonus” and which ones might leave before the official closing date. Also, they should contact temporary staffing agencies and select at least one that will be able to address their needs. Physicians should be careful to accurately analyze their financial and legal obligations with respect to their employees and factor each into their plan.

Mistake 6  Failing to Arrange for the Proper Disposal of Drugs
Physicians must notify the U.S. Drug Enforcement Administration (DEA) and, if applicable, the appropriate state counterpart about their impending retirement. They should seek instruction from each on what steps are necessary to ensure proper disposal. For example, when controlled substances are disposed of or destroyed, the DEA requires registrants to complete a DEA Form 41 and have the disposal or destruction completed by a DEA authorized company.

Both state and federal agencies should be contacted for specific instructions on how to properly dispose of controlled substances and what record retention requirements may be imposed. In addition, physicians must ensure that all unused DEA order forms are voided and returned to the proper authorities at the DEA. Likewise, unused state prescription pads must be voided and returned to state authorities. Finally, physicians must send a certified letter to the DEA informing the agency of their retirement and intent to surrender their DEA registration.
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**Action Step**  
Physicians should contact the DEA and their state counterpart for specific instructions on the disposal of prescription drugs. They should be sure to complete all necessary paperwork and keep copies for their business files.

**Mistake 7  Failing to Notify the State Licensing Board and Other Professional Associations**  
Prior to retirement, physicians must contact their state licensing board, state medical society, the American Medical Association, and any specialty boards and societies of which they are members. In some states, physicians may be able to maintain an active license (with some restrictions) at no cost and/or become exempt from continuing medical education requirements upon request. It is also common for many professional organizations to offer reduced fees for retirees. Each organization must be contacted to learn of its individual policies.

**Action Step**  
Physicians should make a list of all the professional associations, specialty boards, and societies of which they are members. They should contact each to learn their membership options following retirement.

**Mistake 8  Failing to Involve Professionals**  
Having professional legal and financial advice throughout the retirement process will be critical to ensure adequate planning and smooth execution. Involving an accountant early on can help the physician assess his or her financial obligations with respect to creditors, vendors, and employees prior to closing. Working in conjunction with the physician’s legal counsel, an accountant should be able to walk the physician through a systematic process of analyzing his or her financial obligations. For example, it is often recommended that physicians tighten their collection practices and closely monitor their accounts receivable and payable in the months preceding retirement. They should also request final statements from each vendor. This process will serve two purposes. First, physicians will have the peace of mind of knowing that they have taken care of the financial obligations owed to their vendors. Second, each vendor will be properly put on notice of the physician’s retirement and, if applicable, office closing. When the physician’s retirement does not involve the closing of a medical practice but only resignation from the practice, it is still a good idea to notify all of the practice’s creditors and vendors of the retirement, especially if the physician is a partner in the practice. Depending on how the practice is organized, such notification can have a dramatic effect on the physician’s personal liability pursuant to the practice’s future debts.

The physician will also want to engage the services of competent legal counsel. Because the health care industry is highly regulated by state and federal laws, it should be no surprise that a physician’s exit from practice is also laced with potential legal pitfalls. Experienced legal counsel can help the physician successfully navigate many such potential problems. When hiring counsel, the physician should seek someone experienced in health care.
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**Action Step** Physicians should contact an accountant and an attorney early in the planning process and give them a complete picture of their particular situation. Physicians should insist that these professionals work together in mapping out a plan, being careful to consider the many unique aspects of their retirement (e.g., does the retirement involve ending an employment relationship; will the practice be closed or will there be a partnership that may or may not continue?).

**Mistake 9 Forgetting the “Small Stuff”**
Implementing a successful retirement plan involves a number of small, but important, details that must be addressed. It is important that physicians be proactive in thinking through their plans. Among the details that physicians should keep in mind as they plan for their retirement are the following:

- Arrange to transfer health and life insurance policies, if applicable.
- If closing the practice, make sure the legal entity is officially dissolved with the proper state authorities.
- Notify the U.S. Postal Service and forward the mail.
- Cancel subscriptions to newspapers, magazines, and journals.
- Ask vendors if unopened items can be returned for credit.
- Make arrangements with the answering service.
- Donate books, journals, and other materials to the local library or charity.
- Contact the local Social Security office if the physician is nearing age 62.

**Action Step** When developing their retirement plans, physicians should ensure that they consider the “small stuff.” Keeping a current “to-do” list can help track progress, facilitate communication with those who are helping, and assist in record keeping.

**Mistake 10 Failing to Keep Good Records of the Closing**
There are so many issues to address when physicians retire or close their offices that it is easy to forget that one of the most important and helpful steps they can take is to keep accurate and complete records of the retirement or closing process. Such documentation can make a world of difference as they work through the process and can provide an excellent resource if questions or issues arise later. Often many parties are involved in a physician’s retirement or closing, which can make the task challenging. However, that challenge is no more difficult than that of trying to locate all of the relevant materials and parties months or years later if an issue arises.

**Action Step** Physicians should keep accurate and complete records of their retirement and closing process. They should be certain to communicate this need to all of the parties involved in their retirement. If possible, they should designate a staff member to oversee the process for them.
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Conclusion
Retirement should be looked on with great anticipation, but the process of preparing for it must be carefully planned and orchestrated. Physicians approaching retirement must be aware of these potential mistakes and take proper precautions to avoid them.

Additional Resources
- J. Roediger, This Practice Now Closed Take Care of Legal, Operational Responsibilities First (2002), http://www.shands.org/professional/ppd/practice_article.asp?ID=235

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4.6 The 10 Biggest Legal Mistakes Physicians Make in Buy-ins
By Michael F. Schaff, Esq.

Executive Summary
Each year, employed physicians are given the opportunity to buy in to the medical practices in which they are employed. Although this seems like a simple and natural step in the lifecycle of the association between a physician and his or her employer, significant issues are involved in this important event. Often, physicians do not understand the economic and legal significance of buying in to a medical practice and the “potholes” into which they may fall along the way. Mistakes physicians make in their buy-in may have serious economic and lifestyle effects on them and their families for years to come. Thus, it is imperative that physicians learn to spot these issues and avoid their often dire consequences.

Mistake 1 Failing to Consult with Professionals During a Buy-in
A common mistake physicians make in the buy-in process is not hiring their own professional advisers, including an attorney and an accountant. Physicians who have worked for a practice for a number of years may not believe that it is appropriate to do so or they may fear that it will be viewed as insulting if they hire their own professional advisers to evaluate the practice and assist them in the buy-in process. A physician buying into a practice should not feel uncomfortable, since the practice and the existing physicians expect the physician to hire appropriate professionals to advise him or her during the buy-in stage. In fact, the existing owners most likely engaged their own professionals to assist them in their buy-in. Specifically, a physician should not rely on the practice’s attorney or accountant for advice during the buy-in process, since those professionals have a potential conflict of interest and may put the interests of either the senior physicians or the existing practice over the physician buying in.

Action Step Physicians should consult with experienced professionals, accountants, and attorneys who specialize in representing physicians in the buy-in process before negotiating the buy-in to a medical practice.

Mistake 2 Failing to Negotiate the Terms and Conditions of the Buy-in at Commencement of Employment
Physicians joining a practice have a unique opportunity to negotiate the terms of the buy-in before joining the practice as an employee. This is the ideal time for a physician to negotiate
the buy-in because it is then that he or she has the most leverage, since the practice has a
recognized need to expand and the physician is not yet committed to the practice. Also, at this
point, physicians have not yet altered their professional and personal lifestyle and are not
subject to a restrictive covenant that could weaken their negotiating position if the buy-in is
negotiated toward the end of an employment period. In sum, physicians will be able to walk
away from the relationship, with little or no harm, before it has started and they are free to
accept another offer if they do not like the proposed terms of the buy-in. It may not be as easy
for a physician to walk away once he or she has been an employee for a year or more.

Among the questions to ask about the buy-in before commencing employment are the
following: When will the physician be offered a buy-in? How is the purchase price
determined? How is the purchase price paid? What does it mean to become an owner in terms
of compensation and decisionmaking? Will any of the senior owners be retiring shortly? If so,
what will their buyout be? Again, physicians have the most leverage to negotiate these terms
before they begin to work for the practice.

**Action Step** Physicians should discuss and understand the parameters of a future buy-in at
the time they first become employed by the practice. They should show their new employer
that they are thinking about the future and are detail oriented. Also, physicians should be sure
that the employment agreement sets forth the terms of the buy-in.

**Mistake 3 Failing to Analyze the Tax Treatment of the Purchase Price**
Physicians generally do not focus on the tax treatment associated with the buy-in, even
though the allocation and structure of the buy-in amount could have a significant tax effect on
them and the amount of money they receive. For example, if the buy-in amount is $100,000
and characterized as an ownership purchase, the physician must earn about $167,000 to pay
the practice the $100,000, because he or she must pay taxes of about $67,000 in order to have
$100,000 after taxes to pay for the purchase price. If, however, a significant portion of the
buy-in amount is characterized as some type of seniority payment or deferred compensation
for the senior doctors, that amount would be paid by the practice to the senior doctors and
reduce the physician’s salary. The amount shifted to the senior physicians will be pretax
money. This means that, for example, a physician buying in who pays $10,000 for the
ownership and $90,000 as an income shift must earn only about $106,700 to pay the
$100,000 buy-in amount ($90,000 plus $10,000 plus $6,700 in taxes) for a savings of about
$60,300.

**Action Step** To maximize the pretax payment benefits rather than the post-tax payment
detriments, physicians must analyze the allocation and tax treatment of the buy-in amount
and the structure of the buy-in.
MISTAKE 4  **Excluding a Payment for the Existing Accounts Receivable in the Buy-in Amount**

When determining the value of the practice and the corresponding buy-in amount, if the practice requests the physician to “buy into” the accounts receivable, the physician should insist that such value exclude the accounts receivable that exist on the date of the buy-in. If included in the calculation of the value, the physician will pay for the accounts receivable with after-tax money and when the accounts receivable are collected by the practice and distributed to the physician as compensation, the physician will be taxed on it as ordinary income.

**Action Step**  When structuring a buy-in, physicians should make sure that the accounts receivable are not calculated as part of the buy-in amount and, in lieu thereof, establish a mechanism whereby the existing physicians receive the value of the “good accounts receivable” over a period of time. Paying it over time will reduce any significant negative effect on cash flow and distribution.

MISTAKE 5  **Failing to Conduct Due Diligence Prior to Purchase**

As with all significant transactions, it is important that physicians conduct appropriate due diligence of the practice before finalizing the buy-in. Due diligence should include, at a minimum, a review: of practice documents (including its organizational documents); of the practice’s financial statements and tax returns; of all material contracts to which the practice is a party; and of information regarding any potential or pending litigation; as well as such other due diligence that is reasonably necessary.

**Action Step**  Physicians should spend appropriate time researching and reviewing the practice from an economic and legal perspective. They should receive appropriate representations and warranties regarding important issues, and the practice should indemnify them for damages resulting from past actions and any breach of a representation or warranty.

MISTAKE 6  **Having an Inappropriate Structure for the Entity**

Many physicians accept the organizational structure of the medical practice as it exists without asking questions and understanding the ramifications of different structures. The types of structures for a practice include a professional corporation, a partnership, and a limited liability company. It is important to understand the major differences among these entities and how they may affect the physician. Of critical concern is the ability to limit the physician’s personal liability for the entity’s liabilities and to maximize the tax advantages. Although all physicians are personally liable for their own malpractice liability, depending on the structure of the entity they may be able to insulate themselves from the medical malpractice of the other owners, as well as from the practice’s obligations. When the practice is structured as a partnership, there is unlimited liability to the individual physician with regard to the other owners’ malpractice and the general liabilities of the practice. In other
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words, if the practice the physician is buying into is a partnership, the physician could “lose his or her house” if another owner does something inappropriate or has a malpractice judgment brought against him or her.

**Action Step** Physicians must review the structure of the practice to ensure that they are not creating additional unnecessary liability. If the entity is structured as a partnership (with unlimited liability), a physician should strongly recommend converting it to a limited liability company or a professional corporation to the extent it is allowed under state law. Physicians should avoid operating medical practices as partnerships.

**Mistake 7 Failing to Understand Related-Party Transactions**

Often, one or more of the existing owners may own the office in which the practice is located, may own the equipment used by the practice, or may provide services (e.g., billing or management) on behalf of the practice and receive compensation therefore. Also, the practice may employ an owner’s spouse, children, or other relatives. It is important that a physician understand what these “related-party” transactions are and whether or not they are necessary and at fair market value. If they are not necessary or at fair market value, then they may have a negative effect on the physician’s compensation. In addition, it is important to understand how patients are routed through the practice, especially if the physician’s compensation is based on a productivity formula. For example, if the spouse of the senior physician is in charge of scheduling patients, it is very possible that that senior physician may be receiving the “most well-insured” patients, which will increase his or her productivity (and compensation) and, in turn, reduce the other physicians’ productivity (and compensation).

**Action Step** Physicians should be sure that all related-party transactions are disclosed, are necessary, are at fair market value, and are documented. They should specify that patients are to be assigned equitably (based on procedures and payer mix) if compensation is based on productivity.

**Mistake 8 Failing to Understand Events That Trigger a Buyout of a Physician’s Ownership Interest**

It is customary that, upon their admittance as an owner, physicians sign either a shareholder agreement or an operating agreement, which sets forth each physician’s rights and obligations as an owner of the practice. These agreements typically set forth certain events that, when they occur, require the physician to sell his or her ownership interest in the practice to the other owners. A physician generally will be required to sell his or her ownership interest upon his or her death, disability (which must be clearly defined), and other termination of employment. There are also other events that require the sale of a physician’s ownership interest which are not so obvious. Thus, all “triggering” events must be reviewed carefully to make sure that they are reasonable under the circumstances. For example, in some instances the physician may be terminated without cause by the other owners, requiring the physician
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to sell his or her ownership interest in the practice. If this is the case, the physician should understand this and make sure the voting threshold for noncause termination is high. Certain other events, such as the failure to complete charts or a violation of a rule, should not trigger termination and result in a buyout without a notice-and-cure period. The nature of the triggering event may affect the buyout terms and/or the post-termination restrictive covenant.

**Action Step**  Physicians should carefully review and understand the events that trigger a buyout.

**Mistake 9  Failing to Have Clearly Defined Termination Provisions**

In many practices, the agreements for terminating a physician’s employment are not clear or provide that the practice may terminate the physician owner who has bought in without cause or with limited notice. Physicians must remember, however, that they may be wearing two hats in these situations: that of an owner who may want to terminate another owner or that of the physician who is being terminated. Typical termination provisions may include, at a minimum, material breach of the physician’s employment agreement, loss of license to practice medicine, loss of DEA licensure, and loss of privileges.

**Action Step**  Physicians should review termination provisions from both the employer’s and the individual owner’s perspective to make sure the provisions are fair and appropriate. They should make sure that the post-termination obligations appropriately fit the circumstances and have some relationship to the triggering event. Also, they should ensure that appropriate notice is given to allow a physician to attempt to remedy (cure) the breach before termination and the required sale of his or her ownership interests.

**Mistake 10  Failing to Understand the Restrictive Covenant**

In many states, restrictive covenants are enforceable if they are reasonable. Many employment arrangements contain restrictive covenants that prohibit a physician from practicing medicine for a specified time after termination and within a certain geographic area. Restrictive covenants also prohibit a physician from soliciting patients, referral sources, and employees after his or her employment is terminated. Such covenants will result in the physician’s inability to continue to practice for a specific period of time within the local geographic area, which may include the community in which the physician lives. Each physician must understand the obligations (restrictions) that are imposed upon him or her at termination and make sure he or she can live with them.

**Action Step**  Physicians must fully understand the restrictive covenants and the actions they prohibit. They should consider requesting the ability to “buy out” of the restrictive covenant on termination by waiving some or all of the money they are entitled to (the “buyout”) upon their departure so that they can continue to practice in the community.
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Conclusion
Before entering into negotiations regarding a buy-in to a medical practice, a physician should have a clear understanding of the issues that need to be addressed and should obtain appropriate professional advice. By avoiding and addressing the mistakes discussed in this section, physicians will find the post-buy-in relationship to have fewer surprises and disappointments.

About the Author
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4.7 The 10 Biggest Legal Mistakes Physicians Make When Negotiating Buy-ins–The New Partner’s Perspective
By Patrick Formato, Esq.

Executive Summary
Unlike most professions, upon initial employment physicians want to know when and under what terms they will become an equity owner (typically referred to as partner) in the medical practice. In general, except for vague provisions outlining the parties’ intentions, partnership is not addressed in an initial employment agreement. Physicians should use the time they serve as an employee to learn more about the practice and its partners. A partnership is akin to a marriage. Accordingly, physicians should learn as much as they can about their future partners before making a long-term commitment to become a partner in the practice.

Mistake 1 Starting Negotiations Too Late
Although new physician employees want to know from the outset when and under what terms they will become a partner, they often fail to negotiate terms in their employment agreement that will put them in a good position to negotiate their partnership buy-in. For example,
unlike other professions, patients typically identify with their physician, not the medical practice. Accordingly, the medical practice/employer typically imposes a restrictive covenant on termination, for any reason, of the employment relationship. An overly broad restrictive covenant will put the employee in a very weak negotiating position, especially if the general terms of a buy-in were not addressed in the initial employment agreement.

**Action Step** Physicians should consider the effect that the terms in their employment agreement will have on their partnership buy-in negotiations. To the extent possible, the employment agreement should address general partnership buy-in terms, such as the method of calculating the purchase price, the method of payment, and the percentage of ownership interest to be given them.

**Mistake 2 Not Retaining Experienced Health Care Attorneys and Accountants**

Health care law has become a specialty due to the complexity of the rules and regulations governing health care providers and the assorted business arrangements that providers have developed. As a result, there are attorneys and accountants who specialize in services for medical practices and physicians. Too often, physicians negotiating a buy-in make the mistake of not retaining any professionals, since they believe, as the incoming partner, they have no leverage to negotiate terms. When they do retain professionals to assist them, they often fail to engage attorneys and accountants who regularly represent physicians and physician practices, which could result in mistakes that may have lasting effects.

**Action Step** Physicians should engage only those attorneys and accountants with experience in representing doctors and medical practices. They should be sure to do their due diligence before engaging such professionals (e.g., check the professional’s website, inquire at local bar associations and medical societies, and get references from the professionals themselves).

**Mistake 3 Failing to Review Thoroughly and Understand the Partnership Agreement, Shareholders Agreement, or Operating Agreement**

Before consummating the buy-in, the prospective new partner must review the agreements that govern the physician owners (e.g., the partnership agreement, shareholders agreement, or operating agreement). Often, prospective new partners are so excited about becoming a partner that they focus only on the financial issues and neglect to review and understand the other rights, responsibilities, and obligations that they are contracting for, such as the buy-out provisions, voting power, and restrictive covenants.

**Action Step** Physicians should obtain a copy of the governing documents early in negotiations and have it reviewed by competent counsel.
Mistake 4  **Failing to Inquire about and Understand the Relationships among Related Companies**

Often, the physicians of a medical practice have a separate company that owns or leases the premises in which the practice is located. In addition, some practices have a separate management company that owns all the equipment and employs all the nonprofessional personnel. Physicians buying into a practice must inquire about such types of entities and ensure that they are also getting an equity interest in such entities. Otherwise, they may be getting less than a full partnership, especially if excess profits are being distributed from the practice to the affiliated entity under the guise of “rent” or “management fees.”

**Action Step**  Physicians should ask the existing partners questions about the practice (e.g., Who owns the property and equipment? Does the practice have contracts with any related entities?). Physicians should ensure that the buy-in agreement includes representations and warranties to address these issues.

Mistake 5  **Failing to Negotiate Sensitive Issues**

By the time a physician negotiates a partnership buy-in, he or she has often been an employee of the medical practice for a number of years and has developed relationships with the physician partners. The younger doctor often feels uncomfortable in addressing important, but sensitive, issues with the physician partners as a result of their past employer-employee relationship and in fear of offending them. This situation could result in important issues being unaddressed.

**Action Step**  Physicians should let their attorney be the “bad guy”; they can always blame their attorney. It is important for the physician to maintain a good relationship with the partners during the negotiation process while, at the same time, ensuring that important issues are appropriately addressed.

Mistake 6  **Failing to Conduct Due Diligence**

Before buying a house, the buyers typically hire an engineer to ascertain the structural integrity of the house and a termite inspector to ensure that the house is not infested. Furthermore, they conduct a title search (to ensure proper title) and a survey of the real estate. However, when physicians buy an interest in a medical practice, they often fail to conduct a due diligence review to ensure that they are getting what was bargained for.

**Action Step**  Physicians and their advisers should conduct due diligence, including but not limited to, a review of all material agreements and a litigation and lien search of the operating entity.
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Mistake 7  **Failing to Address Tax Issues**
Buy-ins are structured in many different ways. In addition, medical practices can be professional corporations, general partnerships, limited liability companies, or limited liability partnerships. The type of entity and the method and manner of payment of the purchase price all have different tax ramifications.

**Action Step**  Before agreeing to the financial terms of a buy-in, physicians should discuss these terms with their accountant, and relevant tax issues must be considered.

Mistake 8  **Failing to Consider Buyout Obligations**
Partnership/shareholder/operating agreements typically include mandatory buyout provisions. Often, new physician partners focus on their buy-in obligations rather than on their (or the entity's) obligations to buy out existing partners under specified circumstances. How is the buyout funded? Are there “cross-purchase” life insurance policies on the lives of the partners to fund the buyouts? How is the purchase price determined, and how does it compare with the buy-in price?

**Action Step**  Before agreeing to a buy-in to the partnership, physicians should conduct a thorough and comprehensive review of the medical practice’ partnership, shareholder, or operating agreement.

Mistake 9  **Failing to Get to Know the Practice’s Attorneys and Accountants**
It is very important for a medical practice to engage attorneys and accountants who have experience in representing medical practices. Once a physician becomes a partner, the advice of the practice’s attorneys and accountants will affect the new physician. Accordingly, the new physician should be comfortable with the practice’s attorneys and accountants.

**Action Step**  Physicians should ask the existing partners about the qualifications of the attorneys and accountants who represent the practice and do independent research to ascertain their reputation in the legal and medical communities.

Mistake 10  **Overlooking the Age, Experience, and Personalities of the Existing Partners**
For a partnership to be successful, the partners should be compatible and have common goals. If the existing partners have a wealth of experience and are close to retirement age, the prospective new partner must ascertain how these factors will affect his or her future and the practice. Furthermore, the prospective new partner must be comfortable with the existing partners’ approaches to medicine as well as to business. Overlooking differences can lead to messy “breakups” or the eventual financial failure of the practice.
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Action Step  Physicians should use the period of employment to get to know the practice and its partners better. In this period, the parties should be courting one another. Physician employees who harbor any doubts about the practice or the partners must seriously consider these doubts before committing to buying into the practice.

Conclusion
Before entering into a partnership with a medical practice, physicians should consider that a partnership is similar to a marriage. Accordingly, physicians should use the time when they are working as an employee to learn as much as possible about their future partners before making a long-term commitment to become a partner in the practice.

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4.8 The 10 Biggest Legal, Tax, and Economic Mistakes Physicians Make in Fashioning Buy-ins and Buyouts
By Richard J. Flaster, Esq.

Executive Summary
A professional practice usually has three components of value: net tangible assets (e.g., cash, equipment, and furniture less its trade payables); collectible accounts receivable; and goodwill. Whether fashioning buy-ins for new physician-owners or buyouts for the existing owners, the issues are the same, and the agreements should properly reflect each component of value in the most tax-advantaged structure possible. The parties often fail to address the economic realities of the situation, as well as to consider several important tax issues, which could materially lower the net after-tax cost of the transaction.

Mistake 1 Including Accounts Receivable Value in Stock Price
If patients paid their medical bills at the time services were rendered, the medical practice would have no accounts receivable. All revenues would translate into current compensation to the physicians rather than give rise to this “accrued asset.” In structuring their buy-ins and
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buyouts, physicians often wrongfully include a share of the accounts receivable in the buy-in stock price, which mischaracterizes the true economic nature of this component of value (that it is simply deferred revenue) and subjects it to higher than necessary income taxation.

Assume, for example, $100 of accounts receivable value and that the combined federal and state tax rates are 40% on ordinary income and 20% on capital gains. Since payment of the stock purchase price is not deductible, the buy-in physician will be required to earn $167 in pretax income to cover the after-tax payment of $100 to the current owners, who will then retain only $80 after paying capital gain taxes. Accordingly, under this structure, there will be an aggregate tax cost of $87 on the $167 of income devoted to funding this buy-in payment.

Action Step  Remove the $100 of accounts receivable value from the buy-in stock price, have the buy-in physician forgo $133 in compensation, and then pay an additional $133 in compensation to the current owners. Since a compensation payment is fully deductible, the buy-in physician will be required to generate only $133 of gross income (rather than $167) to fund the payment to the current owners, and the current owners will realize the same $80 in after-tax income (as ordinary income) on the $133 they receive. Accordingly, this refashioned structure saves the buy-in physician $34 in pretax income (and $20 in after-tax income) for every $100 of buy-in price that has been so restructured.

Mistake 2 Including Goodwill Value in the Buy-in Stock Price

A professional practice may develop valuable goodwill over time, building an institutional reputation that fosters return visits and referrals from patients and other physicians. If so, this is a separate component of the medical practice’s value and should be reflected in the buy-in price paid that a new physician owner would pay. However, if the goodwill value is included in the stock price, then the buy-in physician would be forced to devote a greater amount of pretax earnings than necessary to the buy-in.

Action Step  To effectuate the buy-in, the goodwill value should be removed from the stock price. Instead, the new physician should forgo compensation entitlements in this amount, which should then be paid to the current physician owners. However, this restructuring will provide the current physician owners with ordinary income in payment for the goodwill. If the current physician owners feel that they are entitled to lower capital gains taxation on this price component (an issue that may be subject to honest debate), the amount should then be increased to account for the higher ordinary income taxation of this compensation payment. As noted in Mistake 1, a payment of $133 in reallocated compensation will still produce the expected $80 in after-tax income to the current physician owners and will burden only the buy-in physician’s pretax earnings by $133 (as compared with $167 of the physician’s pretax earnings if reflected in the stock price). Accordingly, this restructuring will save the buy-in physician at least $20 of after-tax income for each $100 buy-in price, thus producing a lower net economic cost to the buy-in physician. Similarly, on
the buyout, this component of value should be reflected as deferred compensation paid to the
buyout physician.

Mistake 3  Reflecting Goodwill Value in the Buyout Price When the Goodwill Is
Personal and Portable
Physicians who pay for the practice’s goodwill in their buy-in are entitled to be paid for that
value on their buyout, but only if it is left behind with the medical practice. It makes little
economic sense for departing physicians to be paid for goodwill in their buyout if the
goodwill is personal to them and they take it with them.

Action Step  If the medical practice as an entity has a reputation (as distinct from each
doctor having a personal individual reputation), then the practice has goodwill value, and this
component of value should be embodied in the buyout price. However, there should be such a
payment only when the goodwill value is expected to stay with the ongoing practice (on
death, disability, or retirement of the departing physician) and not when the departing
physician will be engaging in a competitive practice and thereafter attracting patients or
referrals away from the original practice.

Mistake 4  Including Receivables That Are “Bad Debts” in Calculating the Buy-in
Price
Consider this scenario: A new physician is asked to pay more than he should in his buy-in
because the calculation of the accounts receivable wrongfully includes an accumulation of
past due accounts or contingent receivables (perhaps from personal injury cases) that may
never be collected.

Action Step  The level of accounts receivable should be carefully reviewed at the time of
buy-in to ensure that all uncollectible receivables are eliminated from value and problematic
or contingent receivables are appropriately discounted in value.

Mistake 5  Not Providing for the Cost of Collecting the Practice’s Receivables
Assume that the medical practice pays the departing physician on buyout for the full amount
of his or her share of collectible accounts receivable, when it will cost the continuing practice
the expense of ongoing administrative services to collect those receivables.

Action Step  The component of value attributable to collectible accounts receivable should
be reduced by 5% to cover the overhead costs attributable to collection of the receivables.

Mistake 6  Not Providing for the Contingency of Multiple Concurrent Buyouts
Buy-out agreements traditionally have focused attention on the payment terms for a single
departing physician owner, but have not characteristically addressed the situation in which
multiple owners become entitled to buyouts at the same time.
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**Action Step**  Agreements should provide for such a contingency by incorporating “antichoke” provisions, which would cap the aggregate amount of the installment payments due the multiple departing owners at a monthly fixed amount (or a percentage of monthly gross revenue), and defer the excess so that it is paid under a longer installment payment schedule than would otherwise apply in the case of a single-person buyout.

**Mistake 7**  Not Planning for Use of Office, Telephone, Etc., on Practice Breakup
In formulating their buy-sell agreements, physician owners often do not plan ahead for the contingency of a breakup of a medical practice. A common area of disagreement results from the failure to establish the rights with respect to the ongoing use of the practice’s telephone numbers, patient information, equipment, and/or use of the corporate office space and personnel.

**Action Step**  The buy-sell agreement should carefully delineate which physician has the right to use the practice’s telephone number; obtain original or copies of patient information; use specific medical equipment; and continue to use office space. The ongoing employment of office personnel also should be addressed. In addition, it is often useful to establish in advance the protocols to be used when announcing terminations and when answering post-termination telephone calls.

**Mistake 8**  Not Providing for the Possible “Ganging Up” on Minority Owners
The governance structure of most medical practices usually provides simply that each physician has one vote. This structure works without difficulty when everything is amicable and each physician is chosen to serve as an officer and director, with mutually acceptable compensation and duty arrangements. However, the simple “one-person, one-vote” structure permits a situation in which the majority owners can use their power to “gang up” on one owner and perhaps unfairly change his or her rights to bonuses or other compensation entitlements or the right to serve as an officer and director or be subject to a fair sharing of duties or on-call scheduling.

**Action Step**  The bylaws and/or shareholder agreement could eliminate such a situation by providing that no changes can be effectuated on certain vital practice issues (e.g., compensation, duty schedules, directorships, and officerships) in the absence of a super-majority vote of the physician owners (a vote requiring more than a simple majority) or perhaps without unanimous approval.

**Mistake 9**  Not Planning for the Taxable Gain Realized on Payments “In Kind” Upon Buyout or Practice Breakup
Many buy-sell agreements provide that in the event of a breakup of the medical practice, the departing physicians or physicians may receive a share of the practice’s tangible assets (e.g., equipment). However, the parties often fail to consider the likelihood that the practice’s tax
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basis for these assets may be lower than their fair market value. This “value-basis”
differential usually arises because the accelerated depreciation deductions permitted for tax
purposes are greater than the economic reduction in value for these assets. When this
situation arises in the context of an incorporated practice, the distribution on buyout or
liquidation will engender a taxable gain, which would not be proportionately shared among
the physician owners.

**Action Step** The physician owners may agree to a “sharing” of the tangible assets and
take the position that the respective “book value” of each asset is representative of its fair
market value. However, the Internal Revenue Service might challenge the assumption that
book value and fair market value are the same for each asset. Alternatively, the physician
owners may agree to share the assets so that each receives a grouping of assets that represents
a pro rata share of the latent gains and/or losses to be realized on distribution. Each physician
owner’s entitlement can then be calculated after taking into account the resulting tax cost to
the practice. Although that approach will not necessarily eliminate the gain or loss to the
practice or to the physician owners, it will ensure that each physician owner pays his or her
proportionate share of the resulting taxes rather than have the tax burden fall
disproportionately (unfairly) on only some of the physician owners.

**Mistake 10  Failing to Address Personally Guaranteed Debt on Buyout**
Medical practices often incur bank debt that is used to fund the cost of “fitting” up its office
space, equipment purchases, and working capital needs, and the bank often requires the
physician owners to personally guarantee the loan. Although such liabilities are taken into
account on buyout to reduce the buyout price paid to the departing physician owner, the
departing physician often remains personally liable for the loan. As a result, if the practice
subsequently defaults on the loan, the departing physician may be forced to bear the
economic burden of the loan a second time.

**Action Step** On buyout, the loan can perhaps be restructured with the lender to have the
departing physician’s guaranty either eliminated or subordinated to the other guaranties.
Further, the buyout agreement could provide for the individual remaining physicians to
obligate themselves to indemnify the departing physician and contribute proportionately to
any debt obligation that he or she is forced to personally bear as a result of his or her ongoing
guarantee.

**Conclusion**
Whether considering buy-ins for new physician owners or buyouts for the existing owners,
physicians should ensure that the agreements reflect the value of the practice and its assets in
a tax-advantaged way. They can do so by addressing the economic realities accurately and by
considering the tax issues that could materially lower the net after-tax cost of any transaction.
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4.9 The 10 Biggest Legal Mistakes Physicians Make When Planning and Structuring a Practice or Business
By Philip A. Goldblum, Esq.

Executive Summary
Physicians, like any business owner, must consider many business, legal, tax, and financial issues and risks when forming and structuring their business operations. The structuring of a physician practice is like any other business enterprise in that it should involve meticulous planning to avoid unnecessarily increasing potential liability. Consultation with legal and financial advisers at an early stage is critical.

Mistake 1  Failing to Consult with Legal and Tax Professionals
Physicians must realize that forming and structuring a medical practice exposes them to many legal, business, and financial risks. The practice will have relationships and agreements with patients, employees, suppliers, other partners or shareholders, and lessors, among others. These relationships and agreements all create potential risks for the practice and physicians, which must be planned for. Physicians should consult with counsel early in order to address these issues properly. Proper planning, structuring, and consideration of the issues will shield physicians from significant liability exposure. If a physician seeks counsel too late in the process, the physician and the practice will have forfeited the ability of counsel to provide the physician with guidance, checklists, proposals, strategies, and tactics that afford maximum protection for the physician and the practice.

Action Step  Like any business enterprise, physicians should immediately consult with experienced counsel when forming and structuring a physician practice.
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Mistake 2  Failing to Properly Consider Whether to Form an Entity and, If So, What Type

The initial consideration a physician faces is whether to form a legal entity to conduct the medical practice and if so, what type of entity to form. The choices include partnerships, limited liability companies, and corporations (S corporations, C corporations, and professional corporations). Each has different legal characteristics, tax attributes, and asset protection features.

The unique features of a corporation are its perpetual existence (i.e., the death of an individual does not terminate the existence of the corporation); and its ability to limit the liability of its officers, directors, and shareholders. Conversely, physicians who participate in sole proprietorships or in general partnerships have unlimited personal liability.

The problem for physicians is that personal liability for malpractice cannot be limited by using a corporation. Although a corporation won’t shield a physician from claims by a patient the physician treats, it can be used to defend against the negligence of a physician partner. If the practice was structured as a general partnership, the physician is legally responsible for any injury caused by his or her partners. Moreover, a partner could bind the physician and the practice to other contractual obligations, which also might create liability exposure.

Except for professional malpractice cases, when the source of the claim arises outside of the physician/patient relationship, the corporation can be an effective device to shield the physician from liability. Thus, with respect to the other injuries that occur at the practice location, employee-related issues, or issues with landlords, customers, or suppliers, the corporation will provide a useful shield against personal liability, thus protecting the physician’s personal asserts.

Action Step   Physicians should consult with professionals to determine the type of legal entity that best suits their medical practice and consider the legal, tax, and asset-protection characteristics of the structure.

Mistake 3   Failing to Watch Out for Personal Guaranties

Anyone doing business with a corporation may require the principals of the practice to give a personal guaranty of a corporate obligation, which may arise in the context of leases or financial transactions. Thus, if the corporation fails to make its payments timely, the landlord or lender can then collect directly against the guarantor. In this manner, a personal guaranty eliminates the benefits of the corporation and limited liability. Like any business arrangement, personal guaranties can be negotiated, so consultation with counsel is important in order to minimize the personal exposure. Physicians should not execute legal documents until they have been thoroughly reviewed and negotiated.
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Action Step  Consult with counsel to aggressively negotiate all contracts and guaranties in order to minimize the personal exposure.

Mistake 4  Failing to Maintain Corporate Formalities and Piercing the Corporate Veil
The protection and limited liability features of a corporation will be available only if the integrity of the corporation as a separate and distinct entity is respected. Plaintiffs will attempt to convince the court that the corporation and the principals are one and the same and thus the corporate entity should not be respected (pierce the corporate veil), and plaintiffs can seek personal judgments against the owners of the business, thus creating unlimited personal exposure.

It is critical that the business be maintained so that it looks and acts the way a corporation should. Physicians should pay attention to the corporate formalities, such as adopting bylaws, maintaining corporate minute and stock books, conducting all business in the corporate name, and maintaining separate corporate bank accounts.

Action Step  Physicians should continuously consult with their counsel and accountant to ensure that corporate formalities are maintained and that the corporation is properly capitalized. They should take all other actions necessary to ensure that the corporate entity is respected in order to ensure that the corporation cannot be pierced. Limited liability comes with a price.

Mistake 5  Failing to Protect Corporate Assets
The practice also must consider protecting the assets of the corporation, which is in the front line of attack for litigation from any source. If the corporation is unsuccessful in defending a suit, all of its assets are subject to seizure. Thus, a logical asset protection strategy should be developed for the corporation as well as for the individual physician. Generally, the corporation, as an operating entity, should have limited assets and should not build up its net worth.

Assets such as real estate and equipment should not be owned by the corporation. Such assets should be held by other entities and leased back to the corporation. Additionally, the corporation should never hold a significant cash surplus. Such surpluses should be loaned or paid out as a salary or another type of distribution to physicians.

Assets such as accounts receivable can be protected against outside creditors of the corporation by creating liens that will have a priority over subsequent creditors. This strategy can be accomplished by having the principals of the professional practice make loans to the corporation for working capital needs and as security for these advances; the corporation can
then give the owners, as collateral, a lien in the receivables. A subsequent judgment creditor would find that the equity in these assets is subject to the superior claims of the owners.

**Action Step** Physicians should consult with counsel to create a structure that also protects the corporate assets. Creative thinking can provide significant protection and frustrate creditors.

**Mistake 6 Failing to Use Multiple Corporations**
If the practice or corporation can be divided into separate businesses, assets can be further protected through the use of multiple entities. For example, a single corporation may own and operate five medical clinics in different locations. If something happens at one of these clinics, giving rise to liability or business failure, the assets of the other successful clinics must be isolated from these claims.

A logical approach would be for each office location to be separately incorporated; thus if one location falters, it would not have an effect on the others. A judgment creditor of one corporation would not be able to reach the assets of the other successful companies.

**Action Step** As the practice grows, physicians should consider using multiple corporations for each practice location or distinct business endeavor. Physicians should consult with advisers to develop a proper plan.

**Mistake 7 Failing to Protect Personal Assets**
Even with the shield of a corporation or multiple corporations, a physician still has potential exposure to professional malpractice claims or the execution of personal guaranties. Also, a physician faces exposure for events outside of the professional practice. If a physician cannot legally be shielded from personal liability, the proper strategy is to protect what the physician owns from potential claims. Several techniques and strategies (such as family limited partnerships, domestic trusts, and off-shore trusts) can be implemented to accomplish this goal, but planning prior to creditor problems is critical.

**Action Step** Physicians should consult with advisers to develop a structure and incorporate strategies to protect their personal assets from potential claims. Planning before creditor problems exist is critical.

**Mistake 8 Failing to Plan for Life’s Curve Ball**
It is important to remember that unplanned events may occur in one’s life. A physician’s practice can obviously be dramatically affected by a disability or the death of a physician. Planning for “life’s curve balls” is critical. Working with financial, tax, and legal advisers and putting a plan into effect that incorporates appropriate insurance and legal documents (such as wills and buy-sell agreements) should be accomplished at an early stage. Moreover, a crisis
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team (which often includes a lawyer, an accountant, a spouse, and key office personnel) should be organized before a crisis occurs. Then, if and when a crisis does occur, the team can respond quickly to patients, lenders, lessors, suppliers, and others to ensure a smooth transition and to maximize the value of the going concern.

Action Step Physicians should consult with advisers to create a plan and have the appropriate insurance and legal documents in place in the event of a life curve ball. A crisis team should be formed prior to a crisis with a documented plan to respond if and when a crisis occurs.

Mistake 9 Failing to Properly Document Relationships with Other Physicians, Key Managers, and Partners

When structuring a new physician practice, it is important to document the structure with written agreements and the rights and obligations of the respective parties. Employment agreements with physicians and other key members should be created, spelling out the compensation arrangements and other critical issues (e.g., such as termination rights, severance arrangements, and noncompetition and confidentiality provisions). If the practice includes multiple owners, a shareholder’s agreement should be prepared documenting the rights and obligations of the owners and the corporation. Any other critical relationships also should be documented properly. Working with competent counsel who can assist in identifying the relationships and agreements that should be documented and then properly documenting those arrangements are critical.

Having these agreements in place at the beginning, when relationships are less contentious, allows the practice and its physicians to understand clearly their respective rights and obligations and will ultimately protect the practice.

Action Step Physicians should consult with counsel to ensure appropriate documentation of relationships and agreements.

Mistake 10 Failing to Develop Personnel Policies That Work

Physician practices, like any employment setting, are potentially subject to employment-related litigation. Prevention is the key to minimizing this legal exposure. Policies and procedures should be created, documented, and reviewed. Key policies should be placed into an employee manual that is prepared by legal counsel in order to ensure that critical issues and disclaimers are included. For instance, the policy manual should state that the practice may, at any time, with or without cause, terminate the employment of the employee and that the practice maintains a strict policy of nondiscrimination. Typically, the employee manual also deals with issues relating to sexual harassment policies, compliance with confidentiality provisions, policies relating to technology and use of the Internet, job descriptions, job requirements, and expectations. By structuring clear employment policies at the outset and
communicating these policies to employees, the practice may be able to avoid significant employment-related litigation.

**Action Step** Physicians should consult counsel to create well-documented employment-related policies.

**Conclusion**
Physicians who are in practice or who are about to start a practice should be cognizant of these mistakes and take steps to provide the highest level of protection. Consultation with counsel at an early stage is critical.

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Executive Summary
Many physician groups believe that complying with the privacy rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is an arduous task. They may therefore think that noncompliance is their best route or that being overprotective of information is an easy way to avoid the rule. However, as patients become more educated on the requirements of the rule and on the rights of individual patients regarding protected health information (PHI), patients could file complaints against the physician group, a covered entity under the HIPAA privacy rule. The rule subjects providers to stiff penalties, including $100 per violation up to a maximum of $25,000 per year, or even as much as $250,000 for a violation that is knowingly done with the intent to sell, transfer, or use PHI for commercial, personal, or malicious advantage, plus imprisonment of not more than 10 years. Given the complexity of the rule, many physician groups have not taken the time to understand the purposes of HIPAA or undertaken HIPAA compliance in a serious manner. Such mistakes can lead to costly results and could compromise the goodwill of the physician group in the eyes of their patients.

Mistake 1 Believing That HIPAA Enforcement Will Never Happen to the Physician Group
The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) is charged with enforcing the HIPAA privacy rule against covered entities, such as physician groups. According to OCR Director Richard M. Campanelli, between April 14, 2003, and the end of February 2004, his office received more than 4,700 HIPAA privacy complaints. In fact, these complaints have been increasing: The total number of complaints in April 2004 was more than double the number in October 2003 (in only six months), which shows that the learning curve for patients in becoming familiar with their rights under the privacy rule is on the rise. According to Campanelli, his office is now receiving an average of about 100 privacy complaints per week. Many different types of covered entities have been subject to the privacy complaints, but physician practices specifically have drawn more complaints than other types of organizations (i.e., hospitals, pharmacies, outpatient centers, and group health plans).

Action Step Physicians should consult with counsel at the earliest point possible to ensure that their office has an appropriate HIPAA privacy rule compliance plan.
Mistake 2  **Having a Compliance Plan in Form Only**
Many physician groups believe that having a standard or form HIPAA compliance plan or manual provided by a professional association or obtained from a colleague will satisfy HIPAA compliance requirements. However, having a compliance plan that is not effective or is not followed can be worse than having no compliance plan at all because not following one’s own HIPAA compliance plan can be taken as evidence that the violation was knowing and willful. Furthermore, having a form HIPAA compliance plan only without proper monitoring or implementation will not serve its intended purpose—to educate and guide the practice and thus alleviate potential complaints to the OCR for violations of the privacy rule.

**Action Step**  Physician groups should implement and maintain an ongoing HIPAA privacy rule compliance plan tailored to their practice and not merely a form or standardized off-the-shelf plan.

Mistake 3  **Believing That Health Care Providers Must Have HIPAA Authorization Before Disclosing PHI to Other Health Care Providers**
Many physician groups believe that in order to discuss the PHI of a patient with another health care provider (e.g., a hospital, nursing home, or consulting physician), a proper authorization under HIPAA must first be signed by the patient. The HIPAA privacy rule, however, does not require an authorization in this instance. A covered entity may use or disclose PHI for its own or another provider’s treatment activities (and, in certain circumstances, for payment and health care operations purposes, as well) without an authorization. The covered entity is required to verify the identity of the person requesting the PHI and the authority of such person to have access to the PHI if the identity of the person is not known to the covered entity. The covered entity may rely on documentation, statements, or representations that meet this requirement, if reasonable under the circumstances. Again, one main point of the privacy rule is that HIPAA privacy should not affect treatment or the quality of treatment in rendering health care services. For treatment purposes, therefore, HIPAA does not require an authorization or otherwise restrict providers when using or disclosing PHI, except as noted above.

**Action Step**  Physician groups should clearly define when authorizations are needed in their uses and disclosures of PHI, and should not restrict uses and disclosures of PHI in the treatment context.

Mistake 4  **Believing That the Minimum Necessary Standard Applies to All Disclosures**
The minimum necessary rule refers to the standard under the HIPAA privacy rule requiring that the use, access, and disclosure of PHI to health care providers and other covered entities be limited to the least amount needed to accomplish an intended purpose. Many physicians, however, wrongly believe that this minimum necessary standard applies to all uses and
COMPLIANCE: HIPAA

disclosures of PHI. Instead, the rule states that the minimum necessary standard does not apply to uses or disclosures: (1) by health care providers for treatment; (2) to the individual who is the subject of the information; (3) made pursuant to a valid HIPAA authorization; (4) required for compliance with the standardized HIPAA transactions; or (5) to HHS when disclosure of information is required under the rule for enforcement purposes. Again, as a rule of thumb, the minimum necessary standard should be part of any physician group’s HIPAA compliance plan. However, the minimum necessary standard should never restrict the use or disclosure of PHI by health care providers in the course of treatment.

**Action Step** Physician groups should clearly define in their HIPAA compliance plans when the minimum necessary standard applies.

**Mistake 5  Believing That PHI Cannot Be E-Mailed or Faxed under the HIPAA Privacy Rule**
Neither the HIPAA privacy rule nor the security rule prohibits the faxing or e-mailing of PHI. The privacy rule allows covered entities to share PHI for treatment purposes without patient authorization, as long as they use reasonable safeguards when doing so. A covered entity may want to consider implementing a mechanism to encrypt and decrypt electronic health information to address technical safeguards in the use of e-mail and faxes.

**Action Step** Covered entities should have a policy that describes when PHI may be faxed or e-mailed, and under what circumstances they will verify the requestor and receipt of the information.

**Mistake 6  Believing That Physician Groups Should Have a Business Associate Agreement with Anyone Who Might Have Access to PHI**
The HIPAA privacy rule defines a business associate as one who performs, or assists in, an activity on behalf of the covered entity that requires the use or disclosure of PHI. A janitor or delivery service should generally not be using PHI on behalf of the covered entity. Any access obtained by a janitor or delivery person would likely be incidental and not subject to HIPAA privacy violations, therefore a business associate agreement is not necessary under the HIPAA privacy rule. However, if the janitor or delivery people are unsupervised, and if the covered entity does not secure PHI in a reasonable fashion, then a violation of the rule could ensue under a lack of security, rather than a business associate, violation.

**Action Step** Physicians may not need business associate agreements with every vendor, but physician groups should not assume that the HIPAA privacy rule will permit all incidental uses and disclosures of PHI, especially when those incidental uses and disclosures are caused by a lack of HIPAA security compliance.
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Mistake 7  Believing That Patients Must Sign the Notice of Privacy Practices for the Physician Group
Many physicians believe that patients who do not sign a Notice of Privacy Practices cannot be treated by the physician group. However, the HIPAA privacy rule requires only that a covered entity provide the notice and make a good-faith effort to obtain a written acknowledgement of the patient’s receipt of the notice. Physicians are often precluded from obtaining signatures from patients in an emergency situation, or sometimes the patient just refuses to sign. If a patient refuses to sign or a Notice of Privacy Practices cannot be signed immediately, the privacy rule allows the physician group to treat the patient, but proper documentation of the circumstances must ensue to protect the covered entity from HIPAA privacy violations.

Action Step  When a patient refuses to sign a Notice of Privacy Practices, the physician group should attempt to obtain an acknowledgement that the patient received the notice, and, if not, the group must at least document its attempts to provide the notice to the patient.

Mistake 8  Believing That Physician Groups and Their Employees May Not Discuss the Care of a Patient with Family Members
The HIPAA privacy rule does not prohibit physician groups or their employees from speaking to a patient’s family members about the patient’s care and treatment. The rule, however, does give the right to patients to restrict disclosures of their PHI to family members if they choose to do so. But HIPAA privacy rule 45 CFR 164.510(b) permits covered entities to share information directly relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient, in the patient’s care or payment for health care. The physician group, therefore, may share relevant information with the family and these other people if it can reasonably infer, based on professional judgment, that the patient does not object. Certainly, if the patient in any way chooses to restrict the PHI to any one of these persons, the physician group must obey that restriction or a HIPAA privacy rule violation will ensue.

Action Step  Physicians should carry out the normal course of treatment on patients and, in relaying information to family members and friends, have the proper policies and procedures in place to comply with the HIPAA privacy rule.

Mistake 9  Believing That Storage of PHI Must Be under Lock and Key, with an Armed Guard, and Appropriate Alarm System
Many physicians have succumbed to “HIPAA-mania,” believing that safeguarding PHI requires myriad security devices and controls to protect leakage of the information. However, the HIPAA privacy rule does not specifically require locking up medical records or having them under 24-hour watch. For example, many groups believe that security for medical records and access to medical records in the office space will require new construction in the
COMPLIANCE: HIPAA

office or new storage facilities. However, the privacy rule requires reasonable compliance measures to protect privacy; nowhere in the rule is it required that physician groups modify office space to comply. Rather, physician groups should concentrate on taking reasonable steps, based on their individual circumstances and resources, to prevent unwarranted uses and disclosures of PHI in the office. Locks and other security measures may be appropriate and reasonable, but are not necessarily required. These reasonable steps should include monitoring unwarranted uses and disclosures of PHI and taking steps to correct those deficiencies when they arise through awareness and training measures.

Action Step Physician groups should consider creating a HIPAA privacy committee to address storage of PHI in the office and take reasonable steps appropriate to the circumstances and resources of the group to safeguard that information.

Mistake 10 Believing That the HIPAA Privacy Rule Prevents the Use of Sign-in Sheets, Calling Out the Names of Patients in Waiting Rooms, and Appointment Reminders

Covered entities, such as physician offices, may use patient sign-in sheets or call out patient names in waiting rooms, so long as the information disclosed is appropriately limited. The HIPAA privacy rule explicitly permits the incidental disclosures that may result from this practice, for example, when other patients in a waiting room hear the identity of the person whose name is called or see other patients’ names on a sign-in sheet. However, these incidental disclosures are permitted only when the covered entity has implemented reasonable safeguards and the minimum necessary standard, where appropriate. For example, the sign-in sheet may not display medical information that is not necessary for the purpose of signing in, such as the medical problem for which the patient is seeing the physician. (See 45 CFR 164.502(a)(1)(iii).) Appointment reminders are considered by HHS to be part of treatment, and therefore are allowed without an authorization. The privacy rule also does not prohibit physician groups from leaving messages for patients on their answering machines. However, as usual, to reasonably safeguard the individual’s privacy, physician groups should take care to limit the amount of information disclosed on any answering machine. For example, a physician group might want to leave only its name, telephone number, and other information necessary to confirm an appointment, or ask the individual to call back.

Action Step Physician groups should identify potential risk areas in the office for unwanted uses and disclosures and should develop policies, procedures, or action plans to reasonably limit improper uses and disclosures without limiting the sometimes necessary incidental or other disclosures that the privacy rule allows. Physician groups should also educate their employees and provide periodic training to employees on the privacy rule and how to use and disclose PHI on a daily basis in the office.
Conclusion
Physician groups that become aware of these mistakes will be better equipped to deal with the HIPAA privacy rule and will better serve their patients while complying with the rule. Failure to understand these mistakes can lead to expensive problems for physician groups and make the practice of medicine unnecessarily difficult.

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5.2 The 10 Biggest Legal Mistakes Physicians Make That Could Result in a Violation of HIPAA
By Scott P. Sandrock, Esq.

Executive Summary
The Health Insurance Portability and Accountability Act (HIPAA) became effective August 21, 1996. One element under HIPAA was the creation of regulations to protect the privacy of personal health care information. The standards for privacy of individually identified health information (referred to as PHI) were initially proposed in 1999, were finalized in December 28, 2000, and subsequently amended on several occasions with the last amendment on August 14, 2002.

While physicians are already bound by the Code of Ethics to maintain the confidentiality of patient information and are subject to additional restrictions under various provisions of state law, HIPAA imposes additional obligations on physicians to provide a written notice of legal rights to patients, to comply with patient directives, and to restrict disclosure of information except as authorized by the patient or specifically exempted under HIPAA. Failure to comply can result in significant fines and penalties.
Mistake 1  **Failing to Give Patients a Copy of the Privacy Notice**
Physicians sometimes believe that because patients may not understand the privacy notice or because patients often throw the notice away, that it is a waste to give them a multiple-page privacy notice. Some physicians believe that merely posting the notice in their lobby or expecting the patient to read one copy of it is adequate for compliance. The interpretive guides to the privacy rules clearly require the health care provider to deliver a copy of the privacy notice in its entirety to each patient at the time of the first office contact. Posting the notice or having patients read it without giving them a copy fails to meet those requirements.

**Action Step**  Physicians should instruct their staff that each patient is to be given a copy of the privacy notice at the time of the initial office contact.

Mistake 2  **Thinking That the Privacy Notice Is a “HIPAA Compliance Plan”**
Physicians sometimes believe that as long as they deliver the privacy notice to the patient they have satisfied their HIPAA obligations. The regulations are clear that while the privacy notice is important, the physician has additional responsibilities: to have a formal policy, to designate a privacy officer, to develop procedures for the accounting of the disclosure of PHI, and to develop internal procedures to train staff to handle each component described under the privacy rules.

**Action Step**  Physicians should engage experienced counsel to prepare and implement a detailed and thorough HIPAA compliance plan for their office.

Mistake 3  **Discussing the Patient’s Health Condition with Their Family Members**
Prior to HIPAA, physicians would routinely discuss with family members the condition of the patient. Under HIPAA restrictions however, physicians may not have that discussion without first receiving prior permission from the patient to identify which members of the family can receive PHI. The failure of physicians to pre-identify with the patient those who are able or authorized to receive the information can result in a significant HIPAA violation.

**Action Step**  Physicians must pre-identify with the patient those whom the patient has authorized to receive his or her PHI.

Mistake 4  **Releasing Health Information to the Patient’s Employer without Having Obtained Written Authorization**
Physicians are often asked to sign forms concerning the health condition of employees, either to permit them to return to work or to show absence from work because of health conditions. While these practices are common, HIPAA imposes new responsibilities on physicians to not release such information without prior written authorization from the patient. Under the HIPAA regulations, there are clearly defined elements that must be in a HIPAA authorization form. The form must be executed by the patient (or an authorized agent of the patient, such as
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a power of attorney), and the form must be signed before the release of the information to the third party. These authorizations must be obtained in any situation in which the health information is released for purposes other than the treatment for the health condition of the patient or for the payment for the health care treatment.

**Action Step**  For any release of information for use other than treatment or payment, the physician must obtain a HIPAA authorization in advance from the patient.

**Mistake 5  Releasing Information without Maintaining a Record of the Recipients of the Information**

In Mistake 4, physicians released information at the patient’s request but without the proper forms being signed. If the signed form is received, physicians must maintain detailed records of any incidence in which such release of information occurred. Under HIPAA, there is a responsibility of physicians to fully account for any release of information in a situation other than treatment or receiving payment for the care. For example, for each release of information to an employer, the physician must maintain in a separate record the date of release, the information released, and the person to whom it was sent. Under HIPAA, the patient is entitled, upon request, to a complete and accurate listing of any such disclosures. This accounting is not required for the routine release of information for the treatment of the patient or to secure payments, such as sending a billing slip to an insurance carrier.

**Action Step**  Physicians must develop procedures to maintain an accurate and complete accounting of the release of any information outside of treatment or payment.

**Mistake 6  Refusing to Give Patients a Copy of Their Records**

Occasionally, patients may ask a physician for a complete copy of their records and the physician will decline to provide the records either because the patients have not paid their bill or because the records contain information that the physician thinks may be detrimental to the patient or to the physician. With the limited exception of information dealing with mental health issues (which have unique rules) under HIPAA, patients are entitled to a copy of their medical records and the physician is entitled to charge a reasonable copy fee for those records. Refusing to release the records or to provide a copy can result in a HIPAA violation.

**Action Step**  Physicians are required to release records to a patient upon the patient’s prior written request.

**Mistake 7  Releasing Records Pursuant to a Subpoena or Letter from the Patient’s Attorney**

Physicians receive requests from attorneys representing patients in a variety of legal proceedings or occasionally receive subpoenas requesting medical records. Under HIPAA, physicians have a heightened obligation not to release medical records without prior written
COMPLIANCE: HIPAA

authorization from the patient. If the request comes from an adverse party, physicians may not release the records without obtaining a specific court order after first taking reasonable steps to obtain a qualified protective order from the court to limit the disclosure of the protected health information. Physicians are further required to edit the file to release only that portion of the medical records related to the injury or condition described in the request. Under the “minimum necessary standards,” physicians may not release the entire medical file and are required to release only that portion of the file that is absolutely necessary.

**Action Step** Physicians should not release medical records simply pursuant to a request by an attorney or a subpoena, but should instead insist on a written authorization or a specific court order.

**Mistake 8 Releasing Test Results over the Phone without First Obtaining Security Clearance**

Physicians run numerous tests and evaluate the condition of their patients. In communicating information, physicians are required to take reasonable steps to verify the identity of the person to whom such information is released. In many cases, the office may contact the patient by telephone and leave a message to call the office. When the patient returns the call, the office staff needs to take reasonable steps to confirm the identity of the person on the telephone (e.g., requesting unique identifiers such as the patient’s Social Security number).

**Action Step** As a part of the HIPAA compliance plan, medical staff should have a policy to require security identification before releasing medical information to anyone over the telephone.

**Mistake 9 Failing to Have Computer Security Systems in Place**

Older computer programs do not contain password protection or other security features. Even though the medical office may have a separate office space, the security regulations require physicians to implement reasonable security measures to prevent unauthorized access to electronic medical records. Those steps include using security passwords, restricting access, repositioning computer screens so that they are not accessible to the public, and other reasonable steps that more modern versions of software programs would provide. Physicians must implement a policy mandating the use of security passwords, restrict computer access to essential personnel only, and otherwise verify security features for their computers and electronic information.

**Action Step** Physicians should develop a proactive security system for electronic records.
Mistake 10  **Relying on Commercial Software That Have No Expressed HIPAA Compliance Warranties**

Physicians have the responsibility to ensure compliance with HIPAA. A blind reliance on commercial software to meet their obligations may not be enough. Physicians should require as a condition of any purchase or license of software that they obtain an expressed warranty by the software vendor that the software is fully compliant under HIPAA and that the vendor will update the software to meet the ongoing changes and corrections in the reporting requirements for data sets under HIPAA.

**Action Step**  Physicians should obtain a written affirmative warranty from vendors of their compliance with HIPAA, including an indemnification of damages to the physician.

**Conclusion**  Physicians should work with experienced health care legal counsel to develop and implement a comprehensive HIPAA compliance plan for their medical practice. Reliance on prepackaged material or the failure to pay attention to training can lead to errors and omissions resulting in liability to the physician.

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### 5.3 The 10 Biggest Legal Mistakes Physicians Make That Could Lead to Liability for Fraud
**By Deborah A. Holzman, Esq.**

**Executive Summary**  The law recognizes a cause of action for fraud in cases in which a party makes a false statement with the intent to deceive and another party relies in good faith on the statement to his or her detriment. Physicians can guard against actions for fraud by being extra careful in their communications with patients, regulators, insurers, and licensing bodies. Clear and complete communications and patience to explain in lay terms when necessary are the best insurance to eliminate or minimize the risk of liability for fraud.
COMPLIANCE: FRAUD LIABILITY

Mistake 1  Failing to Report the Negative Results of Treatment
Physicians who may have deviated from accepted standards of medical care can make mistakes out of fear of serious repercussions, such as negligence or malpractice actions, or even worse, loss of license and their livelihood. But by failing to immediately disclose an error or omission, a physician can cause further pain and suffering, exacerbate an ailment, and prevent the patient from receiving timely medical treatment. Such conduct may give rise to a fraud claim against the physician. In addition, failure to report errors will extend the time within which a patient may take legal action against the physician.

Action Step  A physician should consult with counsel immediately upon realizing that he or she has committed an error that may affect a patient’s well-being or lead to exposure. Rather than assuming the worst and worrying about the personal consequences, the physician should seek professional help to evaluate the facts and determine the appropriate cause of action. Failure to report medical errors will only exacerbate the matter.

Mistake 2  Failing to Adhere to Appropriate and Reasonable Billing Procedures
Physicians often delegate to office staff the task of performing and submitting insurance claims for payment for services rendered to insured patients. Often such claims are submitted without the treating physician’s final review and approval. In some instances, physicians review the forms in a cursory manner, missing or ignoring improper entries. Examples of problematic claims include:

- Billing for more time than the physician spent treating the patient;
- Billing for a service that was never performed, or for a service that was more expensive than the actual service performed;
- Billing separately for each component of a service, rather than using a single accepted billing code;
- Submitting claims at physician rates for services performed by nonprofessionals;
- Billing for the use of nonexisting equipment;
- Billing for unnecessary treatment; and
- Billing for more hours than an individual could reasonably work in a single day, or, in the most egregious cases, more than 24 hours in a single day.

Such billing practices will expose the physician to federal and state fraud actions.

Action Step  Physicians must review all claim forms carefully to ensure that they comply with federal, state, and the insurer’s guidelines before submitting the claims for reimbursement. Experienced counsel and/or billing experts can interpret the applicable guidelines and help educate the physician and the billing staff in the proper methods for completing and submitting claims.
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Mistake 3  Failing to Safeguard Prescription Forms and Pads
Physicians are required by rules and regulations to safeguard prescription forms and pads. Failure to comply strictly with these requirements may subject a physician to a fraud investigation if the physician’s prescriptions fall into the wrong hands and are used to defraud third-party payers.

**Action Step**  Physicians should be familiar with the rules that apply to the safekeeping of prescription pads, and they should implement checks and balances in the office procedures to ensure that prescription forms will not be used in schemes that will subject the physician to fraud investigations. If the physician is subject to such an investigation, contacting experienced counsel early is the appropriate step.

Mistake 4  Failing to Make Full Disclosure on Applications
Supplying false, incomplete, or misleading information on application forms could subject a physician to an action for fraud. Physicians complete numerous application forms during their professional careers, including applications for employment, hospital privileges, state licenses to practice medicine, and controlled dangerous substance dispensing. A physician must furnish all data (which may often include any prior criminal charges, convictions, and pleas), even if the physician believes that the information will have a negative effect on the application.

**Action Step**  Physicians should report all information (including credentials, background, criminal history, and administrative actions) accurately and completely, regardless of how negative the information may seem. When in doubt, the physician should review the question with experienced counsel, who can assist in preparing a response that satisfies the inquiry but guards against adverse consequences.

Mistake 5  Failing to Comply with Recordkeeping Requirements
Patient records must contain sufficient detail to satisfy strict legal requirements. Records must contain, at a minimum, a synopsis of the treatment rendered, clinical impressions, vital signs, risks, and related data. Physicians must safeguard these records and protect computer-generated files and diagnostic testing results. Failure to include all pertinent data, misstating information, and altering or discarding records can all give rise to legal action against a physician, including an action for fraud. Most states have guidelines governing the proper method of correcting or modifying a patient chart or a computerized record. Advancements in technology now enable experts to restore data that have been deleted from computer hard drives. Software can track the dates and times that a user accesses a database and/or alters a record. Similarly, experts can analyze handwriting and ink to detect potential malfeasance in handling hard copies of records.
COMPLIANCE: FRAUD LIABILITY

**Action Step** Physicians should familiarize themselves with the proper recordkeeping requirements of the state in which they practice, consulting with counsel on difficult or close calls as they arise. They should be mindful of the repercussions of modifying or discarding patient records and data other than in strict compliance with legal requirements. If errors or omissions in practice arise, physicians should consult experienced counsel as soon as possible.

**Mistake 6** Failing to Understand the Terms of Patient’s Insurance Coverage
Physicians sometimes assist patients in obtaining insurance coverage or reimbursement for treatment or prescriptions for various conditions. Physicians may be asked or, with the best of intentions in mind, tempted to record symptoms or diagnoses so as to facilitate insurance or managed care coverage. In many cases, physicians write letters, complete forms, or make other written and oral representations to insurance companies without fully recognizing the potential exposure, including possible fraud charges, associated with doing so.

**Action Step** All submissions should accurately reflect the physician’s assessment, opinion, diagnosis, and recommended treatment after careful review of medical records and examination of the patient. When in doubt, the physician should discuss these issues with counsel to avoid denial of coverage or fraud charges.

**Mistake 7** Guaranteeing That a Course of Treatment Will Produce a Specific Result
Physicians, having the best interests of their patients in mind, can be overly optimistic about their own abilities and/or particular courses of treatment. In some cases, the physician’s representations concerning the potential for success or likely outcome could be deemed a misrepresentation. For example, in the case of a new or an experimental treatment, the physician may gain significant recognition if a patient responds in a positive manner. A patient receptive to a revolutionary treatment or “miracle cure” may not appreciate the financial burdens of the treatment or the low probability for success. In many cases, the treatment may not produce the desired result, or, even more egregiously, it worsens the patient’s condition. The physician’s communications before and during the treatment phase and the patient’s expectations based on those representations (or lack thereof) could give rise to an action for fraud.

**Action Step** Physicians should refrain from warranting that a course of treatment will produce a specific result. Physicians should recommend the most intelligent course of treatment in the patient’s best interests, being mindful of financial constraints, risks, and probability for success. Doing so will avoid the potential for fraudulent claims and ensure that the prescribed course of treatment reflects sound choices and good medical judgment in accordance with standard practices in the profession and in the states in which they practice.
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Mistake 8    Failing to Detect Overbilling and/or Overpayments
Physicians may be the recipients of overpayments from an insurer. This results from
erroneous duplicate billing or an error on the part of the insurer. Physicians should never
assume that, given the volume of submissions and payments being made to practitioners,
overpayments will go undetected. Overpayments viewed as a windfall could subject a
physician to serious legal consequences and even fraud allegations.

Action Step    Proper accounting systems will permit physicians and their staff to
immediately detect overpayments as they occur. This, in turn, will enable the physicians to
return overpaid funds to the appropriate government entity or insurer. By maintaining proper
records and adhering to generally accepted accounting procedures, physicians will avoid
unnecessary audits or investigations.

Mistake 9    Paying Fees That May Violate Antikickback Regulations
Physicians often refer patients to other physicians, diagnostic testing laboratories, hospitals,
or other providers. Accepting payment or other things of value for such referrals could violate
applicable antikickback regulations and potentially subject the physician to a fraud action.
This prohibition also applies in cases where physicians refer patients to an entity in which
they maintain an ownership interest. In many cases, physicians make these recommendations
because they are familiar with a practitioner or an entity and are secure in the treatment that
the patient will receive. The federal government has determined that these practices could
have a deleterious effect on patient health and safety, since referrals may be driven, in whole
or in part, by the physicians’ financial interests.

Action Step    Physicians must act in the patient’s best interests, and nothing else, when
making a referral. Physicians may not accept compensation, be it money or any other thing of
value, as an inducement or a reward for making a referral. Counsel experienced in these
issues can decode the complicated legal guidelines and help physicians to structure their
business deals or arrangements within the confines of the law.

Mistake 10    Failing to Disclose Alternative Treatments or Medications
In assessing the best course of treatment for a patient, a physician is duty-bound to disclose
all reasonable alternatives, so that the patient can make an informed decision. Patients often
rely solely on the advice of their physicians when choosing a particular treatment, without
doing any independent investigation of alternatives. Providing a patient with a single
alternative when other viable choices exist could be deemed a misrepresentation of a material
fact.

Action Step    Physicians should make it a practice to discuss all viable treatment
alternatives with their patients before making recommendations. They should respond to all
patient questions carefully and in terms the patient understands, and they should clearly outline the benefits and detriments of each option.

Conclusion
Physicians face difficult situations every day, especially because the decisions they make can and do affect human life. Physicians should be familiar with all legal and ethical requirements of their practices, to protect their own interests and the interests of their patients. They must prepare claim forms, professional applications, and all other documents completely and accurately, consulting with experienced counsel on specific areas of concern as needed. To guard against potential fraud claims, physicians must pay careful attention to detail in their recordkeeping and record maintenance practices and in their communications with patients, insurers, and staff about records, reporting, treatment, and options. Appropriate disclosure, with experienced counsel’s guidance and input along the way, is the best policy.

Additional Resources
- T. Reardon, Investigations of Fraud and Abuse, Report 27 to the Board of Trustees of the AMA (1997)
- T. Reardon, Fraud and Abuse Update, Report 25 to the Board of Trustees of the AMA (1997)
- Doctors Deserve Privacy Too: Credentialing Should Not Require Revealing Your Entire Health History (Jan. 20, 2003), www.amednews.com

About the Author
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5.4 The 10 Biggest Legal Mistakes Physicians Make When Handling Overpayments
By Robert W. Liles, Esq.

Executive Summary
Despite the best efforts of physicians and their staff to ensure that health care claims are properly billed, mistakes are still likely to occur. Medicare and third-party payer coding and billing requirements are extremely complex and ever-changing. A common dilemma many health care providers face is how to handle these instances of improper billing once they are discovered. This section identifies a number of mistakes that physicians make, and issues that should be considered, when deciding how to best handle an overpayment.

Mistake 1  **Failing to Properly Return Overpayments to the Government**
Once it has been determined that an overpayment has been made by the government, physicians and their staff should diligently work to ensure that the overpayment is properly returned. Federal law enforcement agencies are increasingly asserting that a provider has an affirmative obligation to return an overpayment, despite the fact that the government may not have identified that the provider has been overpaid. As guidance issued by the federal Department of Health and Human Services, Office of Inspector General (HHS-OIG) reflects: “Failure to repay overpayments within a reasonable period of time could be interpreted as an intentional attempt to conceal the overpayment from the government, thereby establishing an independent basis for a criminal violation.” (HHS-OIG’s Compliance Program for Third Party Billing Companies; 63 Fed. Reg. 70138, Dec. 18, 1998).

Notably, a provider’s obligation to return an overpayment is not limited to federal health benefits programs. Under 18 U.S.C. § 669, it is a criminal violation to “knowingly and willfully” embezzle, steal, or otherwise without authority covert or intentionally misapply the monies, funds, or assets of a health benefits program.

In addition to federal regulatory and statutory provisions covering the failure to properly return an overpayment, providers will likely find that state Medicaid provider agreements likely include a contractual requirement to disclose overpayments and material violations.

**Action Step** Physicians and their staff should have an effective compliance plan in place. Overpayments should be promptly identified and returned to the proper payer.

Mistake 2  **Turning a Civil Problem into a Criminal Problem**
The vast majority of billing mistakes health care providers make are mere errors, accidents, or simple negligence. Once a problem is discovered, a physician can significantly complicate matters by concealing the problem, destroying evidence, or improperly attempting to
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influence testimony. Under various federal obstruction statutes, a physician may be charged with obstruction of justice for willfully engaging in activities that obstruct, mislead, deceive, or impede a health care fraud investigation. Similarly, false statements made to agents or government officials may lead to criminal charges under 18 U.S.C. § 1001, for the making of false statements.

**Action Step** Physicians should ensure that false or misleading statements are *not* made when dealing with the government in connection with improper billings or overpayments received. Depending on the particular facts and circumstances, it is likely prudent to suspend document destruction activities. Legal counsel should be consulted to ensure that this is properly handled.

**Mistake 3** Improperly Handling “Credit Balances”
Physicians may find that “credit balances” remain on the books for an extended period of time. Office billing staff and payers regularly make adjustments to accounts that sometimes result in underpayments. Other times these adjustments may result in an overpayment that is properly best characterized as a “credit balance.” “Credit balance” funds do not belong to physicians, and serious consequences can result if they are improperly handled.

**Action Step** Physicians should work with payers to ensure that credit balances are properly returned. On occasion, there have been situations where a nongovernment payer responds that for one reason or another, the “credit balance” does not have to be returned. The money still does not belong to the physicians. Physicians should check with legal counsel to determine whether applicable state escheat laws require for the funds to be turned over to the state.

**Mistake 4** Conducting an Internal Investigation of Billing Practices without First Consulting Legal Counsel
When improper billings are recognized, a physician may seek to resolve the problem as quickly as possible, either by directing staff to conduct an internal review or by hiring a billing consultant to review an office’s billing practices. In doing so, staff or consultants may uncover issues that law enforcement would readily obtain should the government initiate an investigation. Internal work papers and documents created in this fashion may later serve as a “road map” for the government’s investigation into possible billing fraud. Physicians should contact their attorney before engaging in these activities. Under certain circumstances, it may be appropriate for legal counsel to conduct or direct the internal investigation. In doing so, the work product and investigative results may qualify as privileged under the attorney work product privilege or possibly the attorney-client privilege.

**Action Step** Physicians should immediately notify legal counsel if they find that improper billing practices have been employed that have resulted in improper payments to the provider.
Legal counsel can assist the physician in determining whether the mistakes were isolated incidents or whether broader, systemic deficiencies may be involved. Moreover, legal counsel can help determine whether it is advisable to conduct an internal investigation, or engage outside billing consultants, through the law firm and under the direction of legal counsel, thus possibly protecting any adverse findings from disclosure.

**Mistake 5 Involving the Wrong Government Entity When Returning an Overpayment**

In returning an overpayment made by a federal health benefits program (e.g., Medicare), it is imperative that physicians fully appreciate how the improper billings may have occurred. Honest mistakes and isolated incidents of improper billing may best be addressed by returning the monies to the applicable carrier or intermediary. In contrast, efforts to resolve incidents involving significant improper payments or fraudulent conduct may require the involvement of HHS-OIG or the Department of Justice (DOJ). Reporting cases of clear fraud to a carrier or an intermediary rather than to HHS-OIG may be viewed as an attempt to avoid review and enforcement. Rather than avoid detection, it may result in the provider’s billing practices being reviewed on an even broader scale. It is important to remember that both carriers and intermediaries are required to report instances of possible fraud directly to HHS-OIG, leaving the physician in the position of appearing both fraudulent and intentionally evasive.

**Action Step** Properly addressing this issue is essential to resolving serious cases of improper billings. Once again, a physician’s legal counsel should be consulted as early as possible in this process. If the decision is made to involve HHS-OIG or DOJ when returning an overpayment, legal counsel will also want to discuss remedial steps that have been taken to better ensure that the these improper billings do not recur.

**Mistake 6 Failing to Consider Federal Programs Other Than Medicare**

Consider this scenario: A physician finds that Medicare has been significantly overcharged due to improper coding or billing practices employed by the physician’s office personnel. Steps are immediately taken to ensure that the underlying problem is resolved, and the physician enters into settlement negotiations with HHS-OIG to arrive at a settlement figure. Problem solved, right? Not exactly. Systemic billing problems rarely affect only a single payer (e.g., Medicare). More typically, a problem that results in overcharges to one payer also adversely affects other payers as well. It is easy to overlook the fact that the HHS-OIG is not the only agency that should concern physicians. A provider may have also overcharged Medicaid (comanaged by the state and HHS), the Federal Employee Health Benefits Program (covering federal employees), and Tricare (covering Department of Defense dependents).

**Action Step** When an overpayment is identified, a physician should identify the full scope of the problem. A physician should work closely with legal counsel. In most cases, it is in the
physician’s best interest to seek a global resolution of overpayments to all federal health benefits programs, not just Medicare.

Mistake 7  **Failing to Consider Third-Party Private Payer Issues When Settling with the Government**

Third-party private payers have become quite aggressive in their efforts to recover improper payments made to providers. After learning of a Medicare settlement, a third-party payer may conduct its own investigation, determine if it was improperly charged, and send an overpayment letter seeking the recoupment of certain payments.

**Action Step**  When a billing problem is identified, physicians should assess the **full scope** of the problem. To the extent that third-party payers have been overcharged, overpayments will need to be returned. In determining whether monies are owed, billing staff will need to carefully analyze the payer contract. Billing requirements and allowances may differ in certain respects from payer to payer.

Mistake 8  **Failing to Fully Appreciate the Importance of Private Insurance Audits**

As third-party private payers step up efforts to identify improper billings, a physician may find that periodic audits are conducted by “program integrity” or similar sections within the payer organization. These reviews should be taken seriously. Rather than simply writing a check covering an overpayment, the physician should document why the payer is incorrect with respect to certain billings.

**Action Step**  As with other audits, it may be prudent to involve legal counsel in preparing a response to the payer’s allegations. Over the last few years, private payers have been found to readily report audit results to state and federal authorities if they believe that fraudulent activity is occurring.

Mistake 9  **Failing to Consider the Full Ramifications of Participation in HHS-OIG’s Voluntary Disclosure Program**

Not all improper billings are the result of mistakes, errors, or mere negligence. When faced with more egregious conduct, a provider may consider participating in HHS-OIG’s Voluntary Disclosure Program. There are a number of significant benefits to voluntarily disclosing improper Medicare billings through the program. Nevertheless, a provider should make this decision only after fully considering all aspects of the program. It is important to remember that under the program, there are no guarantees of protection from immunity from civil, criminal, or administration action. Moreover, admissions to HHS-OIG can be used against a provider in subsequent litigation. Additionally, once the government learns of problems, it is free to expand the scope of its investigation into other billing practices, beyond those disclosed under the program.
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**Action Step**  The decision whether to participate in HHS-OIG’s Voluntary Disclosure Program can be quite complicated. A physician’s legal counsel should be consulted so that an informed decision can be made.

**Mistake 10**  **After Identifying Improper Billings, No Efforts Are Made to Prevent the Problem from Recurring**

All too often, a physician or the physician’s staff identifies that improper billings have been made, refunds are issued, and no real effort is made to fix the problem. If the same problem recurs in the future, a physician will be in the unfortunate position of having actual knowledge that this was an issue. Such knowledge can adversely elevate the nature of a problem. While the initial occurrence may have been unforeseen, repeated mistakes of this type could result in expanded liability under various federal statutes.

**Action Step**  Physicians should take the time to assess how overcharges occurred. Once the problem is properly diagnosed, remedial procedures should be implemented and safeguards put in place to prevent improper billings from recurring. After correcting the problem, staff should be trained (and this training should be documented) so that they will be readily able to recognize future billing problems. Finally, audit systems should be adjusted so that the problem will continue to be monitored.

**Conclusion**

It is critically important that physicians avoid these mistakes when handling overpayments from health care payers.

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5.5 The 10 Biggest Legal Mistakes Physicians Make That May Lead to a Violation of Privacy
By Michael R. Lowe, Esq.

Executive Summary
Physicians must comply with myriad state and federal laws and regulations governing the privacy of patient information and medical records. Navigating the complex and often convoluted maze of laws and regulations presents a daunting challenge for all physicians. The privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA) when combined with applicable state medical record confidentiality laws present an insidious trap for unwary physicians who violate these laws and regulations. Violations can result in civil fines, administrative penalties, and disciplinary action by state licensing boards. Such violations may adversely affect physicians in ancillary areas, such as managed care contracting, licensure applications, medical staff credentialing, and patient relations.

Mistake 1  Failing to Obtain Proper Authorization or Consent to Release Patient Information
Before implementation of the HIPAA privacy regulations, many states had laws and regulations governing the proper release of patient medical records and information. The HIPAA privacy regulations have added to those state laws by creating requirements for the use of written authorizations for the release of patient information in a number of situations, but they do not require a written consent or authorization for the release of patient information for treatment, payment, or health care operations. However, many states have laws and regulations that require a physician to obtain a patient’s written authorization or consent in order to be able to release patient information for payment and some health care operations purposes. Additionally, while the HIPAA privacy regulations do not restrict communications with family members, many states have laws and regulations that prohibit physicians from releasing patient information and medical records to a family member or relative without a written consent or authorization from the patient. Failure to comply with these laws and regulations can result in severe consequences, including civil lawsuits for breach of privacy, administrative action by state and federal agencies, and disciplinary action by state licensing boards.

Action Step  Physicians should ensure that they and their employees are properly trained and educated on the requirements of applicable state and federal laws and regulations governing the proper release of patient information and medical records.

Mistake 2  Improper Handling of “Superconfidential” Information
In many jurisdictions, certain types of patient information (e.g., HIV/AIDS, sexually transmitted diseases, substance abuse, and mental health and psychiatric records) are afforded
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additional protection under applicable laws and regulations. Often, these types of superconfidential categories of patient information require more detailed and specific written consents and authorizations for a physician to be able to release a patient’s superconfidential information. Because of the heightened sensitivity of superconfidential information, physicians who improperly release such information may be exposed to even greater civil and administrative liability than if they had improperly released patient information that is not superconfidential. Therefore, physicians must ensure that superconfidential information in their patients’ medical records is afforded appropriate protection in order to prevent the unauthorized release of such information.

Action Step Physicians should ensure that their employees are properly trained on the handling and release of superconfidential information.

Mistake 3 Improperly Responding to Subpoenas
Almost every physician will receive a subpoena for patient medical records at some point in his or her professional career. Subpoenas are issued in civil, administrative, and criminal cases at both the state and federal levels. Applicable rules of civil procedure and statutory provisions usually govern the issuance and validity of subpoenas and outline the specific requirements for subpoenas that may be seeking patient medical records and information. In addition, the HIPAA privacy regulations have added “reasonable assurance” requirements to an already convoluted subpoena process. Some states have even amended their existing laws and regulations governing subpoenas in reaction to the HIPAA privacy regulations. Failure to properly comply with a subpoena, or failure to observe appropriate patient privacy rights and protections in responding to a subpoena, may subject physicians to unnecessary liability.

Action Step Physicians should consult with experienced legal counsel in order to develop an understanding of how to respond properly to subpoenas and how to release patient information and medical records sought by subpoenas. Physicians should also ensure that their employees are properly trained on the release of patient information and medical records in response to subpoenas.

Mistake 4 Failing to Understand Patients’ HIPAA Privacy Rights
The HIPAA privacy regulations created a number of new patient rights, including allowing patients to access their medical records, request amendments to their records, request accountings of certain disclosures of their medical records, request restrictions on the release of their medical records, and file complaints with a physician’s practice or the federal Office of Civil Rights about alleged privacy violations. The rules accompanying these new patient rights are complex, and in some instances (e.g., record amendments and restrictions on release of records) allow physicians to deny patients their requests to exercise their privacy rights. However, failure to observe the technical requirements associated with these patient rights may result in unintended HIPAA violations.
**COMPLIANCE: PRIVACY**

**Action Step**  Physicians should ensure that they and their staff are familiar with and receive training on the various patient rights under HIPAA.

**Mistake 5  Making Improper Telephone Disclosures**
Because of the busy nature of physician practices, many physicians are required to disclose some patient information by telephone on a regular basis. It would be impossible to operate a physician practice without doing so. However, many privacy violations and improper disclosures of patient information occur during telephone conversations because staff either fail to properly identify the individual to whom they are speaking and confirm that the individual is authorized to receive a patient’s information or they release too much information during a telephone conversation or as part of a potentially unsecure voicemail message.

**Action Step**  Physicians must implement policies and procedures for their staff to follow when making telephone disclosures of patient information.

**Mistake 6  Improperly Storing, Retaining, and Disposing of Old Medical Records**
The disposal of old or out-dated patient medical records is a necessity in any physician practice, since physicians cannot afford to store forever all patient medical records they have created. Unfortunately, many physicians either dispose of records without properly shredding or destroying them or they fail to retain the records for the required period of time under applicable state or federal laws. Failure to properly retain or dispose of patient medical records will definitely lead to privacy violations that will subject a physician to severe and unwanted legal consequences.

**Action Step**  Physicians should develop policies and procedures for the appropriate storage, retention, and destruction of patient medical records and ensure that their employees are sufficiently trained on such policies and procedures.

**Mistake 7  Seeing Staff As Patients**
It is not uncommon for physicians to see their own staff as patients. In these situations, a physician’s other employees often handle another employee’s patient information and medical records, which can lead to unauthorized and unanticipated discussions among staff concerning another employee’s patient information. Employees who are not involved in the care and treatment of another employee should not have access to that employee’s information and medical records. Failure to prevent such access could lead to a privacy violation.

**Action Step**  Physicians must develop and implement policies and procedures that limit access and disclosure by their staff to other employee’s patient information.
Mistake 8  Making Business Associate Contract Mistakes
The HIPAA privacy regulations require physicians who are “covered entities” to enter into written contracts with their business associates. The regulations also require the written contracts to include certain requirements and restrictions concerning the release, access to, and handling of protected health information by business associates. Many physicians fail to properly identify their business associates, enter into written agreements with them, or include the required provisions and restrictions in their written agreements with business associates.

Action Step  Because of the technical and complex legal nature of business associate issues and contracts, physicians should consult with experienced legal counsel regarding business associate issues.

Mistake 9  Ignoring or Improperly Handling Patient Complaints
It is inevitable that most physicians will experience some complaints from patients about privacy and medical records issues. Failure to properly and timely respond to and handle patient complaints could lead to additional issues when patients then take their complaints to an attorney, a state regulatory agency or licensing board, or the federal Office of Civil Rights because they feel that a physician is ignoring or improperly handling their complaint. Timely and appropriate handling of patient privacy complaints can prevent such further action by patients if they feel that a physician cares about their complaint and is providing a proper response to it.

Action Step  Physicians must develop and implement a well-thought-out policy and procedure for responding to and handling patient privacy complaints. Additionally, physicians should have a position on their office staff for a complaint or grievance resolution officer, and the person who fills that position should not only have extensive knowledge of applicable federal and state privacy laws, but also a very patient and understanding approach and demeanor toward resolving patient complaints.

Mistake 10  Releasing Patient Information via E-mail or the Internet
As a requirement of their busy practices, physicians are becoming more dependent on electronic means of communication with their patients, third-party payers, and other treating physicians and providers. However, many physicians operate computer systems and e-mail software and systems that do not include proper security and encryption measures. Also, many physicians often provide care and treatment advice to patients via e-mail without properly confirming that the individual receiving the e-mail is really the patient for whom the physician is providing care and treatment advice. Sloppy Internet, e-mail, and electronic communications practices and procedures will almost certainly result in an unauthorized
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disclosure of patient information or some other type of privacy violation. Also, lack of proper security measures may expose a physician’s computer systems and records to unauthorized access or hacking by third parties.

Action Step Physicians must implement appropriate system safeguards and security measures to protect patients’ private information and medical records and should consult with experienced software and computer system consultants when doing so.

Conclusion Physicians should be mindful of these mistakes and take appropriate steps as outlined to ensure the privacy of their patients’ information and medical records.

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5.6 The 10 Biggest Legal Mistakes Physicians Make in the Certificate-of-Need Process
By Peter M. Mellette, Esq.

Executive Summary
Due to declining practice income, many physicians are exploring ownership of medical equipment that can be used to enhance income and improve access to services for patients. Structuring such ventures requires careful analysis of various state and federal laws and regulations, including the federal Stark and antikickback laws and their state law counterparts, the antitrust laws, the Internal Revenue Service’s intermediate sanction regulations, and applicable reimbursement methodologies. Also, to the extent such additional services and equipment are regulated under a state certificate-of-need (CON) process, physicians must obtain prior state approval to offer the service. Physicians face many roadblocks in the CON process. In addition to failing to recognize that a CON law might
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apply in the first place, physicians wrongly expect to be treated like nonprofit hospitals in the process. Physicians need to be prepared and do their homework before venturing into the shark-infested waters of state CON reviews.

Mistake 1  **Investing in Equipment and Services Before Recognizing That a State CON Law Applies**

Too many physicians make an investment in the construction of an ambulatory surgery center or purchase imaging equipment without realizing that the acquisition and use of the surgery center or equipment may trigger state CON laws. About two thirds of the states require CON approval for various health care services. Before granting Medicare certification for an ambulatory surgery center or for an independent diagnostic treatment facility, Medicare regional offices look to see if the facility requires state licensure. States typically will not issue licenses or licensure waivers to physician-owned and -operated facilities that do not comply with state CON laws.

**Action Step**  Physicians should check their state’s CON law before signing on to purchase or construct any project.

Mistake 2  **Failing to Understand Public Need vs. Private Need**

Most physicians and physician groups that apply for CONs do not appreciate that the purpose of the CON laws is to regulate the location and per capita distribution of health care resources. Many physicians assume that because they have a large volume of patients who require surgery, imaging, or other CON-regulated services and that their practice may be busy enough to use an operating room or an MRI four hours per day, five days per week, they are somehow entitled to CON approval. Typically, CONs are not given to physicians based on their own practice needs but instead are tied to the unmet need for services in a medical service area. Hence, even if a physician practice could meet the volume standards for CON approval, the formulas are typically tied to availability of services within a given region. Thus, underused operating rooms or imaging equipment in one part of the service area may bar CON approval of equipment for a physician practice or even a hospital.

**Action Step**  Physicians should review applicable regulations defining public need, the entire medical service area inventory, and calculations of unmet needs before seeking CON approval.

Mistake 3  **Expecting to Receive the Same Regulatory Treatment As Institutional Applicants**

Many physicians assume that the CON laws apply fairly to all applicants. This assumption is incorrect. CON laws are tied to the needs within a region but favor institutional applicants, such as hospitals. Many CON policies allow expansion of beds, operating rooms, and services in the hospital setting even when there is no regional need. This institution-specific
need may be explicit or simply implicit in the regulatory approval process. As proprietary providers, physicians are at a disadvantage in the public CON process when pitted against nonprofit hospitals claiming an adverse effect if the physician project is approved.

Action Step Physicians should recognize and account for the hospital franchise advantage in CON review. They should also take advantage of institutional franchise opportunities through joint venture arrangements that expand existing services, and they should neutralize any hospital opposition (remembering that half a loaf is better than no loaf).

Mistake 4 Failing to Involve Necessary Consultants
The CON application process is a data-intensive exercise. It involves review of health plans, inventories of existing equipment and services, population statistics, incidence rates, and development of projections for unmet need for various services. It also requires the completion of forms with extensive financial projections and demographic analysis. Physicians need to include, as part of their CON application team, health planning experts to review demographic information and to develop the argument for the need for the service. Accountants are often necessary to prepare financial projections based on historical data and realistic assumptions of future performance. Without a well-crafted application, the physician-sponsored CON project starts at a significant disadvantage. Further, engaging such experts early in the process can help physicians evaluate the feasibility of the project, so that they can decide at an early stage whether to move forward with the CON application process.

Action Step Physicians should budget for and hire necessary consultants early in the CON application process.

Mistake 5 Not Playing to the Audience
The CON process involves public review, typically including public hearings before lay boards that make recommendations on CON projects to the state health commission or commissioner. Public officials who have the public’s agenda at heart (or believe that they do) review the applications and other materials the applicant files. A physician-sponsored CON may attract suspicion from many bureaucrats and lay board members who view the project as a way simply to increase physician revenue rather than serve the public. Physicians must address how the public, especially the uninsured, will be served by their proposed project and should be prepared to demonstrate how a project will not simply “cherry pick” the profitable patients from existing providers. Creative arrangements showing that the project is committed to meeting the needs of the uninsured may improve the likelihood of CON approval.

Action Step As part of the CON review, physicians should address the public’s issues and concerns, not just the issues and concerns of the physicians. They should be prepared to offer concessions regarding charity care.
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Mistake 6  **Not Preparing Adequately for Public Meetings**
One of the worst mistakes a busy professional can make is not to prepare for a board meeting or public hearing on a CON project. Too many physicians, overwhelmed with the demands of their practice, do not take the time to outline key points, anticipate questions, and prepare logical arguments for a particular CON project. Physicians should practice their presentation with their attorney several times, at least a day before the hearing. Also, too many hearings occur without prior communication with CON review staff on potential concerns. The failure to prepare often leads to overstatement or a seemingly arrogant response and disastrous results. Physicians should ask, and state CON staff may tell them, about their concerns before the hearing so the physicians can address them head on at the hearing.

**Action Step**  Physicians should remember that success is 90% preparation. They should tell the truth, and be humble.

Mistake 7  **Not Setting Realistic Goals and Timetables**
A substantial part of the CON analysis turns on the applicant’s ability to demonstrate that the public will use the project at levels that the regulators believe are adequate to demonstrate that “public need” exists. Unfortunately, when developing a CON project, some physicians are unreasonably optimistic with projections and expect to fill an operating room or fully use imaging equipment in the first year. Other physicians may expect to immediately obtain the necessary privileges at various hospitals. The CON agency staff charged with reviewing a CON application is usually very good at seeing through unrealistic projections, and CON reviewers may conclude that a physician applicant is unprepared or, worse yet, not telling the truth. The failure to establish realistic goals or even a phase-in of a particular project may result in its denial. Realistic volumes may also result in a more modest pro forma financial performance, addressing the regulator’s concern that money is the true CON objective.

A corollary to the failure to set realistic goals is the failure to set realistic timetables for project development and implementation. Reviewers want to see a realistic plan for development of a project, often as a precondition to approval. Physicians lose credibility by not establishing a realistic timetable for CON application development that can be accomplished. Discussions with health planning consultants, architects, and regulators are essential prior to CON filing and during CON reviews.

**Action Step**  Physicians should be realistic in their volume assessments and communicate a realistic plan.

Mistake 8  **Not Investigating Other Applicable Laws**
Physicians need to make sure that the proposed project is consistent with other applicable laws, including:
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- Zoning and land use requirements
- Building code requirements
- Radiation health regulations
- Traffic and access requirements
- Medicare and Medicaid antikickback and Stark laws
- State patient referral and antikickback laws
- Wage and hour laws
- OSHA laws and regulations
- Medicare reimbursement statutes, regulations, intermediary policies, and program manual requirements
- Managed care contracting requirements
- Professional licensure laws (including any provisions for office-based surgery)
- Facility and program licensure laws
- Environmental laws and regulations applicable to construction or operation of the proposed services

**Action Step** Physicians need to investigate the regulatory requirements for a proposed venture to make sure that the project will be in full compliance with the applicable regulations as proposed and avoid legal bars to project development.

**Mistake 9  Not Taking Advantage of Public Support**
CON laws allow for public comment on CON applications. Often, intelligent and well-scripted public comment on a project can sway a board member, staff members, and even competing applicants. The opportunity to showcase patients with good experiences with the physician, bad experiences at other available services, or both should not be missed.

**Action Step** Physicians should get their patients involved. Also, they should ask their competitors to support them with letters, and ask for support from legislators or municipal leaders. In addition, they should consider requesting support from local free clinics or other providers of indigent care.

**Mistake 10  Failing to Retain Competent Counsel**
Attorneys who practice before state boards and commissions and who have experience in the CON process are essential to obtaining the best result. While the CON attorney may not need to attend all of the hearings or speak on the applicant’s behalf at each, it is essential to have an experienced attorney who knows the boards and commissions in the CON process and who can advise physicians on potential shortcuts and hurdles. Physicians should involve their attorney early and often to maximize results.
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Action Step  Physicians should retain competent counsel and invest necessary resources up front in their CON project approval process.

Conclusion
The CON process requires that the applicant demonstrate a public need for the project to obtain approval. Public need is established by showing, among other things, that existing facilities are at capacity or otherwise unavailable; that the new project will lower cost, improve access, and improve quality; that competitors will not be harmed; and that charity care in the community will be enhanced. Physicians should involve necessary consultants and legal counsel in developing and presenting the CON application and should be realistic in their goals and timetables. They should expect a frostier reception than the local nonprofit hospital receives. Above all, physicians need to be prepared for and have understanding of the audience reviewing their project. Anticipating these events can improve chances for CON approval.

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5.7 The 10 Biggest Legal Mistakes Physicians Make When Responding to a Medicare Inquiry
By Todd A. Rodriguez, Esq.

Executive Summary
As the single largest payer for health care services, the Medicare program represents a significant source of income for the vast majority of physicians in the United States. Not surprisingly, health care fraud is one of the top enforcement initiatives for the U.S. Department of Justice (DOJ) and is also enforced by a host of other agencies, including the U.S. Postal Service and the Office of Inspector General of the Department of Health and Human Services (OIG). While most physicians are not engaging in health care fraud, billing mistakes when dealing with the Medicare program can have costly consequences. If handled improperly, mistakes can result in intense scrutiny and even prosecution by enforcement authorities. Because dealing with the Medicare program and Medicare officials is a routine part of most medical practices, physicians may mistakenly also treat as routine inquiries by
their Medicare carrier or by the federal Centers for Medicare & Medicaid Services (CMS). However, no inquiry from Medicare should be treated as routine.

**Mistake 1  Failing to Take Medicare Inquiries Seriously**
Medicare “inquiries” may take a variety of forms, ranging from payment denials and notices of unusual utilization patterns to specific audit inquiries. While all of these may be routine functions of the local Medicare carrier or even CMS’s national office, physicians must be aware that any one of them can be an indication that their practice activities are under scrutiny. For example, routine denials of particular services may indicate a problem in the way the service is being rendered, billed, or both. When the carrier identifies a practice as routinely billing for services that are not covered or not billed properly, the carrier may initiate an audit of that provider’s activities. Similarly, when routine utilization monitoring by the carrier identifies physicians who are outliers in a particular area, they will often send a notice to the physician of that finding. Physicians should take these notices as a red flag and promptly identify why their utilization statistics are abnormal and take action to correct any inappropriate or incorrect practices leading to the unusual utilization patterns. Finally, Medicare carriers are charged with routine auditing of physician billing practices, but physicians should not assume that any Medicare audit is routine. Carrier audit initiatives may be based on directives from enforcement authorities all the way up to the OIG. Moreover, the audit may not be routine at all, but rather it could be based on the fact that a physician or practice is the target of an investigation. Generally, there is no way to know whether an audit is routine or a sign of something more serious, so physicians must assume the worst.

**Action Step**  Physicians must treat every inquiry or communication from Medicare seriously and should investigate the basis for the inquiry and take corrective action.

**Mistake 2  Assuming Medicare Will Never Look at One’s Practice Activities**
The Medicare billing, coding, and documentation rules are extremely complex. Given the administrative burden that these regulations impose, physicians may be tempted to cut corners in their coding and documentation under the mistaken belief that their carrier, CMS, or both will never find out. However, physicians must understand that their claims are constantly under scrutiny by the carrier and that they may be targeted for audit at any time. Once a physician has been notified that he or she is the subject of an audit inquiry, it is generally too late to correct errors in coding and documentation.

**Action Step**  Physicians should prepare coding and documentation under the assumption that the records will potentially be reviewed by the carrier or other enforcement authorities.

**Mistake 3  Failing to Research Medicare Coverage Requirements**
Medicare carriers are charged with implementing national Medicare policies at the local level. Carriers have authority to develop policies (known as local medical review policies)
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that implement national policy, provided the local policies are not more restrictive than the national policies they implement. Physicians often receive notices of new local medical review policies from their carrier notifying them of the way in which services must be billed and if and when particular services are covered by Medicare. Physicians may also receive notices from Medicare that the way in which services are billed or coded does not comport with the carriers’ local medical review policy. Physicians should not, however, necessarily take these notices as the law. Rather, they should independently investigate whether the local medical review policy comports with national policy and, if the local policy is more restrictive than national policy, seek a determination from CMS’s national office as to the legitimacy of the policy. Working with experienced health law counsel throughout this research and inquiry process will help physicians ensure that they obtain guidance on which they can rely in dealing with their carriers.

**Action Step**  
Physicians should independently research coverage policies and procedures to ensure that local carriers are not overstepping their authority.

**Mistake 4  Failing to Document Communications with Medicare Officials**  
It is not uncommon for physicians to rely on verbal guidance from their carrier representative on how to properly bill and code their services. However, physicians are often surprised when they receive an audit inquiry suggesting that those services were billed incorrectly. When they are faced with repayment obligations or penalties, physicians often protest that they were simply billing for the services as they were told to by their carrier representative, who at that point may no longer even work for the carrier. Because the guidance was given to them verbally rather than in writing, the physicians have no evidence to support their claims. Similarly, when faced with a deadline to submit records for audits, physicians may request an extension. When that extension is given verbally and the physician fails to meet the written deadline in the audit inquiry letter, enforcement authorities may view this noncompliance as bad faith on the part of the physician. It is important therefore that communications with CMS officials, including local carrier officials, be committed to writing. When conversations are conducted over the telephone, physicians should send follow-up correspondence (using legal counsel as appropriate) and should request written guidance from the carrier when seeking billing and coding guidance. (As discussed in Mistake 5, inquiries to the carrier should generally be made on an anonymous basis.)

**Action Step**  
Communications to and from Medicare officials should be committed to writing to create a record of those communications.

**Mistake 5  Contacting Medicare Directly**  
Physicians may receive general notices from Medicare that prompt them to seek guidance from their local carrier. Physicians must be mindful of the fact that carriers may initiate investigations of physicians based on physician inquiries. So, when a physician contacts a
carrier to discuss the coverage requirements for a particular service, or billing and/or coding
practices, the carrier may use that inquiry as the basis of an audit of the physician. It is
advisable, therefore, to have legal counsel make such inquiries on an anonymous basis so that
the physician may obtain accurate written guidance from the carrier without fear of
implicating his or her own activities. The same applies with regard to inquiries made to
CMS’s national office. Legal counsel can also assist physicians to structure their inquiries to
obtain the most useful answer.

Action Step Physicians should avoid contacting CMS officials directly, but should rather
use legal counsel to make inquiries on an anonymous basis.

Mistake 6 Failing to Comply With Information Request Deadlines
Typically, when initiating an audit, the carrier or CMS sends the physician a letter describing
its authority to conduct the audit, identifying the specific records it wishes to review, and
specifying deadlines for the physician to submit the requested records. Often the information
requested is extensive and may cover several years. When faced with the burden of producing
these records, physicians can easily become overwhelmed and may find that the deadlines
imposed are too restrictive. However, failing to meet a deadline established in an information
request letter may be taken by the carrier and other enforcement authorities as an indication
that the physician is not cooperating or is otherwise acting in bad faith. This in turn may
escalate the seriousness of the audit from an enforcement perspective and may be an
aggregating factor in determining the final action taken against the physician. When faced
with an inadequate deadline, physicians are far better off seeking an extension. In most cases,
auditors grant such a request. However, as discussed in Mistake 4, such requests and the
responses from the carrier should be committed to writing so that there is a record of the
hardship imposed on the physician as well as the auditor’s response to the request.

Action Step Physicians should follow information request deadlines closely and seek
extensions of those deadlines if necessary.

Mistake 7 Altering Records Subject to a Medicare Audit
When they receive an audit inquiry letter from the carrier, physicians may be tempted to alter
the records that are the subject of the audit before submitting them in an attempt to remedy
poor documentation or incorrect coding. If discovered, altering medical records may raise
mere billing mistakes to the level of health care fraud, the consequences of which are not only
potential repayment of funds, but penalties and even criminal prosecution. When reviewing
records to be submitted as part of an audit, physicians should document any discrepancies or
shortcomings identified and, in a cover letter accompanying the records to be submitted,
include an explanation, if there is one, of those discrepancies and deficiencies. In addition,
when the physician regularly uses abbreviations in his or her records, it is advisable to
include a glossary of those abbreviations so that auditors can interpret the records. Finally,
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when documentation is illegible, it is advisable for physicians to transcribe the records in
dictation and include both the original records and the dictated records as part of the
information submitted for the audit with an explanation as to why both are being submitted.
Physicians should never alter original medical records. If necessary, they may include
addendums to the medical records, but those addendums should be signed and dated as of the
date they were made and should not be backdated.

**Action Step**  Physicians should never alter medical records, but should instead include
explanatory comments with records submitted to Medicare for audit.

**Mistake 8  Failing to Keep Accurate Records of Information Submitted to Medicare
in Connection with an Audit Inquiry**

Information requested by a Medicare carrier or CMS in connection with a physician audit
may be extensive, often requiring the submission of boxes of records. Given the tremendous
administrative burden of submitting records for audit, physicians may elect to forego copying
the information submitted. However, unless the physician makes an exact copy of each piece
of information submitted pursuant to the audit, the physician will be at a disadvantage if he or
she is asked later to explain certain pieces of information submitted or if the physician is
forced to challenge the carrier’s audit determination in a hearing or in court. When copying
the records submitted would be administratively unfeasible, physicians should at least make a
detailed list describing each piece of information submitted for later reference. While even
this will be administratively burdensome, failing to do so could put the physician at a
disadvantage later.

**Action Step**  Physicians should keep accurate records of all information submitted to
Medicare authorities.

**Mistake 9  Failing to Take Corrective Measures When Instructed to Do So by
Medicare Officials**

If, after an audit, a Medicare carrier or CMS identifies problems or deficiencies in the way a
physician has billed for services, the carrier, representative, or Medicare will provide the
physician with guidance on how the services should be billed, documented, and/or coded
for going forward. Physicians may be reluctant, whether intentionally or unintentionally, to
implement the revised billing, coding, and/or documentation recommendations. Worse yet,
some physicians may make the incorrect assumption that because they have been audited once,
they will not be audited again. In fact, physicians who have been audited by the carrier are
often flagged for continuing scrutiny and may be audited for the same or different problems
again. Moreover, failing to take corrective action when instructed to do so by Medicare
officials may, upon subsequent audit, indicate a disregard for the law, raising what would
otherwise be billing mistakes to the level of health care fraud.
**COMPLIANCE: THIRD-PARTY PAYER AUDITS**

**Action Step**  Physicians should take guidance from their carrier, CMS officials, or both seriously and implement corrective action within their practice when problems are identified.

**Mistake 10  Failing to Consult with Experienced Health Care Counsel**
With rising overhead costs and shrinking reimbursements, physicians are often tempted to save money by foregoing legal advice. Physicians should be aware however, that inquiries from CMS, their carriers, or both may be precursors to audits and even full-blown investigations that can result in the repayment of significant sums of money, civil penalties equal to three times the incorrectly billed amounts, and even criminal prosecution. Therefore, avoiding involving legal counsel when physicians receive Medicare inquiries may be pennywise but pound foolish. Physicians are advised to consult with legal counsel in advance of receiving Medicare inquiries to establish a protocol for receiving, investigating, and responding to Medicare inquiries. Legal counsel should generally be made aware of any such inquiries and should be consulted as to how best to respond to them.

**Action Step**  Physicians should consult with experienced health care counsel before, during, and after receiving any Medicare inquiry.

**Conclusion**
Physicians must be cognizant of the seriousness of Medicare inquiries and should develop compliance policies and procedures for receiving, investigating, and responding to them. Doing so will help to avoid costly audits, repayments, fines, and penalties.

**About the Author**
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**5.8  The 10 Biggest Legal Mistakes Physicians Make During Third-Party Payer Audits**
By Wendy A. Stimpfl, Esq.

**Executive Summary**
Almost every practicing physician will be the subject of an audit by a third-party payer during his or her career. These audits must be taken extremely seriously. Regardless of whether the
third-party payer is the government (as in the Medicare or Medicaid programs) or a private insurance company, responding to an audit in a proper manner is of the utmost importance. It could mean the difference between a small overpayment, a lifetime exclusion from the health plan, or worse, a federal fraud and abuse investigation.

**Mistake 1  Letting Panic Sink in to Cloud Judgment**
Physicians who have been notified that their practice has been selected for an audit should not panic. Far too often physicians overreact to an audit request and make fundamental mistakes in the way the audit is handled in an attempt to make it go away quickly. Important decisions made in haste can be very detrimental. First, physicians should read the notice carefully to see if it lists the type of review or audit being performed or the reason their practice was selected for the investigation. If a private payer has initiated the review or audit, physicians should review the company’s provider manual to see if any information is listed regarding its right to audit a practice and the types of audits that may be performed. Physicians should take the time to check the company’s website for additional information. Since Medicare and certain third-party payers often conduct reviews and audits for various purposes and even randomly, receiving a notice of an audit does not mean that a practice is doomed.

**Action Step** After receiving an audit notice, physicians should take a deep breath and gather their thoughts. They should outline a basic plan to respond to the audit, starting with which staff must be alerted to the audit and which business professionals must be contacted immediately.

**Mistake 2  Calling the Auditor on the Telephone**
Typically, most third-party payers notify physicians by certified mail that they are under investigation. The physicians should not call the auditor or the insurance company. However, if they are contacted by the auditor by telephone, aside from a brief discussion about the logistics of the audit, physicians should say nothing. There is no reason to answer any specific questions the auditor might ask verbally about the practice or any charts. If the auditor asks questions, the physician should simply say that he or she will be responding in writing. The less the physician says, the better.

**Action Step** After receiving notice of an audit, physicians should refrain from calling the auditor or the insurance company to discuss it. All communication should be in writing.

**Mistake 3  Failing to Consult with Experienced Health Care Counsel**
Physicians should contact their attorney as soon as they become aware that they are under investigation and being audited. Their attorney can guide them through the audit process; physicians should not make the mistake of trying to handle this alone.
COMPLIANCE: THIRD-PARTY PAYER AUDITS

Action Step  Physicians should consult with experienced health care counsel before they have any contact with the auditors or a representative of the insurance company.

Mistake 4  Failing to Respond in a Timely Manner
Physicians should begin preparing their response by having all of the requested charts pulled. They should make sure all information has been appropriately filed and that no information is left in the filing bin in the office. It is important to act promptly because delays can create suspicion. Copies should be made of all of the relevant materials that have been gathered. Physicians should pay close attention to the requested deadlines in the notice. If they are unable to accommodate the time frame specified, their attorney should contact the appropriate party to request an extension.

Action Step  Physicians should always respond to requests for medical records from a third-party payer in a timely fashion.

Mistake 5  Improperly Altering a Medical Record
After receiving a request for medical records from a third-party payer, physicians should not alter the records in any way. Many physicians want to add information to the record in an attempt to justify the billing code. That is unacceptable. If a clarification is necessary, it should be done only as an addendum, on a separate sheet of paper, or in a narrative form to accompany the record. In either case, it should be clear when the addendum was prepared so as not to be misleading. Falsifying medical records can convert an otherwise defensible case into a career-ending fraud case.

Action Step  Physicians should provide only the information requested in the audit letter. However, they need to look at each chart in its entirety. Their attorney may decide to forward additional information from the chart to support the coding.

Mistake 6  Refusing to Hire a Consultant
A physician’s attorney may likely recommend retaining the services of a certified coding consultant to review the requested charts. This is money well spent. It is a good idea to have an outside opinion regarding the accuracy of the coding of the charts that were selected for review. A coding consultant may also be able to identify potential coding problems that may have subjected the physician to review in the first place. Knowing potential problems in advance can help the physician successfully defend the audit, and the physician may be able to provide the reviewer with supporting documentation that justifies the coding used. Also, a coding consultant may help identify other problems (e.g., illegible charts or incomplete histories) and offer advice on how to prevent such issues in the future.
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**Action Step**  Physicians should follow their attorney’s advice and authorize the hiring of a coding consultant. The benefits of having a consultant review the charts far outweigh the fee for the services rendered.

**Mistake 7  Failing to Protect the Confidentiality of a Consultant’s Report**
Physicians who hire outside consultants to review their medical records after they receive notice of an audit should take steps to protect disclosure of the content of the report from subpoenas by investigators, whistleblowers, and other adverse parties. Protecting the confidentiality of the practice’s information from third-party discovery requests is one of the most important steps physicians should take when conducting an internal audit. Before hiring an auditor or a consultant to review their records, physicians should make a formal written request to their attorney asking that he or she conduct a legal review of specific issues involved. The attorney-client privilege and work product doctrine are two rules that can be used to protect the confidentiality of a physician’s information.

**Action Step**  Physicians should make certain that any consultants hired to assist during the audit are hired by their attorneys. All communications with those consultants should be directed through the attorneys.

**Mistake 8  Voluntary Downcoding of Services**
Physicians often ask whether they should review the audit documentation before submitting it to the third-party payer, and whether they should append the record or submit a corrected claim if that audit detects any deficiencies in the documentation. Of course, physicians should review all claims before submission to the third-party payer. Whether or not it is appropriate to include an addendum or supplemental information in the cover letter describing relevant information that is not readily apparent from the original note should be considered on a case-by-case basis. Voluntarily downcoding a claim simply because the documentation does not meet the carriers’ guidelines may not be appropriate at all. Documentation guidelines are, indeed, only guidelines. Therefore, if the code accurately describes the work performed, a physician should not voluntarily lower the code simply because of a documentation deficiency.

**Action Step**  Physicians who performed the service that was billed for and simply did not fully document the visit should challenge any alleged overpayment rather than voluntarily downcode the patient encounter.

**Mistake 9  Failing to Challenge an Alleged Overpayment**
After a review of a physician’s charts, the third-party payer may request a refund for an alleged overpayment. Many physicians mistakenly believe that challenging an alleged overpayment is much riskier than merely paying the amount requested. However, before simply giving in to a refund request, the physician must consider certain factors. For example,
third-party payers may view capitulating to an audit as tantamount to admitting guilt. If they are able to collect an alleged overpayment from a physician easily, they will closely monitor that physician. A physician who simply repays the overpayment with no appeal is nearly guaranteed a future audit. Moreover, succumbing to audits strongly encourages insurance companies to perform future reviews because they are an easy revenue source. In short, simply refunding the money unchallenged invites a return visit and potential problems in the future.

**Action Step** While under certain circumstances repaying an alleged overpayment may be prudent, failing to challenge an overpayment out of fear or intimidation may invite future problems. Ultimately, the decision as to how best to proceed must be made on a case-by-case basis and after consultation with legal counsel.

**Mistake 10  Failing to Take Corrective Action If Necessary**
Physicians should use this time to determine what steps they can take to minimize their chances of another audit. They should meet with their billing staff to discuss the reasons claims are most frequently rejected or denied. They should pull a random sample of charts for each billing provider and determine if documentation improvements can be made. If the practice has a written compliance plan, physicians should review it with staff to make certain it is being followed. If the practice does not have a written compliance plan, physicians should think about implementing one. Also, physicians should be sure the billing staff is working with the most current coding and compliance materials, and that the billing software is up to date on all changes to coding practices. Finally, physicians should not overlook their overall practice policy manual, which may need to be updated to reflect new policies triggered by the audit.

**Action Step** Physicians should make sure that all services are properly documented and consistent with the CPT code(s) being billed.

**Conclusion**
Being audited is not the end of the world, although it may seem so at the time. At the end of the day, the audit will be complete and the practice will survive. Physicians should use the audit as an impetus to reinforce or institute good compliance practices and perform ongoing periodic internal audits to identify and correct any future compliance issues.

**About the Author**
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Chapter 6 Contracts

6.1 The 10 Biggest Legal Mistakes Physicians Make in Negotiating Contracts with Their Employers

By Steven Babitsky, Esq., and James J. Mangraviti, Jr., Esq.

Executive Summary
Each year, tens of thousands of physicians, some just leaving residency and some with more experience, sign employment contracts. The key to the rights of both the employer and the employee are the terms of the written employment contract. Physicians need to be exceptionally careful about what terms the employment contract contains. Many physicians make serious mistakes when negotiating employment contracts, and such mistakes are likely to adversely affect them and their families for years.

Mistake 1 Consulting Counsel Too Late
Physicians often agree to the terms of an employment contract offered after only brief negotiations. Some may consult with counsel late in the process or not until after the contract has been signed. By consulting counsel too late in the process, physicians forfeit the ability of counsel to provide them with guidance, checklists, demands, proposals, counterproposals, strategies, and tactics to achieve better terms, compensation, and working conditions. When physicians consult with counsel early in the process, counsel can negotiate the contract with the employer’s lawyer, which will likely result in better terms and free the physicians from the uncomfortable task of negotiating with a future employer.

Action Step Prospective physician employees should consult with experienced counsel before starting to negotiate any employment contract.

Mistake 2 Failing to Conduct Adequate Research on the Prospective Employer
It is not uncommon for physicians to concentrate so much on the salary and other proposed provisions of the employment contract that they often neglect to do “due diligence” on the employer. While the promises (written and oral) of the prospective employer are important, of equal importance are the employer’s past actions. Before beginning contract negotiations, physicians should research the turnover, percentages of physicians engaged by the employer who make partner, the employer’s profit or loss history, past payouts, malpractice claims, pending litigation, and the reputation of the partners and of the employer. What the employer has actually done in the past may be more important than what the hiring physicians promise to do in the future.

Action Step Prospective physician employees should perform “due diligence” on the employer before commencing employment contract negotiations.
Mistake 3  **Overlooking the Vague Term of Contract**
Physicians often overlook the number of years the contract is to run (the term of the contract), whether the contract is renewable, by whom it is renewable, and on what terms. It is not uncommon for new physicians to sign lengthy contracts with inadequate consideration of cost-of-living raises and escape clauses for the physician employee. Some proposed contracts are self-renewing, renewable by mutual agreement, or renewable by the employer at its option. Many proposed contracts do not even mention renewal. It is difficult, if not impossible, to evaluate a proposed employment contract properly if the term of the contract is not clearly spelled out and if the physician does not fully understand the term.

Ambiguities in a contract are a frequent cause of litigation. If litigation occurs, ambiguous terms will be a subject of dispute, so they should be avoided. For example, a clause stating that the physician must “reside locally as per the current and past policies of the practice” is ambiguous. What precisely does “reside locally” mean? What are the “current and past policies of the practice?” It is much better to state clearly where the physician must reside.

Also, physicians being considered for employment may be induced to sign an employment contract with vague or unclear call duty responsibilities (e.g., “new physician will share work and call duties with the employees of the company”). By agreeing to this type of open-ended call duties, physicians are essentially relying on the employer to be fair and reasonable. Physicians should determine the precise nature of call duty and what happens if one or more physicians get sick, leave the practice, or otherwise cannot fulfill the call duty at a particular time. Physicians would be better protected by obtaining specific language (e.g., “the physician will be on call one day per week”) that does not depend on factors outside of their control.

**Action Step**  Before signing, prospective physician employees should insist that the term of and language in the contract be clear and fair to both sides.

Mistake 4  **Failing to Understand the Legal Significance of Defined Terms**
Employment and other contracts often have defined terms. Such terms are usually recognized in a contract because they are in quotes, italics, or boldface, underlined, or made to stand out in another way. When a defined term is used in a contract, a court is likely to interpret the term according to its definition in the contract, not its common dictionary definition. In other words, what the contract says the term means is what counts, not what an average person thinks the term means. For example, a contract may state that the physician “may be terminated immediately for professional misconduct.” Since professional misconduct is in italics, it is a defined term. What will govern precisely why a physician can be terminated is the definition of this term in the “Definitions” section of the contract.
CONTRACTS: NEGOTIATING WITH EMPLOYER

Action Step  Prospective physician employees must recognize defined terms in the contract, as well as read and understand the contract’s definitions of any and all defined terms.

Mistake 5  Not Paying Enough Attention to Fringe Benefits
While the salary physicians will be paid is of primary importance, it is not uncommon for prospective physician employees to overlook the breadth of potential fringe benefits to be negotiated. Common benefits include:

- Tuition and CME reimbursement
- Health insurance
- Malpractice coverage
- Car allowance
- Vacation leave
- Sick leave
- Maternity leave
- Life insurance
- Professional dues
- Paid holidays
- Journal subscriptions
- Relocation expenses
- Dental insurance
- Profit sharing
- Disability insurance
- 401(k) and other retirement plans
- Parking
- Flex time
- Loans

Action Step  Prospective physician employees, with the help of counsel, should create a checklist of fringe benefits that are available and open to negotiation. These potential benefits should be listed in order of priority and include a “must-have” section.

Mistake 6  Not Specifying the Conditions of Employment
Often, physicians overlook whether the employment contract deals specifically with the actual job description. What physicians will be required to do, where, and how they will be expected to perform these duties are crucial aspects of any physician employment agreement. These aspects of employment should be negotiated prior to negotiating the compensation.

A detailed list of the specific proposed duties for the physician should be negotiated and clearly spelled out in the employment contract. These duties include:
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- Patient appointment hours
- Hospital rounds
- Emergency room call
- Office duties
- Review of blood work and lab results
- Telephone calls
- Medical record documentation
- Preoperative consultations
- Availability of nurses and support staff

**Action Step** With the assistance of experienced counsel, prospective physician employees should prepare a checklist of proposed duties and responsibilities to be used during the employment negotiation. Only when both parties agree to these duties should physicians negotiate compensation issues.

**Mistake 7 Not Having Adequate Information on Bonus Terms**
It is not unusual for physicians to sign an employment contract without having adequate information on the additional compensation (bonus) that they can expect to receive under the contract. In many employment contracts, physician incentive or bonus plans are written to protect the employer and not the physician employee. Some clauses a physician employee should be particularly careful about include:

- The ability of the compensation committee to cancel or prospectively revise the incentive plan
- The need for a site to “break even” before the plan takes effect
- The precise calculation of the physician incentive
- The definition of key terms (e.g., positive net income, negative variance, percentage, gross revenue).

**Action Step** With the assistance of counsel, prospective physician employees should review the proposed incentive plan until they fully understand the plan. The plan should have objective triggers that an unscrupulous employer cannot manipulate against the interest of the physicians. For example, it is preferable for the physician’s bonus to be based on gross income rather than on net income because net income is usually much more subjective and easier for business owners to manipulate. If, for example, the owners have an employee who gets a percentage of net income as a bonus, the owners might have an incentive to pay themselves a higher salary and thus drive down the practice’s net income.
CONTRACTS: NEGOTIATING WITH EMPLOYER

Mistake 8  Failing to Consider Unduly Restrictive Covenants Not to Compete

Often, prospective physician employees go into a negotiation with little or no concern about the “covenant not to compete clause” in the proposed employment contract. Operating in good faith, they have the hope and expectation of long-term employment. Many proposed physician employment contracts provide a noncompetition section.

Prospective physician employees should be concerned with the following noncompetition sections:
- Length of term (in years or months)
- Geographic limitation (e.g., a certain radius in miles or states)
- Provisions for exception (e.g., teaching, working for an insurance company, or working as a medical director of a noncompeting company).

The law generally provides that unreasonable covenants not to compete will not be enforced. However, proving that a covenant not to compete is “unreasonable” requires litigation, time, and substantial legal expense. It is much better to negotiate, in advance, a reasonable covenant. Attorneys can help in this regard by researching precisely what has been found to be reasonable and unreasonable in the jurisdiction in question.

Action Step  Prospective physician employees should carefully consider all of the implications of signing a noncompetition clause and negotiate the clause cautiously. They do not want to spend time and money litigating this issue when leaving the current employment.

Mistake 9  Failing to Recognize One-sided Termination Provisions

Physicians who are negotiating and signing employment contracts should be acutely aware of the full implications of the termination provisions of the proposed contract. What appears to be a generous two- or three-year employment contract with cost-of-living increases, etc., can, in reality, be terminated almost at will. Such contracts can be a serious problem for all physicians but especially for those who have just moved their families to accept new employment in a different location.

Every physician should pay particular attention to the events listed in the contract that can trigger a termination, including:
- 90-day notice by the employer or by either party
- Any event the employer deems to be detrimental to the employer
- Suspension of privileges, including license suspension
- “Material” breach of contract
- Illness
- Disability.
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**Action Step**  
Prospective physician employees and their counsel should look carefully at the termination provisions of the proposed contract to determine if the provisions are fair and reasonable. Provisions that are too one-sided may portend difficulties with the employer. Vague provisions should be clarified.

**Mistake 10  Not Protecting “Additional Income”**  
Physicians negotiating an employment contract often overlook the importance of protecting “outside or additional income.” This outside income, which can become substantial, can include:

- Honoraria for lecturing
- Royalties for writing treatises and articles
- Consulting work
- Testifying as an expert witness
- Inventions
- Patents
- Copyrightable works
- Discoveries
- Other intellectual property

**Action Step**  
Prospective employee physicians should be cautious about signing away rights to outside income, especially when this income is generated outside of regular employment (such as at night, on weekends, or during vacations). Employment contracts should contain specific language stating that the physician retains all outside or additional income. Not addressing this issue in the contract can lead to misunderstandings and bad feelings at best, and litigation and termination at worst.

**Conclusion**  
Any physicians entering into an employment negotiation should be mindful of these mistakes and take steps to avoid them so as to be in the best position to achieve a fair, reasonable, and secure employment contract.

**Additional Resources**

6.2  The 10 Biggest Legal Mistakes Physicians Make in Negotiating Contracts with Their Employers

By Mark E. Stipe, Esq.

Executive Summary
Physicians enter into a wide variety of contractual obligations, and they need to fully understand the implications of those obligations. This includes understanding the obligations and rights covered by the terms of the contract while it is in effect, as well as the rights and obligations of the physician after the contract is terminated. Potential costs both during and after a contract term can be imposed on a physician, and the ramifications of all the obligations and responsibilities imposed should be evaluated before entering into a contract.

Mistake 1  Not Assuming That the Contract Will Be Enforced As Written
During the negotiations, a physician negotiating a contract often deals with a particular individual representing the other party. There is a tendency to act as though the individual the physician is dealing with is the other party and will always be the other party. For example, the physician meets and works with a particular chief administrative officer (CAO) and the tendency is to assume that person will always be the CAO of the other party. If the CAO says that he or she will not enforce a particular contract provision or the CAO’s “management style” leads the physician to assume it will not be enforced, the tendency is to not worry about the particular contract provision.

Unfortunately CAOs do not stay forever. The CAO at the time of a dispute may or may not share the views of the CAO who negotiated the contract. Corporate cultures change. In the
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health care industry particularly, government regulatory actions can force an entity to change the way it has historically approached contracts.

**Action Step**  Physicians should assume that the contract will be zealously enforced as written by a representative of the other party who is not the person the physician negotiated with initially.

**Mistake 2**  **Failing to Understand the Significance of the Entire Contractual Provision Relating to an Issue As It Is Written in the Contract**
The significance of the exceptions and qualifications to the general rule set out initially in a contract must be fully understood by a physician. A three-year contract that allows either party to terminate the contract after six months is not a three-year contract; it is a six-month contract.

**Action Step**  Physicians should understand the exceptions or qualifications to a general pronouncement in a contract, or seek the advice and input of someone who does.

**Mistake 3**  **Not Getting Background Information About the Other Party Before Entering into a Contract With That Party**
Before contracting with an entity (or an individual), a physician should obtain as much background information as possible about the entity. Does it have a litigious culture? Is it facing any government regulatory issues? Are there any competitors or other economic forces at work that could alter the assumptions of the physician contemplating entering into a contract? A rural hospital, for example, may have impressive historical financial data but if another facility is planning to open in the same community, how will the financial performance be affected?

**Action Step**  Physicians should undertake efforts to obtain as much information as possible about another party before contracting with it.

**Mistake 4**  **Failing to Properly Evaluate the Manner and Effect of Exiting a Contractual Relationship**
Physicians should, at the outset, fully understand the ability to exit and the effect of exiting a contractual relationship. If there is a notice requirement for terminating a contract, that date should be calendared, and well before that deadline the physician should evaluate the contract. This includes whether the contract should be renewed, renegotiated, or terminated.

Physicians should fully understand the effect of exiting a contractual relationship. Early termination may trigger liquidated damage provisions, or create legal exposure for the physician from claims as a result of the early termination.
**CONTRACTS: NEGOTIATING WITH EMPLOYER**

**Action Step** Physicians should fully understand the manner and effect of terminating a contractual relationship, and calendar all deadlines associated with a particular contract.

**Mistake 5  **Failing to Properly Evaluate the Dispute Resolution Provisions, If Any, in a Proposed Contract

Physicians should fully understand the method of dispute resolution that is established by virtue of a particular contract. Many contracts contain arbitration provisions or mandatory mediation provisions. If the contract is silent on this issue, then a court will be the third party that ultimately decides a dispute that the parties to a contract cannot resolve. Legal counsel can advise physicians on the potential venues and fact finders that could ultimately determine the dispute, and whether that is favorable or unfavorable to the physician.

If the contract contains dispute resolution procedures, then those provisions should be analyzed by the physician and fully understood. The location of any dispute resolution procedures, the third person(s) who will likely be selected, and the authority given the third person(s) are all relevant to understanding what rights the physician truly has in the event of a dispute.

**Action Step** Physicians should assume there will be a dispute as to the contract for the purpose of understanding how the dispute resolution procedures relating to the contract will likely be applied.

**Mistake 6  **Failing to Understand the Liabilities Assumed by Virtue of Executing the Contract

Often, a contract will call on a physician to make representations and warranties. Additionally, the contract may call on a physician to expressly assume liabilities. Both types of contractual provisions can cause a physician to assume liability that the physician should fully understand before executing the contract.

A provision wherein the physician warrants that the contract complies with the Stark law and antikickback statute, coupled with a provision that the physician is in breach of the contract for violation of the warranties in the contract, means that the physician has assumed that exposure as between the parties to the contract.

**Action Step** Physicians should evaluate the liability assumed not only as to the other party to the contract but also as to third parties as a result of the contract.

**Mistake 7  **Failing to Understand Obligations and Responsibilities That Exist After the Contract Has Terminated

Physicians should understand all of the obligations imposed after the contract has terminated. Nondisclosure or confidentiality provisions should be scrutinized closely as to whether those...
types of provisions are even relevant to the purpose of the contract. Vague and nebulon obligations concerning nondisclosure that survive the term of the contract are rarely of any benefit to the physician.

If patient information is exchanged as a result of the contract, then any privacy compliance issues under the Health Insurance Portability and Accountability Act (HIPAA) should be analyzed and addressed. Who is responsible for retaining patient information and complying with the HIPAA privacy regulations as to that information after the term of the contract? The regulations impose on the parties obligations as to patient information that should be addressed in any contract.

Additionally, the effect of any provision that purports to limit the physician’s ability to practice medicine or engage in commerce should be analyzed. This specifically includes any noncompete, nonsolicitation, or restrictive covenant provisions in a contract.

**Action Step** Physicians should list the obligations imposed on a party to the contract after it has been terminated, and fully understand the costs and liabilities associated with those obligations.

**Mistake 8 Not Causing the Economic Provisions of a Contract to Be Clear and Understood by All Parties**

Many physician contracts are executed to document economic transactions. The contract should clearly address the economic issues. While at times there is good reason to be vague, generally the physician is better served with a contract that clearly addresses the formulas and calculations the parties plan to use. If one (or both) of the parties has always calculated an amount using a specific method, then that method should be defined in the contract. Including an example of a calculation is a good way to document the parties’ understanding if complex definitions become too cumbersome or are susceptible to different interpretations.

If intellectual property issues are relevant, the method of allocating rights and revenue should be addressed. A contract should clearly address what party has the rights to any intellectual property that is arguably covered by the contract.

**Action Step** Whenever possible, physicians should have a third person in health care review the economic provisions of a contract if there is any doubt as to the interpretations of those provisions.

**Mistake 9 Failing to Fully Understand and Review Other Relevant Agreements and Laws**

Contracts often refer to other agreements or laws that are susceptible to revision. The status of those laws and agreements should be analyzed at the time the contract is executed.
Additionally, the effect of future changes should be analyzed and addressed in the contract. For example, if the physician is executing a contract with a hospital that obligates the physician to comply with the provider agreements the hospital has entered into, then those agreements should be reviewed. Alternatively, the hospital should make representations concerning the effect of those provider agreements on the contract. It should be understood that laws are constantly subject to change by legislative action, executive rulemaking, and judicial interpretation.

**Action Step** If a contract references another agreement or a law, the referenced documents should be reviewed and the implications of those documents as to the contract should be analyzed.

**Mistake 10 Not Remembering That When Negotiating From a Position of Strength, the Longer the Contract the Better and When Negotiating From a Position of Weakness, the Shorter the Contract the Better**

If the physician is in a position of strength, then all of the reasonable foreseeable issues—including but not limited to those addressed above—should be expressly addressed in the contract in a manner that is beneficial to the physician. The effect of addressing all the foreseeable issues in such a manner is to make the contract long and some would say exhaustive. If, however, each area of potential dispute has a contract provision addressing how the issue is to be dealt with in the agreement between the parties, then there should be very little room for credible disagreement. This theoretically eliminates potential disputes because, as between the parties, the issue has been addressed.

Conversely, if the physician is negotiating from a position that is not strong, a short contract is better. A third party will determine issues that are not expressly dealt with in the contract if a dispute should arise. That will most likely provide the physician with a better chance of a positive result than if the parties had expressly dealt with the issue at the time the contract was executed.

It should be emphasized this is a merely a rule of thumb that is not absolute. There are many contracts that are concise and very efficient in addressing all contractual issues within a limited amount of space.

**Action Step** If the physician is negotiating from a position of strength, every issue and potential area of dispute should be expressly addressed in the contract.

**Conclusion**

There are a number of issues that a physician should consider before entering into a contract, regardless of the context. Failing to consider all the rights and obligations associated with a
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contract can cause costs to be imposed on the physician both during the contract term, and after the contract has ended.

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6.3 The 10 Biggest Legal Mistakes Physicians Make in Negotiating Contracts with Physician Employees
By Robert A. Blass, Esq.

Executive Summary
“Would you be willing to put that in writing?” — the skeptic’s challenge. There was indeed a time when deals were routinely done on a handshake and controversies were no more prevalent, and probably less so, than today. The current regulatory climate, though, and the perceived expedience of litigation make it imperative that physician employment relationships be in writing. Few physicians have the interest, time, or experience to negotiate employment contracts with employees, but employers should understand that a contract properly prepared by an experienced attorney will help to prevent violations of regulatory compliance laws and avert or minimize the consequences of misunderstandings or disputes.

Mistake 1 Failing to Consult Counsel
Any employment relationship, especially involving physicians, is saturated with legal implications and ramifications. Experienced counsel can guide the employer through legal issues from recruitment to hiring, and help to ensure compliance with state or federal statutes and health care regulations, such as those governing compensation, referrals, insurance, credentialing, tax and benefits considerations, and partnership issues. For formal agreements, an off-the-shelf contract form downloaded from a professional society website or adapted from a form used by a large medical center may look impressive, but “more” is not necessarily better, and may be worse, if its terms are not tailored to the practice. Likewise, a simple form from a self-help employer manual may not be sensitive to the regulatory context in which most physician employment agreements are currently drafted.
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**Action Step**  Employers should consult with experienced counsel to prepare employment agreements suitable to their needs. And while, to the untrained eye, the legalese in contracts may seem impenetrable, this need not be the case. Employers can and should expect their attorneys to prepare an agreement that, while comprehensive, is also readable and understandable.

**Mistake 2  Conducting Inadequate Research on Prospective Employees**
Prevention is the best medicine not only for physical health, but for legal health as well. There is seemingly no limit to the resources and avenues available for background checks on a candidate, in some cases subject to applicable federal or state privacy laws, such as credit searches, drug testing, judgment and conviction searches, and motor vehicle records. Truly basic measures, though, will prevent most hiring mistakes. At a minimum the resume should be carefully reviewed before inviting the candidate for an interview. Gaps in employment and educational history should be noted, and the candidate should be questioned about them. References should be requested and, with the candidate’s written authorization, each of these checked and educational degrees and licenses confirmed.

At the interview (and in the contract), the employee should be asked to disclose pending or threatened license or drug registration restrictions, disciplinary actions, and investigations in the employer’s state and in any other state in which the candidate holds or has applied for a license. The same is true for any pending or threatened proceeding or investigation by any hospital, insurance company, or professional society. (Leave it to the credentials committees of the hospitals to uncover any National Practitioner Data Bank or licensing board issues.) Employers should also ask about prior convictions, and whether the candidate holds a valid and active driver’s license and has automobile insurance.

A harmonious professional working relationship is the most effective means of resolving misunderstandings before they become disputes and then litigation. All of the owners, if feasible, should meet and size up the prospective employee before an offer is extended. Partners should seek consensus on an offer of employment.

**Action Step**  Employers should perform “due diligence” on the employee before making an offer of employment.

**Mistake 3  Not Fully Considering Allocation of Off-Hours and On-Call Duty**
The employee will expect on-call responsibilities to be shared “equally.” But equal allocation of on-call duties may defeat the purpose of recruitment. Physicians should consider that the senior or hiring partner may be responsible for producing most of the business in the office. That partner may also be devoting time to managing the office or perhaps be at a stage in life when there is a professional need to be relieved of such burdens. Employers should consider these factors before agreeing to share call on an “equal” basis.
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**Action Step**  
In allocating on-call duties within the practice, consideration of other practice responsibilities should not be overlooked. The contract can indicate that these responsibilities will be allocated “equitably” (as opposed to “equally”) at the discretion of the employer.

**Mistake 4  Making Vague Bonus Compensation Offers**  
A productivity bonus can be an incentive to an employee while benefiting the practice. A bonus formula that is vague, however (e.g., “Bonuses may be granted at the sole discretion of the Employer”) will make bonuses seem illusory. Essentially, a bonus program is a form of profit sharing, reflecting a “win-win” scenario. A bonus should therefore be based on achieving specific revenue goals, with financial criteria (e.g., net revenue, gross revenue, expenses, and revenue attributable to the employee) clearly defined. A bonus award also implies loyalty and commitment to the practice. Typically, this is expressed as a condition that the employee be employed in the practice through the end of the fiscal year in order to be eligible for a bonus. Distinctions can be made between termination with or without cause in this context.

**Action Step**  
Employers should consult their financial adviser for guidance on developing a bonus formula. Their attorney can then draft the precise bonus language.

**Mistake 5  Failing to Take into Account Fringe Benefits in Compensation**  
How often is it heard that a friend or relative took a job “for the benefits alone”? Considering the range of benefits offered by many companies—vacation, paid office holidays, personal leave, sick/disability leave, auto allowance, medical, dental, life, disability insurance, retirement, deferred-income or profit-sharing plans, parking space, uniforms, continuing education, professional journals and book allowance, tuition reimbursement, professional liability, incentive bonus programs, relocation allowance, etc.—benefits are indeed a powerful incentive. At the same time, benefits programs add significantly to overhead. Many have specific eligibility requirements. And some of these (e.g., health insurance, 401(k) plans) are regulated by federal law. Employers should factor in these costs in order to “back in” to the base salary. Alternatively, the contract can set forth the lump-sum salary figure, but then specify that this amount will be subject to deductions for certain benefits (e.g., health insurance, malpractice insurance, professional dues) elected by the employee.

**Action Step**  
Employers should view base salary as only one part of the overall compensation package; the other aspects relate to employee benefits. Benefits programs, like health insurance, may be sensitive to economic factors, though, and the contract should therefore make clear that benefits programs may be modified or withdrawn at the sole discretion of the employer.
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Mistake 6  Promising Partnership
Not every physician aspires to own or be a partner in a practice, and indeed partnership is not always a desirable goal in every circumstance, but physicians who consider practice ownership a primary career objective want reassurance that partnership is not illusory. Nonetheless, employers should avoid promising or guaranteeing partnership at least until the employee has had an opportunity to prove himself or herself. And only after the employer decides to offer partnership should financial terms be spelled out. Federal and state laws prohibit denial of partnership based on race, religion, sex, age, etc., and employers should base the partnership decision strictly on professional and business considerations.

Action Step  In the contract, the employer should be willing to consider in good faith whether to offer partnership and to reach a decision after an agreeable period of time. The employment contract should state specifically that this understanding is not to constitute or be construed as an offer or promise of partnership.

Mistake 7  Creating Overly Aggressive Postemployment Restrictive Covenants
To some extent, creating overly aggressive postemployment restrictive covenants may be the biggest mistake employers make: reasoning that a more severe restrictive covenant is better. In fact something closer to the opposite is true: The more reasonable the restriction, the better. “Restrictive covenants” is a general term that includes agreements not to compete against the employer, not to divert patients from the employer’s practice, and not to interfere in the employer’s relationships with other employees. A somewhat separate category of restrictions relates to nondisclosure of information considered confidential and proprietary to the practice. Understandably, an employer that has invested heavily in building a practice will impulsively try to impose punitive restrictions, thinking these will be more effective in preventing competition. And yet, employers should know that courts dislike restrictive covenants, the American Medical Association dislikes them, and most significantly, patients dislike them. A court will nonetheless enforce a restrictive covenant that it finds reasonable and not unduly harsh or burdensome to the employee in terms of the scope, time, or territorial extent of the restriction. An ideal and enforceable restriction would have the effect of making it inconvenient, but not impossible, for patients to continue to see the departing doctor. It helps to have the employee acknowledge the reasonableness of the restriction and to acknowledge that he or she has had an opportunity to consult counsel regarding the covenants.

Action Step  The covenants should restrict only to the extent reasonably necessary to protect the integrity of the practice. In formulating restrictive covenants, attorneys often have in mind that the covenant language will be dissected at some point by lawyers and judges. This subject may well be the most litigated issue in physician employment relationships. A well-crafted restrictive covenant will stand up in court and, more helpfully, deter the employee from violating it in the first place.
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Mistake 8  **Failing to Include a Broad Array of Termination Provisions in the Contract**

Employment ends either when the contract expires as of a certain date or is terminated by either party. Many contracts contain automatic renewal clauses so that an agreement continues in effect after the stated period of employment ends, unless either party indicates otherwise in advance of that date (usually no less than 30 days).

Termination of employment is a different matter. State courts to varying degrees follow the “at will” doctrine of jurisprudence, meaning that the employer can terminate employment at any time for any reason (except for an illegal reason, such as discrimination). Typical at-will terminations tend to be based on general dissatisfaction with performance or layoff for economic reasons. Termination of employment at will is an important management prerogative. To make it more palatable, employers can agree to a notice period before the effective date of termination. Typical notice periods are 30, 60, or 90 days, depending on business volume and staffing considerations. Grounds for termination “for cause” should include, at a minimum, loss of medical license or drug registration; loss of hospital privileges; decredentialing by Medicare, Medicaid, or any insurance company; disciplinary action or sanction by a licensing body or professional society; failure to achieve specialty board certification; conviction of a felony; absenteeism; insubordination; substance abuse; material breach of the employment contract; bankruptcy and, of course, death, and disability.

**Action Step**  The contract should include a broad array of grounds for termination with cause, and should also reserve the employer’s right to terminate employment without cause, the “at-will” termination.

Mistake 9  **Failing to Address Outside Activities in the Contract**

Full-time employees are generally expected to devote substantially full time and attention during regular business hours or on-call periods to the practice. Certain outside activities, such as charitable pursuits, professional societies, or medical staff leadership, can certainly enhance a practice. On the other hand, outside activities or second, “moonlighting,” jobs, may also impair performance or bring unwanted publicity to the practice.

**Action Step**  The employment contract should specify that the employee must devote full attention to his or her duties for the employer during regular working hours and while on-call (or, as circumstances may dictate, even when not on call), and that outside activities (e.g., investments, community activities, charitable work, certain professional activities) will be permitted, and noncompetitive income retained by the employee, so long as they are not competitive with the practice and do not adversely affect performance of duties or harm the reputation of the practice. The contract should nonetheless also state that the employee takes
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full responsibility for such activities, and that prior notice to the employer is required before outside engagements are accepted to allow the employer to consider the possible impact on the practice.

Mistake 10  Failing to Address in the Contract the Issue of Trial by Jury
Juries tend to root for the underdog. That’s just an unscientific observation. But if juries were perceived as truly neutral, why is it that plaintiffs’ lawyers routinely demand a jury when suing an employer? Actually, there is, in fact, a great deal of science and psychology behind a plaintiff’s preference, and a defendant’s reluctance, to have a case heard by a jury. Suffice it to say that it is based largely on substantiation of the foregoing perception, that juries are indeed inclined to sympathize with plaintiff employees. Employers can neutralize this “advantage” in the event of a lawsuit by mandating in the contract that lawsuits arising out of the employment relationship be heard by a judge alone and not by a jury.

A brief digression here. Another option for employers (and employees) is to require that all disputes be settled by arbitration. Arbitration (and its less uptight cousin, mediation) is a relatively quick, inexpensive, and private way to resolve disputes. But while arbitration is encouraged and endorsed by the courts, Congress, and the state legislatures, it is not always the last word in resolving disputes, and depending on the nature of the claim (e.g., claims based on discrimination), arbitration agreements may not always be enforceable.

As far as “biggest mistakes” are concerned, though, employers should generally keep employment disputes out of the hands of a jury, where inattentiveness, ignorance, and personal prejudice are rampant. There is no guarantee that a single judge will be any less inattentive or close-minded than any jury member. And there is the view that jury panelists apply collective wisdom and common sense to deciding matters that a judge deciding alone cannot. In litigation, however, juries represent a tactical advantage for a plaintiff employee that an employer can prevent by means of a carefully drafted jury waiver.

Action Step  The employment contract should include a specific waiver by the employee of any right to a trial before a jury and an agreement that all disputes resulting in a lawsuit shall be tried before a judge alone (or an arbitrator). The employee should also acknowledge in the contract that he or she was given the opportunity to ask questions and consult with his or her own counsel regarding the waiver.

Conclusion  Employers generally dictate the terms of employment. A carefully drafted employment agreement will help employer physicians avoid mistakes when contracting with employee physicians.
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6.4 The 10 Biggest Legal Mistakes Physicians Make When Negotiating Contracts
By Marc D. Goldstone, Esq.

Executive Summary
At its most basic construction, a contract consists merely of a mutual agreement between two or more parties and consideration paid for the services performed or goods delivered. In many cases, a bare document simply reciting the nature of the agreement and compensation may be enough to “get the job done.” Unfortunately, contract drafting is a complex art, and the reality is that contracts exist not to marshal the “easy deals,” but rather to define the rights and responsibilities of the parties when the deal is not so “easy.” Contract law takes into account not only what is contained in the document, but also what the document does not contain. For these reasons, it is important to be careful in negotiating and documenting the terms of any contractual agreement. Some physicians feel that the majority of contracts can be negotiated by laypersons, such as their office managers. However, it takes only one poorly worded agreement causing a physician to incur thousands of dollars in unnecessary legal fees to convince that physician otherwise.

Mistake 1 Not Getting an Attorney Involved Early Enough and Failing to Completely Disclose After Doing So
Some physicians choose to consult counsel only when a problem arises in the performance of contractual duties. That’s like calling the building inspector after the house has fallen down. A good contract is built on a strong legal foundation that protects the physician’s interests and furthers his or her intent in entering into the contract. Without that foundation, no matter what the representations of the other parties to the contract, it can be very difficult (and expensive) to force each party to live up to what the physician believes their respective duties to be; and, in some cases, the physician may be denied the benefit of the contract entirely. In the long run, it is much less expensive (in terms both of dollars and aggravation) for physicians to have their counsel review proposed contractual arrangements, and to comment on the written
documents memorializing them, than it is to call their attorney when they are not paid money
they believe they are owed or do not receive goods or services that were paid for.

After physicians retain an attorney, it never pays to withhold relevant information from the
lawyer who is negotiating or drafting a contract on the physician’s behalf. A contract may not
be effective to protect a physician against conditions that he or she knew of, yet remained
silent regarding, even if an attorney drafted the contract document. Physicians should be
honest and forthcoming with their counsel, and not waste money by having the attorney
negotiate or draft documents in ignorance of all of the facts.

**Action Step** Physicians should cultivate a relationship with an experienced health care
attorney. They should be upfront and open regarding their expectations of service and costs.
In addition, physicians should use their attorney to help them negotiate and document
equitable contracts before entering into any deals with their contracting partners. In addition,
physicians should make sure that their attorney knows everything they know about the deal
before the attorney takes substantial action to negotiate the deal. When a physician receives
new information about the deal, he or she should get it to the attorney as soon as possible.
Physicians should not withhold anything from their lawyer; they do “need to know.”

**Mistake 2** **Not Using the Correct Business Entity**
Physicians enter into many types of contracts during their professional lives. Managed care
contracts, employment contracts, real estate contracts, and professional service contracts are
but a few types of the contracts that a typical physician will execute over the years. It is
important to remember that each state offers several types of individual, partnership, and
corporate entities within which to do business. Often, business entities of one type will not be
permitted to do the same sorts of business or enter into the same sorts of contracts as business
entities of another type. In the same vein, two business entities may legally be permitted to
enter into the same types of contracts, but the physician might materially be better situated (at
little or no additional cost) by positioning the contract with one type of business entity rather
than the other (e.g., sole proprietorship versus limited liability company). Finding out after
the fact that an LLC was not permitted to enter into the contract that it did (or to engage in the
business that the contract requires) may bring not only financial liability, but, in some cases,
sanctions against the contracting physician’s license. A physician’s counsel and financial
advisers, working together, can help the physician to understand which types of business
entities work best in the contractual relationships he or she wishes to enter.

**Action Step** Physicians should seek the advice of counsel and financial adviser as to the
most appropriate type of business entity to use before starting negotiations. The type of entity
chosen may dictate how negotiations are conducted.
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Mistake 3  **Not Including Antifraud and Abuse Provisions in All Contracts**
Given the federal government’s recent pronouncements that, for the first time, a majority of cases involving enforcement of the False Claims Act concern health care fraud, all physicians should do what they can to avoid fraud and abuse liability in contractual relationships. Whether discussing the antikickback statute, the False Claims Act, state insurance laws, or other provisions, is it relatively inexpensive to review contracts for compliance with applicable fraud and abuse provisions and to insert appropriately drafted antifraud and abuse provisions into the agreements. With such explicit antifraud and abuse provisions, compliant physicians will have a good defense to claims that they were involved in a “fraud and abuse conspiracy” with another party to the contract; especially where the other party was not compliant. For example, merely stating that a transaction reflects “fair market value” when it does not isn’t an effective way to protect the contracting physician from fraud and abuse liability. Attaching documentation to the contract reflecting the due diligence by which fair market value was arrived at is a good way of forestalling such liability.

**Action Step**  Physicians should operate a compliant physician practice and make sure that their counsel and compliance officer are satisfied with each contract’s antifraud and abuse provisions before signing an agreement.

Mistake 4  **Not Including HIPAA Provisions in All Contracts**
Implementation of the Health Insurance Portability and Accountability Act (HIPAA) and its associated regulations has raised the public’s awareness of medical information privacy and security issues. When a contract creates a HIPAA “business associate relationship,” it is vital for the covered entity physician to insert business associate agreement language in the contract. When a contract does not create such a relationship, but when the disclosure of protected health information is possible within the contractual relationship, the contract should contain such confidentiality, security, and indemnification provisions as necessary to adequately protect the physician from HIPAA liability.

**Action Step**  Physicians should operate an effective HIPAA privacy and security plan, and make sure that their counsel and privacy and security officer are satisfied with each contract’s business associate agreement/confidentiality provisions before signing the agreement.

Mistake 5  **Relying on “Whereas” Clauses If Not Incorporated**
On the front page of most contracts are a series of clauses that start with the term “Whereas.” These clauses often set forth the basis on which the contractual agreement has been negotiated. However, even though these clauses are physically part of the contract document, they are not part of the contract itself unless they are expressly “incorporated” into the contract. For example, an incorporation provision looks something like this: “Whereas Clauses: The Whereas Clauses preceding this document are hereby incorporated and made a part of this document by reference.” If physicians want the “Whereas” clauses to be part of
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their contract, they have to make sure that the contract expressly includes them. If they aren’t made part of the contract, they are most likely unenforceable.

**Action Step** Physicians should make sure that their counsel negotiates incorporation of the “Whereas” clauses into their contracts, as appropriate.

**Mistake 6 Believing Less Is More**
Many physicians believe that the shorter a contract is, the less “trouble” it can get them into. The reverse is actually true. Voluminous contracts are long because they reflect myriad prior court cases, each of which created an “exception” or other judge-made rule that must be complied with in later contracts. To avoid being ruled by these judge-made exceptions (which may run completely counter to one’s intentions), it is best for physicians to expressly set forth expectations regarding as many eventualities as possible in writing. Otherwise, if litigation results from the contract, a judge will have to insert his or her discretion where the physician’s express provision could have been placed, but was not.

**Action Step** Physicians should not insist on “short and sweet” contracts against the advice of counsel. A physician should allow the attorneys to do their job, and make the contracts as long as they need to be to adequately protect the physician, within the bounds of their negotiating ability.

**Mistake 7 Not Including Choice of Law and Choice of Forum Clauses**
Sometimes contracts must be litigated. Where and how they are litigated is often the choice of the first person to get to the courthouse. In a large state (or in multistate or federal matters), that choice can significantly disadvantage the other party, who may have to travel for hours to get to court, and, even worse, have to pay their attorneys for hours of nonproductive travel time. A “choice of forum” clause can help prevent that result by setting forth the mutually agreed-upon location where disputes regarding the contract will be heard. Equally as important in multistate agreements is a “choice of law” forum. A physician in state A may conform his or her contractual behavior to state A law only to find later that a court has decided that state B’s law applies to the contract. A “choice of law” clause sets forth, in advance of any dispute, which state’s law controls.

**Action Step** Physicians should insist on negotiating an appropriate choice of forum and choice of law clause in each and every contract they sign.

**Mistake 8 Relying on Boilerplate Forms and Leaving Blanks**
Some physicians use preprinted “boilerplate” forms to document their contractual relationships. In some cases, use of such a form may not be a problem; in most cases, the “generic” nature of the forms is simply a lawsuit waiting to happen. Worse yet, some physicians use the boilerplate forms and fail to “fill in the blanks” that must be completed to
make the documents effective. If a boilerplate form does not include enough terms to govern a dispute, or contains blank lines, then a judge will have to use his or her discretion to decide what the rights of the parties are. Physicians should protect themselves by having qualified counsel draft their contract documents.

**Action Step** Physicians should forego the use of boilerplate agreements and have their counsel draft their contractual agreements.

**Mistake 9  Not Identifying Upfront the Intent of the Parties**
The intent of the parties in negotiating the agreement is one of the single most important items of information used by courts when adjudicating contract disputes. However, in most cases, the parties must try to prove their intentions “after the fact.” Drafting a simple “intent of the parties” clause and inserting it into the written contract can help ensure that the court interprets the contract as the parties envisioned when they negotiated the agreement. For example, a triple net real estate contract intent clause might read:

Intent of the Parties: The parties intend this contract to provide net cash flow to the landlord in the amount of $10/square foot leased, per year. All other costs of operating the premises are to be paid by the tenant as additional rent. In the event that unforeseen circumstances cause extraordinary costs in operating the premises, the parties intend that such extraordinary costs NOT conflict with the landlord’s right to collect $10/square foot, net income, each year, from the tenant.

**Action Step** Physicians should include an appropriately worded intent clause in every contract they sign.

**Mistake 10  Not Including a Termination Without Cause Provision in New Contracts**
All new contractual relationships should permit the parties to go their separate ways after a trial period. When the parties do not know each other and are not sure that the relationship will work out, the physician should be able to terminate the contract without cause, upon specified notice (usually 60 or 90 days), without damages. Physicians should beware of any negotiation in which the other party resists such a provision. A counterproposal may be to provide for liquidated payments in the event of such a termination, so as to make the parties whole for monies spent in operationalizing the contract, rather than excluding a termination without cause provision. However, there are few things worse than being forced to engage in business with a party that is loathed. All new contracts (and renewals, if possible) should include a termination without cause provision, if possible.

**Action Step** Physicians should include a termination without cause provision in all new contracts, and, wherever possible, in all renewal contracts.
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Conclusion
Contract negotiation and drafting are specialized skills. Just as physicians would not expect an automobile mechanic to perform orthopedic surgery, wise physicians should not expect to be able to negotiate and draft contracts that provide them with the maximum benefits and protection available under the law. Physicians should retain experienced health care counsel to help them negotiate and draft the best contracts possible, and to avoid unnecessary litigation and headaches in the future.

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6.5 The 10 Biggest Legal Mistakes Physicians Make in Negotiating Contracts for In-Office Ancillary Services
By Thomas J. Onusko, Esq.

Executive Summary
In light of the financial challenges facing physicians in the operation of their practices, including reduced reimbursement levels and soaring medical malpractice premiums, physicians are turning to alternative sources of revenue to supplement their incomes. One such alternative is the offering of ancillary services in their offices. However, physicians often lack the expertise to develop and operate such ancillary services on their own, are reluctant to invest the resources that it takes to acquire the necessary equipment and technical support staff, or both.

To meet this need, suppliers of ancillary equipment and services are proposing contractual arrangements to physicians to offer various types of ancillary services in their office with relatively little financial risk to the physicians. While this can be a successful strategy for physicians to augment their practice income, physicians often make easily avoidable mistakes
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when entering into such arrangements that can result in significant financial and legal risks for the physicians.

Mistake 1  **Agreeing to a Deal That Sounds Too Good to Be True**
The old maxim, “If a deal sounds too good to be true, it probably is,” often applies to physicians who contract with outside vendors for in-office ancillary services. Vendor representatives have become very aggressive in marketing “turnkey” arrangements to physicians, whereby the vendor promises to provide all the services and equipment necessary to operate the ancillary service, with little or no financial investment or other effort required on the part of the physician. The terms of any such “sweetheart” deal must be carefully reviewed, since the fine print of the contract drafted by the vendor’s attorney often contains onerous provisions that place an undue burden on the physician.

In addition, these types of arrangements have drawn close scrutiny from government enforcement entities, particularly the Office of Inspector General (OIG), which issued a special bulletin on the matter, *Contractual Joint Ventures*, in April 2003. In the bulletin, the OIG expressed concern over the proliferation of these types of “questionable” arrangements and characterized as “problematic” arrangements that exhibit the following elements:

- A physician is expanding to a related line of business that is dependent on referrals from the physician and primarily serves the physician’s existing patient base.
- The physician neither operates the new service himself or herself, nor commits substantial financial or human resources to the venture, but instead contracts out substantially all of the operations to an outside entity in an exclusive arrangement that includes noncompetition provisions.
- The vendor is an established provider of the same service as the physician’s new line of business, and absent the contractual arrangement, would be a competitor for the new line of business.
- The physician and the vendor share the economic benefit of the new business; and the aggregate payments to the vendor depend on the volume or value of business generated for the new service by the physician.

**Action Step**  Although it may be counterintuitive, physicians should avoid entering into arrangements that are too favorable to them in light of the criteria outlined in the OIG’s bulletin. Physicians should enter only arrangements that involve a reasonable amount of financial risk and effort on their part.

Mistake 2  **Selecting the Wrong Vendor**
When approached by a vendor’s marketing representative, physicians often like what they hear and rush to sign a contract, not realizing that there are often other alternative vendors available for any given ancillary service. This presents an opportunity for physicians to send out a request for proposal to different vendors and consider competing offers from them.
before signing a contract. The financial terms of, and legal risks presented by, such arrangements can vary greatly from vendor to vendor.

**Action Step**  
Physicians should not accept the first proposal they hear, but instead should research what other vendors are available and send out requests for proposals. Background checks should be done on any proposed vendor to determine the satisfaction rate of other physicians doing business with that vendor, the vendor’s success rate, and whether the vendor or any of its shareholders or officers have ever been investigated or convicted for a Medicare or Medicaid fraud violation. Physicians should also consider alternative sources for such services, including management companies, local hospitals, and other physician groups in their area.

**Mistake 3  Failing to Qualify for Protection Under an Antikickback Safe Harbor**  
The antikickback statute prohibits the payment or receipt of any remuneration in return for the referral of an item or a service to be reimbursed under the Medicare and Medicaid programs. Violations are punishable by monetary penalties of up to $15,000 per violation, exclusion from the Medicare and Medicaid programs, and jail terms of up to five years. In light of the OIG’s bulletin, it is clear that the OIG views contractual joint ventures for ancillary services as a potential violation of this law. However, an arrangement can be structured to fit under applicable safe harbors for personal service contracts and leases.

**Action Step**  
Any contract with an outside vendor for an in-office ancillary service should avoid the problematic provisions described in the OIG’s bulletin. The parties should structure the contract to meet the applicable safe harbors under the antikickback statute, which require: a written contract with a term of at least one year; fixed compensation that is set in advance and does not take into account the volume or value of referrals (i.e., per use and percentage of revenue arrangements should be avoided); and the compensation paid should reflect the fair market value of services actually rendered.

**Mistake 4  Failing to Qualify for Protection Under a Stark Exception**  
The Stark law prohibits a physician from making a referral for a designated health service to an entity with whom the physician, or an immediate family member, has a financial relationship. Violations are punishable by monetary penalties of up to $25,000 per violation, denial of reimbursement, and exclusion from the Medicare and Medicaid programs. The offering of an in-office ancillary service by a physician presents potential Stark issues to the extent that the physician is ordering a service from himself or herself, and to the extent the physician would be making a referral to the vendor with whom the physician has the contract to provide such services.

The Stark law defines “designated health service” to include the following services often offered by physicians in their offices: clinical laboratory; physical therapy; occupational
therapy; radiology and other diagnostic imaging; radiation therapy; durable medical equipment; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services; and outpatient prescription drugs. If a proposed in-office ancillary service does not involve any of these designated health services, the Stark law does not apply. However, if a designated health service is involved, the arrangement will have to be structured so as to qualify for protection under one of the Stark exceptions.

There is a Stark exception for in-office ancillary services referred by the same physician or another physician in the same group practice as the referring physician. To qualify for this exception, the ancillary service must be provided or supervised by the referring physician or another physician in the same group practice; offered in the same building in which the physician, or another member of the same group practice, offers physician services; and billed by the physician or the physician’s group practice.

Any contract with an outside vendor must be structured to meet the applicable personal service contract and lease exceptions, which contain substantially the same requirements as the corresponding safe harbors described in Mistake 3, except that the Stark exceptions specifically permit per use, per unit of time, and/or percentage of revenue compensation, so long as the level of same reflects fair market value and is not dependent on the value or volume of referrals between the parties.

**Action Step** The offering of any in-office ancillary service that involves a designated health service should be structured in a way that meets the Stark in-office ancillary service exception. The contract with the vendor should be structured to meet the applicable Stark personal service contract, lease exceptions, or both.

**Mistake 5 Agreeing to an Excessive Management Fee**
Many vendors often propose excessive management fees, including both a base fee and a percentage of the revenue generated from the ancillary service. Paying an excessive management fee can have not only an adverse financial effect on the physician, but can also aggravate the antikickback and Stark issues presented by the arrangement.

**Action Step** Physicians should negotiate the management fees proposed by the vendor to a reasonable level and try to avoid any fees based on a percentage of revenue. Fees should be limited to the fair market value of the services actually provided by the vendor. Fee quotes should be obtained from one or more alternative vendors.

**Mistake 6 Failing to Check Terms of Office Lease for Restrictions on Offering of Ancillary Services**
Many office leases, particularly those involving space in a medical office building located on a hospital campus, contain restrictions on the ability of physician tenants to offer ancillary
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services in their office. Breach of such a provision could result in a financial penalty being imposed on the physician, an eviction action, and/or injunction preventing the offering of the ancillary service.

Action Step Before entering into any contract with a vendor for the offering of an in-office ancillary service, physicians should review the terms of their office lease carefully and obtain any required consent from their landlord in advance.

Mistake 7 Agreeing to Overly Restrictive Covenants
Most vendors propose clauses in their contracts that give them the exclusive right to provide the ancillary service for the physician, but prohibit the physician from offering a competing ancillary service. The presence of such a clause is one of the factors identified in the OIG bulletin that may give rise to a fraud and abuse violation. These clauses often extend for years beyond the termination of the contract, even if the contract is terminated through no fault of the physician, and leave the vendor free to provide services in competition with those provided by the physician.

Action Step Restrictive covenants should be avoided if at all possible. If they are unavoidable, they should be reasonable in terms of time and geographic area, and they should be mutual (i.e., the vendor should also be prohibited from providing services to a competitor of the physician). Such clauses either should not extend beyond the termination of the contract or should not apply if the contract is terminated for cause by the physician or without cause by the vendor.

Mistake 8 Failing to Require the Vendor to Have Adequate Insurance
While most vendors require that the physician maintain a certain level of insurance for professional and general liability, the typical contract a vendor proposes does not contain any corresponding insurance obligation on the part of the vendor. If the vendor will play an active role in providing the in-office ancillary service, either through its employees or subcontractors, or through equipment it acquires, the vendor’s breach of any applicable standard of care could expose the physician to liability.

Action Step Physicians should insist on contractual provisions requiring the vendor to maintain adequate levels of insurance and to provide them with certificates of insurance evidencing that they have done so.

Mistake 9 Failing to Provide Required Level of Physician Supervision
In their enthusiasm to sell their products and services, a vendor’s representatives often promise physicians that the ancillary service will be offered in the physicians’ office with little or no effort required on the part of the physicians. However, Medicare reimbursement rules often require a certain level of physician supervision over in-office ancillary services as
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a condition of the physician being able to bill Medicare for such services. Depending on the service involved, the level of physician supervision required can range from setting appropriate clinical standards and being available for consults, to availability in the office at the time the services are being rendered, all the way to physical presence while the service is actually performed.

**Action Step** Physicians should not rely on the representations of vendor sales representatives, but should check for themselves the applicable Medicare regulations before entering into an arrangement so that they can determine what level of physician supervision will be required on their part in order to offer the ancillary service in question.

**Mistake 10 Committing to Long-Term Contracts**
Vendors typically want physicians to enter into contracts that obligate the physicians to them for many years and often leave the vendors with the right to terminate the contract if certain volume levels are not achieved, or if the vendors simply decide they want out of the deal.

**Action Step** Contract terms should be limited to one or two years and the physician should retain the right to terminate the contract if the vendor fails to perform or if the physician reasonably determines that continuation of the contract is no longer in his or her financial best interest.

**Conclusion**
While the addition of in-office ancillary services can be a successful strategy for enhancing practice income, physicians entering into contracts for such services should be mindful of the issues involved and consult with experienced legal counsel to avoid these common mistakes and the adverse financial and legal consequences they entail.

**Additional Resources**

**About the Author**
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EXECUTIVE SUMMARY
For their first job after residency, physicians will almost certainly join an existing practice group, which will ask them to sign an employment contract. The provisions of that contract, and the exact language in which it is expressed, will control their obligations, responsibilities, and rights in their new job, as well as their employer’s obligations and responsibilities to them. Many new physicians make the fundamental mistake of thinking they can negotiate and review the employment contract on their own, without the assistance of an experienced lawyer to help them both understand the significance of the document they are presented with and negotiate any necessary changes.

MISTAKE 1  NOT CONSULTING LEGAL COUNSEL
Physicians are highly intelligent people who are used to making critically important decisions. Thus, it is often difficult for them to admit that they may need help in looking out for their own and their family’s interests as they enter into a legally binding agreement that may affect their professional and personal life for many years to come. A lawyer who is experienced with physician contracts knows the pitfalls, the loopholes, and the special legal meaning that courts or legislation has given to what seems to the layperson to be ordinary English words. Such a lawyer is trained to spot ambiguities and knows what contract terms should be there but are not. Just as physicians would not rely on lawyers to diagnose an ailment, they should not rely on their own ability to review or draft an important contract.

ACTION STEP  Physicians should find a lawyer who has experience with physician contracts early in their job search process, so that when they get to the point of putting things in writing with a specific employer, they will be able to move quickly.

MISTAKE 2  FAILING TO ASK QUESTIONS AND RESEARCH THE PROSPECTIVE EMPLOYER AND EMPLOYMENT SITUATION
A lot is happening when physicians are looking for their first professional position: They are finishing a residency, taking the boards, and trying to decide where they may be spending the rest of their life. It is natural in such circumstances to focus on what the job promises, where
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it is located, and how much it pays—and easy to overlook the fact that they should be spending just as much effort in checking out a potential employer’s “credentials” as the employer is in checking out theirs. Physicians should remember that what employers have done in the past may be a far better predictor of what to expect from them than any promises they make.

Physicians should ask a lot of questions about the proposed job: What would the duties be, including nonpatient care duties? When would the physician be expected to take call, and what would that involve? How are call duties determined and assigned? If pay is based partly on productivity, how would that be measured? How are patients assigned? Would the physician be replacing someone who has left the practice? (If so, the physician should try to get that person’s name and ask why he or she left. Then the physician should follow up with a call to that person to hear what he or she has to say.)

Physicians should find out everything they can about what the practice is truly like. How much physician and support staff turnover has there been? How profitable is the practice? Does the practice have or will soon have heavy buy-out or deferred compensation obligations to retired partners? What is its malpractice history? Are there any lawsuits pending against the practice? Are the physicians trained in proper documentation and billing? Does the practice have a commitment to regulatory compliance?

In meeting other physicians in the practice, a physician should find out how long they have been there, what the patients are like, how physician extenders are used, how often the physicians are on call, what the volume of work is, and anything else he or she can think of that will affect day-to-day life in the practice. They should be sensitive to the “feel” of the place. Do the doctors and staff seem happy or tense? What is the reputation in the community of the physicians in the practice?

**Action Step** Physicians should find out everything they can about a practice as soon as they start to consider employment there.

**Mistake 3 Waiting Too Long to Consult Legal Counsel**

The time for physicians to consult a lawyer is before they have agreed to anything in writing, in any form. This includes a bulleted list of employment terms or the letter of intent that they are asked to cosign or otherwise agree to (such as by sending a letter back accepting the terms). Saying that he or she would like to think about such an informal proposal for a couple of days and get back to the potential employer gives the physician an opportunity—before the basic deal is finalized—to consult a lawyer and then to raise points that he or she may have overlooked. When the physician has decided to accept a job and has received a proposed employment agreement, the physician should send a copy of that agreement to his or her lawyer without delay. Physicians who don’t have a lawyer should find one now.
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**Action Step** Physicians should consult with experienced counsel *before* they start to negotiate an employment contract.

**Mistake 4  Relying on Oral Promises Not Reflected in the Written Contract**
It is not uncommon in employment situations for various matters to be discussed that do not end up in the written employment agreement. For example, a physician may have been told that he or she will have to take weekend call one weekend per month, but the contract states: “Physician’s professional obligations shall include night and weekend call in accordance with the rotation established by the practice.” Or the physician was told that all employed physicians receive an annual cost-of-living increase, but the contract is silent on that point. Since it is the written contract that controls, if the number of call obligations or the cost-of-living adjustment is important to the physician, these matters should be clarified as precisely as possible in the agreement.

**Action Step** Physicians should make sure that all oral promises that they are relying on are clearly reflected in the written employment agreement.

**Mistake 5  Overlooking Fuzzy Contract Language**
Having to read something twice in a contract to figure out what it means may be a good indication that the language is ambiguous. Even if it seems clear, there may be another way to read a provision that can lead to difficulties. Physicians don’t want to be in a position in which they think they are obligated to do one thing but their boss thinks they have promised to do something else, or in which their view of their time commitments is different from that of their boss. This is an area in which a lawyer’s counsel is needed, since lawyers are trained to be sensitive to possible alternative meanings in language.

New physicians often get into trouble by paying insufficient attention to the term of the contract (i.e., the number of years it will run), the conditions for its renewal, and how and when it can be terminated. They do not want to be locked into a long-term contract with no provision for salary increases and promotion, and no way to get out of it. Nor do they want to be fired under a clause that allows the employer to terminate without cause on 30 days of notice, when they thought they had a two-year commitment and were expecting to be at that job for the full two years.

**Action Step** Physicians should make sure that the terms of the contract are both clear and something they can live with before they sign it.

**Mistake 6  Not Paying Attention to Covenants Not to Compete**
Historically, many physician employment contracts have contained promises stating that if the newly hired doctor leaves the practice, he or she will not compete with the former employer by practicing medicine within a specified geographic area for a particular period of
time. In 2004, the federal government adopted regulations that make such restrictions impermissible in situations in which a hospital (or other entity from which the physician may order ancillary services) provides an income guarantee or other financial incentive in order to attract the physician to practice in its community. Under these regulations, if a physician agrees to such a contractual provision and then admits a Medicare patient to the hospital or orders lab tests, x-rays, or other services from it, the physician (as well as the hospital) will be in violation of the Stark anti-referral law.

When there is no such income guarantee or hospital financial incentive involved, a physician still needs to be wary of these noncompetition clauses, since they can prevent the physician from making a living in the community if his or her employment ends for any reason. In other words, physicians who leave their current employer, voluntarily or involuntarily, and try to set up a new practice on their own or to join another practice can be sued by their former employer to prevent them from doing so. These physicians would be much better off negotiating, before the employment agreement is signed, a reasonable noncompetition clause they can live with. A lawyer will know whether their state’s law permits such covenants not to compete, or (in the majority of states where they are permitted) what noncompetes will be deemed reasonable and thus enforceable by the courts.

**Action Step** Physicians should review the language and implications of any noncompetition clause with their lawyer before signing the agreement, and do their best to negotiate something they can live with if they leave the new job for any reason.

**Mistake 7 Failing to Understand the Full Implications of Malpractice Insurance Provisions**

In these days of rising malpractice insurance costs, physicians need to make sure that the employment agreement states clearly the employer’s obligation to provide malpractice insurance for them, at the employer’s expense. The contract should specify the amount of insurance to be provided, and it should be adequate both to protect a physician’s personal resources and to meet any applicable requirements of state law. If the law in the state where the physician will be practicing requires an additional payment to a state reinsurance fund or similar entity, the employer’s obligation to pay that should be specified as well. A lawyer can advise the physician on other key issues relating to malpractice insurance, such as scope of coverage and provisions on how a legal defense will be handled by the insurance company if the physician is sued.

**Action Step** Physicians should make sure the contract specifies that their employer will pay for their malpractice insurance.
**CONTRACTS: FIRST EMPLOYMENT CONTRACT**

**Mistake 8  Failing to Make Sure the Contract Specifies Terms and Conditions of Employment**

Physicians may neglect to make sure that their employment agreement specifically describes their actual conditions of employment: what they are expected to do, where and when they are expected to do it, and what human and other resources will be made available to help them. If possible, physicians should nail down these details before they discuss compensation, otherwise how will they be able to gauge whether they are being offered fair pay for their work?

**Action Step**  Physicians should reach agreement with their new employer about their specific duties and responsibilities before negotiating compensation issues. They should make sure that their duties and responsibilities are clearly spelled out in the employment agreement.

**Mistake 9  Signing a Contract Containing One-sided Termination Provisions**

A physician may have the best contract in the world, but if his or her employer can terminate it at will, it is not worth much. The time to make sure the contract is worth the paper it’s written on is before a physician packs up and moves to a new city. Physicians should look closely at what events can trigger a termination, including

- 90 days of notice by employer (or by either party)
- Loss of medical staff privileges
- Accusation of improper actions (e.g., fraudulent billing) by the any party
- Any event deemed by the employer to be detrimental to the employer
- “Material” breach of contract (a lawyer can explain what this means)
- Illness or disability

**Action Step**  Physicians should review the language and implications of the contract term and termination provisions with their lawyer, and make sure the terms and provisions are fair and reasonable. Vague provisions should be clarified. If the new employer will not agree to changes to achieve these results, a physician should seriously reconsider whether to accept the position.

**Mistake 10  Failing to Fully Understand Compensation and Bonus Terms**

The compensation of employed physicians is often based at least in part on a mathematical formula that takes into account such factors as number of patients seen, revenue the practice receives for those patients, new patients the physician employee attracts to the practice, and the practice’s profitability. If the physician’s income will be wholly or partly based on anything other than straight salary, it is up to the physician to make sure that he or she understands the formula and that it is fully and fairly set forth in the employment agreement (or in a separate document attached to the agreement as an exhibit and incorporated into it by reference).
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Physicians should be aware that the “physician incentive plan” or “bonus” provisions in many physician employment contracts are written to protect the employers and not the physician employee. Factors that may negatively affect the flexible portion of the physician’s compensation include the following:

- Provisions that allow the employer unilaterally to revise, or even cancel, the incentive plan
- The precise method by which the incentive portion of the physician’s compensation is calculated
- How key terms (e.g., positive net income, negative variance, percentage, gross revenue, etc.) are defined
- Whether compensation depends on factors controllable by the employer and outside the physician’s control (e.g., assignment of patients with inadequate insurance coverage to the physician; when a key element in the payment formula is actual dollars the practice receives for patients the physician sees; compensation based on net rather than gross income, which an employer can manipulate by paying the partners a higher salary so as to increase costs and thus reduce net revenue)
- How practice expenses are factored against practice revenue in making the calculation
- Conditions that must be met before the incentive plan goes into effect (e.g., practice site must meet certain net revenue or patient volume targets)

**Action Step** Physicians should review the proposed physician incentive plan carefully with a lawyer and seek necessary clarifications, so that they fully understand how it works. They should try to make sure that the part of the agreement describing the flexible portion of their compensation is clearly written and relies on objective measures that cannot be manipulated by the employer to affect the outcome.

**Conclusion**
To avoid being burned by their first employment contract, physicians should follow three basic rules: Know what they’re getting into, consult a knowledgeable attorney, and get the details down in writing, clearly stated.

**About the Author**
Jennifer A. Stiller, Esq., has concentrated her practice in health law since 1975. Now in solo private practice in suburban Philadelphia, she was for many years chair of the Healthcare Practice Group at Montgomery, McCracken, Walker & Rhoads LLP. In 1999, she was named one of the best lawyers in Philadelphia by *Philadelphia Magazine*. Stiller lectures frequently on health law topics, and has held leadership positions in the American Health Lawyers Association, the Pennsylvania Society of Healthcare Attorneys, and the American Bar
6.7 The 10 Biggest Legal Mistakes Physicians Make in Dealing with Noncompete Issues
By Holly B. Williams, Esq.

Executive Summary
Many employment agreements contain a “covenant not to compete” or a “noncompetition” or “noncompete” provision. These terms are often used interchangeably. Such a provision places conditions and restrictions on a physician’s practice following termination of the agreement. For example, a contract may specify that the physician cannot practice medicine within a 50-mile radius for one year after the termination of employment. This type of agreement is disfavored by the law and must be properly drafted to be enforceable. A physician employer should consult counsel to ensure that an agreement is enforceable and protects the employer’s legitimate business interests. A physician employee should pay careful attention to such provisions and not treat them as an afterthought in the negotiation of a broader employment agreement.

Mistake 1 Being Ignorant of the Law
Because a noncompete provision is a restraint of trade, it is generally disfavored by the law. The enforceability of noncompete provisions is governed by state law and varies widely from jurisdiction to jurisdiction. Although most jurisdictions impose at least some limitations on the enforceability of noncompete provisions, the unique nature of the physician-patient relationship has led some states to prohibit these types of provisions with respect to physicians; other states impose particular requirements, some of which are discussed in this section.

Action Step Physicians should consult with counsel, licensed and knowledgeable in the law of the jurisdiction where their practices are located.

Mistake 2 Treating the Noncompete As an Afterthought
Generally, when negotiating the terms of an employment contract, physician employees naturally focus on duties, compensation, and fringe benefits. At the time the contract is signed by both parties, goodwill exists, and employees tend not to think about the termination of the contract. Employers may insert noncompete provisions in the contract without negotiation or discussion, hoping the physician employee will accept the proposed terms. Months, or even
years, may go by before the contract terminates, at which time the physician employee is surprised to discover that there may be restrictions on his or her right to continue to practice.

**Action Step** In consultation with counsel, physicians should consider from the beginning the implications of a noncompete provision. If possible, it is generally in the physician employee’s interest not to accept such a provision.

**Mistake 3  Assuming the Noncompete Will Never Apply**
Physician employees who are aware of noncompete provisions in their contracts may assume that such provisions will never be triggered because employment will continue indefinitely. As time goes by, the physician employee may realize that continuation of the employment relationship is not in his or her best interest. The physician employee’s options will be greater in the absence of a noncompete provision or with the least restrictive provision possible.

**Action Step** If a noncompete provision is included in an employment agreement, physician employees should assume that the provision is valid and will be triggered by the termination of employment. Attention should be given at the negotiation stage to ensure that both parties’ interests are protected by the agreement.

**Mistake 4  Not Limiting the Trigger to Specific Circumstances**
Employers try to impose a noncompete provision that is triggered by termination of employment for any reason. There are circumstances when both parties will agree that termination is appropriate; however, in the scenario in which the employer fires the physician, the physician has no control over his or her employment situation and will need to take immediate steps to begin his or her own practice or seek other employment. Arguably, the employer’s interest in preserving its investment in the physician employee is preserved if the trigger is limited to circumstances under which the physician initiates termination of the contract. If the employer decides to discharge the physician, then the employer is obviously dissatisfied with the physician. Under these circumstances, the departing physician should not be constrained in his or her future employment opportunities.

**Action Step** The parties may desire to limit the circumstances under which a noncompete provision will apply following the termination of employment.

**Mistake 5  Failing to Exchange Adequate Consideration to Support the Agreement**
As with all contracts, a covenant not to compete must be supported by consideration. In some jurisdictions, the consideration given by the employer for a promise by the employee not to compete must specifically give rise to the employer’s interest in restraining the employee from competing, and the covenant must be designed to enforce the employee’s consideration or return promise. For example, if an employer gives an employee confidential and proprietary information or trade secrets in exchange for the employee’s promise not to
dispatch them, then the consideration given by the employer (the trade secrets) is related to and gives rise to the employer’s interest in restraining the employee from competing. Often, contracts recite that this consideration is exchanged, but in reality the employer has not provided adequate consideration to support the employee’s promise not to compete.

**Action Step** A physician employer should ensure that adequate consideration is exchanged to support the noncompete provision.

**Mistake 6** Having Unreasonable Restrictions on Time, Geographical Area, and Scope of Activity in the Agreement

To be enforceable, a noncompete provision must have a reasonable time, geographical area, and scope of activity. These limitations vary from jurisdiction to jurisdiction, and physicians are well advised to consult counsel who will be familiar with their particular jurisdictions. However, in general, restrictions longer than two years probably will not be enforceable. Similarly, most courts will not enforce a restriction over geographical area that is broader than the practice area. For example, a court is unlikely to restrict a physician from practicing anywhere within the state, when the employer’s practice is limited to a particular metropolitan area. The principle here is that the restraint must be no greater than is necessary to protect the goodwill or other business interests of the employer. If a noncompete provision is found to be too broad, some courts will strike the entire provision (or even the entire agreement). Other courts will “reform” or rewrite the provision so that it is more limited. In this case, however, the court is imposing its interpretation on the parties. It is preferable that the parties negotiate a reasonable time, area, and scope themselves.

**Action Step** Physicians should negotiate a reasonable time, geographical area, and scope of activity for a noncompete provision.

**Mistake 7** Failing to Consider Nonsolicitation Provisions and Patient Information in the Agreement

Apart from noncompete provisions that address where and under what circumstances the physician employee may go to work for a subsequent employer, some contracts contain nonsolicitation provisions that purport to limit the departing physician’s ability to contact patients and “solicit” them to follow the physician. Because of the particular nature of the physician-patient relationship, state law may require the employer to provide the departing physician with certain information regarding his or her patients and access to their records upon appropriate authorization by them.

**Action Step** Physicians should consider nonsolicitation provisions and ensure that state law requirements regarding access to patient information are followed.
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Mistake 8  **Failing to Include Buyout Provisions in the Agreement**
Some states require a noncompete agreement to contain a buyout provision. Whether or not required by state law, a buyout provision may be advisable. A buyout provision allows the departing physician to pay a certain amount of money in exchange for a release of the noncompete agreement. The buyout should be set at a reasonable price, and the parties may wish to consider some method of ascertaining such a price. Arbitration is one option; however, the parties should agree upon a method of selecting the arbitrator and other procedural issues at the time the noncompete agreement is negotiated.

**Action Step**  Physicians should pay attention to buyout provisions, including the method of determining a reasonable price.

Mistake 9  **Failing to Include Remedies for Violations in the Agreement**
Both parties should consider what the consequences of violating the noncompete provision will be. It can be difficult to measure the employer’s damages if the departing physician takes all of his or her patients. Some agreements contain a specific dollar amount, known as liquidated damages. Liquidated damages, which attempt to address the speculative nature of determining damages, must be a reasonable measure of the harm suffered by the employer. If the liquidated damages amount is too high, it may act as a disincentive for breach, but it may also be unenforceable.

**Action Step**  Physician employers should consider the advisability of liquidated damages provisions and/or other provisions that address the remedy for breach of the noncompete provision. Physician employees will want the liquidated damages amount to be as low as possible.

Mistake 10  **Failing to Address Other Specific State Law Requirements**
There may be other specific limitations on the enforceability of noncompete agreements. These restrictions will vary from jurisdiction to jurisdiction.

**Action Step**  Physicians should be sure to consult with counsel knowledgeable about the specific state laws applicable to their jurisdictions.

Conclusion
Whether employer or employee, physicians should consider the implications of noncompete provisions often included in employment contracts as an afterthought. This area of the law varies widely from jurisdiction to jurisdiction.

**Additional Resources**
- www.breakyournoncompete.com
**CONTRACTS: NONCOMPETE ISSUES**

**About the Author**  
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Chapter 7 Criminal Law

7.1 The 10 Biggest Legal Mistakes Physicians Make When Being Investigated for or Charged with Civil or Criminal Fraud

By Deborah A. Holzman, Esq.

Executive Summary
The rising increases in the cost of health care have led to all-out efforts to contain such costs. An important component of those efforts is a strategy to minimize the losses resulting from fraud and abuse in billing for health care services. It is therefore no wonder that thousands of physicians each year face investigations for real or imagined billing and related fraud. Such investigations, whether by regulatory agencies, law enforcement, or private insurers, can be costly, since they usually involve voluminous medical and billing records, and the costs associated with such investigations include not only legal fees, but also substantial staff and professional time, disruption of office routines, and expert fees. Physicians who are not prepared can make substantial, sometimes career-threatening, mistakes when facing an investigation or charges of civil, or worse yet, criminal fraud. Physicians facing fraud investigations need to explore all available rights, develop an action plan, and prepare family and staff for the rocky road ahead.

Mistake 1 Trying to Respond without Counsel
Physicians often forgo consulting with an attorney at the start of an investigation, and wait too long to engage experienced counsel. Convinced they have done nothing wrong, they decide (incorrectly) that they do not need professional legal advice. Or they assume that, as highly educated and intelligent professionals, they are equipped to handle legal issues on their own. Investigations can take months or even years to complete. The passage of time, especially the periods of relative inactivity, give the impression that the matter is resolved or dropped. Physicians may conclude (again, incorrectly) that they can put the matter off rather than confront the problem. Thus, physicians may wait to seek competent legal advice until the problem magnifies itself and the investigation reaches a critical point, such as the filing of litigation, adverse license action, or even worse, an arrest.

Action Step Physicians should consult with an experienced attorney as soon as notice of an investigation is received, especially if it involves law enforcement and the risk of criminal charges. Physicians must keep in mind that fraud investigations put career and even liberty at stake.

Mistake 2 Sparing Counsel Some of the Details
When trying to determine a course of action in a particular matter, physicians sometimes fail to appreciate the legal implications of seemingly unimportant facts, and therefore may conclude that they can spare counsel from some of the details surrounding an event or
occurrence. Experienced counsel can help the physician to wade through potential legal
claims and evaluate the degree of exposure, if any, but only when all facts are presented and
analyzed. Physicians need not fear that what they tell their counsel may hurt them; subject to
very limited exceptions, the attorney-client privilege protects a physician’s communications
with an attorney from disclosure, in much the same way that communications between
physician and patient are protected. Physicians should be aware that they can and should
discuss matters freely and without reservation with their counsel, who can be their best ally in
times of need.

**Action Step** Physicians should present all details and documents relating to the matter at
hand to their counsel so that a complete analysis and informed decisions on strategy can be
made at the earliest possible date.

**Mistake 3 Talking Too Much or to the Wrong People** Physicians should exercise caution when communicating with individuals who may be
witnesses in an investigation. Such individuals may misinterpret the physician’s statements or
modify their own statements based on the physician’s recollection of the events. Witnesses
may also be called on to testify not only about a specific event, but also about what the
physician may have said about it. This could lead to even greater exposure for the physician.
In the worst case, an innocent statement could subject an unknowing physician to allegations
of witness tampering.

**Action Step** Physicians should consult with experienced counsel before speaking with
witnesses in a pending matter. In many cases, those witnesses have engaged their own
attorneys and have responded to questions by the authorities. The safe and conservative route
is to avoid talking too much, or talking to the wrong people. Seeking counsel’s advice first
will protect all parties involved in an investigation.

**Mistake 4 Failing to Understand Physicians’ Roles as Employers and Supervisors** Physicians sometimes do not fully appreciate their potential exposure when a subordinate or
an employee acting at the physicians’ behest engages in improper, illegal, or fraudulent
conduct. To be sure, the subordinate or employee may indeed be acting on his or her own
behalf, engaging in potentially wrongful or fraudulent acts outside the scope of employment.
But, in routine work situations, such as the completion and submission of insurance forms,
physicians are presumed to be aware of their subordinates’ conduct and are responsible for it.

**Action Step** Physicians should be sufficiently familiar with all business aspects of their
practices, including office procedures, preparation and retention of medical records, and,
especially, the billing and collection systems. Each of these systems should include sufficient
and reasonable checks and balances to ensure compliance with all applicable regulations.
When important issues arise involving a subordinate, physicians should consult with an
experienced attorney, who can advise on potential exposure and employment and related issues.

**Mistake 5  Failing to Cooperate with the Authorities**

Some physicians, certain that they have done nothing wrong and feeling put upon by intrusive authorities, fail or refuse to respond to or cooperate with the authorities conducting an investigation. Usually investigators view such conduct, however innocent, as evidence that the physician is misleading, interfering with, or stalling in an inquiry or investigation. Failure to cooperate with investigations may result in additional allegations or charges.

**Action Step**  Physicians should consult with experienced counsel as early in the investigation process as possible. Counsel can field and address questions and advise on the best way to present the information investigators are seeking. In some cases, investigators’ demands can be overly burdensome and objectionable. Counsel can assist in distinguishing between a proper and routine inquiry and an improper demand for documents or information.

**Mistake 6  Keeping Staff in the Dark**

Physicians may not appreciate the importance of appropriately communicating with their entire staff—from secretaries, billing personnel, and other key staff members, to the rest of the professional staff—at the start of an investigation. It is inevitable that staff will become aware that the physician is under investigation. Often investigators will simply show up at the door of a physician’s office and demand that staff provide books and records. Some patients may become aware of the investigation and seek information from the staff. Newspapers may contact the office for information, and news reports may contain unsavory accounts of the inquiry. Well-meaning physicians sometimes try to shield their staff from the uncomfortable details of a pending investigation. But most times this backfires, especially if an employee is questioned by investigators, patients, the media, or others.

**Action Step**  Physicians should plan for the best time and manner to inform key staff members that an investigation is being conducted, and the best way to explain what is happening and what is expected of staff if the office receives an inquiry. Physicians should involve counsel in those meetings and discussions, as appropriate. Staff should know how to address and route all inquiries from investigators, news sources, and patients.

**Mistake 7  Producing Records and Other Documents for Investigators without Appropriate Advice or Procedures**

Physicians under investigation for civil or criminal fraud are understandably anxious to clear their names. Some may conclude that the easiest and fastest way to do so is by giving the investigators all of the records that, in the physician’s view, will prove that no fraud was committed. In doing so, they allow investigators unfettered access to their patient and billing records and other file materials. Mistakes, such as supplying original data to investigators
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without retaining copies, are common. At times, physicians turn over original patient records, which investigators may then retain for long periods of time. This becomes even more problematic when a patient needs continuing medical care.

**Action Step** Physicians should not turn over any materials to investigators unless and until they have contacted experienced counsel who has advised on the appropriateness of the requests. Counsel can help implement a system that tracks every document produced. Later, the physician may require proof that a document has in fact been turned over. If and when a surprise visit from the authorities occurs at home or at the office, physicians should immediately contact their attorneys for advice on how to respond. A physician’s well-meaning but misguided document production could be used in making a case against the physician.

**Mistake 8  Failing to Respond Fully to Application Forms**
Throughout their professional careers, physicians complete myriad forms, such as license renewals, patient requests for insurance payments, employment applications, and applications for hospital privileges. Often, such applications call for disclosure of information relating to prior or pending civil or criminal investigations. Sometimes, application forms use vague or ambiguous wording that can be confusing even to trained professionals.

**Action Step** Physicians should err on the side of disclosing pending investigations, subject to the advice of an attorney who specializes in such matters. Often, counsel can advise on the interpretation of the question, can draft an appropriate response to a troubling question, and may serve as a buffer between the physician and the hospital, insurer, or licensing body.

**Mistake 9  Rellying on the “Advice of Counsel” As an Absolute Defense**
Some physicians under investigation inform the authorities that they engaged in a particular course of conduct at the direction of their attorney. This is particularly applicable in kickback investigations because most physicians do consult with counsel before entering into a business arrangement. The “advice of counsel” defense is used to show that the physician did not intentionally violate the law. But this defense is not always applicable, especially if, unwittingly or otherwise, the physician failed to provide counsel with all relevant facts and information. It may also result in a waiver of the attorney-client privilege.

**Action Step** Physicians should consult with an experienced attorney before taking a position on the theory of defense, especially when considering the “advice of counsel” defense, given the risk of waiver of privilege. Placing the attorney-client communication at issue in the investigation could operate as a waiver of the privilege.
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Mistake 10  Clarifying or Changing Information in Existing Records
Some physicians may be unaware of the strict regulations that govern modification and maintenance of patient records. With the best of intentions in mind, some physicians, faced with a fraud investigation, modify or supplement patient records, appointment books, logs, and other materials maintained in the ordinary course of their businesses. They also may make changes to computerized databases and recordkeeping systems and may even delete data that they believe is benign or irrelevant. Less computer-savvy practitioners are unaware that a technical specialist can easily detect these alterations and restore deleted material from a hard drive. Moreover, today’s computer experts can easily make the additions and alterations come to light. Depending on the timing and nature of the modifications, such conduct can subject the physician to even greater scrutiny and charges of tampering with evidence.

Action Step  Physicians facing a fraud investigation should be familiar with the rules and regulations governing the changing or amending of medical and related records, and they should consult experienced counsel before making any changes in existing documents, computer materials, logs, and related items, especially if they have been subpoenaed. Innocent modification or destruction of records could lead to evidence tampering allegations.

Conclusion  Physicians must consider the potential ramifications of a fraud investigation as soon as they become aware that they are the subject of such an investigation. They should assemble all data requested, prepare staff, and consult with experienced counsel before responding to investigators. By facing the problem head-on, the physician will have the benefit of a clear and well-thought-out response plan designed to eliminate or minimize exposure and steer the matter to conclusion in as painless a way as possible.

Additional Resources
- T. Reardon, Investigations of Fraud and Abuse, Report 27 to the Board of Trustees of the AMA (1997)
- T. Reardon, Fraud and Abuse Update, Report 25 to the Board of Trustees of the AMA (1997)
- Doctors Deserve Privacy Too: Credentialing Should Not Require Revealing Your Entire Health History (Jan. 20, 2003), www.amednews.com
7.2 The 10 Biggest Legal Mistakes Physicians Make That May Lead to Criminal Investigations or Charges
By Donna Lee Mantel, Esq., RN

Executive Summary
Beginning as far back as the U.S. Civil War, the False Claims Act, a law that to this day is little known to physicians, imposed civil and/or criminal liability on any person who defrauded the federal government. In 1986, the stated focus of the law became health care fraud. With the considerable weight of the federal government now shifting to target any physician or practice across the country, this law was further potentiated in 1992 when a separate unit within the Financial Crimes section of the FBI began coordinating its investigations with other law enforcement agencies and even individual state regulatory agencies, officials at Medicare and Medicaid, all of the state boards of medical examiners, and a host of other federal and state agencies. As a result, the number of agencies that have the legal authority to investigate, prosecute, and refer physicians for prosecution has grown immeasurably in the last decade, and there are no signs that this situation will abate.

While this section outlines 10 mistakes, the common thread that runs through the fabric of almost all of the criminal charges against physicians today, and the tie that binds for successful prosecutions, is the physicians’ lack of understanding of “fraud” in all of its forms and permutations. Punishment does not depend on the conduct of the doctor being intentional; even if it is simply committed recklessly, it can mean fines for each billing instance, incarceration, loss of licensure, or any combination thereof. It is against this backdrop that the following advice is offered.
**CRIMINAL LAW: CRIMINAL CHARGES**

**Mistake 1  Upcoding of Evaluation and Management Patient Visits (CPT Codes 99211-99215)**

One of the easiest ways to become ensnared in a fraud investigation is to bill inaccurately, or fail to document, for the range of evaluation and management (E&M) office visits. Strict guidelines have been established for each of the five levels of service of established patient visits. Not only must the visit have all the elements of the billed code (e.g., a comprehensive history and medical decisionmaking of high complexity for a 99215 visit), but also documentation must exist that demonstrates that the visit has met the requirements of the billed code. A physician or practice that cannot provide adequate proof of compliance (i.e., documentation) will certainly face adverse scrutiny. Determining who is cheating and “upcoding” the level of the visits for financial gain is a readily available allegation in this age of computers. Simply tallying each physician’s number of 211 to 215 visits each year and the number of 99215 visits for that year allows a carrier or an agency to calculate the percentage of level 5 visits that were billed. While such investigation is not confined solely to the 99211-99215 series (consultation coding or CPT 99261-99265 and 99271-99275 receives extremely high scrutiny by Medicare in particular), this is the most common trigger of auditing, particularly of internists and pediatricians, the majority of whose practice day is composed of patient office visits. Results that are any higher than the established range of below 5% guarantees that the doctor will be processed as an “outlier” (billing that “lies outside of the norm”) and will be referred to the fraud or special investigations unit of the carrier or agency. In most states, once this determination is made by a carrier, the state law may require that the physician be reported to that state’s medical board, the respective insurance fraud prosecutor, or both for further investigation and potential prosecution.

**Action Step**  Physicians should educate themselves as to the requirements for each level of service, faithfully adhere to the guidelines, unfailingly document compliance with each element required for the level of service billed, and routinely monitor their office statistics as to E&M billings. Practices may consider using technological advances, such as an electronic medical records (EMRs), which can bring to the practice the means to build such documentation required for producing overly burdensome administrative reports.

**Mistake 2  Inflating or Misstating Medical Necessity for Cosmetic Procedures**

Cosmetic procedures, plain and simple, are not covered by insurance. It is only when what is normally a cosmetic procedure becomes “medically necessary” that coverage is available to the patient. The arbiter who has the authority to gauge when a procedure is medically necessary is the physician. However, health plans provide enhanced scrutiny of billed procedures that are generally considered cosmetic. For example, injecting Botox into the forehead area for wrinkles is strictly cosmetic and cannot be claimed by the physician or patient under medical insurance coverage. A vastly different scenario is one in which the patient is diagnosed with a condition known as essential blepharospam and the Botox injections are used to reduce or eliminate the muscle spasms. Due to the noncosmetic
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pathology, the very same treatment becomes compensable. However, any health plan providing coverage for such services will carefully scrutinize the validity of the diagnosis and audit patient charts for clues that the diagnosis is not valid. If there is no detailed history, no diagnostic tests to corroborate the pathology, minimal treatment notes, and no plan of action for the future, the allegation will unquestionably be made that the billing was submitted as a vehicle to entice patients who might not otherwise be financially able, or desire, to pay cash for cosmetic treatments.

Action Step  Physicians should ensure that, when a generally cosmetic procedure is performed on a noncosmetic basis, due to medical necessity, the diagnosis can be fully supported. Each office record must contain objective supportive evidence (e.g., diagnostic tests and/or specialist consultative reports) that independently substantiates the diagnosis.

Mistake 3  Not Reporting and Returning Insurance Overpayments
Under federal law, each physician’s office or group practice must review the accuracy of all payments received from a federally sponsored plan, such as Medicare or Medicaid. When a payee determines that it has received an overpayment, by law, the overpayment is considered an immediate debt to the government or carrier. While there is no federal time frame mandated (although for Medicare, there is a time frame of 30 days), a “reasonable” period of time is expected and enforced and any extensive delay in so reporting and repaying may be viewed as an indication that the physician intended to retain the overpayment for economic gain. Overpayments from private insurers are protected by both federal and state criminal statutes. While myriad laws provide for a wide range of punishments, failure to repay any such overpayments can lead to fines and/or imprisonment of up to 10 years for theft, up to 20 years if the health care fraud results in serious bodily injury, and 25 years for insurance fraud. The amount of the monies retained or embezzled will generally determine the level of the punitive action.

Action Step  Physicians should educate office staff as to the importance of reviewing all payments received to determine any overpayment. Once an overpayment is discovered, there must be an office procedure in place to notify the physician, who must then promptly authorize a return of the funds to the source.

Mistake 4  Falsifying Records When Confronted With an Audit, an Investigation, or a Malpractice Case
Letters from carriers requesting multiple charts for review, subpoenas in malpractice litigation, and notices from plaintiff’s attorneys requesting a patient’s records all strike fear into the heart of any physician. Severe anxiety can result from each and that is normal. It is also normal, upon reviewing the chart that has to be sent out of the physician’s office, for the physician to wish that he or she had documented better, conducted a more detailed history, ordered more diagnostic tests, and so on. What is not normal (and what exposes the physician
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to enormous risks) is to translate that wish into reality by altering the chart. While the temptation is enticing, nothing can torpedo the legal well-being of any physician faster than to be caught altering any part of a medical record. Even if the event or conversation actually did happen, including that fact at a later date to make it look like the data were entered at the time of the event is, of itself, fraudulent behavior. Carriers and government agencies are incredibly adept at discerning any signs of alteration: a year’s worth of notes in the same handwriting with no spaces in between entries, notes as to informed consent written in the margins, arrows indicating where notations should be placed, multiple entries that exonerate the physician from liability (“patient acknowledged her responsibility to call if ... occurs”) are all red flags indicating alteration of a medical record. No matter the legal arena, the ramifications for such actions are both dramatic and devastating. In every state, it is a crime. In a malpractice case, the finding of adulteration of a chart will lead to a negative jury charge as to the conduct. If found as a result of a payer audit, there will be a referral to appropriate authorities, such as the state medical board for a licensure action and/or the department of insurance fraud for civil or criminal prosecution. In extreme cases, the incident can be referred to the local prosecutor’s office for criminal investigation. No finding of malpractice, or a poorly documented patient chart, is ever worth risking the loss of a physician’s license, facing the prospect of imprisonment, or actually spending time in jail.

Action Step  Physicians should routinely perform chart analysis or provide for a staff member to do so. Once any deficiency or inconsistency is noted, any deficient charts should be acknowledged and a vow to correct charting procedures from that time forward should be made. Physicians should not succumb to the temptation to fix perceived or actual charting deficiencies once notice of an investigation or audit is received.

Mistake 5  Violating Antikickback Laws
The federal antikickback laws prohibit physicians from soliciting or receiving any remuneration in return for referring patients for the furnishing or arranging for the furnishing of any item or service payable under Medicare or Medicaid, or in return for purchasing, ordering, leasing, or arranging for the ordering of any good, facility, service, or item payable by Medicare or Medicaid; and for offering or paying any remuneration to any person to induce such person to refer an individual for the furnishing of or arranging for the furnishing of an item or service payable by Medicare or Medicaid, or to purchase, lease, order, or arrange for or recommend the purchasing, leasing, or ordering of any good, facility, service or item payable by Medicare or Medicaid. Anything of value, not just cash, is prohibited by this statute. Even indirect arrangements, such as having a laboratory as a tenant (to which the physician refers patients) pay a higher than normal rent can be viewed as an illegal kickback scheme. Even referrals that are made for legitimate medical reasons can run afoul of this law if any kind of benefit is obtained by the physician making the referral. Consultations fees, free personal services, free medical supplies, free office spaces, and all other similar benefits could lead to a felony conviction, a $25,000 fine and up to five years of imprisonment, loss of
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Medicare and Medicaid participation, reporting to the National Practitioner Data Bank, and, potentially, incurring a referral to the state board of medicine for a licensure action. Most states also have wide-reaching antikickback laws that complement and often mirror the federal prohibitions. While each state may vary in the provisions of its laws, violation of the local laws will result in similar professional sanctions.

**Action Step** Physicians should always pay fair market value for all equipment, space, and services; must secure appropriate documentation of that sum; and must never pay, in any form, for the referral of patients or business.

**Mistake 6 Violating Self-Referral “Stark” Laws**

The federal physician self-referral, or “Stark,” laws (the name of the congressman who sponsored the legislation) prohibit referrals between physicians and other health care entities that have certain financial relationships. Before 1995, the first phase of this set of laws applied only to clinical laboratories (Stark I). Amendments to the law expanded its reach to include a host of other health care settings. Stark laws prohibit referral of patients to entities for the provision of certain specified health services or items (“designated health services”) that are reimbursable by Medicare if the referring physician or the physician’s immediate family members have a financial relationship with the service entities. Designated health services now include clinical labs, physical therapy services, occupational and speech therapy, radiology (MRI, CAT, and ultrasound included), radiation therapy and supplies, durable medical goods, parenteral (and enteral) nutrients and supplies, prosthetics, home health services, outpatient prescription drugs, and hospital services. States have also enacted local versions of this federal law and have often expanded the list of prohibited designated health service entities. Most notably, common misperceptions cause physicians to violate the proscriptions in this law, since a family member is defined to include even such relatives as a grandchild’s spouse and a grandparent’s spouse. Similarly, the law does not require that one intend to violate the proscribed behavior; the simple act itself implies the intent, and the physician can be held responsible and sanctions can be imposed.

**Action Step** Physicians should keep informed of the applicable Stark laws and should seek legal advice as to whether an action is a “referral” or a relationship is “family” within the meaning of this law, if there is any relationship at all.

**Mistake 7 Speaking With Investigators or Law Enforcement Officials Without Legal Counsel or Advice**

While every physician has a duty, by law, to be cooperative with investigations conducted by public agencies and a contractual duty to cooperate with representatives of payers representing patients who are treated, cooperating does not require spontaneous discussions without the benefit of counsel being present or simply being consulted. If the physician is concerned that certain conduct will be detected, no amount of charm or “candid” discussions
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with the officials or agents will persuade them to “go easy” on a particular physician. Generally, the most damaging admissions are made by physicians in their first contact with authorities and this is the reason that, most times, investigators will present themselves at the office door without warning. Attempts to portray oneself in a favorable light often backfire (“I’m so concerned about my patients’ welfare that I don’t even charge copays”), and investigators are well trained to solicit such admissions. Cooperation is best when tempered by time and the advice of experienced health care counsel.

**Action Step** Physicians should cooperate with all officials but not interpret that to mean that they must make themselves available for all manner of questioning on an instantaneous basis. If there truly is an emergency, such as federal officials at the door with a subpoena and requesting charts, physicians should not be shy about calling their attorney and, no matter what, not enter into substantive discussions on the scene.

**Mistake 8 Treating a High Number of Patients Involved in Motor Vehicle Accidents**

While there is absolutely no prohibition against treating personal injury victims, physicians who bill for a high volume of motor vehicle treatments will undergo rigorous scrutiny by automotive insurers. Increasingly, each state has formed a fraud investigation unit that focuses all of its investigative efforts on the abuse of payments to physicians on behalf of accident victims. States also increasingly have enacted stringent reporting requirements. Physicians can become ensnared in motor vehicle accident investigations due to fraudulent behavior, such as “runners” who solicit victims and transportation entities that facilitate and encourage patient visits even if not medically necessary. The best defense to allegations of motor vehicle accident fraud is to perform comprehensive exams, require diagnostic corroboration for the diagnosis, and maintain scrupulously detailed notes regarding the progress of treatment.

**Action Step** Physicians should not respond to solicitations by any individuals or companies that promise to refer motor vehicle accident patients to them for treatment. Physicians should be vigilant in their evaluation of such patients so that any phony “patients” will be potentially identified and measures, such as referrals for consultations and diagnostic testing, can be put in place to triage the fraudulent “victims.”

**Mistake 9 Not Having a Compliance Plan for Detecting Errors or Potential Risks**

As part of its fraud prevention initiative, the federal government has issued compliance guidelines for particular group sectors of the health care industry, including hospitals, home health care agencies, labs, and billing companies. Moreover, more recent compliance statements have focused on the individual or small-group physician practice. Seven areas of practice are recommended and endorsed: internal monitoring and self-auditing, implementation of compliance standards, designation of compliance officer, provision of
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training and education, appropriate responses to detected offenses, open lines of communication, and enforcement of standards through well-publicized guidelines. Physicians can protect themselves and their practices by preventing improper conduct on their part, or by those in their employ (which will be imputed to them) or by, at the very least, detecting such improper conduct. Certain areas, such as billing and coding, documentation, referrals, and other contractual agreements, should be periodically reviewed and carefully scrutinized for any violations.

Action Step Physicians should implement a compliance plan in their offices, even single-practitioner offices, since violations do not need to be intentional to cause sanctions and the physician can be implicated even if only by the unsupervised conduct of staff or billing personnel.

Mistake 10 Indiscriminately Disclosing Violations of Conduct or Law

Trust in others is a powerful tool to enhance and foster relationships. Disclosed, confidential information is a powerful weapon against the unwitting. Physicians may supply ill-chosen confidantes with information that could come back to haunt them and result in fines and loss of license to practice medicine. Called “qui tam” actions (“he who” brings the action), their use has escalated with support from the legislature and the judiciary. While trusted long-time employees can be absolutely indispensable to the practice, and provide much-needed support for a stressed-out and overburdened practitioner, confessions of illegal or improper behavior can be devastating. Not many physicians are aware that government agencies have harnessed the power of such disclosures for their own ends. A little-known amendment to the False Claims Act empowers private citizens to become “private attorneys general.” Such individuals can actually prosecute physicians who have defrauded the government. Strong motivation exists for such actions; they get to keep a healthy percentage of the money collected when they prove the case on behalf of the government. Hundreds of such cases have been filed nationally and these private attorneys general are most often employees who have insider knowledge about a physician or a practice (however, disenchanted spouses are another fertile source of claimants and such individuals have been known to exact revenge for all manner of conduct by contacting a variety of agencies, including the Internal Revenue Service). In qui tam actions, the laws have increased the highly motivating return from an amount of “up to 10%” to a minimum 15% recovery.

Action Step Physicians should keep their own counsel, particularly in matters of known or suspected legal violations. They should also confide instances of such conduct only in their legal counsel, who do not disclose or profit by such confidences.

Conclusion Physicians must be extremely vigilant in their efforts to ensure that their own conduct, and that of their employees and associates, complies with the myriad rules and regulations that are
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being enforced rigorously. Implementing a compliance plan will deter any punishable behavior, encourage optimal conduct by all concerned, promote better patient care, and provide for the legal safety of the physician.

Additional Resources

- False Claims Act, 31 U.S.C.
- Federal Bureau of Investigation, Mission Statement, Health Care Fraud Unit, www.fbi.gov/hq/cid/fc/hcf/about/jcf_about.htm
- Health Care Fraud (American Bar Association 1994 and subsequent years)
- Health Care Fraud and Abuse: Legal Implications for Attorneys and Health Care Providers (New York State Bar Association 1998)
- Legal Manual for New York Physicians, Fraud and Abuse (New York State Bar Association)
- OIG, “OIG Issues Guidance” (news release), www.oig.hhs.gov/fraud/docs/compliance

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7.3 The 10 Biggest Legal Mistakes Physicians Make After They Have Been Charged with a Crime

By Phil D. Mitchell, Esq.

Executive Summary

Each year thousands of people are investigated and charged with committing criminal acts. Although some of those charged are innocent, they must still go through the embarrassment of being prosecuted and the time and expense of defending the charges. Physicians are not immune to such charges, and prosecutions have been levied against doctors, some for the media value of a high-profile prosecution. When facing a criminal charge or an investigation,
there are some basic “do’s and don’ts” for physicians to consider. In no other area of the law is an attorney’s advice and assistance more needed than in connection with the defense of a criminal charge.

**Mistake 1 Interviewing With Police Without an Attorney Present**

Physicians should understand the police investigator’s role in the process: The investigator is not a friend and will use efforts to gain information from them to obtain a conviction. Law enforcement interviewers are skilled, and their interviews are calculated and choreographed to elicit information that is helpful to the police investigation. Police investigators are schooled in tactics of interrogation that are unknown and foreign to the average person. However, certain rules of law and standards must be met in connection with police interviews. Criminal defense attorneys are sufficiently knowledgeable in this area to ensure that the investigators do not overstep the legal lines in conducting such interviews. Anytime a law enforcement officer contacts a physician for an interview—whether the physician is told that he or she is being investigated for a crime or simply that the officer wants to interview the physician in connection with an investigation—the physician must resist the urge to talk with any law enforcement official without having an attorney present to ensure that proper procedures are employed during the interview. Even after being arrested, the physician has the right to insist that his or her attorney be present for any questioning. The physician should not answer any questions without his or her attorney being present.

**Action Step** When requested by law enforcement officials to provide an interview regarding the investigation of a crime, physicians should not submit to an interview without their attorney being present. Physicians should contact their attorney immediately to discuss the matter in detail and have the attorney communicate with law enforcement officials. If arrested, physicians should not submit to an interview without their attorney being present.

**Mistake 2 Trying to Talk One’s Way Out of the Problem**

Physicians who have violated Mistake 1 should not complicate the situation by attempting to talk their way out of a criminal charge. Often, the authorities have a solid theory as to what they believe happened in connection with a crime. An interview with the physician gives them an opportunity to obtain facts that could strengthen their theory or to obtain information that they can use to disprove the information provided by the physician. This mistake is further complicated if “false” information is provided during an interview. False information can easily be disproved by competent authorities, and many jurisdictions mitigate the punishment for a crime based on not misleading investigating authorities. Physicians should talk with the authorities only after they have consulted with their attorney and the attorney has advised them to provide an interview.
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Action Step  It is rare for a person to be interviewed by the authorities and then released because the matter was resolved by the information provided during that interview. Physicians should not mislead authorities if they are interviewed, but they should also remember not to make Mistake 1 by talking with authorities without their attorney being present.

Mistake 3  Failing to Assume That One’s Every Action Is Being Watched
In connection with the investigation of a crime, the most telling and damning evidence often comes from the criminal defendant’s recorded actions and words. Physicians who are aware that they are under investigation for or have been charged with a crime must assume that their every action is being watched, filmed, photographed, and recorded. They should not engage in any activities that are suspect or would lead an ordinary person to question their motives in connection with such actions. Often it is small details, innocuous by themselves, that are stacked together to build a compelling circumstantial case for the jury to convict the defendant.

Action Step  The actions of physicians who are under investigation or have been charged with a crime are “super suspect.” Such physicians must take extraordinary precautions not to engage in activities that would allow the prosecuting authorities to build or strengthen the case against them.

Mistake 4  Failing to Contact an Attorney Promptly
Once a physician learns that he or she is under investigation for a crime or has been arrested for a criminal charge, the physician should contact an attorney immediately. Failing to do so can be devastating to the physician’s defense. It is imperative that a criminal defense attorney become involved in the process as quickly as possible, since several steps may need to be taken: taking statements of witnesses, collecting or examining physical evidence, taking photographs, and documenting facts. Over time, memories fade and physical evidence becomes lost. Criminal cases often turn on facts that are discovered and documented quickly by counsel.

Action Step  Physicians should contact their attorney immediately upon learning that they have been charged with or are under investigation for a criminal charge.

Mistake 5  Misleading One’s Attorney
Misleading their attorney is probably the most common mistake a criminal defense attorney sees their clients make. Despite the fact that the clients come to them for help with arguably one of the most trying and difficult matters they face, the clients are apt to embellish their stories or leave out important facts when relating information to their attorney. Clients seem to feel they must “sell” their facts or defense to the attorney before the attorney can help them. Such action is unwise and often leads to a conviction that may not otherwise have
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occurred. An attorney cannot effectively represent a client unless the client is completely honest with the attorney. The attorney will tailor the defense to a charge based on the facts and information the client provides. An important, but undisclosed, obvious fact that surfaces during the trial provides the attorney with little latitude to adjust the defense.

**Action Step**  In consulting with their attorney regarding the defense of a criminal charge, physicians should provide complete details and all of the information they have. Physicians should not think that withholding information from their attorney will allow the attorney to provide a better defense to the charges against them.

**Mistake 6  Not Taking a Charge Seriously**
All criminal charges are serious. Law enforcement officials and government authorities do not pursue charges unless they think there is a reasonable probability of a conviction, and that is their ultimate goal. Physicians should not be confused by a seemingly lackadaisical attitude by the authorities in connection with a crime. Any physician charged with a crime faces the very real possibility of monetary fines and jail time. Additionally, criminal charges are immeasurably damaging to a physician’s reputation. A physician who is under investigation for or charged with a crime should not think that it will go away or that it is a “minor” matter. Many defenses and hearings may be unavailable and waived unless timely asserted in the process.

**Action Step**  Physicians who are charged with any crime should consider it to be a serious matter that needs their full and immediate attention. They should not ignore the charges, especially if nothing has been scheduled in connection with the case by the authorities.

**Mistake 7  Failing to Guard One’s Credibility**
In a criminal case, a defendant must attempt to maintain credibility with the court and the jury. Once credibility is lost, it is difficult to obtain a successful result in a criminal trial. Physician defendants should guard their credibility at all costs. They should not make any false or misleading statements at any stage of the process—from the investigation of the charge to the trial of the case. They should show respect to the court, to the jury, and to the solemn nature of the process at every stage of the proceeding. Prosecutors are skilled at exploiting inconsistencies from criminal defendants. For this reason, many criminal defendants decline to testify at trial. However, physicians who decide to testify based on the advice of their counsel must do so fully, truthfully, and unevasively in order to avoid a loss of credibility with the finder of fact (either jury or judge). However, such action is never recommended without substantial preparation as to what the physician may expect upon cross-examination from the prosecution.

**Action Step**  Credibility must be guarded and maintained throughout the entire criminal process from investigation through trial. Physicians should not provide any false or
misleading information that would allow the prosecution to destroy their credibility. They must remember that they are not required to provide information to the authorities or testify at trial.

Mistake 8  **Failing to Follow the Advice of Counsel**

In a criminal proceeding, the attorney is the expert who knows the law and how the process works. For physicians, this means that their attorney will guide them through the process while protecting their rights. Although the attorney will not make decisions for them, he or she will counsel and advise physicians so that they can make the best decision for their particular situation. Many defendants have been convicted of criminal charges based on their failure to follow the advice of counsel on matters related to the process. Criminal proceedings are both complex and technical. Often, clients feel that if they can just “tell their side of the story,” the jury will rule in their favor. This is rarely the case in criminal proceedings. Failing to follow the advice of counsel in a criminal proceeding can quickly lead to dire results, including substantial fines and even imprisonment.

**Action Step**  Physicians should establish a relationship with a knowledgeable attorney in whom they have confidence. They should trust their attorney to provide them with advice and follow that advice, especially in connection with decisions regarding the proceedings of a criminal matter.

Mistake 9  **Failing to Consider Plea Bargaining to Attempt to Settle**

Most criminal matters are resolved without a trial through a plea bargain resolution of the case. When the weight of government bears down on a single criminal defendant, pressures mount to unimaginable levels. Many defendants do not feel able to expend the physical, mental, and emotional costs necessary to defend a criminal case. But trials are not only costly, they are also uncertain in their outcomes. Many defendants simply do not think they can “roll the dice” with the high risk of jail sentences hanging in the balance. Therefore, it is always wise for physicians to have their attorney explore the possibility of resolving the case through a plea bargain. Plea bargains come in many forms. Often cases are settled on a guilty plea for a lesser included offense, or for an agreed upon sentence and fine that is then entered by the court. The more serious the criminal charge, the more risk that is involved in the potential outcome. Plea bargains offer certainty in an uncertain process. A guilty plea, advised by counsel, may not be exactly what a defendant would like, but it does provide a resolution to the matter without the risk of greater punishment following a potential conviction at trial.

**Action Step**  After counsel has conducted a thorough investigation of the facts and has researched the law applicable to the case, the physician should discuss the reasonable probabilities of the outcome of trial and probable sentences if convicted. Based on these
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reasonable probabilities, a plea-bargaining process should be explored to attempt to settle the case if counsel so advises.

**Mistake 10   Failing to Comply With Postconviction Requirements**
Often after a criminal case is resolved, a conviction will result in a period of probation, house arrest, or parole. Courts place many conditions on such programs, but such conditions invariably contain requirements that the defendant obey all laws and timely pay all fines and/or court costs or restitution as ordered by the court. Defendants who have been placed on probation should not assume that the process governing their imprisonment will be the same as the one afforded to them for the initial process. Many jurisdictions require a lesser burden of proof to revoke probation than to convict on an original charge. Those who are on probation must be overly cautious in complying with all the terms and requirements of their probation.

**Action Step** Physicians who have been placed on probation should take all of the steps required to complete the required terms of their probation. They should not engage in any suspect activity or become involved with anyone who is involved in criminal activity of any kind, since such involvement will invariably lead to a prison cell.

**Conclusion**
Being investigated for or charged with a crime is a daunting and foreign experience. For physicians, it is likely to affect all aspects of their life. Physicians who find themselves in this situation should immediately employ counsel to guide them and protect their rights throughout the process.

**Additional Resources**
- G. Spence, *How to Argue and Win Every Time* (St. Martin’s Press 1995)

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7.4 The 10 Biggest Legal Mistakes Physicians Make When Hiring a Criminal Lawyer
By Douglas M. Nadjari, Esq.

Executive Summary
The U.S. government contends that of the $1.3 trillion spent on health care during 2000, more than $100 billion was lost to fraudulent health insurance claims. Thus, even in the wake of the terrorist attacks of Sept. 11, 2001, the U.S. Department of Justice continues to make the investigation and prosecution of health care fraud a top priority. Not to be outdone by their federal counterparts, local prosecutors have redoubled their efforts to fight health care fraud. In New York, the district attorneys and the New York state attorney general have established active insurance fraud or health care units to scrutinize the activities of physicians.

Accordingly, the time has long since passed when a physician’s legal issues could be handled by a general practitioner or a malpractice lawyer. Today, the most important tasks facing even the most scrupulous physicians may be recognizing a problem that requires the expertise of a criminal lawyer and choosing an attorney who can both recognize the potential for criminal exposure and deal with it decisively.

Mistake 1 Not Recognizing the Problem
Almost overnight, the legislative landscape that governs the practice of medicine has undergone a hostile sea change. Business relationships that were once commonplace have been branded criminal and forbidden under penalty of imprisonment. Investigators are focusing, with increasing regularity, on the relationships between physicians and their referral sources in search of transactions they will seek to describe as illegal kickbacks. They are examining relationships between physicians, testing labs, pharmaceutical manufacturers, suppliers of durable medical equipment and others for evidence of illegal relationships.

Action Step Before entering a business relationship, physicians should consult a criminal lawyer experienced in health care issues who can scrutinize the arrangement.
Mistake 2   Assuming That All Counsel Can Handle All Billing-Related Issues
Collection lawyers are zealous in helping to maximize their clients’ profits, but they may be ill equipped to handle broader inquiries into their billing and coding practices. In recent years, the insurance industry has also used the veil of “health care fraud” to conceal its concerted effort to balance the industry’s books at the expense of physicians. Indeed, as the economy flattened and the stock market dropped, insurers began to pour more money into fraud and abuse investigations. Both the federal government and private insurance companies have developed sophisticated software that identifies aggressive billing and coding patterns, thereby targeting particular physicians for audit. In certain cases, insurance investigators may work in tandem with state and federal prosecutors, who may then target a physician for criminal investigation and prosecution.

Accordingly, when facing repeated requests for chart entries or an audit by a third-party payer, many physicians mistakenly rely on collection counsel or the practice’s regular civil attorney to deal with these requests. Unaccustomed to the ways of criminal prosecutors, these attorneys may fail to perceive the threat posed by such inquiries. Similarly, they are ill equipped to implement a strategy designed to show that the issues at hand do not suggest an intent to defraud. Finally, the wrong lawyer may mistakenly provide investigators with information about the physician’s practice that may later be used against the physician.

Action Step   Physicians should not delegate responsibility for corresponding with entities requesting audits without ensuring that staff are fully cognizant of what has been requested and by whom. If a physician’s billing and coding practices are called into question, the physician should consult an appropriately trained and skilled attorney.

Mistake 3   Using Collection or Civil Counsel as the First Line of Defense in a Response to No-Fault Insurance Denial of Payment
Over the last 10 years, state and local prosecutors, in concert with the insurance industry, have targeted dishonest practitioners who “grind their grist” in Medicare and no-fault insurance “mills.” In law enforcement parlance, a “mill” is a concern whose business is the mass generation of medical bills for treatment that was either not indicated or never rendered. Over the last decade, these mills have become a multi-billion-dollar illicit industry. While some physicians make their living defrauding both government and private health care insurers, many honest physicians place themselves in harm’s way simply by seeing a perceptible volume of no-fault patients. Prosecutors working in tandem with insurance investigators have targeted certain physicians and use the statutorily required examination under oath to obtain sworn statements that may be used against a physician in an insurance fraud or a perjury prosecution. The failure to perceive or appropriately deal with such dangers may prove problematic.
Physicians should avoid practices that concentrate on the treatment of soft-tissue injuries and whose patients, by and large, do not have objective evidence of injury. Practices that treat “no-fault” patients exclusively are inviting scrutiny. Physicians should consult an appropriately trained and skilled lawyer before agreeing to appear at an examination under oath.

Mistake 4  Shopping for the Lowest Price Legal Advice
Physicians should not be “penny wise and pound foolish.” While there is nothing wrong with shopping around for an attorney, quite often, as the saying goes: “You get what you pay for.” The practice of law is a business. If an attorney quotes a physician a bargain basement retainer that drastically undercuts the retainer fees quoted by other attorneys the physician has consulted, it is likely that the lower priced attorney does not have a grasp of the task at hand, is planning to render a “bargain basement” defense, or is simply unqualified to handle the matter.

Physicians should beware of publicity hounds that may sacrifice their best interests in exchange for some good media attention. They should consider calling other capable attorneys, physicians, and state or county medical societies for a good reference.

Mistake 5  Talking About the Problem With Partners or Employees
While the conduct of a physician’s partners or employees may be the subject of scrutiny, the physician’s interests may differ from theirs. When the heat of a criminal investigation intensifies, partners and employees may turn on one another to save themselves. When that happens, secrets are revealed, confidences are betrayed, and anything the physician may have said to once-trusted friends or colleagues may be twisted and used against the physician.

Physicians who believe that a criminal investigation may be afoot should gather the relevant documents and quietly consult a criminal lawyer skilled in health care matters. Efforts should be taken by the attorney to conduct a “shadow” investigation to control employees and stem the flow of information into the hands of prosecutors.

Mistake 6  Amending or Rewriting Records When Faced With an Audit
Faced with dwindling reimbursement, physicians are pressured to see more patients in less time. As a result, many physicians make up for lost time by charting sparsely and coding aggressively. When facing an audit of records by a third-party payer, many will be tempted to rewrite notes to meet coding standards or to create notes that may be missing. Such actions may be deemed fraudulent and can result in criminal charges being filed against the physician.

Entries in a physician’s office records should not be rewritten; they must be submitted in their original form. An attorney familiar with both health care regulations and
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criminal law should be consulted before a physician even considers amending the records in any way.

Mistake 7  **Believing That an Audit Is Routine and One Can Go It Alone**
Given the advances in software technology, by the time physicians have been notified that they have been selected for an audit, they may assume that the audit is anything but routine or random. In fact, the possibility exists that a physician has already been targeted as a potential fraud suspect and his or her response to being notified of an investigation will be scrutinized carefully.

**Action Step**  A physician’s response to being notified of an audit should be reviewed in conjunction with a lawyer who has the requisite training and experience to analyze the physician’s exposure. If it is determined that the physician’s response may raise suspicions of fraud, the physician and the lawyer may together craft a strategy to identify alleged fraudulent claims and arrange for prompt repayment before an accusation is even levied.

Mistake 8  **Hiring a Billing and Coding Expert to Analyze Records After Receiving a Subpoena or Notification of an Investigation**
Despite a physician’s best intention to revamp his or her billing practices, conversations the physician may have had with his or her compliance expert are not privileged. Therefore, prosecutors may subpoena their work papers and they may be forced to reveal the physician’s most candid admissions. Similarly, their written observations and conclusions, which may contain sensitive or damaging comments, may be subpoenaed and used against the physician.

**Action Step**  Physicians should implement a compliance plan in conjunction with their criminal lawyer. In most jurisdictions, the law permits the attorney to hire compliance experts as legal consultants. As such, a physician’s interactions with them (and their work papers) are protected by the attorney-client privilege and may not be obtained by subpoena or any other means.

Mistake 9  **Waiting Too Long**
Criminal investigations are often plodding, long-term affairs that may continue for months or years after the physician has been contacted. While they may seem dormant, they usually are not.

**Action Step**  When a physician retains a criminal lawyer early on, that attorney may be able to meet with prosecutors and explain certain issues before a prosecutorial mindset pervades the investigation. When prosecution cannot seemingly be avoided, early intervention by a criminal lawyer may allow the lawyer to explore areas of possible cooperation and may stave off an indictment. If an indictment cannot be avoided, early
intervention by the attorney may help identify the source of the information and thus minimize any damages.

**Mistake 10  Believing That Walking Away From a Bad Situation Provides Absolution**

Walking away from a situation in which the actions of peers may have been criminal will not necessarily insulate a physician from prosecution. The failure to report misconduct (criminal or otherwise) on the part of colleagues is, in many states, professional misconduct in and of itself and may result in the physician losing his or her license for failing to report it. Furthermore, if a physician has worked in a “no-fault” mill or some other endeavor that raises suspicions, the physician’s actions (and those taken by others in his or her name) will be as closely scrutinized as those of the true criminals by the authorities and may be misconstrued. It is likely that such a physician may also become the subject of a grand jury investigation.

**Action Step**  Physicians should retain a criminal lawyer capable of assessing their exposure and determining whether they should offer information to law enforcement officials in a way that they will make them understand that the physician is a witness to criminal activity and nothing more. A skillful criminal lawyer may be able to negotiate an agreement in which the physician may avoid both prosecution and professional discipline in exchange for his or her cooperation.

**Conclusion**

Given the regulatory climate and the “criminalization” of health care, the days of one-stop shopping for an attorney have long since passed. The attorneys who handle real estate purchases or employment contracts will be ill equipped to step into the criminal arena. While these attorneys may be very good at what they do, they do not have contacts in the law enforcement community and may be unable to recognize vital issues. They lack the requisite experience to conduct an appropriate investigation or construct a winning defense. The moral of the story is that one should choose carefully: The career you save may be your own.

**About the Author**

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**THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE**

**7.5 The 10 Biggest Legal Mistakes Physicians Make When Being Investigated for Potential Criminal Charges**

By Harold L. Reiser, Esq.

**Executive Summary**

Physicians often believe that if they are honest and forthright they do not need to worry about being interviewed or questioned by an investigator looking into potential criminal charges. Before speaking with any investigator from any investigative agency, physicians should carefully consider the pitfalls of making statements that can later be used in criminal charges. Physicians who are contacted by any investigator should know their rights and statutory protections and consult with competent legal counsel before making any statements to anyone.

**Mistake 1  Failing to Get the Investigator’s Name and Proper Identification**

When contacted by an investigator or a government representative, physicians should ask for a business card and picture identification that includes the person’s name, title, and employing organization or agency. Physicians should not be timid about asking to copy the picture identification. They should politely ask that each person present identify himself or herself by card and picture identification. Physicians should keep the business cards and other identifying information so that they can later contact and distinguish the investigators. At times, investigators (one a criminal investigator and the other an administrative investigator) from two or more agencies may contact a physician. A physician’s rights, protections, and duties may differ depending on the type of investigation and the agency conducting it. For example, a state’s professional licensees may not have the same constitutional rights as ordinary citizens because of administrative rules governing licensed professionals. A state licensee may not have the same rights to a *Miranda* warning that ordinary citizens may have. Rights and protections in administrative investigations differ significantly from those in criminal investigations. Physicians may not appreciate the subtle nuances and legal issues arising from an investigation until and unless they can identify the people and the agency making the contact.

**Action Step**

When contacted by an investigator or a government representative, physicians may, understandably, be nervous, frightened, and not likely to think clearly. They should collect their thoughts and politely ask the investigator to return at the end of the day or wait until they can respond appropriately out of the sight of patients and staff and after they have consulted with an attorney. Physicians should ask the investigator why they are being contacted and what the government representative seeks. After considering the response (if any response is even given) as well as the issues discussed in this mistake and the other mistakes discussed in this section, a physician may then decide how best to respond to the contact.
Mistake 2  Failing to Consult With an Attorney Before Meeting With an Investigator or Before Making a Statement

Physicians have the right to have an attorney present during any and all interviews, conversations, or investigations. Investigators or government representatives may say that a physician does not need an attorney, or they may say that if the physician gets one things will only go worse for him or her. Investigators may try to persuade physicians that they will look guilty if they contact an attorney. This is absolutely untrue. Physicians may politely inform an investigator that they will respond promptly when lawfully subpoenaed, after a patient has given written consent to disclosure of requested documents, and after they have consulted with their attorney. When an investigator tries to convince a physician not to consult with an attorney or not to have one present during an interview, the physician should ask himself or herself why the investigator would be offering this encouragement. Is the investigator or government representative truly acting in the best interests of the physician or is the agent discharging his or her duty to someone else?

Action Step  Physicians should remember that it is not the investigator’s duty to protect them. In fact, they should not expect an investigator to protect them, to help them out of a “problem,” to take their side, or to be their advocate because an investigator won’t. It is not the investigator’s job to do so, and it is not the reason the physician has been contacted. Once a physician has met with an investigator and given a voluntary statement, it may be too late to clarify or amend that statement. It is best to get competent legal advice before meeting with an investigator.

Mistake 3  Failing to Protect One’s Constitutional Rights

Physicians who have been contacted by an investigator or a government representative for any reason have the lawful and constitutional right not to be interviewed, not to make a statement, not to speak on the telephone, and not to answer any questions until they are lawfully subpoenaed (or have written permission from a patient) and only after they have had the opportunity to consult with an attorney. Physicians have the constitutional right to remain silent even when threatened or intimidated. That silence cannot be construed as guilt or as an obstruction of justice. Physicians have the right to be subpoenaed and to have a reasonable time (usually at least 14 days or as otherwise ordered by a court) to respond to a subpoena. They always have the right to remain silent and to speak with an attorney before being questioned, whether or not the investigator or government representative tells a physician of these rights.

Action Step  Conversely, physicians have the right to defend themselves vigorously, make statements, and provide other information to the investigator if they choose. Physicians who have something to say that will address the concerns and answer the questions of an investigator should first calmly gather their thoughts, review appropriate documents, and
consult with an attorney. An ethical and lawful investigator will be willing to wait for lawful cooperation so that the physician can make a full, thoughtful, informed, and honest response.

**Mistake 4  Failing to Make Informed and Lawful Responses to Investigators**

An investigator or a government representative may not lawfully or ethically threaten anyone with criminal prosecution in order to get a statement or gather information from that person. These agents use surprise, confusion, subtle or outright intimidation, and threats to get people to say things they may not truly mean, answer questions they may not fully understand, or agree to events that never happened the way the investigator or others have portrayed them. Unless a subpoena or search warrant commands immediate delivery of documents, physicians do not need to respond “on the spot.” Physicians should not feel hurried, stressed, intimidated, or confused when speaking with an investigator. They can never be interviewed or questioned on the spot without first having the opportunity to consult with an attorney, unless they waive their right to consult with an attorney and choose to answer questions voluntarily. The investigator may not be lawfully obligated to remind the physician of his or her constitutional rights against self-incrimination and the right to an attorney. An investigator may try to persuade a physician to give information immediately under the guise of “not bothering you anymore” or so that the matter “can be closed.”

**Action Step**  Physicians should not be persuaded to waive their constitutional rights until they have had an opportunity to make informed decisions about their response (if they choose to respond). In many investigations, it’s not what a person did not say that caused problems, but rather what was said without first being fully informed and competently advised that caused a problem or misunderstanding.

**Mistake 5  Believing Everything That Was Seen or Read**

Investigators, government representatives, and police officers do not have to give truthful or accurate information when interviewing or questioning a person. They may not know the information gathered thus far in an investigation is incomplete, inaccurate, or false. A physician may have been contacted to clarify, corroborate, interpret, or dispute information gathered from other witnesses. An investigator may innocently or purposely tell the physician something that is potentially misleading, incomplete, or false to see the physician’s reaction, to elicit a response, or simply to gather more information in the course of the investigation.

**Action Step**  Physicians should not believe everything they are told by any investigator. Conversely, if they decide to say anything, after they have consulted with an attorney they should always give complete, accurate, and truthful information when answering any questions or providing any documents.

**Mistake 6  Meeting With an Investigator Alone**

Physicians risk confusion or misunderstanding if they meet with an investigator or a
government representative alone or talk to these agents on the telephone. These agents cannot be identified or their credentials verified over the telephone. Face-to-face meetings allow better interaction and dialogue and facilitate more thoughtful responses than a quick telephone call. An unscrupulous person may falsely identify himself or herself as an investigator to obtain information unlawfully. In addition, in some states (but not all), for example, any party to a conversation may secretly record that conversation (although a person cannot lawfully intercept a conversation without a court order). Therefore, it is lawful for an investigator or a government representative to record the conversation without telling the other party to that conversation. Physicians who are interviewed alone can be misunderstood or misquoted by an investigator when they were honestly trying to explain in good faith. Such comments or explanations become difficult to dispute and a challenge to correct if the conversation was not recorded or another person was not present.

**Action Step** Physicians should not meet alone or speak with an investigator or a government representative on the telephone.

**Mistake 7  Failing to Understand That Anything Said Can and Will Be Used**
When talking to an investigator or a government representative, anything a physician says can and will be used against him or her. Unless the physician has been arrested or is in custody (prevented from leaving the room), an investigator or government representative may not be required to give a *Miranda* warning (i.e., “You have the right to remain silent, anything you say can and will be used against you in a court of law. You have a right to have an attorney present during questioning, . . .”). A *Miranda* warning is required only when a person has been arrested or is detained in a criminal investigation. The statements of physicians who have not been arrested or detained, or are being investigated administratively (e.g., by a licensing board) rather than criminally are deemed voluntary and can be used against them. Even in criminal investigations, if a physician is not being detained or has made statements voluntarily, what the physician says can be used against him or her.

**Action Step** In response to any contact by any investigator or government representative, whether or not they are told of their rights, physicians have the right to remain silent, the right not to incriminate themselves, and the right to speak to an attorney before answering any questions. Physicians have all their constitutional rights no matter the reason for the contact. They will not look “guilty” by asserting their constitutional rights and taking a reasonable time to respond to an investigator. An investigator cannot give or take away constitutional or statutory rights; people have them regardless of any warning (or lack thereof) that they are given. Under certain circumstances, an investigator only has to inform a person of his or her constitutional rights and protections before questioning that person and may not lawfully continue to question (or even directly contact) that person if he or she asks to speak with an attorney. Therefore, a physician’s rights do not arise because an investigator invokes them on the physician’s behalf; those rights always exist under the U.S. Constitution, state
constitutions, and other statutes and rules until and unless a physician waives them and makes a voluntary statement.

**Mistake 8  Failing to Tell the Truth, the Whole Truth, and Nothing But the Truth**
When communicating with an investigator, physicians must always provide full, accurate, and absolutely truthful information in response to any questions they choose to answer and as advised by their attorney. Physicians must always lawfully cooperate with an investigation. It is unlawful for any person to advise physicians not to cooperate with an official investigation. Likewise, preservation of their constitutional rights does not always mean that physicians can withhold certain information when lawfully subpoenaed or given a proper request by a patient. Physicians must never obstruct any investigation; unlawfully withhold any lawfully requested or subpoenaed information or testimony; destroy, alter, or hide documents or other information; give or encourage false, inaccurate, or misleading information; encourage or suggest that others should not cooperate lawfully and fully with any investigation or proceeding; or threaten others not to cooperate lawfully with an official investigation. The crime of witness tampering is a felony in most states. Such a charge can be an effective tool used by prosecutors to sanction unlawful contact with potential witnesses. There are notable incidents in which people have not engaged in any criminal or other unlawful conduct until after they were contacted by an investigator, at which point they attempted to cover up perceived wrongdoing or encouraged others not to cooperate with an official investigation. Recent events involving Martha Stewart well illustrate the caution with which one must approach an investigation and the careful response that must be made to questions from any investigator. Notably, Stewart was not charged with the crime for which she was originally investigated, insider trading. Rather, she was charged with and convicted for conspiracy, obstructing justice, and lying to federal investigators, all of which allegedly occurred after she sold her shares of stock in ImClone.

**Action Step**  Physicians should not tell a colleague, patient, employee, or friend what to do when they are contacted by an investigator, other than to encourage them to contact an attorney.

**Mistake 9  Disclosing Confidential Information Without a Proper Written Release or Subpoena**
Medical records, patient charts, and billing information maintained in physician offices are confidential and should be discussed only after proper written releases are obtained or lawful subpoenas served. Other communications might be privileged and therefore lawfully protected from disclosure. For example, privileged communications that include correspondence and discussions with attorneys, communications with spouses, and oral or written communications concerning peer review and health care quality improvement are usually protected under state law and federal regulations. By discussing such communications with others, physicians may unwittingly waive the protections afforded to them under the law.
and may incur liability to a patient or others for disclosing confidential and/or privileged information. Before responding to a request to discuss any information or provide any documents to any investigator, it is wise to discuss or inform the patient whose records are requested and to discuss the request with other colleagues, a HIPAA and/or compliance officer, and legal counsel before allowing inspection or copying of such records. Because of strict guidelines and regulations under HIPAA (the Health Insurance Portability and Accountability Act), physicians must be careful to respond lawfully to any request for personal health information. Some investigators will claim, perhaps correctly, that the requested documents are exempt from HIPAA or that other laws or regulations permit immediate inspection of documents. There is an exemption under HIPAA for law enforcement to obtain certain information. However, the confidential information must still be lawfully subpoenaed or produced in compliance with HIPAA.

Action Step Physicians may determine for themselves whether the investigator has lawfully and correctly informed them of their rights and duties under the law after careful review and legal consultation. They may then determine what documents may be lawfully inspected or copied. If documents have been lawfully requested, physicians should provide only photocopies of the documents and never the originals.

Mistake 10 Failing to Lawfully Maintain and Protect Patient Charts
All original patient charts and other records, including billing statements and underlying documentation, must remain within physician offices and within physician control at all times. Original documents should never be released to any investigator or government representative in exchange for an evidence receipt. Physicians should make copies of the records and provide the copies in response to the request. Physicians may recover the reasonable cost of copying the requested documents. If they release original patient charts and other documents, physicians have no way to know whether any particular document is altered, lost, or destroyed. They will be unable to review their own records to respond to an investigation. The only way to ensure the integrity of their own patient charts and billing records is to always keep the original documents within their possession, custody, and control. Further, physicians have a lawful obligation to protect certain information under HIPAA and other laws.

Action Step To protect themselves and to comply with all applicable laws, physicians should respond only to lawfully issued subpoenas or after a patient has given written permission for inspection and copying of the documents.

Conclusion Physicians dealing with criminal investigators should avoid the mistakes discussed in this section.
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Chapter 8 Disability Insurance

8.1 The 10 Biggest Legal Mistakes Physicians Make When Filing a Claim for Disability
By Edward O. Comitz, Esq.

Executive Summary
The significant increase in physician disability claims over the past several years has caused insurers to scrutinize the terms of their policies and any claims made under them more closely and to use novel and creative theories when denying benefits. At the same time, insurance companies are attempting to increase revenue by significantly raising premiums on new policies, which provide far fewer benefits than policies issued less than a decade ago. Because physicians are no longer a targeted group for disability insurance sales, insureds should familiarize themselves with their policies and the claims process, and continue paying premiums on any policies that they may have purchased through the early 1990s. Since physician claims are scrutinized closely, it is critical that the following mistakes are not made during the claims process.

Mistake 1    Failing to Consult With Counsel
Physicians who are considering filing a claim for disability insurance benefits are advised to meet with an attorney experienced in the area before submitting a claim for payment. Disability provisions vary greatly in the language used, and coverage is often circumscribed and restricted by qualifying words and phrases. Accordingly, each insurance policy must be individually reviewed to determine whether a particular claim is covered and, if so, how that claim is best presented to ensure payment.

Action Step    Physicians should make a coordinated effort with the assistance of an attorney when interpreting their policy, presenting their claim, and providing subsequent information to their carrier.

Mistake 2    Misunderstanding the Definitions of “Disability” and “Occupation”
Because there is no such thing as a “standard” disability insurance policy, the definitions of “disability” can significantly vary. Most physicians purchase “own-occupation” policies, which provide compensation following a disability that prevents the insured from performing the particular duties of his or her occupation. Thus, the insured may be entitled to benefits even if he or she could in fact perform work of a different nature. The central issue in many cases is the definition of “total disability,” which could variously mean that the insured cannot perform “all” or “every” duty of his or her occupation, or the “substantial and material duties” of his or her occupation. Similarly, the term “occupation” may be specifically defined in the policy (e.g., “invasive cardiologist”) or may refer to the insured’s occupation immediately prior to the time that disability benefits are sought. In the latter situation, if the
physician reduces his or her hours in the months preceding claim filing, the insurer may consider his or her occupation to be part-time rather than full-time. Similarly, the term “occupation” may be comprised not only of the duties of a physician’s specialty, but also of significant travel time, teaching engagements, or other areas in which the physician spends time or draws revenue. For example, “occupation” may be defined as “internist/professor/business owner,” in which case the physician may not be “totally disabled” if he or she can still teach or perform management functions.

**Action Step** Physicians should read and fully understand their policy terms before filing a claim for benefits.

**Mistake 3 Inadequate Documentation**
When submitting a claim and speaking with their carrier, it is important that physicians take notes to assist them in remembering what was said in the event that their claim is denied. They should keep notes of all telephone conversations (including the date and time of the call, and what was said) and identify the person with whom they were speaking. Every conversation with the carrier should be confirmed in a letter sent by certified mail so that there are no misunderstandings. The “paper trail” may later be used as evidence to establish unreasonable treatment during the claim administration process.

**Action Step** Starting with their first telephone call to their insurer, physicians should document in detail their conversations and meetings, and confirm everything in writing, sent by certified mail.

**Mistake 4 Blindly Attending an Independent Medical Exam**
After submitting their claim, physicians may be asked to submit to an “independent” medical examination by someone chosen and paid for by their insurer. They may also be asked to undergo exams by someone other than a physician. Before submitting to an independent medical exam or any other exam or evaluation, physicians must first ensure that their carrier has a right to conduct the exam per the policy language. For example, a neuropsychological exam is conducted over several days by a psychologist, not a physician, and insurers often use the subjective findings from such an exam to deny benefits. If the policy requires submitting only to “medical exams” or exams “conducted by a physician,” there is certainly an argument that a physician need not submit to neuropsychological testing. Further, physicians may wish to be accompanied by an attorney or other legal or medical representatives who can monitor the independent medical exam. Other considerations include receiving the examiner’s *curriculum vitae* in advance; limiting the scope of the exam to ensure that no diagnostic test that is painful, protracted, or intrusive will be performed; having the exam videotaped or audiotaped; and receiving a copy of all notes and materials generated.
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Action Step Because the “independent” medical exam is a tool used for denying benefits where possible, physicians should work with an attorney to ensure that their rights are protected during this process.

Mistake 5 Believing All Mental Conditions Are Excluded or Subject to Limitations
Most disability insurance contracts differentiate between mental and physical disabilities. More recent policies cut off benefits for psychiatric conditions after two or three years. Insureds often blindly accept their carrier’s decision to deny or limit benefits based on these conditions without considering numerous relevant factors, including whether there are any physical aspects to the mental condition, whether the mental condition has a biological/organic cause, or whether another, covered condition was the legal cause of the disability. Without exploring these issues in detail, insureds often blindly accept that certain conditions are limited or excluded from coverage when in fact they are not.

Action Step Physicians should understand their policy’s mental conditions limitation and work with counsel on submitting their claim in such a manner as to ensure payment of benefits.

Mistake 6 Engaging in Inadequate Communication With Treating Physician
Physicians should not discuss their claim or that they are considering filing for disability insurance benefits with their treatment provider until after they have had several visits. Physicians are often reluctant to support claims for benefits if they question the motivations behind the claims. A physician who has treated, without success, the physician making the claim will likely be more willing to cooperate. It is also important that the physician making the claim communicate his or her symptoms and limitations to the treating physician in an organized and detailed manner so that all relevant information is recorded in the medical records, which the insurer will ultimately request. When finally speaking to the treating physician about the claim, the physician should ensure that the treating physician understands the definition of “disability” under the insurance policy, so that he or she can accurately opine as to the inability of the physician making the claim to work.

Action Step Physicians should fully discuss their condition with their treating physician to ensure supportive medical records and, after several appointments, work with him or her on submitting the claim for “disability” as defined in the policy.

Mistake 7 Quantifying Time
Physicians should be wary of insurance companies asking them to compartmentalize in percentages what activities they were engaged in pre- and postdisability. To the extent that there is any crossover, companies will often deny benefits or provide benefits for merely a residual disability. It is important that physicians broadly describe their important duties—rather than their incidental duties—so that the insurer has a clear understanding of the thrust
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of their occupation. For example, in response to a question about principal duties and the percentage of time spent on each duty, an anesthesiologist may be better off stating “100% surgical anesthesia” rather than compartmentalizing each and every incidental task (e.g., patient intake, supervising nurses during surgery, postoperative visits) into discrete percentages. The reason is the insurer may erroneously consider an incidental task a “principal duty,” and therefore downgrade the amount of benefits. For example, where a physician has duties as a businessman (e.g., supervising staff, overseeing payroll), the insurer may argue that the disabled physician can still manage his or her practice and is therefore only partially disabled.

**Action Step** Physicians should not quantify their time until after they fully understand the definitions of “principal duties,” “disability,” and “occupation” under their policy.

**Mistake 8 Ignoring the Possibility of Surveillance**
Insurers are likely to videotape or photograph physicians who have filed for disability insurance benefits. Physicians who engage in any activities that they claimed they could not perform and are caught on tape are likely to have their benefits denied and the contract could be terminated.

**Action Step** Physicians should not compromise their policy benefits by submitting a fictitious claim.

**Mistake 9 Blindly Accepting That Subjectively Diagnosed Conditions Are Not Covered**
Disability insurers often deny benefits by insisting that the insured’s subjective symptoms do not provide objective, verifiable evidence of disability. In many cases, there is no provision or contractual requirement mandating that the insured submit objective evidence of disability. Therefore, from the insured’s perspective, these insurance companies are merely trying to save money by generously interpreting policy language in favor of a claim termination. Notwithstanding the subjective nature of a particular condition, the insured may be able to secure benefits with ample evidence bearing on the extent and severity of his or her limitations, which is far more important than providing a definitive diagnosis.

**Action Step** The severity and extent of the limitations are more important than an objectively verifiable diagnosis and must be fully communicated to a physician’s insurer.

**Mistake 10 Tossing Out Application, Policy, and Claims Documents**
From the time of application forward, physicians should keep copies of everything (including notes from meeting with the insurer’s sales representative or agent, the policy application, and the policy itself). If the sales representative provided a letter or a verbal representation that the physician jotted down, those notes can go a long way if the insurer says that the
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policy says something different. Similarly, information that the physician provided on the
application may have a bearing on his or her reasonable expectations at the time of purchase.

Action Step Physicians should keep all of their disability insurance papers and notes in an
organized file.

Conclusion
Insurance companies are vigilant in protecting their own interests, which often means not
paying claims. Insureds may often need to be even more vigilant in protecting their own
interests by seeking experienced counsel to assist them in submitting their claims for benefits.

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Chapter 9  Divorce

9.1 The 10 Biggest Legal Mistakes Physicians Make in a Divorce
By Jimmy Vaught, Esq., and Janet McCullar, Esq.

Executive Summary
A multitude of physicians are involved in divorces each year and have to deal with a rollercoaster of critical decisions and emotions in the break-up of their marriage, in addition to maintaining their practice and attending to the needs of patients. Many physicians make serious mistakes in their divorce, ranging from hiring inappropriate or inexperienced counsel to having unrealistic expectations about the outcome of their divorce and the length of time for it to be finished. These mistakes are likely to adversely affect the physician and his or her children and medical practice for years.

Mistake 1  Hiring Inappropriate or Inexperienced Counsel
Physicians often look to their corporate or health care counsel to represent them in their divorce. In addition, they frequently hire an attorney who is an inexperienced divorce counsel or does not have experience in representing physicians in divorce. For example, Texas is a community property state, which means that all property and income received during the marriage by one or both of the spouses belongs jointly to the husband and wife. Separate property of one spouse (which includes property owned prior to the marriage, gifts to one of the spouses, inheritance received by a spouse, and certain parts of personal injury settlements or recoveries) cannot be divided at the time of divorce. As a result, determining the character of a couple’s property as either separate or community property and the value of property is significant in every divorce. Community property may include complex property, such as real estate, professional practices, business entities, trusts, limited partnerships, employment benefits, retirement funds, IRAs, 401ks, profit-sharing plans, and stock options. In addition, divorce counsel with experience representing physicians are knowledgeable about the characterization and valuation of a physician’s practice or a physician’s interest in a practice.

Action Step  Physicians should not hesitate to inquire into the experience of divorce counsel, as well as seriously consider retaining divorce counsel who is board certified in family law.

Mistake 2  Disclosing Only Limited or Incomplete Information
Physicians (and other clients) often fail to disclose up front to counsel all of their bad conduct or “warts.” Withholding damaging personal and/or business information from counsel can have devastating consequences. Such damaging information can include the existence of an affair, funds spent on the paramour, problems with the practice, as well as alcohol or substance abuse problems. Counsel who is aware of such damaging information can deal with it and frequently neutralize it. Rarely does such damaging information not come to light, and
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counsel cannot effectively help the physician if he or she first learns of it during a hearing, deposition, or other critical juncture in a case.

Action Step  Physicians should be sure to disclose to counsel, and be completely candid about, all of their potentially damaging personal and/or business information.

Mistake 3  Not Insisting on a Confidentiality Agreement
Physicians often fail to insist on a confidentiality agreement to protect their patient list, and other confidential and proprietary information related to the practice. “Confidential information” usually means information that constitutes or contains financial or business information relating to the practice and may include any document, oral communication, or other information, the improper use of which is likely to cause injury to the physician or practice. A confidentiality agreement can limit disclosure of information except: to a party; to counsel and the counsel’s paralegal, computer, clerical, secretarial, and other employees and contract workers; to consultants or experts retained by a party or his or her counsel to whom disclosure is necessary; to a witness whose testimony is being taken either during deposition or at trial; and as evidence in a trial or hearing. A confidentiality agreement is especially important to limit disclosure of confidential and proprietary information by a valuation expert retained by the physician’s spouse.

Action Step  Physicians should insist on a comprehensive confidentiality agreement to protect their patient list and other confidential and proprietary information related to their practice.

Mistake 4  Understating or Overstating the Value of a Medical Practice
Physicians often understate or overstate the value of their practice or interest in a practice. The value of a physician’s practice or interest in a practice is frequently a hotly contested issue in a divorce. In Texas (as in many states), personal goodwill is distinguished from commercial goodwill. Personal goodwill is based on an individual’s reputation, experience, training, and ability, and it attaches to the person of the physician as a result of confidence in his or her skill and ability. In Texas, personal goodwill does not possess value or constitute an asset separate and apart from the person of the physician or from the physician’s ability to practice medicine (i.e., personal goodwill is not divisible upon divorce). Commercial goodwill relates to an entity’s reputation and its ability, as an entity, to attract and retain patients, even with a change of personnel, especially physicians. Commercial goodwill is often divisible upon divorce. Personal goodwill is most significant in a sole proprietorship practice and is less significant in a partnership or professional association.

Action Step  Physicians should recognize that the value of a physician’s practice or interest in a practice is often a hotly contested issue in a divorce. They should work closely
with divorce counsel (and their valuation experts) to distinguish personal goodwill from commercial goodwill.

**Mistake 5  **Assuming Equal Division of Marital Property

Physicians often assume that marital property will be equally divided between spouses by the courts or that their spouse will be entitled to no more than 50% of the marital property. In Texas, marital or community property is divided in a manner that the court deems just and right, having due regard for the rights of each party and any children of the marriage. A spouse may be awarded a disproportionate share of the marital or community property for the following reasons:

- Fault in the breakup of the marriage (e.g., adultery or cruelty)
- Fraud on the community or marital estate
- Benefits the “innocent spouse” may have derived from the continuation of the marriage
- Disparity of earning power of the spouses and their ability to support themselves
- Health and ages of the spouses
- Education and future employability of the spouses
- Community or marital indebtedness and liabilities
- Tax consequences of the division of property
- Earning power, business opportunities, capacities, and abilities of the spouses
- Need for future support
- Nature of the property involved in the division
- Wasting of community assets by one or both of the spouses
- Credit for temporary support paid by a spouse
- Community or marital funds used to purchase out-of-state property
- Gifts to or by a spouse during the marriage
- Increase in value of separate property through community efforts by time, talent, labor, and effort
- Reimbursement claims
- Expected inheritance of a spouse
- Attorney’s fees to be paid
- Creation of community or marital property through the use of a spouse’s separate estate
- Size and nature of the separate estates of the spouses
- Creation of community or martial property by the efforts or lack of efforts of the spouses
- Actual fraud committed by a spouse
- Constructive fraud committed by a spouse
- The spouse to whom custody of the child or children is granted
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- Needs of the child or children of the marriage
- Excessive community-property gifts to the parties’ child or children

**Action Step** Physicians, with the assistance of their divorce counsel, should evaluate and consider the various factors that could affect a division of the community or marital property and develop an appropriate strategy to address those factors.

**Mistake 6 Having Unrealistic Expectations**
Physicians often have unrealistic expectations about the outcome of their divorce and the length of time it takes for the divorce to be finished. Divorce counsel frequently hear predictions of what should or will happen in divorces based on the experiences of friends, colleagues, or family. However, every divorce is unique based on the characteristics and circumstances surrounding the spouses, the children, and the property. In addition, most states have a waiting period between the time one spouse files for divorce and the time that the court may grant a divorce, whether contested or uncontested. (In Texas, for example, the waiting period is 60 days. However, very few divorces involving physicians are completed within 60 days and may last for up to six months to one year, if not longer.)

**Action Step** Physicians should discuss the possible range of outcomes and their expectations, as well as a time line, with their divorce counsel at one of their initial meetings so that they will know what to expect.

**Mistake 7 Disregarding Deadlines and Requests for Information**
Physicians are and should be focused on their patients and their practice. As a result, they often fail to respond timely to requests from divorce counsel for pertinent information and documents. Physicians are very busy, and working on their divorce (by meeting with divorce counsel, working on discovery, gathering documents and other information, and attending depositions) is probably a low priority. However, divorce counsel must often respond to discovery requests from opposing counsel with deadlines imposed either by statute or by the courts. Disregarding deadlines and requests for information and documents, as well as withholding information from divorce counsel and not making time to work on their divorce, will only make the process more difficult and ultimately more expensive, and could also result in monetary or other sanctions.

**Action Step** To the extent possible, physicians should attempt to respond in a timely manner to requests from divorce counsel for pertinent information and documents and to provide the most complete information possible. In addition, physicians need to be actively involved in their divorce, make time to work on their divorce, and avoid the temptation to delegate most of the work to another, such as a staff person.
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Mistake 8  **Not Using Experts**
Physicians often fail to consider that they will need additional expert advice in their divorce (e.g., a valuation expert to value their practice or interest in a practice or a certified public accountant to assist with scenarios for the division of community or marital property, to advise them and their divorce counsel about federal and state tax consequences arising out of the divorce, and perhaps to perform a tracing of separate property). If there are children in the marriage, a therapist may also be necessary.

**Action Step**  Physicians and their divorce counsel should develop a list of potential experts who may be needed in the divorce, so that the experts can be retained early in the process if it is determined that they are necessary or advisable.

Mistake 9  **Exhibiting Inappropriate Motivation and Behavior**
Physicians often exhibit inappropriate motivation for the action or strategy that they want divorce counsel to use (e.g., inflicting pain or humiliation on their spouse or placing all of the blame on their spouse). Physicians often engage in inappropriate personal behavior (e.g., sharing a residence with a girlfriend or boyfriend, taking a girlfriend or boyfriend on an expensive vacation, or purchasing expensive gifts for a girlfriend or boyfriend). In addition, physicians often attempt to communicate with their spouses by telephone, e-mail, or text messaging.

**Action Step**  Physicians must recognize that inflicting pain or humiliation on their spouse and refusing to accept any responsibility are not effective strategies in a divorce. In addition, physicians must avoid inappropriate personal behavior and be totally candid with divorce counsel about such behavior. Further, as a general rule, when communicating with their spouses by telephone, e-mail, or text messaging, physicians should not say anything or send a message that they would not like to have repeated in court.

Mistake 10  **Not Having Had an Active Role As Caregivers of the Children**
Physicians often have not had an active role as caregivers for their children because of their busy and sometimes unpredictable schedules. After the spouses separate and divorce proceedings begin, physicians find themselves having to adjust to the care of and responsibility for their children and attempting to balance that care and responsibility with their busy schedules.

**Action Step**  Physicians must make plans for daycare and after-school care for their children, which may include hiring a nanny. Physicians must also make plans for the care of their children in case they are called to the hospital in the middle of the night.
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Conclusion
Physicians involved in a divorce who are mindful of these mistakes and take steps to avoid them will be in a better position to weather the divorce with a minimal effect on their children and their medical practice.

About the Authors
Jimmy Vaught, Esq., and Janet McCullar, Esq., are the founding members of McCullar Vaught PC, and have more than 35 years of combined legal experience. Vaught and McCullar specialize in family law, including divorces involving complex property and child custody. They are both board certified in family law by the Texas Board of Legal Specialization. McCullar Vaught PC, is located at 7200 North MoPac Expressway, Suite 250, Austin, TX 78731; telephone 512-342-9933; fax 512-342-9996. Vaught may be contacted by e-mail at jimmy@mccullarvaught.com; McCullar may be contacted by e-mail at janet@mccullarvaught.com.

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9.2 The 10 Biggest Legal Mistakes Physicians Make When Divorce Proceedings Have Been Filed
By Lois R. Beasley-Carlisle, Esq.

Executive Summary
Physicians are not spared from life’s problems. One such problem physicians often face is their relationship, or lack of relationship, with their spouse and family. Physicians often find the demands of their occupation to adversely affect their martial relationship. As a result of longer work hours and time away from their spouse and family, physicians can find that their marriage is strained or coming to an end. This section identifies the 10 biggest legal mistakes physicians make when their marriage is strained but before divorce proceedings have been filed.

Mistake 1 Failing to Periodically Assess the Marital Relationship
Physicians who have just been served with a summons and complaint informing them that their spouse is seeking a divorce shouldn’t be surprised. If they are, it is likely that they are unprepared for the actions of their spouse, which means their spouse probably has the upper hand.

Action Step By periodically assessing their relationship with their spouse and family, physicians are better able to spot and maybe prevent marital problems that lead to divorce. Physicians might consider having a monthly meeting with their spouse and other family
DIVORCE: DIVORCE FILING

members to do nothing but discuss problems and how to solve them. In family and marital relationships, an ounce of prevention is better than a pound of cure.

Mistake 2 Not Seeking Counseling
Physicians should ask themselves the following questions: Am I often stressed out from the rigors of my work? Do I have a spouse who understands or is my spouse too busy to understand my problems? Does my spouse have his or her own problems? Am I too proud to discuss my own problems or my marital problems with another professional? Physicians are highly trained and educated. They probably could even put a label on the mental or emotional problems that they, their spouse, or other family members may be experiencing. Just as lawyers would be foolish to represent themselves, physicians would likewise be foolish to diagnose and treat any mental or emotional problem that they or their spouse may have, or in their marital relationship. Just as lawyers should hire other lawyers for their own legal problems, physicians should likewise be open to seeking professional help for such mental, emotional, or marital problems. If divorce is contemplated but the couple wants to try to work things out, they should seek professional marriage counseling immediately. Divorce is always stressful and involves the deepest emotions of the physician and his or her spouse and other family members. Physicians who are in the process of divorce, their spouse, and their children can only benefit from counseling. Physicians need to be mentally and emotionally healthy not only for not their children, but also for themselves. They need to show to the court that they are mentally and emotionally stable. In fact, the judge will evaluate the demeanor of physicians (e.g., courtesy to the judge and opposing counsel, and how they respond to questions) every time they appear in court.

Action Step Physicians should recognize the benefits of obtaining professional help when necessary for their mental and emotional well-being, as well as the well-being of their spouse and children.

Mistake 3 Not Being Aware of the Marital Estate
Many physicians have nonworking spouses. These spouses often pay the marital bills and other debts and often have a better knowledge of the marital estate than the physicians do. In this regard, physicians should ask themselves the following questions: Can I accurately state, within $5,000, how much money my spouse and I have in savings? Does my spouse have a separate account and if so, how much is in it? Which credit cards are in my name and which cards are in my spouse’s name? What are the credit limits on our various accounts? Where all the marital assets located? What are our marital debts? Not being aware of the marital estate can hinder the ability of a physician’s attorney to discover the value of the physician’s estate. Not being aware of the marital estate encourages and enables a physician’s spouse to hide money and marital assets. The court can award a physician a fair share of the marital estate only if the physician knows what the marital estate is.
**THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE**

**Action Step**  Physicians whose marriage is strained should strive to make copies of all tangible documents showing debts and assets of the marriage. These tangible documents are inclusive but not limited to the following: income tax returns for the preceding years; all of the physician’s business records; all of the spouse’s business records if they can be obtained; copies of monthly billing statements on debts; a list of all stocks, the companies that issue them, and the names of the relevant agent or broker; copies of all retirement plans; copies of deeds to all property; copies of the spouse’s driver’s license number and Social Security card; the children’s Social Security card numbers; copies of the physician’s birth certificate and those of his or her children; and pictures of the contents of the marital household (which are also good for insurance purposes in case of a burglary or destruction of the home). The physician should keep these financial records in a location that the spouse does not have access to.

**Mistake 4  Not Protecting an Interest in the Marital Estate**
Most physicians and their spouses have joint banking accounts. This means that spouses have access to money with which to hire a lawyer. A spouse could remove all of the money in the banking accounts if he or she has the desire to do so. Physicians who have a large savings account should check with the local branch manager to find out what restrictions can be placed on the account (before trouble arises in the marriage) to prevent all or most of the account from being depleted. Failure to act promptly when a spouse has closed an account and removed all of the money can have far-reaching consequences.

**Action Step**  Physicians should be prepared to close all joint bank and credit accounts immediately, as well as to revoke durable powers of attorney pertaining to their spouse. Also, they should immediately change their will. In addition, they should open up a separate banking account and move one half of the assets into that account, as well as secure credit in their name only. But foremost, if their spouse withdraws large sums of joint assets, physicians should immediately consult with their attorney.

**Mistake 5  Failing to Select a Divorce Attorney**
These are litigious times. Physicians who do not have a family attorney need one. Physicians who have a family lawyer who does not handle divorce cases should ask that lawyer to recommend a list of divorce attorneys. Prompt selection of a divorce lawyer is very important, and physicians should not wait until their spouse has filed for divorce to consult with a divorce attorney. Failing to choose a lawyer is the most important mistake in this list of legal mistakes. Physicians must be able to trust and respect the lawyer they choose. They must feel comfortable talking to their domestic attorney to such an extent that they can divulge all relevant information about their marital history.

**Action Step**  Physicians should incorporate the following when choosing a lawyer to handle their divorce:
DIVORCE: DIVORCE FILING

- Get referrals from friends and relatives who have used a lawyer in their divorce;
- Call the local bar association for a referral to a divorce lawyer and check with the local better business bureau (some lawyers are listed with this service);
- Attend divorce court to find a lawyer or to evaluate lawyers who are potential candidates (look for lawyers who appear well trained and have a good rapport with the court and other lawyers);
- Choose a lawyer whose personality and presentation style the physician finds appealing;
- Schedule an initial consultation with the lawyers who appear to be good candidates (before this initial consultation, find out what the consultation fee will be);
- Prepare questions for the lawyers and be prepared to give a complete marital history;
- Discuss the lawyer’s fees and how the lawyer will handle the case; and
- Ask about the lawyer’s availability to take and return the physician’s telephone calls and his or her availability after being retained by the physician.

Physicians should trust their instincts about the lawyer. Most domestic judges encourage settlement because the physician will almost always be happier with a mutual agreement than with a decision made by a judge. Therefore, it is important for physicians to look for a domestic relations lawyer who has good negotiation skills.

Mistake 6  **Continuing an Affair or Having an Affair While Separated**
Physicians who have been having an affair should cease seeing their paramour until they are divorced. Adultery is a fault ground for divorce in, for example, Alabama. Even a physician who is separated and no longer living with his or her spouse should not have an extramarital affair. Although domestic judges place more emphasis on extramarital affairs that happen before separation, those that happen after separation are still unlawful and can be used against a physician. A spouse may have hired a private investigator to watch the physician’s activities. Physicians who choose to have an affair or to continue having an affair give the domestic relations judge a reason to award to their spouse a higher amount of alimony and a disproportionately favorable property settlement. Extramarital affairs will anger a spouse, hinder reaching a mutually acceptable agreement, and more often than not increase attorney’s fees and lengthen the time to dissolve the marriage.

**Action Step**  Divorce cases can often be resolved in about 12 to 18 months. Abstaining from an extramarital affair will not only net a better division of the marital assets, but will also keep down the attorney’s fees and the amount of alimony that might be awarded to a spouse.

Mistake 7  **Not Hiring an Investigator**
People get divorced for many reasons. The three most common reasons involve abuse (either
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

mental or physical), financial factors, and third-party relationships (extramarital affairs).
While a physician is working 12 hours a day, the physician might wonder what his or her
spouse is doing with their children and others. An investigator can help a physician find out
what is going on in his or her absence. The evidence that can be acquired from an investigator
could result in the physician obtaining custody of his or her children. An investigator could
obtain evidence that would reduce or terminate the physician’s risk of having to pay alimony
or child support.

Action Step Physicians should consult with their attorney about the usefulness of an
investigator. Most lawyers would suggest hiring an investigator to those who can afford one.
The physician’s lawyer should be able to suggest investigators whom he or she has used in
the past and be able to estimate the cost of employing their services. At the very least, by
hiring an investigator, a physician will have confirmed whether his or her spouse is honest
and faithful. Having such peace of mind will make resolution of the divorce case easier.

Mistake 8 Not Recording Conversations with a Spouse
It is legal in the state of Alabama, for example, to record conversations with a spouse even if
the spouse does not know that the conversation is being recorded. A spouse may make
statements to a physician in person or on the telephone that he or she might later recant in the
courtroom.

Action Step Physicians who are in a strained marriage should record conversations with
their spouse. They should be aware of what they say during those conversations because their
spouse will have the right to acquire copies of the recording at a later time, and those
recorded conversations can be introduced into evidence for many purposes.

Mistake 9 Not Keeping a Calendar of Events Concerning a Spouse or Children
Keeping a diary or a calendar with notes is evidence that a physician may be able to introduce
at the divorce trial. Even though physicians are well educated, without a point of reference,
they sometimes forget important information that could have been introduced at trial had they
not forgotten it.

Action Step Physicians in a strained marriage should begin keeping a calendar of events
or diary concerning their interactions with their spouse and children. Physicians may be
allowed to use these documents to refresh their recollection on the witness stand if they forget
major points that they intend to bring out in the trial. Often, the domestic relations judge
assigns greater truthfulness to recorded events than to testimony alone.

Mistake 10 Failing to Document Required Communication with a Spouse
Unfortunately, physicians who are married and are sharing the household bills, childrearing,
or both must have some communication with their spouse. Because both the physician and his
or her spouse may be emotional in their interactions with each other, there is a great need for
the physician to follow up on communications with a spouse in a letter confirming their
conversations. Such letters are evidence that the physician may be able to use at trial to clear
up disputes. Circumstances that might need to be documented include visitation periods,
attempt to arrange visitation, and other issues involving children or assets.

**Action Step** Physicians should get used to writing confirmation letters until the divorce is
over, the children are grown, or there are no more ties to their spouse.

**Conclusion** Physicians should be mindful of these mistakes and take steps to avoid them. By taking these
steps, the physician will be best positioned to receive an equitable division of assets and time
with their children.

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### 9.3 The 10 Biggest Legal Mistakes Physicians Make after Filing for Divorce

**By Stephan V. Futeral, Esq.**

**Executive Summary**
Approximately one in three married physicians will go through a divorce. According to a
1997 Johns Hopkins study, the divorce rate for physicians is 32% (although the study’s
authors note that they examined only Johns Hopkins medical school graduates from 1948 to
1964, whereas today’s society has a greater acceptance of divorce). Compared with
professionals in other fields, physicians’ financial exposure in a divorce may be significantly
greater because of their greater earning potential. When a physician or a physician’s spouse
files for divorce, the physician needs legal counsel as a guide through the process, since many
issues—such as child support, alimony, or the division of property—may affect the physician
for many years after the divorce is final.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

Mistake 1  Failing to Consult with an Attorney
Some physicians consider it a waste of time or money to retain a lawyer for their divorce and attempt to work matters out for themselves. Divorces are procedurally and legally complicated and often have long-term consequences for both parties that are not readily apparent to a layperson.

**Action Step**  A physician contemplating filing for divorce should consult with and retain experienced counsel before doing so. If it is the physician’s spouse who has filed for divorce, the physician should consult and retain counsel immediately and not act without the advice of an attorney.

Mistake 2  Using an Attorney As a Therapist
Clients often talk with their lawyer about personal problems, trying to use the lawyer as a therapist, especially since the lawyer is closely involved in the divorce proceedings. Although lawyers allow clients to vent and to discuss personal problems, they typically charge fees for such time, and often have no advice to offer regarding their clients’ personal problems.

**Action Step**  Lawyers are not typically trained to help clients with nonlegal issues. Physicians should talk with their spiritual adviser, a licensed therapist, or someone qualified to render personal advice.

Mistake 3  Having Unclear Objectives
Sometimes, parties to a divorce go through the litigation process without clearly defining their goals. Instead of taking an active and planned approach, they have a “knee-jerk” reaction to issues as they arise.

**Action Step**  Physicians should set goals in the litigation process by first determining which issues matter most and defining their objectives regarding such issues as division of debts and equities, child custody and visitation, and alimony.

Mistake 4  Failing to Consider Tax Consequences
Often, physicians fail to consider the tax effects of a court award or the concessions that they may make after the divorce is filed. Physicians involved in a divorce often overlook such issues as capital gains tax, dependency exemptions, taxable basis of properties, and the tax consequences of alimony versus child support.

**Action Step**  Physicians should hire a tax consultant to work with them and their attorney regarding the potential tax consequences related to the divorce.

Mistake 5  Failing to Make a Complete Inventory
Often, physicians do not have a complete mental grasp of what they own and what they owe.
DIVORCE: AFTER DIVORCE IS FILED

During a divorce, failing to have or make a complete inventory of assets and liabilities may have devastating consequences. If the physician inadvertently fails to disclose an asset to the court, for example, the court may take the view that the physician is purposefully trying to hide assets.

Action Step  Physicians should make a complete inventory of all assets and liabilities in the physician’s name, in the name of the physician’s spouse, or jointly in both parties’ names.

Mistake 6  Getting Advice on Divorce from Friends and Family Members
Typically, friends and family members want to help someone going through a trying time, such as a divorce. They often have anecdotal advice based on their own experiences or on second-hand information. Regardless of the source of their information, they are typically not objective in their views, nor may they have the professional background necessary to render such advice.

Action Step  Physicians should not rely on the advice and observations of friends and family members, but should instead seek the counsel of a licensed attorney.

Mistake 7  Trying to Win Back a Spouse by Being Too Generous
Sometimes, physicians who are not ready for their marriage to end believe they can win back their spouse by giving generously to the spouse in excess of what the court would award or what is fair. If a physician gives away everything by agreement, then it may be too late to reverse that action in court. Similarly, a physician who is too generous during the divorce may be setting a precedent that the court could follow later when making its award.

Action Step  Physicians should separate their emotions from their finances and resist the temptation to try to buy back their spouse. Instead, they should follow the advice of legal counsel and be fair. Physicians who want to save their marriage should do so by suggesting that both parties attend couples therapy or marriage counseling.

Mistake 8  Trying to Punish a Spouse through the Legal System
Too often, when married parties allow their emotions to get the best of them, including feelings of anger, they may attempt to use a lawyer and the legal system to punish their spouse. Ultimately, they may find themselves spending more money fighting about the case than the case is worth. When the divorce is final, they often realize that the thousands of dollars spent on attorneys fees to punish a spouse did not buy them satisfaction.

Action Step  Although it may be difficult in the heat of the moment, physicians should try to be pragmatic about their goals and needs and consider the cost to themselves when they choose to fight over certain issues.
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Mistake 9  Being Too Anxious to “Get It Over With”
Physicians who believe that the sooner the divorce is over, the quicker they can heal emotionally and financially and get on with their lives are often willing to make too many concessions to avoid the cost and time associated with a divorce. Such shortsightedness can lead to dire future consequences.

Action Step  Physicians should have patience during the divorce process. Barring an appeal, there may be only one opportunity to handle properly the financial and family issues that are important to the physician. Instead, the physician should make decisions cautiously, giving careful consideration to the long-term consequences.

Mistake 10  Putting the Children in the Middle
It is easy for children to become caught in the middle of their parents’ divorce. Often, children are made to feel that they are partly to blame for the divorce or that they must choose sides between their parents. Children are also used as messengers between their parents or are pumped for information about the other party.

Action Step  The divorce, in and of itself, puts a significant emotional strain on most children. Placing them in the middle only causes further emotional damage and, ultimately, may permanently hurt the physician’s relationship with the children. The physician should do everything possible to assure the children that the divorce is not their fault. Also, the physician should not make disparaging remarks about the other parent nor act in a way that puts the children in the middle of the divorce.

Conclusion
As soon as a physician decides to file for divorce, he or she should seek legal counsel. Physicians who rely on the advice of their attorney, set goals for the divorce, and take steps to avoid these mistakes are more likely to move on professionally, financially, and emotionally than physicians who do not take such steps.

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Chapter 10 Employment Law

10.1 The 10 Biggest Legal Mistakes Physicians Make When Terminating an Employee
By Eugene K. Hollander, Esq.

Executive Summary
In addition to the heavy demands of running a medical practice, physician owners are often called on to make the difficult decision of terminating an employee. The group practice is unusual in that it employs medical professionals, such as doctors, nurses, and physician assistants, as well as clerical personnel. The terms and conditions for each type of employee may vary. In general, however, physicians need to be extraordinarily careful in monitoring any employee’s employment from the inception of employment. Failure to take the appropriate steps when terminating an employee may lead to a costly lawsuit, even if the physician successfully defends the case. Adhering to the following action steps will ensure that the physician will preserve employee morale, avoid claims, and, when an employment claim is filed, minimize legal fees and potential judgments.

Mistake 1  Failing to Obtain Employer’s Liability Insurance
One of the biggest mistakes physicians can make even before they hire an employee is not obtaining employer’s liability insurance. While almost no physician would practice “naked” (without malpractice insurance), most physician employers do not even consider procuring employer’s liability insurance. In terminating an employee, physicians may face a claim for breach of contract under state law or for discrimination under municipal, state, or federal laws. An employer’s liability insurance policy may cover judgments for such claims as sexual harassment or age discrimination, in addition to paying for legal fees. Even if the physician successfully defends the claim, it may cost tens or hundreds of thousands of dollars in legal fees to do so. Worse yet, a judge or jury may find against the physician. While under federal law, most awards of compensatory and punitive damages are capped at a level determined by the number of employees the physician employs, the award could nonetheless be devastating.

Action Step  Physicians should obtain employer’s liability insurance covering the group practice and check with their insurance agent on an appropriate policy.

Mistake 2  Failing to Document the Employee’s Deficiencies
When confronted with the problem employee, physicians and most small employers fail to document the employee’s misconduct. This mistake can be fatal. It is important to establish a timeline with respect to the employee’s record. If the physician documents the problems, it is more likely that a judge or jury will believe that the employee’s conduct was deficient. Further, certain state laws govern the production of personnel files. In Illinois, for example, if the employer fails to timely produce personnel documents upon a written request, those
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documents will be inadmissible in a subsequent legal proceeding. In other words, the physician will not be able to later “recreate” these nonexistent documents.

**Action Step** Physicians should document any employee misconduct or performance deficiencies, and at a minimum, do so during an annual review.

**Mistake 3  Failing to Afford the Employee Progressive Discipline**
In conjunction with Mistake 2, a mistake physicians often make is failing to afford progressive discipline to an employee. While there is no federal or state law requiring physicians to afford the employee progressive discipline, the physician’s own employee handbook may require it. Even if the handbook explicitly disclaims any requirement that the physician afford the employee such corrective action, the physician employer should nonetheless attempt to follow such a policy. Again, while not legally required, there is an element of fairness to the procedure. If the physician employer first verbally counseled the employee, then provided the employee with a written warning, then probation, following by termination, it is less likely that the jury would find against the physician in an employment claim. In addition, when the physician appears to be acting fairly, the employee may be sufficiently deterred in even bringing such a claim.

**Action Step** Physicians should afford progressive discipline to their employees where appropriate.

**Mistake 4  Failing to Follow the Employee Handbook**
Many physician employers have an employee handbook, which may serve a number of purposes. It may provide employees with guidelines regarding their terms and conditions of employment, and it may also serve as a public relations document for physicians. The handbook may, however, also be used as a sword by employees in employment litigation if physicians do not follow their own policies. For instance, the physician’s failure to follow certain steps in a corrective action setting when the handbook requires that the physician do so may give rise to a breach of contract claim or appear to be discriminatory. Another fertile area for mistakes is the promise of annual reviews to be conducted if none are held.

**Action Step** Physicians should carefully draft their employee handbooks and diligently follow their policies. They should be careful not to include language that binds them to certain obligations.

**Mistake 5  Failing to Consult with Counsel**
Many potential employment claims can be avoided or diffused if the physician consults with counsel before terminating the employee. Counsel may provide critical legal advice as to whether the potential termination may violate state or federal law and a recommended course of conduct, which, if adhered to, may avoid such a costly claim. Counsel may also be
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instructive in providing the appropriate progressive discipline, as well as in drafting a proper severance agreement, general release, or postemployment notices (e.g., COBRA notification). Further, in some employment claims, it is proper for the jury to consider the physician’s failure to consult with counsel in determining whether to award punitive damages.

Action Step Physicians should always consult with counsel before terminating an employee.

Mistake 6 Failing to Incorporate an Arbitration Provision in the Hiring Documents
One point that cannot be stressed enough is that employment litigation is expensive. One way to save many thousands of dollars in legal fees is to require employees to agree to binding arbitration at the outset of employment. Binding arbitration will avoid jury trials, which generally favor employees, and streamline the litigation process, thus reducing fees. Depending on the employee, the arbitration agreement can be included in an employment application or employment agreement. While the law is continually evolving in this area, the agreement must generally be fairly drafted and not onerous (i.e., requiring the employee to pay all costs of arbitration). To avoid a successful challenge to the arbitration agreement, the physician may wish to assume all costs of the proceeding.

Action Step Physicians should incorporate arbitration provisions into their hiring documents.

Mistake 7 Failing to Incorporate Noncompete Agreements into the Employment Agreement
Another mistake a physician may make even before terminating an employee is failing to incorporate a legally enforceable noncompete or nonsolicitation agreement into the employment agreement. If the physician employer has not secured that protection, the departing employee may seek to raid his or her former employer’s patient base or lure away key employees. To provide the maximum protection under applicable state law, the physician should retain counsel to determine what restrictions are permitted under the local jurisdiction. Generally, the restrictions must be reasonable in time and geographic scope. For instance, a two-year time limitation with a 15-mile radius of any of the physician’s offices may be deemed reasonable to enforce.

Action Step Physicians should incorporate noncompete, nonsolicitation agreements, or both, into their employment agreements. Reasonable limits must be placed regarding time and geographic scope.

Mistake 8 Failing to Pay the Employee All Compensation
A frequent mistake physicians make is not paying terminated employees all the compensation to which they are entitled. These sums may include regular wages, overtime pay, bonuses,
unused vacation time, unused personal days, and retirement benefits. Physicians should check with their office or human resources manager retirement plan trustee to ensure that all such sums are paid timely. Physicians who fail to do so may be subjected to various claims under state and federal laws, as well as an inquiry from the U.S. Department of Labor.

**Action Step** Physicians should create a checklist of all compensation and benefits due, and ensure that the employee is timely paid all compensation upon departing the practice group.

Mistake 9   **Failing to Be Honest with an Employee During Termination**

Often, and for various reasons, the employer may not be truthful when terminating the employee. While not being truthful may not in and of itself give rise to a legal claim, it may provide fuel for the fire in the event that there is a colorable case. For instance, in an employment discrimination claim, the physician employer’s untruthful reason for termination may constitute sufficient pretext to contradict any legitimate reason that the physician had in terminating the employee. Further, if the physician is not consistent in his or her reason for terminating the employee, the physician may not appear credible to a jury. Inconsistencies may arise between what the physician told the employee, the Department of Labor, the local human rights agency, and the Equal Employment Opportunity Commission. If the employer appears truthful, however, the employee may be sufficiently deterred in bringing the claim in the first place.

**Action Step** Physicians need not provide a detailed explanation for termination, but where one is given, they should provide the employee a truthful reason.

Mistake 10   **Failing to Negotiate a Severance Agreement with an Employee**

After deciding to terminate an employee, one of the biggest mistakes physicians make is not negotiating a severance agreement and general release with the terminated employee. While physicians may be reluctant to pay the terminated employee any additional compensation, in the long run, doing so will insulate the practice group from expensive employment-related claims. To make the agreement legally enforceable, physicians must provide the employee legal consideration to support the agreement; in other words, compensation to which the employee would not ordinarily be entitled. Physicians may be able to obtain many favorable concessions from the employee in such an agreement. Key terms may include:

- Release of all employment claims under federal, state, and municipal laws
- Acknowledgement that all compensation has been paid in full
- Agreement not to compete for a certain period of time, in an appropriate geographic radius, or both
- Agreement not to solicit employees for a certain period of time
- Agreement not to initiate litigation
EMPLOYMENT LAW: CALL DUTY

- Agreement not to encourage others to initiate litigation
- Agreement to return all company property
- Agreement not to disparage the physician
- Agreement to arbitrate any provision of a breach of the agreement
- Selection of a forum for litigation/arbitration
- Agreement to cooperate regarding a malpractice claim
- In the event of a breach of the agreement, a provision for the award of attorney’s fees and costs

**Action Step** Physicians should be willing to pay a terminated employee a modest sum to obtain a severance agreement and general release.

**Conclusion** Physicians may make many costly mistakes when terminating an employee. Many of these mistakes can be avoided by consulting with counsel and drafting appropriate hiring and termination documents. Even if all claims cannot be avoided, costs can be contained by obtaining employer’s liability insurance.

**Additional Resources**


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### 10.2 The 10 Biggest Legal Mistakes Physicians Make When Negotiating Call Duty with Their Employer

By Lisa D. Taylor, Esq.

**Executive Summary**

Call responsibilities significantly affect physicians’ quality of life, both personally and professionally. Nevertheless, many physicians fail to have candid discussions with prospective employers about this crucial issue because they do not want to be perceived as being unwilling to work hard. Also, they believe incorrectly that nothing could be worse than the workload of residency and fellowship. Understanding how call is addressed in an
Employment situation can be indicative of how many other matters are handled by the employer. In addition, unwillingness by an employer to discuss this important consideration candidly could indicate that the employer may be hiding something or that call responsibilities are unfair, unduly burdensome, or both. It is imperative that physicians fully understand what constitutes call responsibility in a practice.

**Mistake 1  Assuming Call Will Be Divided Fairly among All Physicians**

Physicians often assume that call will be divided fairly in a practice. They assume that if there are two physicians, call will be divided evenly between the two; if there are three physicians, call will be divided evenly among the three; and so forth. Also, physicians typically focus on compensation and benefits when they review and negotiate employment terms and not on call responsibilities. However, discussions regarding call often reveal crucial information about how an employer treats its employed physicians overall. An employer that is reluctant to discuss call (and be fair about it) often is secretive and unfair in connection with other aspects of practice operation.

**Action Step**  Physicians should seek to discuss call candidly with prospective employers before an offer of employment is accepted. If a prospective employer is not forthcoming about the issue, physicians should ask why. If they do not get an acceptable answer, employment should be reconsidered. Assumptions should never be made.

**Mistake 2  Failing to Ask about Senior Status**

Many practices either informally or formally excuse physicians from taking call when they reach a certain age or have practiced for a certain length of time. This is particularly common in obstetrical and surgical practices. Aside from adding to the work and call responsibilities of the other physicians, there can be economic implications for everyone if the physicians working less do not have a commensurate adjustment in their compensation.

**Action Step**  It is essential for physician candidates to ask specifically if and when physicians are excused from call responsibility and how this affects compensation. The ages and tenure of all of the practice’s physicians should be calculated on a time line to determine how call will be affected going forward assuming that there is no change in physician staffing. If, based on this analysis, it appears that the call responsibilities for the remaining physicians will increase significantly, the addition of new physicians or the modification of exemptions from call should be considered, as well as adding a stipend for call. Reductions in call responsibility should result in compensation adjustment so that funds are available to compensate for the greater workload being assumed by the other physicians and/or to retain additional physician staff.
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Mistake 3  **Failing to Ask about Cross-Coverage**
Many physicians, especially those in small practices, cover for each other so that the call responsibilities are shared among a larger number of physicians. This is known as “cross-coverage.” The benefit of cross-coverage is that each physician has to assume call less often. One disadvantage is that the volume of patients being covered under a cross-coverage arrangement is much higher because the physician on call covers for a larger number of physicians. There is also greater liability risk associated with cross-coverage because the covering physician often does not know the patients who require assistance while he or she is on call. Reimbursement for services can be a problem, and patient complaints can arise if they are billed for noncovered or out-of-network services. Covering groups should participate with the same insurers and managed care organizations to avoid billing complications.

**Action Step**  Physicians should ask about cross-coverage arrangements. Cross-coverage arrangements should be entered into only by compatible practices. Communication between the covering physician and the physician with regular responsibility for the patient is essential. A mechanism to ensure sufficient timely communication must be implemented by the practices covering for each other.

Mistake 4  **Failing to Ask about Ward Service**
Under federal regulations, hospitals are required to have a list of physicians in each specialty who will be available to treat patients after they have been evaluated by emergency room physicians (sometimes referred to as “ward service”). Since the hospital must ensure coverage in each specialty seven days per week, 52 weeks per year, depending on the number of physicians on staff at a hospital, ward service can be extraordinarily burdensome, simply by virtue of the number of days and nights that need to be covered. This burden is exacerbated by the fact that many patients who require services from on-call specialists are uninsured or indigent. Also, the medical staff bylaws at some hospitals exempt physicians who have been on staff for a long time from having to participate in the rotation, thereby increasing the responsibilities of the remaining physicians. Some hospitals provide stipends to physicians providing ward service, but many do not.

**Action Step**  In evaluating a practice opportunity, physicians should inquire about ward service at the hospitals at which privileges will be maintained. They should ask whether and how hospital ward service is integrated into the practice’s call rotation. If the employer physician is exempt from, or otherwise does not participate in, hospital ward service, this responsibility may be separate from, and in addition to, call responsibilities for the practice.

Mistake 5  **Failing to Ask about Holidays**
Illnesses and injuries do not take holidays but physicians must remember holidays when considering call responsibilities. Both national and religious holidays should be discussed to ensure that national holidays are allocated fairly and that religious accommodations can be
made to the extent possible. Some practices rotate so that each physician covers some of the
national holidays. If physicians in a practice are of different faiths, it may be easier to
accommodate each physician’s religious needs because they are usually not the same. How
will religious conflicts, particularly if holidays overlap, be addressed? Also, physicians
should consider how holidays will be handled if they fall on a weekend or on a Friday or a
Monday. If a holiday falls on either day, will coverage for the holiday be part of weekend call
so that noncovering physicians have a long weekend off?

Action Step  Physicians should discuss how holidays are handled in a practice. How call
for a given holiday is handled may vary from year to year depending on when the holiday
falls on the calendar. However, some general agreement as to responsibility for covering both
national and religious holidays should be reached.

Mistake 6  **Failing to Ask about Vacations**
The amount of vacation and education leave each physician takes can substantially affect the
actual burden of call responsibility. This is particularly true in a two- or three-physician
practice in which physicians cover each other for weeks at a time, especially if consecutive
weeks of vacation are taken. A significant disparity between the amount of vacation taken by
the senior and junior physicians can greatly increase the call burden for the junior physician,
even if call is otherwise divided equally, because the number of weeks per year that call is
actually shared will be limited.

Action Step  Physicians should determine the vacation and education allotment for all of
the physicians in the practice. They should also ascertain whether consecutive weeks of leave
are permitted. If call is to be divided equally and one physician has a larger vacation
allotment than another, the physician with the larger allotment should be on call a greater
percentage of the time than the physician with the smaller allotment to ensure that over the
year, call is scheduled equitably.

Mistake 7  **Failing to Define Hours of Call Duty**
It is important that hours of call duty be agreed upon so that the physician going off call can
transfer responsibility to the physician going on call on a timely basis. It is also important that
the turnover occur at a time that is practical given each physician’s other professional
responsibilities. For example, transition will seldom be smooth if it occurs when one
physician is in the operating room or both physicians are in the middle of office hours with
patients. A failure or inability to assume call responsibility on a timely basis can cause
friction between physicians.

Action Step  Physicians should agree on hours of call duty in advance to avoid transition
problems.
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Mistake 8  Failing to Define the Expectations of Call Duties
Physicians should define what services constitute call responsibility. At a minimum, an on-call physician will be required to respond to medical emergencies that arise while the office is closed. Depending on the nature of the patient population and the practice specialty, some problems can be handled by telephone while others will require the covering physician to see the patient at the office or hospital. Since the appropriate response will depend on the nature of the emergency, the response required will not be known in advance. However, there should be an overall trend in the number and types of calls received, how often calls can be taken at home, how often it will be necessary to go to the office or a hospital. A physician should ask about these trends, as well as determine whether the on-call physician is responsible for any other professional or administrative matters. For example, some practices require that the on-call physician review and approve all of the telephone requests for prescription renewals received on that day.

Action Step  Physicians should determine what services are generally required to be rendered while they are on call.

Mistake 9  Failing to Clarify Reimbursement and Compensation Issues
Physicians should clarify how services rendered while on call are affected by reimbursement and affect compensation. If substantial uncompensated services or disproportionate call coverage is rendered, adjustment to compensation may be appropriate. Similarly, if services are rendered to patients who are insured through a capitated contract with an insurer or other payer that makes a fixed monthly payment to the patients’ primary care physician and services are rendered by an on-call physician who cannot bill for his or her services, how will the on-call physician be compensated? Physicians should also determine how additional services for patients first seen while on call (e.g., those who presented in the hospital emergency room) will be provided. For example, if a patient requires surgery, will the physician who saw the patient while on call provide it?

Action Step  Physicians should address reimbursement and compensation issues related to their call responsibilities.

Mistake 10  Failing to Obtain Commitments
It is important for physicians not only to ascertain how the practice handles call and matters that can affect call responsibilities, but also to obtain a commitment as to how they will be handled during the term of their employment. An employment agreement need not include the specificity of a call schedule, but it should at a minimum address how call will be allocated and scheduled. Physicians should also have a good understanding about any exemptions from call, the duties to be undertaken during call, and follow-up care. Any uncertainties should be addressed.
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Action Step  Terms relating to the parameters of call responsibility should be incorporated into a written employment agreement signed by the parties.

Conclusion
Physicians contemplating employment relationships should be sure that they have a good understanding of what call responsibility entails. They should obtain a commitment from their employer that call responsibilities will be equitable and reasonable.

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10.3 The 10 Biggest Legal Mistakes Physicians Make When Disciplining Employees
By Rosa M. C. Cumare, Esq.

Executive Summary
No matter how excellent physicians’ clinical skills, their practices will suffer if employees are not managed properly. Knowing when, why, and how to impose discipline is essential in employee management. Small performance problems that are not addressed promptly or properly often develop into continuing sources of aggravation and stress for physicians and their support staff. Such problems also can grow into serious trouble for the practice, exposing physicians to litigation by employees, patients, and vendors. This chapter discusses nonunionized workplaces only. Collective bargaining agreements or civil service regulations usually have their own rules on when and how to discipline employees.

Mistake 1  Not Having Clear Timekeeping and Attendance Standards and Records
Associating time clocks with blue collar working environments, physicians’ offices often keep time cards and attendance records on an informal “honor” system. Some employers do not keep such records at all, under the assumption that timekeeping is not required because
the office employees are “salaried.” Too often, staff are not given clear directions on when they must arrive and when they may leave; they are not instructed to note time off for lunch or for extended breaks; they are not told when they may work overtime. Clear guidelines are not set for sick, personal days, or vacation days; paid holidays; or leaves of absence. Because payroll is likely to be the most sizable portion of office overhead, employee productivity is critical to a successful, profitable practice. Equally important, failure to keep accurate time and attendance records can expose a medical practice to significant litigation and penalties by both current and former employees.

**Action Step** Physicians should establish timekeeping and attendance rules that fully comply with federal and state laws and regulations. Accurately maintained timekeeping and attendance records will reveal problems that need to be addressed. If the “honor” system does not work, physicians can use a punch-type time clock.

**Mistake 2 Not Having Suitable Written Job Descriptions or Performance Standards**
Most physicians in the United States practice in groups with fewer than nine doctors and fewer than 20 employees, therefore their offices tend to be run in a “we are family” style. Many small practices do not have written job descriptions or employee manuals or written policies and procedures. It is difficult to discipline employees when job requirements have not been spelled out or employees have not been informed of the expected standards of conduct.

Many physicians’ offices rely on cookie-cutter, one-size-fits-all manuals or policies and procedures that are available from the local chamber of commerce, professional associations, or a human resources consultant. While helpful, such materials, can be a hindrance if they have not been tailored to the particular needs and preferred management style of the practice, have not been checked for accuracy and internal consistency, or are not kept up to date with the latest laws and regulations.

**Action Step** Employees need to know what is expected of them, and they should be told clearly what is not acceptable behavior. Physicians should develop and implement management tools (e.g., job descriptions, employee manuals, or written policies and procedures) that comply with federal, state, and local laws and regulations, are kept up to date, and specifically fit the physicians’ practice needs and styles.

**Mistake 3 Not Conducting Regular Performance Evaluations**
In a small office environment, physicians may think that conducting regular performance evaluations is a waste of time because the physicians work so closely with staff that the staff presumably knows if their performance is or is not acceptable. However, self-assessments are rarely introspective, and employees usually err on the side of perceived excellence. Even in
practices where employees are regularly evaluated, the reviewer may gloss over shortcomings and highlight strengths so that the employee will “feel good” at the end of the review.

**Action Step** Physicians’ offices should evaluate all employees (even if they have only one) at least once a year to address the good and the bad. Evaluations should be based on attendance, job requirements, and relevant office policies and procedures. The evaluations should include specific timetables for correcting shortcomings and goals for further development. In an evaluative setting, problems can be discussed in a nondisciplinary way; for example, constructive criticism can be combined with positive reinforcement. Physicians should document the evaluations and ask employees to acknowledge receipt of the evaluations by signing the documentation.

**Mistake 4  Not Adhering to Established Standards or Applying Standards Inconsistently**

Even though physicians’ offices may have formal management tools in place, for various reasons (e.g., lack of training, press of business, “family-style” supervision, or reluctance to criticize), these tools may be neglected or be inconsistently applied. For example, employees may not fill out timecards showing tardy arrivals or early departures, may not note time taken off for lengthy breaks or lunch, or may not indicate overtime worked. Staff supporting certain doctors in the practice may have more leeway than other staff in taking time off, attending to personal business, engaging in unprofessional behavior, and the like. Certain individuals are given perks and benefits that others are not. Some must keep up with demanding doctors, while for others the attitude is *laissez-faire*. Inconsistent and unequal application of attendance standards, employment policies, and benefits leads to morale problems and problems with discipline. Worst of all, inconsistency and unequal treatment may violate applicable laws or regulations.

**Action Step** All employee policies must be applied fairly, equally, and consistently. Exceptions to established policies should be granted rarely and only after careful consideration of the consequences. If necessary, physicians should consult experienced employment counsel.

**Mistake 5  Dealing with a Problem Too Quickly or Too Late**

Sometimes a problem provokes an immediate, unconsidered response (e.g., “You’re fired”). Sometimes, physicians put off dealing with a problem either because other pressing matters intervene or because they want to avoid confronting the offending employee.

**Action Step** Physicians should address employee problems in a timely manner and tell the employee or employees involved that their conduct will be dealt with appropriately. Physicians should never discipline an employee while they are angry or upset with the employee, but should wait until their emotions have cooled. On the other hand, physicians
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should not wait so long that memories have faded and the facts leading to the need for discipline have become fuzzy. Depending on the issue, physicians should tell the employee or employees involved that an investigation into the misconduct or circumstances surrounding the misconduct may be necessary. They should not let the offending employees think that no action will be taken, and notify whoever is responsible for personnel management prompt promptly that a problem has arisen.

Mistake 6  Not Conducting an Appropriate Investigation
Physicians too often ignore problems or complaints and investigate a problem only after it has become a crisis. Even then, the investigation may be cursory or incomplete.

Action Step  Physicians should adopt proper investigative procedures and recording techniques. No matter how slight an employee performance problem appears to be, physicians should conduct an investigation into the circumstances leading to the problem. A plethora of employment and civil rights laws prohibits discrimination in the workplace; therefore, disciplinary measures must be applied equally to all employees. At a minimum, physicians wishing to conduct a proper investigation should do the following:

- Appoint an investigator who is not directly involved in the situation.
- Refer to the employee manual, office policies and procedures, or any other rules or guidelines that apply to the misconduct at issue.
- Examine the actual behavior that calls for discipline (i.e., interview the parties involved and review the pertinent written documentation or other tangible evidence).
- Keep an open mind. Sometimes performance problems are “personality conflicts” and not outright violations of office policy.
- Remember that employees have a right to privacy but not a right to secrecy. Thus, the investigator should be as discreet as possible and keep information confidential; however, no employee involved in an investigation can be promised anonymity. Everyone involved should be cautioned against engaging in conduct that could be regarded as retaliatory.
- Ask open-ended questions: who, what, where, when, why, and how. Make sure to ask if there are any witnesses or any documents or other tangible evidence.
- Keep good notes of the investigation. Identify the interviewer, the witness, and the date.
- Depending on the seriousness of the matter, ask the persons involved and any witnesses to give written statements.
- Keep the notes, statements, and results of the investigation in a separate investigative file.
Mistake 7  Disciplining Employees Differently
A common problem in private practice is that particular employees may receive favored treatment and are not disciplined for violating the practice’s policies, while others who are not so highly regarded are punished for engaging in the same type of misconduct.

Action Step   Physicians should refer to prior history before imposing discipline and consider the future consequences of the discipline. If misconduct arises out of the type of activity that employees normally engage in during the course and scope of their employment, precedent is important. Physicians should ask how the problem was dealt with in the past. If this is the first time this type of misconduct has occurred, how it is dealt with will establish a precedent for the future. Physicians should remember to deal with all employees equally. Exceptions to the rules should be made rarely, if at all.

Mistake 8  Failing to Make the Punishment Fit the Crime
Because most physicians have busy practices, they often fail to impose discipline that is appropriate to the misconduct or performance problem that has arisen. Instead of making the punishment fit the crime, they may simply express their impatience in passing or vent their frustrations at the employee without taking the time to engage the employee in a thoughtful disciplinary process.

Action Step   Physicians should fit the discipline to the misconduct and follow up appropriately to address the causes and the consequences. To be effective, discipline must fit the misconduct at issue and should include guidelines and/or time frames for improvement. The disciplined employee must be clearly informed why the misconduct requires discipline, what the discipline will be, and that improvement is required. Physicians should try to address the root cause of the problem. If ignorance of office procedures is the trouble, additional training should be provided. If attendance is the issue, and family or personal problems are the cause, a referral to a counseling service may be helpful. If attitude or personality clashes cause difficulties, physicians should monitor the behavior of all involved more closely and, if possible, separate the employees. Physicians should follow up with the disciplined employees and their supervisors to make sure the problem has not reoccurred.

Mistake 9  Failing to Document Discipline
Although physicians are trained to maintain patient charts, they often do not apply those skills to maintain employee disciplinary records. Contemporaneous notes are essential in dealing with disciplinary issues for the same reason they are essential in treating patients: The notes memorialize what was said and which actions were recommended and taken. Reliance on memory alone is ill advised, especially if the discipline results in adverse employment actions, such as suspension, demotion, or termination.
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Action Step Physicians should document all discipline given, including oral warnings. Depending on the policies and procedures adopted by the medical practice, employees may be subject to progressive discipline. In other words, the policy first calls for oral, then written, warnings before termination. No laws require employers to adopt a system of progressive discipline. Under certain state laws, systems of progressive discipline may create an employment agreement to terminate only for good cause. If that is the applicable law, a progressive disciplinary system is not recommended. Regardless of the disciplinary system adopted, physicians’ offices should document all discipline. Thus, even an oral warning should be noted in the employee’s file. If possible, the employee should acknowledge in writing that a warning or other discipline was given.

Mistake 10 Not Taking Applicable Laws into Account
A multitude of laws affect physicians’ ability to discipline certain categories of employees. For example, if a problem arises out of an employee’s frequent absences from a workstation and those absences are directly related to a disability or pregnancy, discipline may be problematic because laws protecting disabled or pregnant employees require that employers make reasonable accommodation for their conditions. Likewise, if a problem arises because an employee does not wish to adhere to a work schedule, a schedule adjustment may be needed to accommodate that employee’s religious beliefs, jury or military service, or request for family or medical leave. Wage and hour laws may limit the type of discipline; for instance, exempt employees can lose their exempt status if their pay is docked for disciplinary reasons. Employees who have complained about the terms and conditions of their employment may be protected against employer retaliation. If a link exists between the complaint and the discipline, an employer may be liable.

Action Step Physicians should ensure that employees are not being disciplined for reasons that arise out of the employees’ protected status and that the discipline imposed does not violate any applicable laws. They should check with trained, experienced human resources professionals or employment counsel before taking any substantive disciplinary action.

Conclusion Physicians’ offices that adopt and adhere to proper employment policies and procedures, including consultation with legal counsel when necessary, will be able to monitor performance better, impose appropriate discipline, and avoid the stress and cost of nonproductive employee behavior.

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10.4 The 10 Biggest Legal Mistakes Physicians Make When Terminating Employees

By Rosa M. C. Cumare, Esq.

Executive Summary
Terminating an employee is probably the most difficult personnel decision a physician can make. Contrary to popular reality television shows, “You’re fired” is not easily said. Often, a termination is an emotion-charged event for employee and employer alike. If not carefully handled, a terminated employee may file claims for workers’ compensation, wages due, wrongful discharge, and/or employment discrimination with related claims for personal injuries, such as infliction of emotional distress or defamation. Defending such claims is time-consuming and costly. Properly managed terminations can avoid such claims or, at a minimum, provide physicians with viable defenses and limit the disgruntled employee’s claims.

Mistake 1 Not Having an Express “At Will” Employment Agreement
In general, employment may be terminated either “at will” or “for cause.” At-will employment agreements provide that an employee can be discharged at any time, for any reason, with or without advance notice. For-cause agreements provide that an employee can be discharged only for good reason. Often, for-cause agreements also require that, whenever possible, an employee must be given advance warning with an opportunity to improve. Physicians who do not have express at-will agreements with their employees do not have as much latitude in making termination decisions as physicians do who have ensured that employment is at will.

Action Step Physicians should provide for at-will employment by giving notice in personnel management materials and documents that employees sign. Written notice of at-will employment should be included in employer policies and procedures and documents that employees sign (e.g., application forms, acceptance and/or offer letters, receipt of employee manuals or handbooks, disciplinary notices, and descriptions of benefits). Language indicating that employees’ at-will employment status may be changed only by a written agreement signed by the manager of the practice should also be included.
Mistake 2  **Implying That Termination Will Be Only “For Good Cause”**
If employment is not expressly terminable at will, under certain circumstances employment can be interpreted as terminable only for cause. Some factors that may give rise to an implied agreement to terminate only for cause are oral or written promises of continued employment, a history of positive performance evaluations with regular promotions and merit increases, longevity of employment, or an employer’s practice of terminating only for good cause. If such conditions exist, physicians should consult with legal counsel to determine whether an employee may be discharged at will or if other conditions must be met first.

**Action Step**  Physicians should not engage in conduct that could transform at-will employment to an implied agreement to terminate only for cause. They should reaffirm employees’ at-will employment status whenever possible.

Mistake 3  **Not Spelling Out What Types of Conduct May Result in Termination**
Regardless of whether employment is terminable at will or for cause, many physicians’ offices fail to have guidelines on what type of conduct could result in termination.

**Action Step**  Physicians should give employees written guidelines that they sign and that describe the types of misconduct that may result in termination. Employee manuals, handbooks, and/or written policies and procedures should include examples of terminable offenses, especially for such misconduct as tardiness, absenteeism, failure to adhere to professional standards in conduct and appearance, drug and/or alcohol use that impairs an employee’s judgment, violations of patients’ rights to privacy, violence in the workplace, dishonesty, abuse of telephone and/or computer access privileges, and discrimination or harassment of other employees, vendors or patients. Catch-all language indicating that the practice reserves the right to terminate for additional reasons that are within its sole discretion also should be included.

Mistake 4  **Believing That Progressive Discipline Is Always Required**
A common disciplinary method, known as progressive discipline, generally requires that prior to termination an employer must follow a rigid pattern of imposing discipline. First, the employer must give one or more informal oral warnings. Next, the employer must give one or more written warnings. Thereafter, the employer may impose penalties, such as suspension without pay. Only after all these steps have been taken can the offending employee be fired. Many physicians mistakenly believe that they must adopt this disciplinary system. However, outside of the unionized or civil service setting, this type of system is not required by any laws or regulations. Even agreements to terminate only for cause do not require adherence to such a formal disciplinary system. Well-written for-cause documents (such as employee handbooks and application forms) usually provide a shortcut to termination if the offending conduct warrants immediate discharge (e.g., violence in the workplace or intentionally endangering a patient).
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Action Step  Physicians should implement, in writing, a flexible system of discipline that enables the practice to manage employees and terminate when necessary, with or without prior warning or notice.

Mistake 5  Delaying Termination or Transferring the Employee in the Hope That Conduct or Performance Will Improve

Physicians, like employers generally, usually are reluctant to terminate employees who do not meet expectations. For example, physicians’ offices may choose to extend a newly hired employee’s probationary or training period instead of terminating the employee when problems appear, such as chronic tardiness, unexplained absences, unprofessional behavior, uncooperative attitudes, or inability to follow office procedures. Furthermore, in an attempt to avoid termination, physicians sometimes decide to transfer offending employees to other positions, reporting structures, or departments in the hope that a change of job duties or surroundings will result in improvement.

Action Step  Physicians should be vigilant when dealing with employees who exhibit conduct or performance problems and terminate rather than continue to keep them employed. Unless a problem is directly related to the performance of a specific task that experience has shown is difficult to learn, it is highly unlikely that a new hire’s performance will improve over time. New employees usually are on their best behavior at the outset of employment, when they need to prove they can do the job. If their “best” falls short, physicians should terminate. Problems that show up at the beginning usually stay problems and often become worse. The same is true for regular employees with problems: If they do not improve within a set period of time after having been warned of their deficiencies, they should be terminated. Physicians should not use transfers as a means of avoiding termination. Although on rare occasions a transfer may succeed, generally the adage of a single rotten apple’s spoiling the whole basket holds true. A difficult employee tends to remain a difficult employee no matter where he or she works in the office or to whom he or she reports.

Mistake 6  Signaling to Employees That They Will Be Terminated

Physicians who have decided to discharge an employee sometimes give signals in advance that they have made the decision to terminate the employee. Such signaling should be avoided because an employee who knows termination is coming has the opportunity to engage in preemptive actions (e.g., going on “stress” leave, filing claims for worker compensation or harassment or discrimination, or complaining about other terms and conditions of his or her employment). These types of employee claims can affect the termination decision by raising the specter that the employee is being terminated in retaliation for engaging in protected conduct (a virtual presumption under current California law). Adverse employment actions, such as termination, may be regarded as retaliatory, and retaliatory conduct qualifies as a separate violation of a multitude of employment laws and regulations.
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**Action Step**  Physicians should not tip off employees that they are going to be discharged. They should make arrangements for issuance of final paychecks, benefits information, and/or exit interviews with those who have a need to know and can be trusted to maintain confidentiality. Physicians who own or operate practices employing more than 100 people and who plan to engage in a “mass layoff” of 50 employees or more should consult with legal counsel because the provisions of the federal Worker Adjustment and Retraining Notification (WARN) Act may require advance notice. (State law variants of the federal act exist as well.)

**Mistake 7  Terminating Employees without Considering the Employees’ Protected Status**
Physicians often decide to terminate a problem employee without considering whether the employee belongs to a protected class. A plethora of federal and state laws prohibit employers from engaging in adverse employment actions, such as terminations that are motivated, even in part, by the employee’s protected status. For instance, civil rights laws prohibit discrimination or harassment on the basis of employees’ race, color, gender, pregnancy, sexual orientation, religion, national origin, ethnicity, mental or physical disability, age, or veteran status. Other laws prohibit adverse employment actions against employees who are on jury duty or military leave, who have been subpoenaed to testify, or who have “blown the whistle” on the employer. Terminations for garnishments of wages or complaints filed by the employee about payroll violations also may be circumscribed. Termination decisions that are not carefully examined to ensure that they do not run afoul of applicable laws will cause great trouble to a physician’s practice.

**Action Step**  Physicians should consult with a knowledgeable human resources professional and/or employment counsel before terminating an employee to make sure that the termination does not violate applicable laws protecting the employee. Especially laws protecting the disabled or pregnant employee must be considered because those laws require employers to provide reasonable accommodation of the disability or pregnancy for employees who are otherwise qualified to perform the essential functions of the job. “Reasonable accommodation” may include modification of job requirements, including attendance, transfer to an available less strenuous assignment, and other measures designed to help the disabled or pregnant employee perform the functions of the job.

**Mistake 8  Giving Employees a Reason, False or Otherwise, for the Termination**
Employees who are being terminated usually demand to know the reason. Physicians who do not have an agreement with their employees to terminate only for cause do not have to give a reason for a termination decision. Often, physicians want to “soften the blow” by calling the termination a layoff instead of an involuntary discharge. In general, a layoff implies that the employee has been terminated because the position has been eliminated or the practice is retrenching financially and the employee is eligible for rehire when circumstances improve. Unless the circumstances warrant using the term, physicians should not call an involuntary
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discharge a layoff. Likewise, physicians should not give a false or misleading reason for a
termination. If the employee files a claim against the practice, such matters as the reasons
given, whether orally or in writing, are in dispute, and physicians can have their credibility
challenged if they provide different reasons for the decision during the course of defending
against the employee’s claims.

**Action Step** Physicians who are going to give one or more reasons for a termination
should prepare the wording carefully and have it checked by an experienced human resources
professional and/or employment counsel. Physicians should not let the terminated employees
pressure them into saying more than they have cleared with their advisers.

**Mistake 9** **Conducting the Termination Interview Alone and without Proper
Advance Preparation**
Termination interviews are seldom pleasant. Employees may be confrontational or emotional
in other ways. One of the biggest mistakes physicians can make is to conduct a termination
interview alone. The second biggest mistake is to conduct a termination interview unprepared
and simply to “wing it.”

**Action Step** Physicians should prepare carefully for the termination interview and have a
checklist of topics to be covered and materials to be handed out or collected. They should not
conduct the termination meeting alone. Whenever an employee is terminated, physicians
should make sure that at least two people other than the employee are present: one conducts
the termination; the other is a witness who takes notes of the meeting. Before the meeting, the
physician should prepare a list of items to be covered (e.g., presentation of the final paycheck,
arrangements for payment of outstanding reimbursable expenses, recovery of office
equipment and security information, postemployment benefits, and methods of dealing with
job reference requests). The physician should ask the employee for and obtain all office keys,
access codes, computer passwords, identification badges, and office equipment (e.g., cellular
phones, beepers, and laptop computers). If the employee does not have the information or
equipment immediately available, the physician should accompany the employee to the
location where they are kept or, if not on the premises, obtain a signed, written agreement
from the employee that the requested materials will be returned by a date certain. The
physician should conduct the termination discreetly, preferably near the end of the workweek
so that office gossip can be kept to a minimum, and allow the employee time to clear out his
or her workspace under supervision. If necessary, the physician should make arrangements
with the employee to have someone present on a weekend. Also, the physician should
document the materials the employee takes and have the employee sign the documentation.
The physician also should prepare a neutral statement to explain to other staff why the
terminated employee is no longer at work, without making the employee “an example” or
disclosing information about the reasons for the termination to persons other than those with
a need to know.
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Mistake 10  **Offering a Termination Package without Obtaining a Release of Claims**

Often, in an attempt to overcome feelings of guilt for terminating an employee, physicians offer the employee severance pay without obtaining a release of all claims. Sometimes the practice has a formal severance policy set forth in employee manuals or offer letters. In those cases, the terms of the policy must be followed. In all other cases, severance is entirely discretionary and, if offered, should be expressly conditioned on the employee’s agreeing not to file any employment-related claims against the practice, other than a claim for unemployment benefits where applicable.

**Action Step**  Physicians should consult with experienced employment counsel before offering severance pay to a terminated employee and obtain the necessary written severance agreement and release of claims. Releases for employees who are over age 40, for instance, must conform to the special requirements of federal law.

**Conclusion**  Physicians who want to manage their employees effectively must be prepared to terminate ineffective employees. Because of the many traps for the unwary that exist in carrying out terminations, physicians should always consult with experienced human resources professionals and/or experienced employment counsel before discharging an employee.

**About the Author**

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10.5  **The 10 Biggest Legal Mistakes Physicians Make When Interviewing Job Applicants**

By Margaret J. Davino, Esq.

**Executive Summary**

There are multiple issues that physicians should consider when interviewing potential employees, whether physician employees or nonphysician employees. These issues range
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from avoiding claims of discrimination to ensuring that the physician employers know the background and experience of the person they are hiring.

**Mistake 1  Not Checking References**

Some studies have shown that more than half of employers do not check in total or in part the references of a prospective employee. One reason that reference checks are so important is the possibility of litigation if an employee with a history of problems harms a patient and that history could have been discovered if references were checked. Second, reference checks can often provide important information about an employee’s attendance or performance at a previous employer.

Many employers are reluctant to provide any information when asked for references (other than dates of employment, position title, salary, and perhaps reason for termination) due to concerns about libel or slander suits if the information provided is negative. However, positive information will often be shared with a prospective employer, and it can help in making an employment decision. In addition, even limited factual information can be compared with the information the applicant put on the employment application to verify its accuracy.

**Action Step**  Physicians should check both professional and personal references of all applicants before making a decision as to employment.

**Mistake 2  Asking Questions That Could Lead to a Discrimination Suit If the Applicant Is Not Hired**

Federal and many state laws protect people from being discriminated against on the basis of characteristics such as race, color, creed, sex, national origin, age, disability, or pregnancy, and, in many states, marital status. These laws pertain not only to employees, but also to job applicants. There are rare exceptions for bona fide occupational qualifications (e.g., a male obstetrician is required to have a female in the room with him during an examination, and therefore will hire only a female as a medical assistant).

Physician employers must therefore ensure that during the interview they do not make any statements that might seem to indicate a preference for a certain “type of person” and that their employment application does not ask for information about, for example, marital status or age. Because the Americans With Disabilities Act protects only people who can perform the essential functions of their job, with or without reasonable accommodation, physicians can ask, “Are you able to perform the essential functions of the position you are applying for, with or without reasonable accommodation?” They can also ask an applicant who states that he or she needs reasonable accommodation what kind of accommodation is needed. In general, many employers feel that disabled employees have better than average productivity and attendance.
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Action Step  Physicians should not ask job applicants (verbally or on the employment application) about race, color, creed, sex, national origin, age, disability, pregnancy, or marital status.

Mistake 3  Considering Factors That Should Not Legally Be Considered in the Interview or Hiring Process
Consistent with Mistake 2, during the interview process not only should no remarks be made about any characteristic protected by law (e.g., race, color, and creed), care must also be taken not to make hiring decisions based on whether other people (whether staff or patients) would prefer someone “like them.” Federal law does not generally allow patient preference to dictate hiring decisions (e.g., it is not allowable to refuse to hire someone of a certain race or nationality because a physician is concerned that his or her patients may not be comfortable with that race or nationality). Although claims by applicants who are not chosen for a job are less common than claims by employees who are terminated, claims by applicants do occur. In addition to the federal Equal Employment Opportunity Commission (EEOC), under which an aggrieved person may file a hiring complaint, many states have divisions or commissions on human rights with which a person may file a hiring or employment complaint, without the expense of going to court or hiring a lawyer.

Action Step  Physicians should consider only those factors that are tied directly to job performance in determining whether to offer someone a job.

Mistake 4  Making a Job Offer Before the Preemployment Screening Process Is Concluded
It is wise to have a thorough preemployment screening process that includes more than reference checks. Preemployment screening may include verifying—by contacting previous employers, by conducting a criminal background check, or through drug screening—that everything on the employment application is true. In all cases, the applicant should not be allowed to start working until all of the necessary information has been received. The applicant can be told that he or she has the job pending the return of all of his or her information. If the preemployment screening information is not received in a timely manner, the applicant can be asked to contact his or her references or previous employers to forward the necessary information. On the rare occasion when it is absolutely necessary that a person start working before all background information has been received, the applicant should be asked to sign a statement that he or she realizes that the physician employer reserves the right to terminate the employment based solely on any negative information that is received.

Action Step  Before hiring job applicants, physicians should wait until all information requested as part of preemployment screening has been received.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

Mistake 5  **Not Asking about Gaps in a Resume**
The timeline on an applicant’s resume or employment application should always be reviewed to see if there are any breaks in time between jobs. If such breaks exist, the applicant should be questioned about them. The reason for a break between jobs may have been to take off time to travel; alternatively, it may be because the applicant didn’t want to list a job that ended badly. Regardless of the answer, the physician employer should be aware of the situation and judge its importance.

**Action Step**  Physicians should look at the job applications and resumes of potential employees to see if there are any breaks in time between jobs and if there are any, ask the reasons for the breaks.

Mistake 6  **Not Having Any Notes of the Interview**
For each job applicant, a file should be created that contains the employment application, resume (if obtained), and notes of any interview with the applicant. Notes of an interview are important for several reasons; for example, during an interview some applicants make sweeping statements about their capabilities that do not represent their true abilities once they begin work. It is always helpful to have documentation of what applicants said about their experience and ability during the interview process so that a decision can later be made as to whether they misrepresented their abilities and whether this is a reason for termination. It is also helpful to have documentation that the physician informed the applicant during the interview process of the requirements of the job (e.g., working Saturdays), so that if the person hired is unable to perform that job function (e.g., cannot work Saturdays because of religious observance), he or she cannot make a claim of being discharged for a discriminatory reason.

In addition, although lawsuits or EEOC or other administrative agency claims against employers by applicants who are not hired are not as common as claims by employees who are terminated, it is not unusual for an applicant to file a claim with an administrative agency (such as the EEOC or a state division or commission on human rights) complaining of discrimination in the hiring process. The best defense to such a claim is the assertion that the applicant was not hired because the employer selected a better qualified person. A review by the EEOC as to whether the person hired truly was “better qualified” often will involve assessing both individual’s resumes, experience, and skills, as documented in interview notes. It is always helpful to be able to go back to interview notes and use them to demonstrate that the person hired discussed experience or abilities during the interview that led the employer to believe that person was best for the job.

**Action Step**  Physicians should take and retain notes of interviews that document why an applicant was or was not hired.
Mistake 7 Overlooking Warning Signs
Part of the preemployment screening process is to look at factors regarding an applicant’s experience, education, background, and attitude that can be helpful in deciding whether the applicant would be a good fit for a job. A number of warning signs can appear in the process, including applicants talking about prior bosses whom they hated, or stating that co-workers at their last job didn’t like them because of their race, religion, etc. Other warning signs are when an applicant’s previous supervisor refuses to give any information when called for a reference check, or when an applicant does not have a good explanation for a three-month gap between two previous jobs. By itself, any warning sign may mean nothing or may mean something. The purpose of the preemployment screening process is to try to determine whether a person is appropriate to hire. However, physician employers must be aware that if a job applicant tells them something about their marital status, a possible disability, or a pregnancy, for example, they cannot refuse to hire that person on those grounds. If that person is not hired based on other legitimate grounds, the physician should be sure to have documented that the failure to hire was tied to the other legitimate reason in order to avoid being accused of discriminating based on a protected status.

Action Step Physicians should look for signs in the preemployment screening process indicating that an applicant has had problems in prior jobs that may be repeated in their new position.

Mistake 8 Not Explaining Clearly the Parameters of the Job
It is always wise to discuss in detail during an interview what the job may entail. This is even more important in a medical setting where staff may be exposed to sensitive areas, such as people’s bodies and bodily fluids. Such an in-depth discussion is important for a several reasons: to evaluate the applicant’s comfort level with the functions involved in the job and the applicant’s experience with various job functions; to ascertain if the applicant is willing to learn things that he or she has not done before; and to give the applicant notice of all of the functions of the job so that the applicant can decide if he or she is willing to perform them. If employees may have to help with patient care and do paperwork, it is important to ensure that they are comfortable doing both. The interview is also a good time to explain to applicants the confidentiality requirements involved in working with patients. It may seem like common sense to someone who has been working in the field for years, but it is always best to instruct applicants that no patient information can leave the office, regardless of whether the patient is a stranger or a staff member’s neighbor.

Action Step Physicians should explain clearly to applicants what may be involved in a job, including contact with patients, and instruct applicants regarding confidentiality requirements.
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Mistake 9  Making Promises or Assurances of Job Security
If an employee does not have an employment contract, the law generally considers that person to be an employee at will, allowing either the employer or the employee to terminate the employment at will. However, some courts have recognized statements made by an employer as creating a verbal employment contract (the law requires very few contracts to actually be in writing). These statements can be references to “permanent” employment after a “probationary period” or “you will have a job here as long as you want it.” Courts are particularly alert to situations in which an employee left a previous job to come to a new job, allegedly because the employee relied on promises made by the new employer as to the security of the new job.

Action Step  Physicians should never promise applicants anything about the duration and permanency of a job.

Mistake 10  Failing to Determine a Job Applicant’s Work Ethic
Although physicians certainly can’t expect other people, including their employees, to treat their practice as their own and work as hard as the physicians do, physicians should be able to expect their staff to have a good attitude and put forth their “all” during the hours that they are on site. In that regard, physician employers can ask about these things during the interview process, including the job applicant’s flexibility to do the multiple tasks that can occur in a physician’s office, their willingness to work overtime if needed, and their ability to interact well with others, both patients and staff. Physicians also can ask applicants whether they are able to work overtime, how much notice they will require prior to working overtime, whether they have a “service” philosophy toward patients, and how they get along with others. Physicians should beware of applicants who seem to have a chip on their shoulder, or who talk about how prior employers treated them poorly and expected them to do extra tasks.

Action Step  Physicians should ask during the hiring process about an applicant’s ability to work overtime or flexible hours, and avoid hiring someone who acts resentful toward people.

Conclusion
Physicians should avoid making these mistakes when interviewing potential employees.

About the Author
Margaret J. Davino, Esq., specializes in health care law, including transactional, compliance, contractual, corporate, regulatory and risk management legal issues for Kaufman
10.6 The 10 Biggest Legal Mistakes Physicians Make When Hiring an Employee

By Margaret J. Davino, Esq.

Executive Summary
Physicians often make mistakes when hiring employees. The 10 biggest mistakes in this regard follow.

Mistake 1  Failing to Clearly Explain the Parameters and Expectations of the Job
People working as medical assistants or receptionists in physician offices may have never worked in a medical setting before and may not be aware of the importance of certain skills that are not always necessary in other businesses, including having the flexibility to perform multiple job functions; as the “face” of the office, having that face be a friendly, smiling, and helpful one; being able to assist with exams or procedures that may involve blood or body fluids, and being able to keep patient information private. One requirement of the patient privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) is that all physician office staff receive training on the confidentiality and other requirements of HIPAA. Staff should be aware that they may not mention patient names or identifying information to anyone outside of the office, even if their neighbor showed up with an interesting condition. HIPAA is being enforced by the federal Office of Civil Rights, which has received thousands of complaints, ranging from breach of confidentiality to refusal to release medical records.

Action Step  Physicians should maintain a checklist of expectations for office staff, which should include the importance of being friendly and helpful to patients at all times, a
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

description of the staff member’s job, the need for flexibility, and the requirement that patient information will be kept confidential at all times.

Mistake 2   **Having Documents That Create Other Than At-Will Employment Status**

Generally, an employee without an employment contract is an employee at will, whose employment can be terminated by either the employer or the employee at any time with or without cause. However, courts in some states have construed certain documents in the workplace as creating an “implied” contract between an employer and an employee. These documents are usually policies or procedures in the workplace, or employment manuals, that can be read to “promise” that employees will be given certain protections in their jobs. For example, a policy may state that before an employee will be terminated, that employee must be given a written warning. If a physician has terminated an employee without giving the employee a written warning, the employee could claim that this policy created an implied contract between the physician and the employee, that the employee relied on the promise of a written warning, and that the physician’s failure to give a written warning violated this implied contract. Likewise, some policies state that employees may be terminated only for certain reasons, and then list those reasons. If a physician terminates an employee for a reason that was not listed, the employee could claim that the termination was a breach of the implied contract between the physician and the employee that termination would be only for certain stated reasons. In addition to reading through carefully all policies to ensure that the physician, as the employer, has sufficient flexibility to take actions needed, many employers include a cover page in employee manuals or policy books that states: “This manual and these policies shall not be construed to create a contract of any type between the employer and the employee, may be changed by the employer at any time, and do not take away from the fact that employment at [name of employer] is at will.”

**Action Step**  Physicians should ensure that they do not have policies or employee manuals “promising” that an employee will receive certain rights before termination or will be terminated only for certain reasons.

Mistake 3   **Classifying an Employee As an Independent Contractor**

When bringing a new staff member on board, particularly a new physician, it is sometimes tempting to treat that new staff member as an independent contractor, rather than an employee, and save on payroll taxes, FICA, withholding, and even the cost of having someone figure out the appropriate amount to withhold from every paycheck. However, the Internal Revenue Service considers workers who perform tasks in the same environment over repeated intervals of time to be employees, unless an examination of the relationship truly demonstrates that the worker is not subject to the direction and control of the employer. The IRS has 20 factors that must be reviewed before considering a worker to be an independent contractor, including whether the worker must comply with instructions about the work, whether services are integrated into the business, whether services must be rendered
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personally, whether the working relationship is continuing in nature, whether set hours of work must be followed, whether the worker works full-time for this employer, whether work must occur on the employer’s premises, whether payments of regular amounts are received at set intervals, whether the employer furnishes tools and materials, whether the worker offers services to the general public, and more. The fact that the worker is a professional such as a physician is not sufficient to classify that person as an independent contractor. If the IRS determines a worker to have been misclassified as an independent contractor, it can seek to have the employer be responsible for any withholding taxes (Social Security and personal income taxes) that were not taken from the employee’s paycheck. This can be an expensive mistake.

**Action Step** Physicians should ensure that new workers are properly classified as employees versus independent contractors and be aware that the IRS considers most workers to be employees with the requirement that taxes be withheld from their paychecks.

**Mistake 4 Not Considering Whether to Have a Contract for a Physician-Employee**

When hiring a physician, whether or not to have a contract with that person is always a consideration. Without a contract, employment is generally considered to be “at will:” at the will of either the employer or the employee. It is often to an employer’s benefit to have an at-will employment arrangement. However, a physician’s employer should have at least two things in writing. The first is an agreement by the physician to reassign to the employer his or her right to collect payment (sometimes simply in a billing form rather than in a contract). The second is a restrictive covenant, if both parties have agreed to such. A restrictive covenant often prohibits an employed physician from leaving and taking confidential information (such as lists of patients); from hiring away the employer’s employees; and from practicing within a certain radius of the employer’s office for a certain defined period of time (often one or two years) after leaving the employer. The trade-off of obtaining these protections is the need to enter into an employment contract to do so, and therefore no longer having an at-will relationship with the employee, in which the employment may be terminated at any time upon the will of either the employer or the employee. However, the parties may agree to include in an employment contract whatever termination provisions they both feel are appropriate, although the employer will generally desire the ability to terminate the contract without cause upon fairly short notice and the employee will want the security of knowing that the contract cannot be easily terminated.

**Action Step** Physicians should consider whether they want to trade the flexibility of not having an employment contract with employees for the protection of having a noncompete provision in an employment contract.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

Mistake 5  Not Considering Stark Regulations to Ensure That a New Physician Hire Fits into a Safe Harbor

When bringing in new physicians, the Stark regulations should be considered as to the compensation arrangements with those physicians and whether the physicians will be considered members of the group practice so as to cover any of their referrals for in-office ancillary services. Stark defines a “member of the group” to include a physician owner of a group practice, a physician employee of the group practice, a locum tenens physician, or an on-call physician while the physician is providing on-call services for members of the group practice. However, an independent contractor is not a member of the group under Stark regulations, and a leased employee is a member of the group only if that person meets the definition of employee under both Stark and IRS requirements (which look largely at whether the group controls such person). The location of the new physician is also a consideration under Stark. Under the in-office ancillary services exception (allowing physicians in a group practice to refer for ancillary services performed by the group), services covered under Stark must be furnished to patients in the same building where the referring physicians provide their regular medical services, or in the case of a group practice, in a central building. Under the March 2004 tests for “same building,” referring physicians or group practices must have offices in the building that are normally open to their patients a requisite number of hours per week. Finally, compensation arrangements with physicians must meet Stark requirements. For example, physicians may be paid productivity bonuses based on personally performed services, but productivity bonuses based on supervising services covered under Stark are more limited.

Action Step  Physicians should review the requirements of the Stark regulations when structuring a new physician relationship or a compensation arrangement.

Mistake 6  Giving an Open-Ended Letter Referring to an Annual Salary or Multiple Years

Without an employment contract, employment is usually considered to be “at will.” Either the employer or the employee can terminate the employment at any time for any reason or no reason at all. However, certain writings (even if not a formal “employment contract”) can sometimes be considered equivalent to a contract for certain purposes, restricting the ability of the employer to terminate the employment relationship at will. One writing that courts have found to contain promises that restrict an employer’s right to terminate employment is an “offer letter.” When an offer letter contains language that seems to promise employment indefinitely, or for a long period of time, courts have at times held such a letter to be an employment contract for some period of time. Because an offer letter that discusses an annual salary can sometimes be construed as a contract for a year, it is advisable to offer salary in terms of what the employee will make per week or per month, rather than per year.
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**Action Step**  Physicians should write offer letters to employees without open-ended language that could be construed as promoting employment, and reference salary in terms of weekly or monthly, rather than an annual rate.

**Mistake 7  Misclassifying an Employee as Exempt for Purposes of Overtime**

Unless specifically exempted from coverage under the Fair Labor Standards Act (FLSA), most employees must receive overtime pay for hours worked in excess of 40 in a workweek, at a rate not less than time and a half their regular rate of pay. A workweek is seven consecutive 24-hour periods that may begin on any day. The overtime requirement may not be waived by agreement between the employer and the employee.

New rules were issued by the U.S. Department of Labor on April 20, 2004, that modernize the standards to determine whether executive, administrative, professional, sales, and computer employees are “white collar” employees exempt from FLSA’s overtime requirements. If such employees do not earn at least $455 per week, they are entitled to overtime pay when working more than 40 hours in a workweek. In addition, the employee must regularly receive a predetermined amount of compensation each pay period, the compensation may not be reduced because of variations in the work performed; and the employee must be paid the full salary for any week in which work was performed. Some deductions are permitted, namely for absence from work for one or more full days for personal reasons (not sickness or disability); absence from work for one or more full days of sickness or disability if the deductions are made under a bona fide plan for such; to offset jury, witness, or military pay; penalties for violating major safety rules; unpaid disciplinary suspension of one or more full days; or unpaid leave taken pursuant to the Family and Medical Leave Act.

**Action Step**  Physicians should ensure that employees who work more than 40 hours in a workweek receive overtime pay unless they are clearly classified as being exempt.

**Mistake 8  Speaking or Acting in a Way That Could Be Considered Discrimination in Employment**

An employee who files a claim or lawsuit against his or her employer for discrimination often brings up statements made in the workplace as evidence of discrimination. For example, courts have looked askance at statements such as, “I want someone with more energy,” or “I want some fresh blood in here,” or “So-and-so has gotten tired,” as possible indications of age discrimination. Similarly, negative comments about pregnant workers can come back to haunt a physician employer if a staff member becomes pregnant. In addition, a statement suggesting that someone with a disability needs time off can be considered a preference against employing someone with a disability, in contravention of the Americans With Disabilities Act. The best reason to discipline an employee, or terminate someone’s employment, is always performance that relates to patient care. Therefore, physicians should
document any performance problems, and ensure that this documentation is retained in the employee’s file.

**Action Step** Physicians should document reasons that employees are disciplined or terminated, and those reasons should always be related to performance (preferably performance that relates to patient care).

**Mistake 9** Not Having Written Policies in the Office for Employees to Follow

Physician offices, like any other employer, should have written guidelines for employees (both physician and nonphysician employees) to follow. A large medical office may have an employee manual, but a small office should at least have a policy handbook that provides employee guidance. In June 2000, the Office of Inspector General (OIG) of the Department of Health and Human Services published Draft Compliance Program Guidance for Individual and Small Group Physician Practices, which sets forth guidelines that may be used both for compliance purposes and for employee purposes. If a physician ever receives a knock on the door from the OIG (or worse, from the U.S. Attorney, acting on behalf of the OIG) with a question about the practice, whether about a billing issue or otherwise, it can be helpful to have a compliance/personnel manual in the office that establishes the office’s corporate compliance program and sets out guidelines for the staff. The OIG guidelines suggest that each physician practice take reasonable steps to respond to each of the seven elements of the compliance guidance, depending on the size and resources of that practice. These include developing a code of conduct and written policies and procedures; assigning compliance responsibility to a designated person; conducting training on practice ethics and policies and procedures; looking periodically at high-risk billing and coding issues; developing lines of communication with staff to allow problems to be reported; enforcing disciplinary standards; and responding to detected compliance violations. Although the compliance guidance is written around the concept of a compliance program, the elements are consistent with a good personnel structure as well.

**Action Step** Physicians should have a written compliance/personnel manual for office and billing staff that follows the OIG’s Draft Compliance Program Guidance for Individual and Small Group Physician Practices.

**Mistake 10** Thinking That Having a Probationary Period Prevents Being Sued by an Employee

Many employers describe the first three months of employment as probation, during which an employee can be terminated more easily. Although the concept of probation may be helpful because employees’ expectation of continued employment is less, probationary employees can bring many of the same claims and lawsuits that they can bring if terminated at any other time during employment. The federal and state laws that protect employees from discrimination, from being fired for whistleblowing, and the like, apply to all employees, with
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no distinction for probation. The benefit of probation is sometimes the strength of employer policy language that makes clear that termination is at will during the first few months of employment. A dangerous component of probation is the not uncommon thought of employers that they do not need to document the reason for termination during probation. The best way to defend a claim that a physician unlawfully discharged an employee is to show that the employee was discharged for a legitimate reason, and the best reason is always documented poor performance.

Action Step Physicians should document why a staff member’s employment was terminated and realize that such documentation should evidence poor performance, even if the employee was in a probationary period when terminated.

Conclusion Physicians should be careful to avoid these mistakes when hiring employees.

About the Author Margaret J. Davino, Esq., specializes in health care law, including transactional, compliance, contractual, corporate, regulatory and risk management legal issues for Kaufman Borgeest & Ryan LLP, in New York. She served as General Counsel of St. Vincent's Hospital and Medical Center of New York for almost 11 years and also served as general counsel of St. Joseph's Hospital and Medical Center in Paterson, N.J., for three years. She has been involved with bylaws and governance matters, physician-hospital contacts, affiliation and/or service contracts, employment agreements, managed care issues, computer contracts, regulatory compliance, medical staff affairs, setting up physician practices and faculty practices, physician disciplinary matters, mergers and formation of hospital systems, and providing advice in areas such as consent and confidentiality. She is a member of the American Health Lawyers Association, the New York State Bar Association and its Health Law Section, and the New Jersey Bar Association. She is also a registered nurse. She can be contacted by telephone at 212-980-9600 or by e-mail at mdavino@kbrny.com.

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10.7 The 10 Biggest Legal Mistakes Physicians Make That Could Lead to Liability for Discrimination
By Joyce F. Glucksman, Esq.

Executive Summary There are myriad state and federal employment laws that both employers and employees may encounter. Getting professional advice from an employment attorney and understanding
which laws apply to a particular situation before action is taken can save thousands of dollars in future bills.

**Mistake 1  Thinking Discrimination Laws Apply Only to Large Employers**
Federal laws against discrimination due to race, sex, religion, color, national origin, and disability apply to employers that have 15 or more employees. The federal law against age discrimination applies to employers that have 20 or more employees. The Equal Pay Act, another federal statute, applies to almost all employers. All employees, including part-time and temporary workers, are counted in determining whether the employer is covered under the Equal Pay Act. If, during any calendar year, the requisite number of employees was working in any 20 weeks, whether or not the weeks were consecutive, the employer is covered under the act. Some states also have discrimination laws that may apply to employers that do have enough employees to make them subject to the federal statutes (see Mistake 9).

**Action Step**  Physicians should review the number of employees on their payroll. Even if the requisite threshold numbers aren’t met at the beginning of the year, they may be met toward the end of the year and subject the employer to the discrimination laws.

**Mistake 2  Thinking Partners, Owners, or Other Employed Doctors Can’t Make Discrimination Claims**
Most physicians practice within a corporation, limited liability partnership, or limited liability corporation. They are employees of the entity, and if they discriminate against other physicians, whether associates or owners who are also employees, they can be held liable. Whether or not a principal of a medical practice is considered an employee is a fact-specific issue. The factors to be considered include whether the organization can hire, fire, or set the rules and regulations of the individual’s work; to what extent the organization supervises the individual’s work; whether the individual reports to someone higher in the organization; and to what extent the individual is able to influence the organization. Also considered are whether the parties intended that the individual be an employee, as expressed in written agreements or contracts, and whether the individual shares in the profits, losses, and liabilities of the organization.

**Action Step**  Physicians should consult with employment counsel and consider these factors when deciding how the practice will be organized. Everyone, including the doctors, should be educated about discrimination and liability for discrimination.

**Mistake 3  Thinking That Employee Leasing or Multiple Entities Will Avoid the Threshold Number of Employees**
Under certain circumstances, more than one business can be aggregated to meet the minimum number of employees for coverage and liability purposes. This happens when there is an integrated enterprise. The factors involved are the degree of interrelation between the
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operations, the degree to which the entities share common management, centralized control of labor relations, and the degree of common ownership or financial control over the entities.

**Action Step** Physicians should review how their practice is organized and who the owners are, especially the physicians who share facilities, labor relations, and common ownership with any other entity. Assume, for example, that a corporation owns the building in which the doctors practice and it is leased to the practice and to other practices in the building. The building corporation employs a building manager (who reports to the office manager), day and evening porters, and a building engineer. The doctors’ practice, which has 12 employees, shares benefits, accounting functions, payroll, and hiring with the building corporation. This organization would be considered an integrated enterprise.

**Mistake 4 Not Having a Written Discrimination Policy**
Physicians’ offices should have a written antidiscrimination policy specifying that discrimination (which includes harassment) based on sex, race, color, religion, age, or handicapping condition is illegal and will not be tolerated. The policy should clearly set forth what to do if an employee believes that he or she is a victim of discrimination. The policy should have at least two alternatives for reporting discrimination, including one that bypasses the alleged discriminating official. It should also inform employees that they will not be retaliated against for making a complaint of discrimination. Some states have antidiscrimination laws that cover sexual orientation, and it may be a good idea to include sexual orientation in the policy, even if not required by state law.

**Action Step** Physicians should print the antidiscrimination policy in the company’s employee handbook or as a separate document and disseminate it. They should review the policy with each employee and have each employee sign an acknowledgment that he or she has received, read, and understands it. In addition, the policy should be prominently posted in a break room or anyplace else where employees congregate. Display posters may be obtained for free from the Equal Employment Opportunity Commission.

**Mistake 5 Not Understanding What Is Considered Sexual Harassment**
The sexual harassment policy should define sexual harassment as any unwelcome sexual conduct, including sexual advances, requests for sexual favors, and other verbal or physical conduct that enters into employment decisions or creates an intimidating, hostile, or offensive working environment (i.e., one that unreasonably interferes with an individual’s work performance or other terms and conditions of employment). The offensive conduct may be heterosexual or homosexual. Any time an employee suffers a negative tangible employment action as a result of sexual harassment by a superior (e.g., a demotion or termination for refusing sexual advances), an employer will be held strictly liable for the consequences. In cases in which a supervisor creates a hostile work environment only (i.e., no tangible employment action against the victim), the employer will be held liable for the harassment if
the victim follows whatever steps are in the policy but the employer fails to take measures to prevent and correct the situation. When an employee is subjected to a hostile work environment by a coworker, the employer will be held liable for the harassment if the employer knew or should have known about the harassment and failed to take immediate and appropriate responsive action. Liability for sexual harassment may also be found where there is a consensual relationship between employees that ends but where one party doesn’t want it to end or has bad feelings that cause him or her to behave in ways that negatively affect the workplace.

**Action Step** At least once a year physicians should have a short presentation given for all employees concerning illegal discrimination and harassment, including a discussion of the company’s complaint procedures. Physicians should consider having an employment lawyer give the talk. In addition, interoffice dating should be prohibited.

**Mistake 6 Ignoring Complaints of Discrimination**
It isn’t enough simply to have a discrimination policy; employees have to know that the policy will be enforced and that all complaints will be thoroughly investigated and, if warranted, prompt remedial action will be taken. In addition, retaliation against employees who complain about discrimination is prohibited by law, and it is not unusual that a retaliation claim has more merit than the underlying discrimination case.

**Action Step** Physicians should decide who will investigate each allegation (e.g., the office manager, the human resources department, outside counsel, or another service) and give them the authority to do a thorough investigation, which includes talking with the victim and the alleged perpetrator.

**Mistake 7 Failing to Deal Appropriately with a Pregnant Employee**
Having a pregnant employee in a small to medium-size office where there are 15 to 20 employees can put added stress and work on the other employees, both before and during the maternity leave. Nonetheless, pregnancy must be treated in the same manner as disabilities. If a male doctor is ordered to take three months off following a heart attack, then a pregnant woman must be allowed to take off the time her doctor orders as well. Similarly, one may not establish mandatory maternity leave that is not related to the employee’s ability to work. Even when the motive is to protect the unborn child, it is illegal to discharge the employee unless it is demonstrated that no less restrictive alternatives exist or that the employee would be exposed to unsafe levels of radiation or a similarly toxic environment and it is determined that only women would be affected by the hazard.

**Action Step** Physicians should be consistent in the manner in which they treat temporarily disabled workers, including pregnant employees. In addition, physicians should not ask about a prospective worker’s intention to become pregnant.
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Mistake 8  **Not Realizing That FMLA Applies to Professional Practices**
It is not unusual for practices, especially those in big cities, to have 50 or more employees, which would mean the Family Medical Leave Act applies. When the act applies, the employer must allow any employee, except a key employee, as many as 12 weeks of leave in any 12 consecutive months, starting with the first day of leave under the act if the employee or the employee’s spouse, parents, or children have a serious medical condition or for the birth or adoption of a child. The leave time may be taken consecutively or intermittently. At the employer’s discretion, FMLA leave may be with or without pay; however, employee benefits must be maintained during the period of leave. Upon return to work, the employee must be reinstated to the same or an equivalent position. A key employee is one who is salaried and eligible for FMLA leave but is within the top 10% of employees residing within 75 miles of the worksite.

**Action Step**  Physicians should require employees to bring proof of the need for FMLA leave. Pregnant employees may be required to use FMLA leave if employees with other temporary disabilities are required to use it as well.

Mistake 9  **Failing to Realize More Generous Employee-Oriented State Laws May Apply**
States can and do have their own employment statutes, many of which are more generous than the federal laws and apply to any employer regardless of size. Some states have statutory or case-based actions for discrimination, wrongful termination, public policy exceptions to “employment at will,” negligent hiring and/or retention, promissory estoppel or negligent misrepresentation, intentional infliction of emotional distress, invasion of privacy, defamation, assault and battery (usually raised along with a sex harassment allegation), and breach of contract.

**Action Step**  Physicians should check with an employment lawyer as soon as a discrimination issue arises, since state statutes have varying statutes of limitations, which can range from as little as 180 days to several years.

Mistake 10  **Pressing Employees to Decide Immediately Whether to Waive Rights in Exchange for Severance Pay**
While it may be tempting to give an employee severance pay (or receive severance pay) in exchange for a general release of all claims, including the Age Discrimination in Employment Act of 1967 (ADEA) claims, employees who are 40 years or older are covered by the Older Worker Benefit Protection Act. That means if the employer wants to preclude or settle a dispute without litigation, the employee must be given something of value over what any other employee would receive, 21 days to consider the offer (which must specifically refer to releasing ADEA rights or claims), and seven days to rescind the acceptance of an
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offer. They also must be advised that they can and should seek legal counsel. If the offer is part of an early retirement package, the employee must be given 45 days to consider it.

**Action Step** Before terminating an employee and getting a release of claims arising out of the employment or before waiving any right, physicians should consult with an employment attorney. The attorney will evaluate the situation and advise the employee on the offer or on whether there are viable claims that could be asserted that are more valuable than the severance pay.

**Conclusion**
Physicians, whether employees or employers, have to be mindful of both state and federal discrimination laws that may affect their practices. By understanding what conduct is prohibited, physicians will be less likely to engage in inadvertent acts that can lead to liability for discrimination.

**Additional Resources**

**About the Author**
Joyce F. Glucksman, Esq., has had her own client-oriented firm representing individuals and small businesses since 1986, primarily in the areas of employment and family law. Glucksman strongly believes in preventive legal services and knows that addressing an issue at its earliest stages, such as reviewing a contract or a proposed severance agreement before it is signed, can save time and money in the future. In addition, she works with her business clients to avoid problems and consults on such matters as employment contracts, noncompetition and nonsolicitation agreements, investigations, employee handbooks, trade secrets, divorce, alimony, custody, child support, and adoption. She may be contacted at 2970 Clairmont Road, Suite 950, Atlanta, GA 30329; by telephone at 404-633-5579; or by e-mail at joy@joycefglucksman.com.

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10.8 The 10 Biggest Legal Mistakes Physicians Make with Employment Laws

By Joyce F. Glucksman, Esq.

Executive Summary
Physicians’ offices are subject to the same employment issues as other businesses. Doctors pride themselves on being professionals and tend to forget or to delegate the business matters to their office managers without providing oversight. As a result, making any of the following mistakes can be costly in terms of liability, disruption of the practice, and legal fees.

Mistake 1  Not Checking References
Physicians often forget to check references for new employees, which can lead to malpractice liability for an incompetent doctor, nurse, or other professional. Likewise, a physician could be susceptible to a claim of negligent hiring or negligent retention for several reasons, including when an employee has left another job due to incompetence or for bad conduct that might be repeated in the physician’s office, when an employee has been disciplined by a state or licensing entity, when an employee has not met continuing education requirements, and when an employee is posing as a doctor or other medical professional but does not have the requisite education or licenses. It is often beneficial for the physician to hire a referencing business to do the background checks, since such businesses have access to the necessary databases and are experienced in asking the right questions and following up to get a true picture of the applicant.

Action Step  Physicians should not hire anyone without checking references. Also, they should make sure any employee who deals with money is bonded or at least bondable.

Mistake 2  Failing to Have Job Descriptions
Among the many different job positions in a doctor’s office, some may overlap or employees may undertake actions or conduct procedures for which they are not licensed. Having a written job description covering the essential functions of the position and the lines of authority ensures that all employees know what they should be doing and to whom they report. Essential functions are those that if they were not done, the job could not be accomplished.

Action Step  Physicians should draft job descriptions taking care to include the essential duties of each job, mark these duties as essential in the job description, and review the descriptions with employees.

Mistake 3  Not Having an Arbitration Agreement
Since the U.S. Supreme Court allowed mandatory arbitration agreements, the number of
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businesses using them has increased dramatically. Litigating employment disputes can be very costly. Arbitration is a less formal and typically quicker way to resolve these disputes. The agreement should set forth the procedure to be used and include processes for discovery of the employer's relevant records. Without the ability to discover relevant employment information, the agreement is subject to challenge as patently unfair and thus unenforceable. Some states also require the employee to initial the arbitration provisions if they are included in a larger document, such as an employment contract or a noncompete agreement.

Action Step Employers should have all employees sign agreements to arbitrate all disputes using the employment protocols developed by the American Arbitration Association or other major provider of alternate dispute resolution services. Employees should examine arbitration provisions carefully as soon as an issue arises to determine if they are valid and binding.

Mistake 4 Not Having Noncompete and Nonsolicitation Agreements

While an employer can’t unreasonably restrict an employee’s right to work, it can require an employee to sign reasonable covenants not to compete and nonsolicitation agreements so that the employee doesn’t take patients or other employees with them when he or she leaves. State laws differ on these agreements, but in general, they must be reasonable in time limit, geography, and scope. In addition, some states construe these types of contracts very strictly and will not “blue pencil” the document (i.e., change certain parts to make it valid). In these states, because the agreements are either valid or invalid, portions of the agreement cannot be enforced unless the whole document is valid. In other states, a court will rewrite the agreement to make it enforceable. These provisions may be more restrictive and strictly enforced against a partner or co-owner leaving or selling his or her practice.

Action Step Physicians should have their employment or business counsel draft or review these types of agreements in accordance with state laws before the agreements are signed.

Mistake 5 Letting Employment Taxes Slide

Employment taxes do not belong to the physician practice and cannot be appropriated for other needs. There is a 100% penalty for failing to pay employment taxes, and physician employers or their officers can be held individually liable for them.

Action Step Physicians should get their accountant, bookkeeper, or payroll service to handle their taxes and reporting requirements. Having a professional handle these matters is far better than trying to handle them alone or ignoring them altogether.

Mistake 6 Not Having an Employee Handbook

The chance of incurring liability for disparate treatment or other forms of discrimination is greatly reduced if employees know the rules and that they will be enforced. An employee
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handbook should cover such matters as annual, sick, and personal leave, hours of work, overtime, discrimination and harassment policies, disciplinary and grievance procedures, and benefits and eligibility requirements for benefits. It should also include a statement that the handbook does not create a contract for employment and that the employee acknowledges that he or she is an employee at will subject to any state or federal laws. Some states have restrictions on employment at will.

Action Step    Employers should determine what their policies should be and draft an employee handbook or ask an employment attorney to do so. Each employee should be given a copy of the handbook and instructions to read it and ask questions if anything in it is not clear. Employers should be sure to get a signed, dated receipt for the handbook, certifying that the employee has read it and was provided the opportunity to ask questions. Employees should be sure to read the handbook and ask questions if anything is not clear.

Mistake 7    Not Protecting or Disclosing Trade Secrets
Most employees in a doctor’s office are aware of the restrictions on disclosure of patient information; however many employees do not realize they are entrusted with trade secrets that include financial data, financial plans, or a list of actual or potential patients or suppliers that is not commonly known by or available to the public. This information derives economic value, actual or potential, from not being generally known and not being readily ascertainable by proper means by other persons who can obtain economic value from its disclosure or use. In addition, it is the subject of efforts that are reasonable under the circumstances to maintain its secrecy. In many states an employee who discloses trade secrets can be subject to an injunction and liable for damages.

Action Step    Physicians should check the state law regarding trade secrets and include a trade secrets provision in their employee handbook. Liability for disseminating trade secrets can result in an injunction, damages, and/or a lawsuit against both the employee and the new employer.

Mistake 8    Neglecting the Unemployment Hearing or Appeals Process
Generally, an employee who resigns is not entitled to unemployment insurance payments. The same is true for employees who are fired “for cause” (e.g., theft, violation of written policy, or violation of other work rules). However, employees terminated for incompetence are not necessarily disqualified from collecting unemployment insurance. Neither the employee who was fired and who applies for unemployment compensation nor the employer should neglect the hearing or the appeals process. The employer will have the burden of proving that the terminated employee is not entitled to collect unemployment. It should be noted that statements made under oath in an unemployment proceeding may be used in a subsequent lawsuit regarding the termination. Also, a court finding in an unemployment case will have a preclusive effect in a separate federal action between the parties. Like a
discrimination case, even if the claim is not identical, one cannot relitigate an issue that has been judicially decided.

**Action Step** A physician who decides to terminate the relationship with an employee should consider offering that employee the option of resigning. A physician who is an employee should avoid a hearing on unemployment if there is a good federal lawsuit.

**Mistake 9  Not Paying Overtime**
Time and a half must be paid to all workers who earn $455 or less a week and work in excess of 40 hours a week unless they are specifically exempt. Doctors are exempt. Registered nurses who earn in excess of $455 a week salary and are licensed by the state nursing board also are exempt. Registered nurses who are paid on an hourly basis and licensed practical nurses are not exempt. Other categories of employees who do not possess advanced knowledge in a field of science customarily acquired by a prolonged course of specialized intellectual instruction also are exempt. The burden of proof in an overtime case is on the employer to produce records that demonstrate the number of hours worked by the nonexempt employee. Employers that do not pay overtime are subject to suit going back two or three years if the violation is willful. There is no voluntary work; if one is a nonexempt employee and the employer “suffered or permitted” the overtime to be worked, the employee must be paid overtime.

**Action Step** Physicians should keep good records and should not require employees to record on their time sheet that they worked no more than 40 hours in a week if that is not true.

**Mistake 10 Not Providing Evaluations and Feedback on Performance**
Evaluating an employee and providing feedback on performance are crucial to both employee and employer but are often overlooked in a small office. Although it is a difficult process, all employees are entitled to know how they are doing on a job. In addition, periodic evaluations help avoid the scenario in which an employee is surprised when the employer terminates him or her for poor performance. In fact, regular employer feedback often determines the difference between employees who look to sue and those who accept the fact that they have strengths and weaknesses and that their job might not be right for them. Giving employees who are to be terminated for poor performance (not insubordination or because the employee can do the job but won’t) the choice to resign or be fired will often make the difference in whether or not the employee gets another job.

**Action Step** Physicians should evaluate employees in quarterly or semi-annual meetings, or at least once a year, to assess performance and help improve performance if needed, and use a standard evaluation format. Between formal evaluations, physicians should document specific performance problems (including dates of specific incidents and the names of other people involved), have the employee sign the documentation to show he or she has seen it
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(even if the employee disagrees with the documentation), and place the documentation in the employee’s personnel file.

Conclusion
There are many state and federal laws that affect employment. Either as an employee or an employer, steps should be taken to understand applicable rights and obligations. It is up to each physician to make informed choices in the employment arena that will have a significant effect on his or her professional and economic life.

Additional Resources
- The Physicians News Digest, www.physiciansnews.com

About the Author
Joyce F. Glucksman, Esq., has had her own client-oriented firm representing individuals and small businesses since 1986, primarily in the areas of employment and family law. Glucksman strongly believes in preventive legal services and knows that addressing an issue at its earliest stages, such as reviewing a contract or a proposed severance agreement before it is signed, can save time and money in the future. In addition, she works with her business clients to avoid problems and consults on such matters as employment contracts, noncompetition and nonsolicitation agreements, investigations, employee handbooks, trade secrets, divorce, alimony, custody, child support, and adoption. She may be contacted at 2970 Clairmont Road, Suite 950, Atlanta, GA 30329; by telephone at 404-633-5579; or by e-mail at joy@joycefglucksman.com.

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10.9 The 10 Biggest Legal Mistakes Physicians Make after They Are Terminated
By Michael R. Lowe, Esq.

Executive Summary
Termination of a physician’s employment can be very unsettling and difficult to handle for a physician, even if the physician employer terminates the employment. In many cases, the post-termination rights and obligations of both the physician employee and the physician’s employer are governed by a written employment contract. Additionally, a physician’s
transition away from a former employer following termination may be affected or governed by either federal or state health care regulatory laws and regulations. Physicians must be cognizant of their rights, duties, and obligations as they exist under both a written employment contract and applicable federal or state laws and regulations so that they may avoid making mistakes that will generate additional and potentially serious legal consequences. Such mistakes and consequences may adversely affect a physician for years after an employment termination.

Mistake 1 Consulting Legal Counsel Too Late
Physicians often fail to understand all of their rights, duties, and obligations that may arise out of the termination of an employment relationship. Many physicians simply accept an employer’s termination of their employment and the employer’s explanation or interpretation of the physician’s duties and obligations following termination. By consulting legal counsel too late in the process, physicians may forfeit certain contractual rights or violate certain contractual obligations, fail to maximize their potential benefits (e.g., bonus and deferred compensation), or create legal consequences or statutory or regulatory violations that they otherwise could have avoided through consultation with legal counsel.

Action Step Physicians should consult with experienced legal counsel as soon as they decide to terminate their employment relationship or discover that their employer is terminating the relationship.

Mistake 2 Failing to Understand and Recognize Contractual Rights and Obligations
Following termination of their employment, physicians often focus on obtaining new employment, moving their families to a new location, or simply trying to survive the shock of being terminated. However, one of the most critical issues for a physician in employment termination involves the physician’s ability to understand and recognize his or her contractual rights and obligations (or other rights and obligations if no written employment contract is involved). Physicians must be aware of the benefits to which they may be entitled based on their employment contract or relationship (e.g., the transition of their retirement plan and health insurance benefits, deferred and bonus compensation, and medical malpractice insurance policy continuation). Physicians must also be keenly aware of any post-termination obligations imposed on them by written employment agreements, such as the requirement to purchase “tail” insurance coverage or retroactive medical malpractice insurance coverage if the physician’s employer provided a claims-made medical malpractice insurance policy, as well as restrictive covenants (e.g., nondisclosure, nonsolicitation, and noncompete provisions in their written employment agreement). Physicians must also understand the basis for their termination. For instance, many physician employment agreements permit either the physician or the employer to terminate “at will” (meaning either party may simply terminate with appropriate notice) or “for cause” based on a material breach by one of the parties (e.g.,
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loss of professional license by the physician, excessive malpractice by the physician, failure to pay compensation or benefits by the employer). In many cases, a physician’s post-termination obligations, such as purchasing tail insurance coverage or complying with a restrictive covenant, may be affected or nullified depending on the type of termination. Failure to be aware of and understand contractual or employment obligations, rights, and duties can have far-reaching and unforeseen consequences for physicians after termination.

**Action Step** Physicians should ensure that they are aware of the applicable contractual rights, duties, and obligations under their employment agreements and seek experienced legal counsel to help them with such issues.

**Mistake 3** **Failing to Understand the Role of Medical Malpractice Insurance Policies**

Employers often provide and pay for a physician’s medical malpractice insurance coverage as a benefit or condition of their employment. Termination of employment may result in termination of such coverage. Additionally, employment contracts may require physicians to obtain tail coverage for a defined period of time following termination if the policy covering the physician was a claims-made policy. If the physician’s employer has provided an occurrence policy, then the purchase of a tail policy may not be an issue. But physicians must ensure that in any case they have appropriate medical malpractice insurance coverage following termination, and that they have avoided creating gaps in their coverage history. Failure to obtain appropriate coverage may expose the physician to unnecessary liability and may also result in a breach of a post-termination obligation under the physician’s employment agreement.

**Action Step** Physicians should ensure that they understand any requirements in their written employment agreements concerning medical malpractice insurance coverage and post-termination obligations.

**Mistake 4** **Improper Handling of Patient Medical Records**

Physicians often fail to handle the transition of patient medical records in accordance with applicable state and federal laws and regulations, as well as medical record ownership provisions in written employment contracts. In many instances, physicians unknowingly violate contractual provisions and applicable state and federal laws and regulations by simply taking patient medical records with them from their former employer following termination. In many states, the physician who creates a medical record is deemed to be the medical records owner; however, medical record ownership laws often bestow ownership on a physician’s employer if the physician has an employment contract that states that the employer owns the patient medical records. Moreover, failure to properly inventory, transfer, or photocopy patient medical records can result in lost records, which in turn may result in violations of state medical record laws and regulations that require physicians to maintain
patient medical records for a defined period of time. Also, mistakenly taking an employer’s patient medical records may result in allegations of theft or conversion of an employer’s property.

**Action Step** Physicians must know and understand their statutory, legal, and contractual rights to patient medical records and should consult experienced legal counsel about whether they may take patient medical records with them following a termination.

**Mistake 5  Failing to Understand Restrictive Covenants and Their Application**
Many written physician employment agreements include restrictive covenants, such as noncompetition, nondisclosure, and nonsolicitation covenants. Generally, physician employment contracts define each party’s rights, duties, and obligations under these restrictive covenants, as well as the applicability of such covenants in a post-termination setting. In many instances, some portions of restrictive covenants in an employment agreement may not apply depending on the reason for the termination of the physician’s employment. For instance, some employment contracts state that restrictive covenants will not apply in the event the physician terminates the employment contract due to a material breach by an employer. Physicians must be aware of the potential applicability and enforceability of such restrictive covenants contained in their employment contracts, and should be particularly careful not to breach them.

**Action Step** Because restrictive covenants often raise complex and complicated issues, physicians should consult experienced legal counsel about the potential applicability and enforceability of such covenants in a post-termination environment.

**Mistake 6  Failing to Take Advantage of Available Benefits**
Whether or not the physician has a written employment contract with the physician’s employer, the physician may be entitled to certain post-termination benefits and compensation. The physician may have earned deferred or bonus compensation that the physician’s employer is required to pay over a defined period of time following termination. Also, the physician may be able to transition certain life, health, or disability insurance policies on more favorable terms than the physician could obtain by purchasing new insurance policies. Physicians should also be aware of their rights to transfer or maintain retirement accounts, such as simple IRAs, SEP IRAs, and 401(k) plans. Failure to understand and properly handle benefits can result in severe financial loss for the physician.

**Action Step** As soon as possible following termination, physicians should consult with a financial or benefits adviser and ensure that they have obtained all applicable summary plan descriptions and benefit plan documents from their former employers.
Mistake 7  **Failing to Properly Contact and Notify Patients**
State laws and regulations often require physicians to contact and notify their patients of the relocation or termination of their practice. Failure to do so can result in disciplinary action being taken against a physician by the licensing board. Additionally, failure to properly contact and notify patients of the relocation or termination of their practice may expose physicians to claims for patient abandonment, which may carry with them exposure to both civil and regulatory liability. Physician employment contracts often contain provisions governing the terms and conditions upon which a physician may contact or notify his or her patients. Failure to comply with these provisions may expose the physician to claims of breach of nonsolicitation and noncompetition covenants by the physician’s former employer.

**Action Step**  Physicians should contact their state licensing board to obtain information concerning the appropriate notification to patients concerning the relocation or termination of their practice, and they should consult with experienced legal counsel concerning such issues.

Mistake 8  **Forgetting to Notify State Licensing Boards of a Change of Address**
State licensing boards generally require physicians to ensure that their practice and mailing addresses are current and properly updated in the event of a change. State laws and regulations often require physicians to notify state licensing boards of changes in their practice or mailing addresses within a defined period of time after such changes occur. Failure to do so may result in disciplinary action being taken against a physician’s license.

**Action Step**  Physicians should contact their licensing board to obtain information concerning changes of address and ensure that they provide change of address information to their state licensing boards in compliance with applicable state laws and regulations.

Mistake 9  **Failing to Appropriately Transition Patient Care**
While physicians often want to complete their termination process as quickly as possible, they should not overlook the fact that they are still professionally obligated to ensure appropriate transition of ongoing patient care. Failure to properly transition patient care, complete hospital rounds, review outstanding patient medical records, and finish required medical record documentation may expose a physician to myriad liabilities, including professional negligence, patient abandonment, and overpayment or false billing allegations.

**Action Step**  Physicians should ensure that they complete their professional obligations and properly transition patient care to other physicians if they will no longer be seeing patients.

Mistake 10  **Failing to Properly Transition with Third-Party Payers**
When physicians terminate their employment with one employer and transition to a new employer, they must ensure that they update information with third-party payers in order to...
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avoid confusion as to how and to whom third-party payers should pay claims for professional services. Physicians who do not provide new billing information to third-party payers may find that claims for services rendered on behalf of a new employer are paid to a former employer. Physicians who fail to properly terminate or change their Medicare provider number following a termination may experience significant difficulty in getting paid for services rendered to Medicare beneficiaries at a new employer.

**Action Step**
Physicians should ensure that they provide change of address and location of service information to third-party payers, and in particular to the Medicare carrier in their state as soon as possible.

**Conclusion**
Physicians in a termination situation should be mindful of these mistakes and take appropriate steps as outlined to achieve a smooth transition during their post-termination phase.

**About the Author**
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10.10 The 10 Biggest Legal Mistakes Physicians Make That Could Lead to Liability for Sexual Harassment

By Lawrence A. Strid, Esq.

**Executive Summary**
Claims and lawsuits alleging sexual harassment can be among the most daunting and potentially devastating claims affecting physicians, both in their capacity as an employer and as a health care professional. Civil, criminal, and administrative consequences can ensue. In addition to potential legal liability, which in many cases is predicated solely on the word of the accuser against the physician, the mere fact of such claims, no matter how unsubstantiated
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or frivolous, can have far-reaching consequences on the emotional state, personal life, reputation, and professional standing of a health care professional. To be forewarned is to be forearmed.

Mistake 1  Not Having a Written Sexual Harassment Policy

It is pragmatic not only for large medical practices to have a sexual harassment policy, but also for sole practitioners whose practice may consist of only the physician and a receptionist. Any multiemployee office should have a written employee policy handbook that includes a section on sexual harassment. The provision should declare a zero tolerance policy toward such conduct by the employees, and the policy should encourage employees to report directly to the physician or the office manager any instances of such misconduct that they have been subjected to by either a coworker or a patient.

Action Step  Physicians should consult with an experienced employment law attorney for the exact content to be included in an employee policy handbook. Physicians should provide the employee policy handbook to every employee and update it as needed.

Mistake 2  Not Documenting Reports of Sexual Harassment by Employees

Under federal law and many state statutes, the employer is strictly or automatically liable for sexual harassment perpetuated by a supervisor or manager on an employee, but is liable for sexual harassment committed by a coworker against another employee only if the employer fails to take appropriate action upon learning of the harassment. Therefore, the employer should take seriously any report of sexual harassment by a coworker against another coworker, whether supervisory or not. Also, the employer should document the report in writing, including who said what, and what corrective action, if any, the employer will be taking.

Action Step  This is not the time to shy away from paperwork or executive decisionmaking. The complaint should be thoroughly documented. To resolve the problem, the physician will have to make difficult decisions about employee discipline, including the possibility of termination, if necessary.

Mistake 3  Not Posting Prohibitions Against Sexual Harassment

Many companies provide literature to employers detailing the laws against sexual harassment and discrimination. They also provide pamphlets and posters to make available to employees. Any office big enough to contain a company bulletin board should have such a poster prominently displayed for the benefit of employees. Having these materials on hand will prove that the physician has a sexual harassment policy in effect if it becomes necessary to counter a charge.
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**Action Step**  Such literature is not expensive and is easy to obtain. The cost will always be less than trying to prove later that the physician disapproved of sexual harassment in the office but had no written guidelines for reference.

**Mistake 4  Not Maintaining a Professional Office Environment**
It is a professional failing and a potential legal liability situation to allow a lax or permissive office environment wherein off-color jokes, sexually suggestive photographs or pictures, or access to adult Internet sites is the norm. Sexual harassment is defined not only as unwelcome and persistent romantic or sexual advances by one person to another, but having to work in a sexually charged atmosphere that is both objectively and subjectively offensive to a worker of reasonable and ordinary sensitivity. Allowing the opposite to occur in the spirit of ribald fun can become a problem for a physician if a disgruntled or easily offended employee makes it an issue.

**Action Step**  Physicians should not countenance unprofessional and sexually suggestive comments and memorabilia in the practice setting.

**Mistake 5  Not Documenting the Reasons for Employee Termination**
Most states are “at-will,” which means that the employer is not required to have a reason to terminate an employee. However, most employees do not take to termination kindly and may, in response, bring claims for unemployment compensation, workers’ compensation, and even sexual harassment. Providing employees with a documented reason for termination that is noted in their personnel file can help to disprove such post-termination claims and put the employees at a disadvantage in any later proceedings related to the dismissal.

**Action Step**  Physicians should put in writing any pre-termination problems with employees and the reasons for their termination. They should also have the employees acknowledge in writing the receipt of the employer’s documentation.

**Mistake 6  Not Avoiding Unprofessional Physical Interaction with Employees and Patients**
Physicians step into dangerous territory when they engage in physical contact with employees or patients that the recipient or an observer could interpret as being romantically or sexually suggestive. Even if the physician’s intent is purely platonic, the recipient or an observer may view with alarm or suspicion back rubs, pats on the buttocks, hand-holding, hugging, or other close physical interplay involving someone with whom the physician does not already have a close and personal relationship. If the physician’s intent is other than platonic, the potential outcome for a legal problem will be magnified.

**Action Step**  Physicians should keep their hands to themselves.
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Mistake 7  **Not Avoiding Office Romance**
It is a fact of life that many romantic relationships develop in the workplace. If a physician is already committed to a serious relationship, then the reason for avoiding an office romance with an employee should be self-evident. If the physician is not so committed but finds an employee to be attractive enough to flirt with or to even ask for a date, then the employee should probably not have been hired in the first instance. Persistent demands for a relationship or a date that are not favorably responded to by the employee in response to the employer are more often than not the genesis for a sexual harassment action. While an inquiry by the physician to an employee would probably not constitute sexual harassment if it were not persisted in after an initial refusal, the atmosphere could become permanently altered by such an overture. The overture could arise in a legal case if the employer-employee relationship were to sour thereafter.

After the initial blush of romance fades, and especially if the relationship turns bad, having had a romance with a patient is a near guarantee for a malpractice claim or a professional disciplinary problem later.

**Action Step**  Physicians should pursue romance in places other than where they hang their medical license.

Mistake 8  **Not Having a Nurse or a Physician Assistant Present When in an Examination Room with a Patient of the Opposite Sex**
While probably more of a consideration for a male physician with a female patient, having a nurse or a physician assistant present also may be prudent for a female physician with a male patient. Innocent parts of a physical examination may be misinterpreted by a patient as being sexually or physically intrusive. Also, it is not uncommon for some patients to view their physician with an affection that is other than what is normally present in the routine patient-physician relationship. If such a patient felt he or she was being “spurned” and had an ax to grind, the absence of a credible witness on behalf of the physician may put the matter into a “he said-she said” contest in which the physician may end up the losing party, either in a lawsuit or in front of the medical board as a subject of professional discipline.

**Action Step**  Physicians should practice medicine defensively, especially when a physical examination requires inspection by the physician of an intimate area of the patient’s anatomy.

Mistake 9  **Not Knowing What Insurance Will Cover**
Most physicians with an office have two basic types of insurance coverage: liability insurance, which covers accidents and events in the office unrelated to the professional rendering of services (such as a fall in the lobby); and malpractice or errors and omissions insurance, which relate to claims arising in the professional rendering of services. At a time when sexual harassment claims are common, many general liability and professional liability
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policies have specific exclusions for claims made that allege sexual abuse, sexual harassment, sexual discrimination, or similar types of sexual misconduct.

Insurance is supposed to provide two different considerations of value: to pay the claim if there is merit to it, and to pay for the attorney’s fees and other legal expenses incurred in defending the claim, regardless of whether payment is made. If the policy has an exclusion for sexual misconduct, then the physician will have to incur and be responsible for attorney’s fees and related legal expenses, in addition to the value of the claim itself if a settlement is possible or an adverse judgment is rendered against the physician.

**Action Step** Physicians should make sure their insurance broker obtains general liability and professional policies that do not have sexual harassment exclusions. Such policies may not be available in some insurance markets. Moreover, physicians should not take the broker’s word for what is excluded or included in the policy, but rather get an opinion from an attorney who has expertise in insurance coverage and claims. Obtaining legal advice before a problem arises is invariably cheaper than obtaining it after a problem arises.

**Mistake 10 Committing Sexual Harassment**
While this admonition may be self-evident, some professionals, blinded by the elevated status of their profession, by an inability to accept that someone doesn’t appreciate their advances, or by an uncontrollable urge, may decide to persist in repeatedly visiting their attentions on an employee or a patient who is unreceptive to such advances.

Civil sexual harassment claims can subject a defendant to compensatory damages to the victim for emotional distress, physical trauma, medical expenses, loss of wages, attorney’s fees, and even punitive damages. If the nature of the harassment is physical, then it also may constitute the basis for criminal charges for assault, sexual battery, or other penal code violations. Also, charges of sexual harassment can result in a physician being professionally disciplined, including suffering the loss of license.

**Action Step** Sexual harassment is not worth it, and those who truly can’t contain themselves should not practice medicine.

**Conclusion**
Understanding the consequences of sexual harassment claims and educating themselves and their staff are the best safeguards against such a claim. Having appropriate insurance coverage in case a claim should arise is the next best step.

**Additional Resources**
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Chapter 11  ERISA/Retirement Plans

11.1 The 10 Biggest Legal Mistakes Physicians Make Under ERISA

By B. Janell Grenier, Esq.

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Executive Summary
In today’s competitive work environment, many physicians are expected to provide their employees with a number of perks and benefits. However, very few physicians realize that, for the most part, providing perks and benefits to employees is governed by a complex body of law known as ERISA (the Employee Retirement Income Security Act of 1974), which has wide-ranging consequences for the average physician. The purpose of ERISA’s enactment was to develop guidelines for administering retirement plans and other benefit arrangements so that the interests of participants and beneficiaries would be safeguarded. In effect, ERISA was designed to ensure that those entitled to pensions and benefits can collect them.

Generally, ERISA governs the offering and maintenance of all types of retirement plans, including 401(k), profit-sharing, pension, cash balance, and employee stock ownership plans (ESOPs). It also covers welfare plans, which include plans that provide—through the purchase of insurance or otherwise—medical, surgical, or hospital benefits; benefits in the event of sickness, accident, disability, death, or unemployment; vacation benefits; apprenticeship or other training programs; day-care centers; scholarship funds; prepaid legal services; and severance plans in certain instances. Physicians who err by not getting the qualified legal help they need upfront in establishing and implementing these arrangements could face penalties from government agencies and unexpected exposure to liability under ERISA.

Mistake 1  Implementing Benefits Programs Based on “Free” Advice
Physicians often rely on advisers when it comes to establishing, implementing, and maintaining benefit programs for their employees. They need to realize, however, that much of the “free” advice they receive from advisers could be colored by those advisers’ pecuniary incentive in the physicians’ implementation of the arrangement and can sometimes overlook the legal nuances surrounding the benefit arrangement. Moreover, such advisers are generally not trained in the complicated laws and regulations under ERISA, and they are limited in their knowledge. A case in point involves the author’s experience with a client who had been told by multiple advisers that she could engage in certain action with respect to her 401(k) plan. When the author advised her that the action was not permissible under governing laws, she went back to the advisers, who then admitted that they had made a mistake. The client was saved from suffering the expensive legal consequences of a bad decision by seeking the advice of ERISA legal counsel.
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Action Step Before relying on the advice of an adviser in implementing and maintaining a benefit program, physicians should seek the counsel of their attorney to make sure that it comports with ERISA laws and regulations.

Mistake 2 Having an ERISA Plan Without Knowing It
Often, physicians implement a benefit arrangement (health plans, life insurance plans, disability plans, etc.) in their practice without realizing that the plan they have established is subject to ERISA. In some cases, an option is available as to whether the plan can be structured so that it falls under ERISA. It may sometimes be beneficial for the practice to characterize a benefit plan as an ERISA plan; in other cases, it may be more advantageous if the arrangement is structured so that it falls outside the scope of ERISA. Either way, it is important to know whether the plan is subject to ERISA in order to comply with the laws governing the plan, such as reporting and disclosure requirements, fiduciary standards, and documentation requirements. It is also important because ERISA can sometimes impose harsh penalties on those who ignore its mandates.

Action Step Physicians should, with the assistance of counsel, make sure they understand which benefit plans are subject to ERISA and what options exist for structuring a desired plan subject to, or outside the scope of, ERISA.

Mistake 3 Not Having Proper Plan Documentation in Place
It is not uncommon to find that physicians do not have the proper documentation in place pertaining to their ERISA plans. ERISA generally imposes two basic documentation requirements on plans that are subject to it: the actual plan must be governed by a written plan document; and participants and beneficiaries of the plan must be given a summary of pertinent plan provisions, including a description of their rights under ERISA, in what is referred to as a “Summary Plan Description.” Many physicians are not careful about having their plans reviewed by legal counsel, and therefore do not have the proper documentation in place to comply with ERISA.

Action Step Physicians should determine whether benefit arrangements are properly documented and make sure that all documents are properly adopted, executed, and implemented. Also, benefits and ERISA laws frequently change, through congressional action and/or governmental agency regulations. Attorneys who are engaged to represent physicians should make sure that the physicians are apprised of any changes in the law that could affect plan documentation after implementation. Physicians should also make sure that any amendments to the plan are also properly adopted, executed, and implemented. Those who audit ERISA plans often find that intended plan amendments were never prepared or adopted, even though they were implemented.
Mistake 4  **Failing to Deposit Employee Contributions Into a 401(k) Plan Promptly**
Physicians who maintain a 401(k) plan and allow their employees to make contributions to the plan often do not realize that once the money is deducted from the employee’s paycheck, the money must be transferred promptly into the plan. Failure to do so can subject physicians to fiduciary liability under ERISA, prohibited transaction excise taxes, and a 20% penalty imposed by the U.S. Department of Labor (DOL), the agency that oversees the implementation of ERISA. In fact, DOL has made this issue a top priority when a plan is audited. DOL states on its website that failure to segregate and forward participant contributions to a plan from the general assets of the employer in the time frames prescribed would result in a prohibited use of plan assets in violation of ERISA. In addition, if a physician’s plan is subject to the plan audit requirements, plan auditors must now determine whether the physician employer has been meeting this requirement and answer accordingly on the plan’s IRS Form 5500. The rule is that the money must be deposited into the plan no later than the earliest date on which such contributions can reasonably be segregated from the employer’s general assets. In one example in the DOL regulations, the reasonable time frame was only two business days. Similar rules apply to other benefits arrangements as well, such as health and other welfare plan contributions.

**Action Step**  
Physicians or their practice managers should work with staff to ensure that 401(k) and other participant contributions deducted from employee wages are deposited as soon as possible into the appropriate accounts. If delays occur, physicians should seek advice about correcting the error under DOL’s Voluntary Fiduciary Compliance Program.

Mistake 5  **Administering Retirement Plans and Investing Plan Assets Without Understanding and Complying With ERISA**
Physicians often maintain a 401(k) plan, profit-sharing plan, or other pension plan for the purpose of accumulating retirement assets for themselves as well as for their employees. Often, highly trained attorneys, consultants, and actuaries may be involved in complex plan designs for physicians and their practices. However, when it comes to administering the plans and investing the assets, many times physicians serve as trustee of the plan(s) or on the plan committees that administer the plan(s) and direct the investment of plan assets. Frequently, physicians who do so are unaware that they are, by virtue of the functions they perform, deemed to be “fiduciaries” under ERISA. Moreover, even those who are aware they are fiduciaries are often untrained and ill advised about their duties and obligations under ERISA. What many physicians fail to realize is that they are personally liable (meaning that personal assets are at stake) if they breach their fiduciary duties under ERISA and are sued by employee participants for losses incurred as a result of the breach.

**Action Step**  
No physician should be involved in administering or investing the assets of retirement plans without understanding his or her duties and obligations under ERISA. Plan documents can be drafted to minimize liability, physicians can be covered by fiduciary
liability insurance policies, and experts can be used to make sure physician follow “prudent processes” with respect to the duties they assume in connection with the administration of retirement plans. Above all, physicians should document the processes being employed in fulfilling their obligations under ERISA.

**Mistake 6 Not Having Fiduciary Liability Insurance in Place for Plan Fiduciaries**

As mentioned in Mistake 5, physicians often serve as plan fiduciaries for their retirement plans. Many times, they have the fiduciary bonding in place that is required by ERISA. (ERISA requires all fiduciaries and other persons who handle plan assets or funds to be bonded in order to protect the plan and participants against loss from fraud or dishonesty.) However, physicians may be unaware that they can also purchase fiduciary liability insurance to protect themselves from liability due to a breach of fiduciary duty or plan administration error. Although hiring the necessary experts to help them fulfill their duties under ERISA can go a long way toward insulating physicians from personal liability, purchasing fiduciary liability insurance should be an added step in protecting their personal assets in the event an unforeseen turn of events creates exposure to liability under ERISA.

**Action Step** Physicians should determine whether they serve as fiduciaries under ERISA. If they do, they should seek to have fiduciary liability insurance in place to protect them in the event of allegations of fiduciary breach and/or negligent plan administration. ERISA counsel should negotiate the terms of the liability policy with the physicians’ insurer to make sure that it adequately protects them from liability.

**Mistake 7 Unknowingly Entering Into “Prohibited Transactions” Under ERISA**

Imagine this scenario: A group of physicians who serve as trustees for their profit-sharing plan decide to purchase property that will serve as medical office space for their practice. They further decide that their profit-sharing plan will make a loan to the practice, which will then purchase the land and the building. The practice will then make payments on the loan, which will include a favorable interest rate, and the plan will take security for the loan in the property. The physicians believe this will be a good deal for the plan, since they will pay an interest rate equal to rates charged under similar circumstances by lending institutions. Also, they would rather pay interest to the plan than to an unrelated third party. The physicians decide to implement the transaction. Have they done anything that violates ERISA?

Unfortunately, yes. The physicians, as fiduciaries for the ERISA-covered plan, have just caused the plan to enter into a “prohibited transaction,” a complicated ERISA term denoting a transaction between the plan and a party related to the plan (here the employer). While it may in the end be a good deal for the plan, the physicians will now owe significant excise taxes on the transaction. If the prohibited transaction relates to the leasing of property, the lending of money, or other extension of credit, the transaction will generally be treated as giving rise to a prohibited transaction on the date the transaction first occurs, plus multiple prohibited
transactions on the first day of each taxable year thereafter until the prohibited transaction is corrected.

**Action Step** Physicians should be wary of any transaction that involves sales, loans, leases, exchanges, or other transfers of plan assets to, with, or from parties related to the plan in some way (i.e., the employer, the shareholders or owners of the practice, employees, and service providers). Physicians should also stay away from transactions using plan assets that personally benefit them or individuals related to them in some way. If such transactions are seriously contemplated, physicians should seek advice first. The good news is that there is sometimes a way they can enter into such a transaction without violating the law; that is, by making application for an individual prohibited transaction exemption with DOL and instituting the transactional safeguards required by DOL for the granting of such an exemption.

### Mistake 8 Reducing Staff for the Wrong Reasons
The cost to physicians of providing health care and pension benefits for their employees can be daunting when combined with the other rising costs of a medical practice. Physicians often believe they must make changes to their staff to control the costs of such benefits. Very few physicians are aware of the legal pitfalls involved in the process of making such decisions. ERISA prohibits an employer from discharging an employee for the purpose of interfering with the attainment of any right to which the employee may become entitled under an ERISA plan. Courts have held that such practices as terminating employees based on benefits cost to the employer, outsourcing work to an outside contractor to lower benefits cost, or changing the status of an individual from “employee” to “independent contractor” for such purposes have violated ERISA.

**Action Step** Physicians should have a bona fide business reason for the change in staff other than reducing benefits cost. They should document the business reason in advance of the staff reduction and proceed with the change only after seeking the advice of an attorney.

### Mistake 9 Structuring a Long-Term Disability Plan as an ERISA Plan
One type of benefit program that needs to be structured in such a way that it is not covered by ERISA is the long-term disability plan. There has been a spate of news articles reporting how ERISA is being used as a legal shield, creating difficulties for disabled physicians and others to succeed in valid claims for disability. It seems unbelievable that a statute designed to make retirement plans and other benefits secure under the law is being used to accomplish a different result. However, due to the complex procedural aspects of ERISA as well as interpretation by courts, many of these insurance policies have been weakened. Disability insurance policies can be purchased on an individual basis, or if purchased on a group basis, can be structured in such a way that ERISA does not apply. If ERISA does not apply, the
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The likelihood of recovery for physicians and their employees in the event of incurring a disability is much greater.

**Action Step**  Physicians should make sure that any long-term disability policy is structured so that it is not covered by ERISA. Such plans will not be covered by ERISA if they are purchased on an individual basis. However, plans that are purchased on a group basis will also not be covered by ERISA if they meet four requirements: (1) no contributions are made by the employer; (2) participation is completely voluntary for employees; (3) the sole functions of the employer with regard to the insurance program are—without endorsing the program—to permit the insurer to publicize the arrangement to the employees and to collect premiums from the employees through payroll deductions and remit them to the insurance company; and (4) the employer receives no consideration in connection with the program except reasonable expenses.

**Mistake 10  Not Taking ERISA Seriously**

Some physicians and their advisers have ignored the requirements of ERISA, particularly with respect to a small practice, thinking that no one will ever complain and that government agencies are lax with respect to enforcement. However, there are many reasons physicians should take ERISA seriously, including the following:

- Physicians should understand that the number of Internal Revenue Service (IRS) and DOL audits is rising; the agencies have publicly stated that they are strengthening enforcement initiatives and are sending more agents out on examination. Moreover, if IRS agents discover benefits programs to be amiss, they can refer the cases to DOL, the agency responsible for enforcing ERISA requirements.

- Noncompliance with ERISA can unnecessarily expose physicians to liability from lawsuits brought by disgruntled employee participants.

- Physicians are often involved in mergers with other practices or acquisitions by other practices. Astute attorneys representing the buyer will want to have representations that the physicians have complied with ERISA and will ask for disclosures of items where the physicians have failed to comply with ERISA. A history of ERISA compliance failures could affect the price that the physicians might negotiate for sale of the practice, since failure to comply with ERISA creates liability exposure that acquiring entities do not generally want to assume.

**Action Step**  Physicians should take ERISA seriously when it comes to establishing and implementing their benefit programs for employees. If they feel that they have not had adequate advice about compliance with ERISA, a good step toward compliance would be to hire ERISA counsel to perform a compliance audit of all benefit plans. (It is important that legal counsel be involved to protect any information uncovered by attorney-client privilege.) Keeping benefits programs compliant with ERISA will help ensure that, in the event of a
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DOL or an IRS audit, participant lawsuits, or mergers or acquisitions involving the medical practice, the physicians are not penalized or exposed to undue liability for failure to comply.

Conclusion
Physicians adopting and implementing benefit arrangements for their employees should be mindful that often there are ERISA requirements that must be met with respect to these benefit programs. Failure to comply with ERISA could subject physicians to unwanted excise taxes and penalties, exposure to personal liability, and difficulties when selling or merging a medical practice. Also, there may be options with advantages and/or disadvantages for structuring a benefit offering so that it is either covered, or not covered, by ERISA. Physicians should explore these options with their ERISA legal counsel.

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11.2 The 10 Biggest Legal Mistakes Physicians Make in ERISA Claims
By Sheldon Weinhaus, Esq.

Executive Summary
The Employee Retirement Income Security Act of 1973 (ERISA) is a very peculiar statute. It was the subject of congressional concern for about 10 years, and it was finally enacted because of the Studebaker Motor Company disaster in the early 1970s, in which Studebaker dissipated pension funds to be used to pay worker pensions. When Studebaker went out of business, there was no money in the pension fund to pay benefits. What does the Studebaker disaster have to do with doctors? Very little. But as enactment was being considered to impose heavy protections on pension funds and to protect workers as to their retirement benefits, Congress wanted to encourage more employers to provide pensions for their
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workers. For the most part, the pension provisions help to protect workers. Under ERISA, one such encouragement for employers willing to provide for pension benefits is that they no longer have to be concerned about complying with the individual laws of each state in which they operate; state laws were superseded. Employers’ pensions would have to meet only federal (and U.S. Treasury and Internal Revenue Service) requirements. There would be a uniform standard for pension vesting, for fiduciary responsibility, and so forth.

Congress even put in a provision that requires these plans to be informative to the plan participants. If the benefit was to be denied, the plan was required to provide “adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a matter calculated to be understood by the participant.” It also then went on to require that the participant whose claim had been denied, to be afforded “a reasonable opportunity . . . for a full and fair review” by the appropriate named fiduciary of the decision denying the claim.

Now pensions have little to do with the practice of medicine and delivery of medical services and care for the patient. But as enactment of ERISA drew close, the health, life, disability, and other benefit insurers together with jointly administered employer-union plans approached Congress and asked that the law be expanded to cover not only pensions, but also all of the “welfare” type benefits (which includes benefits for patients, such as health coverage, long-term disability, etc.). They argued that in addition to protecting them from having to comply with the various regulatory laws in each of the 50 states, if Congress could establish national standards as well, employers would be encouraged to provide welfare-type benefits. The health care of Americans would increase, Congress was told. (It never happened.) And without any careful thinking about whether such expanded coverage of the law would require other or different kinds of protections from pensions, Congress added “welfare” benefits to the law.

The protections on claims handling quoted earlier became a curse rather than a protection. For Congress left the interpretation of the law to the federal judiciary. Those who serve as federal judges do not have backgrounds in patient protection; rather they come primarily from representing large insurance companies and businesses, whose interests are not patient-oriented. And even though Congress said the protection claim procedure cited earlier requires mandatory submission of any claim, the federal judiciary demanded that anyone and everyone who has a claim must follow any administrative exhaustion procedure the health insurer, the disability insurer, and the welfare plans set up, even though nowhere in the statute is that provided.

What is that administrative procedure? It’s a procedure that starts and a record that is developed without the employee’s knowledge. The physician often gets involved in the administrative procedure without even realizing it. If the physician is asked to provide
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medical records for the patient and the physician supplies them, he or she is participating in the development of an “administrative record,” which, as explained later, is the trial record. So the physician is, in fact, unknowingly participating in the development of the trial record. The physician who is sent a form by the insurer to answer questions is actually filling out a legal document. At this point in the process, there is no attorney to object to the insurer’s request or to point out that the questions are skewed, biased, incomplete, or insufficient to address the problem. Neither the physician nor the patient is warned that an adversarial legal proceeding has begun and the trial record has started. Only the insurer and the plan (and the federal judge to later rule) know that.

Sometimes this “trial” procedure starts simply by mailing the physician an explanation of benefits (EOB). If the doctor writes back explaining why the billing is proper or the procedure is necessary, this explanation becomes part of the “trial” record. No doctor realizes that sometimes, especially with cutting-edge medical procedures, it is important to submit in-depth medical peer-reviewed articles. Or the doctor may not know that the issue is whether the patient’s condition was preexisting, and thus be unaware that to help the patient (and to get the bill paid by the insurer), the doctor must show why the condition did not preexist under the definition of the policy.

Fortunately, there is a review process. The review is supposed to be conducted by a “named fiduciary.” But unlike trust law, as judicially interpreted under ERISA, “fiduciary” means “adversary.” Part of the reason for this interpretation is that when Congress enacted ERISA, it was thinking of the administration of pension trust funds, not health insurance and disability insurance in which there are usually no trust funds, so Congress allowed the employer, as plan sponsor, to name its officers, who are concerned about the corporate bottom line, to act as the fiduciary. Likewise, Congress allowed the health insurer to insist when it sold the policy that it would be the reviewer. Congress did not think of or demand an independent review, for at the time of enactment it was thinking about trust funds and their administration. So worker patients get an adversary deciding their fate in the review procedure.

The record made in the review procedure is added to the earlier record. If there is an adverse decision, the worker patient can sue in federal court regarding, for example, the denial of the benefit or the denial of payment of the doctor’s bill. But there is ordinarily no trial; the “trial” has already occurred: It was the administrative record for which the physician may have supplied information, not being aware that he or she would be unable to testify at a real trial, not aware of anything else in the record. Unlike all other cases, physicians may not be allowed to testify before a judge and perhaps jury. They were already at the “trial” and usually have no opportunity to explain or give details as they might have had they known they were participating in making a trial record.
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Mistake 1  **Failing to Realize That a “Trial” Is Taking Place**
Physicians should understand that they are in a trial when their patients have insurance provided through their place of employment and they are asked to provide information on the care of those patients to the insurer. When asked for such information, physicians should not assume that all they are doing is providing a simple report. They are testifying; their medical records are testifying. If the medical records are not complete, do not address the real questions at hand, or do not provide sufficient informative data (through no fault of the physician, since he or she was unaware of the nature of this “trial”), the physician has unintentionally hurt or at least jeopardized the patient’s case.

**Action Step**  Physicians should make sure they understand the issue, and carefully and fully support their medical opinion. If they send medical notes, they should state something like, “Not every note is intended to be a diagnosis and report of every continuing condition for claim purposes. These notes were written for the purpose of treatment and evaluation, cognizant of earlier notes that may not require repetition and still be relevant, and are not made for insurance evaluation or intended to address insurance issues.” Physicians should check with their attorney. Also, if the amount warrants it, the physician should suggest to the patient that a trial record is being prepared by the insurer and the patient must decide what he or she wants to do about it. Physicians must be aware, however, that several federal judges have frowned on the intervention of attorneys in these administrative proceedings, even though the trial record is being prepared, and prefer the patient to be unaided by legal counsel (which makes it a lot easier for the insurer to win if the patient later has to file suit).

Mistake 2  **Staying “In the Box” When Filling Out a Form About the Patient**
Often insurers send physicians questionnaires to be filled out. The questions and choices are “loaded” to try to limit answers, and often the choices to be checked are not how the physician might ordinarily answer. If, for example, the physician is convinced that the patient cannot work on a sustained basis in a competitive environment for any length of time during the day, but the only question asked is whether the patient can do some sedentary work, the physician might check the “yes” box, not aware that “yes” will be interpreted by the insurer (and likely by the federal judge) to mean the patient can do sedentary work on a sustained basis six and a half hours a day, day after day.

**Action Step**  In filling out forms regarding a patient’s treatment and condition, physicians must be vigilant in looking for “trick” questions. In such instances, they should not check the box but give a narrative answer. There is no law requiring the physician to answer trick questions. Physicians should give answers, but in a way that helps the patient. Physicians should not stay in the box, but rather be aware that an innocent-looking question can be loaded.
Mistake 3  **Giving Information Before Understanding the Issue Involved**
Often the insurance company or benefit plan will ask misleading questions. A physician who is asked whether he or she thinks the patient is disabled should ask to be given the written definition of disabled in the policy before replying. Also, the physician should ask for a detailed description of the job from hour to hour, and for the cognitive and physical requirements of the job. Sometimes the physician may not think the patient is disabled, but what the physician’s idea of disability is and how it is defined under the policy may be different. The physician may state that a patient is not disabled believing that if the patient is accommodated and given light duty, the patient might be able to work. But ordinarily those suppositional conditions are not part of the definition of disability under the plan. So physicians must be careful, since they are likely to answer questions in a way they would not have had they known what they were really being asked. Physicians must always be wary of the “trick question syndrome.” Many doctors have disqualified their own patients when they did not mean to do so.

**Action Step**  Physicians must remember they are participating in a “trial” that has already begun even though there may be no lawyers present or even retained. They should refuse to answer questions unless they have been given policy definitions and accurate job descriptions. Physicians should go on the offensive; they have a right to know the foundation of any question they are asked.

Mistake 4  **Failing to Be Wary of Calls From Insurance Case Workers and Others**
Sometimes the insurance investigator, case resource manager, or even a doctor hired by the insurance company will call the physician to discuss or ask for the doctor’s opinions about a particular patient.

**Action Step**  The best option when physicians are called for their opinions on a patient’s case is to ask that all questions be put in writing to give them time to think about their answers. Physicians should also ask for job descriptions, job expectations, plan definitions, and so forth. Usually, the callers are reluctant to comply because they do not want to be pinned down or forced to be accurate. However, physicians should insist. It may also save a physician time in the long run and might even result in the physician being able to talk first with the patient’s lawyer, if the patient has one. Few do at that stage because they are unaware of how dishonest a process is developing.

Mistake 5  **Failing to Impose Rules When Speaking With Insurance Case Workers and Others**
The typical pattern of insurers is to call the physician, talk unrecorded, and then send the physician a letter stating the insurer’s view of what the physician said and that the physician (really the patient) is bound by what the insurer says that the physician said, unless the physician’s statements are corrected in an inordinately short period of time. The physician
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has a lot of things to do. The insurer will surely misquote or mischaracterize his or her statements. This sort of conduct is a trap, and physicians should not fall into it.

It would not be inappropriate for physicians to insist that the insurer’s representative record the telephone call and that an unedited copy of the entire recording be sent to them, as well as a transcript, if the insurer prepares one. If the representative says he or she has no recording device, physicians should insist that they be sent an agreement in advance of any discussion by telephone or in person stating that they can have as much time as they need to review and correct any letter the insurer prepares that characterizes what the insurer thinks they said. Physicians should not accept any short time limits. Physicians practice medicine, and have neither the time nor the inclination to meet an insurer’s time limits. In fact, physicians may not even want to look at what the insurer said they said until it becomes an issue.

**Action Step**  By specifying the conditions listed in this mistake, physicians may find that insurance representatives—from caseworkers to physicians representing the insurer—may not want to talk to them. Physicians will not be falling into a rigged procedure to manufacture evidence that is not accurate. In addition, physicians will be asking for too much information that the insurance representatives know will better prepare the physicians for what may occur later. Finally, physicians will find themselves saving time for what they do best: practicing medicine and treating patients.

**Mistake 6  Failing to Warn the Patient**
As has been said repeatedly in the other mistakes in this section, by the time physicians receive a request from the insurer for information about a patient, the trial has already started. Physicians may be more aware than the patient that they are not being given definitions and job descriptions by the insurer and that they are not being given fully open forms and sufficient meaningful boxes to check (making it appear that the insurer is trying to limit the information they are given).

**Action Step**  When this scenario occurs, physicians should tell the patient to start thinking about having a lawyer to participate in creating a “trial record.” This is when a lawyer should get involved if a lawyer would be able to help. At times, the amount involved may be too little to justify the hiring of a lawyer, but there are patient advocacy groups that help patients too, such as the Patient Advocate Foundation of Newport News, Va., which does not charge the patient. Other similar groups, and some physician organizations, are now available to help patients develop a “trial record.”

**Mistake 7  Believing the Doctor Retained by the Insurer Who Claims to Be an Independent Medical Examiner**
Many independent medical examiner organizations are really defense organizations that use doctors they have tested to ensure they will give biased reports in favor of the insurer. Often,
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these doctors are not specialists, and they will rely on medical literature that is not peer reviewed.

**Action Step**  Physicians who receive telephone calls from doctors retained by the insurer should treat the call as has been described in previous mistakes in this section. Physicians should establish rules. Simply because the physician calling has a medical degree does not mean he or she is trustworthy. In fact, the physician receiving the call should find out if the physician representing the insurer knows the plan’s definition of disability and all the requirements (both physical and cognitive) of the job. In many cases, the insurer does not want to pay these physicians for the time it takes to even find out this information. Rather, they are paid to give an opinion that is adverse to the patient’s claim, often based on a paper review of only selective information. A physician receiving such calls should ask the questions, rather than allowing the doctor representing the insurer to do so.

**Mistake 8  Failing to Inform the Patient of Contact by the Insurer**
Physicians who are contacted by an insurance representative, whether it is a caseworker, a benefits analyst, a medical doctor, or someone else, may neglect to tell the patient. In one instance, a doctor received an EOB advising him that his treatment protocol was not an acceptable standard in the community and was not efficacious in the view of the insurer. The doctor did not send evidence to the contrary or any peer-reviewed research studies, and did not tell the patient until the patient found out later that he had large unpaid and unreimbursed medical bills. The insurer and court said that the patient was not entitled to a full and fair review because it was previously given to the doctor.

**Action Step**  In such scenarios, if doctors tell their patients of their contact with the insurer, the patients might by able to retain a lawyer to help both of them. Often, the patient’s doctor does not know that there would be no other opportunities to explain and support the patient’s medical record and treatment; that there would be no live trial.

**Mistake 9  Failing to Give Time to the Patient’s Attorney**
Doctors are busy. They want to practice medicine, not help lawyers make the patient’s case. Some fear that in doing so, they will have to take time away from their practices, which is usually not true for ERISA cases.

**Action Step**  Doctors take the Hippocratic Oath to protect their patients, and because the trial starts before the attorney gets involved, it is most important that they talk to the patient’s attorney. If it turns out that the insurer is trying to misstate the doctor’s opinion, the lawyer must be brought in to provide explanation and correction, and to do that the lawyer must rely on the treating or other doctor supplying him or her with medical reports. There is really no other way to do it.
Mistake 10  **Paying Back Claimed Overcharges**

Sometimes insurers providing insurance under ERISA benefit plans and other benefit plans demand that doctors pay them back for treatment they had paid for but later determined they did not have to pay. This happens, for example, in Medicare payments when an insured is not covered, but the insurer did not learn of the Medicare entitlement before the claim was paid. It may also occur when the insurer or plan finds out that the patient obtained a recovery from a third-party tortfeasor and refuses to pay the insurer or plan back under a reimbursement or subrogation obligation. Under ERISA, there is no remedy against its own participant, who is the doctor’s patient. Knowing they will not be able to get that money easily from the patient, they go after the doctors.

**Action Step**  Physicians should not pay back money to insurers or plans unless they have a separate contractual agreement with the insurer or plan to so allow chargebacks. Without such agreement, the insurer likely cannot recover from the doctor. Physicians should insist that the insurer’s fight is with the patient and that they should be left out of it. There is a lot of law providing that the insurers cannot be successful against doctors in these situations, so physicians should not give in.

**Conclusion**  Physicians should be aware of how the ERISA law works and how to avoid the above mistakes to better help their patients.

**About the Author**

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ERISA/RETIREMENT PLANS: QUALIFIED PLANS

11.3 The 10 Biggest Legal Mistakes Physicians Make in Establishing or Operating Qualified Retirement Plans

By John T. Mulligan, Esq.

Executive Summary
For many physicians, a tax-qualified retirement plan (such as a pension plan, a profit-sharing plan, or a 401(k) plan) is, or will over time, become their biggest single financial asset. They will rely primarily on that asset to finance a comfortable retirement. Nonetheless, physicians often make serious mistakes in establishing or operating these plans. These mistakes, while common, are avoidable.

Mistake 1 Not Prioritizing Goals in Connection With the Plan
Physicians often establish a retirement plan without clearly identifying or prioritizing their goals. Is the plan simply being set up as a tax shelter; that is, to enable them to shelter the maximum amount of income from taxation? Is it designed to maximize contributions as quickly as possible with a view toward retirement, or is it designed to facilitate hiring or retaining other physicians or nonphysician staff? Perhaps it is being set up because the physician has reluctantly decided that he or she “has to have a retirement plan” but wishes to do so in the most economical fashion.

Action Step Before establishing a plan, physicians need to identify their goals. In doing so, they need to understand how retirement plans work, the types and advantages of the various retirement plans, and how the different plans relate to the physicians’ goals. These goals must be communicated to a physician’s advisers.

Mistake 2 Failing to Periodically Review the Plan Structure
Just because a particular retirement plan might have been at one time the best suited to achieve a physician’s goals does not mean that it will continue to be so. Over the last 15 years or so, there have been tremendous changes in the various types of retirement plans. For example, revisions have been made in the laws related to 401(k) plans. These changes provide increased flexibility to plan participants and enable physicians to lower their costs for staff participation in the plans. In addition, some physicians and groups are finding defined benefit pension plans to be attractive. Changes in the tax laws permitting significant profit-sharing contributions have eliminated the need to maintain multiple plans in order to obtain a maximum plan allocation.

Action Step Physicians have a right to expect their professional advisers to periodically provide them with advice on new planning opportunities. However, physicians should not assume that their advisers will always initiate giving them this advice. Rather, physicians...
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should ask their advisers from time to time if they should be doing something different that would enable them to meet their goals more effectively.

Mistake 3  **Failing to Coordinate the Involvement of Outside Professional Advisers**
The use of competent professional advisers is critical in establishing and operating retirement plans. Different advisers provide different types of services. It is imperative that the physician’s advisers know exactly what their role is and that they communicate with each other in a smooth, harmonious fashion. This becomes particularly important as the number of advisers increases. The more advisers who are involved, the more likely it is that problems and miscommunication will occur and that certain matters will slip through the cracks. For example, two advisers might each think that the other is handling the filing of the annual IRS 5500 series report, with the result that neither one files it.

**Action Step**  When establishing a retirement plan, physicians should hold a meeting of all of their advisers and make it clear exactly what they expect from each of them. As new advisers are added, physicians should make certain that their identity and role are promptly communicated to all of the other advisers. If a physician suspects that matters are not being tended to properly, he or she should not hesitate to convene a meeting at which all of the advisers are required to attend to work out any problems.

Mistake 4  **Failing to Understand or Abide by Retirement Plan Provisions Regarding Contributions for Employees**
In many situations, employees are erroneously excluded from receiving retirement plan contributions because physicians or their advisers have misinterpreted the plan’s eligibility provisions (e.g., participants who terminate before the end of the year, former participants who are rehired). In other situations, employees are given contributions when, under the plan, they are not eligible. Both of these scenarios create serious problems that typically surface long after the mistakes occurred, at which point corrective action is difficult, if not impossible.

**Action Step**  Before the end of each plan year, physicians should prepare an employee census that includes every individual employed at any time during the year. Physicians should then compare each employee’s situation with the plan’s eligibility provisions to determine if the employee qualifies for a contribution. If an employee does not qualify, physicians should make a written record of why not. Physicians should confirm this record with their professional advisers.

Mistake 5  **Failing to Meet Fiduciary Responsibilities in Terms of Investment Activities**
Even though a retirement plan can be their biggest single financial asset, physicians in busy practices often fail to adequately investigate or monitor the investment performance of the
investment managers to whom they have entrusted their funds. These managers should understand the physicians’ goals. If a manager proclaims to have an investment philosophy, the manager should stick with it. A physician’s other financial advisers can be good sources of information on the investment performance of the physician’s investment manager.

**Action Step** Physicians should carefully investigate and monitor their investment manager. They should demand regular reporting and meet face to face with the manager not less than annually. Physicians should make sure that the investment manager understands their situation and goals, that they understand the investment philosophy of the manager, and ensure that they are compatible. A physician who has any suspicions about his or her manager should act promptly, never forgetting the adage, “If it sounds too good to be true, it probably is.”

**Mistake 6 Permitting Unlimited Individual Direction of Account**
To meet the various investment philosophies of difficult plan participants, physician groups often permit broad investment discretion by plan participants. Doing so can create serious problems. Keeping track of all of the assets held in numerous individual accounts managed by numerous advisers can become an administrative nightmare when it is time to prepare annual reports or beneficiary statements. Permitting unfettered individual direction of accounts also runs the risk that plan participants may invest plan assets in prohibited investments (e.g., collectibles).

**Action Step** Physicians who offer participant investment direction of accounts should consider restricting the rights to a “family” of funds. Unless the practice is very small, physicians should not permit unlimited individual direction of accounts. Also, they should make sure that the nonphysician plan participants have the same level of ability to direct their investments as the physicians and that they are made aware of their options.

**Mistake 7 Failing to Adequately Document Retirement Plan Loans or Monitor Loan Repayments**
Failing to adequately document retirement plan loans or monitor loan repayments is another common mistake. The Internal Revenue Code has strict rules on loan repayments, and failure to make payments in accordance with the rules and the plan provisions can subject the plan participant to serious adverse financial consequences.

**Action Step** Physicians should be certain that loans are adequately documented and that the documentation strictly conforms to legal requirements and those of the plan. Also, physicians should create a mechanism for monitoring the payback of plan loans. Requiring that loan repayments be made through salary deductions is one alternative, although eliminating the loan provision from the plan is one way to avoid the issue entirely.
Mistake 8  **Failing to Adhere to Plan Provisions and Legal Requirements on Distribution to Beneficiaries**

Retirement plans always contain provisions specifying the timing and manner of distributions to plan participants or beneficiaries. For example, those provisions may permit distributions only after the close of the year during which an employee terminates employment, or after one or more years during which an employee has a “break in service.” The Internal Revenue Code’s provisions mandate certain types of distributions and others prohibiting the plan from making a distribution until a participant has made a request to do so. Problems can also arise if the plan contains a vesting schedule. In certain circumstances under federal law, the forfeited amount must be restored if the participant resumes employment within a specified period of time.

**Action Step**  Physicians should be certain to comply with all documentation requirements regarding benefit distributions and that the distributions are made in accordance with the time frames set forth under law or in the plan. If the plan’s provisions on the timing of distributions are different from what a physician has been doing, the physician should either change the plan or change his or her practice. The reallocation of forfeitures should be handled strictly in accordance with the plan.

Mistake 9  **Delaying Depositing 401(k) Monies, or Using Plan Assets for Business Purposes**

In some situations, employers delay depositing 401(k) contributions into a plan in order to use the funds for a period of time to alleviate cash-flow problems. Taking funds from a qualified plan to meet a short-term financial need of the practice is strictly prohibited under federal law. These actions will cause serious legal liability.

**Action Step**  Physicians should use plan assets only for plan purposes. They should pay elective 401(k) deferrals as soon as they can segregate the amounts from business assets; in other words, as soon as they make the compensation payments.

Mistake 10  **Failing to Understand the Long-Term Implications of Deferring Contributions**

Most physician groups are cash-basis taxpayers; in other words, their income is recognized upon receipt and expenses are recognized upon payment. Federal tax laws, however, permit a retirement plan contribution to be deducted even if it is not actually made until the following fiscal year. For cash-flow purposes, or as a means to reduce profit, a physician or physician group may want to defer making the contribution until the following tax year. Doing so on a regular basis results in the revenue produced in the subsequent year always being used, in part, to satisfy the prior year’s retirement plan contribution. If a group ceases medical practice, the year in which this occurs would have a doubling up of the retirement plan contribution but a deductibility for only one contribution, which could create a tax liability.
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**Action Step** Any buyout or deferred compensation payment provision involving physician owners should consider any accrued obligation remaining to be paid to the retirement plan. The tax liability that may have to be dealt with if there ever is a doubling up of retirement plan contributions in a single fiscal year should also be considered.

**Conclusion**
Physicians should avoid these mistakes when administering the qualified retirement plans of their practices.

**About the Author**
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Chapter 12  Estate Planning

12.1  The 10 Biggest Legal Mistakes Physicians Make Involving Trusts
By Daniel S. Rubin, Esq.

Executive Summary
From “insurance trusts” to “intentionally defective grantor trusts,” trusts are becoming more ubiquitous in estate planning. The two major reasons for the increasing use of trusts in estate planning is the fact that trusts can provide a mechanism for saving estate taxes at death, as well as a mechanism for avoiding potential future creditors. Trusts are, however, intricate legal relationships in which pitfalls abound, and physicians must take care in establishing and administering their trusts in order to avoid potentially serious mistakes.

Mistake 1  Failing to Consider Grantor Trust Status
The tax law provides for three basic types of trusts: simple trusts, complex trusts, and grantor trusts. Simple trusts require all income to be paid out to the trust beneficiaries and, as a consequence, the beneficiaries rather than the trust will be taxed on the trust’s income. Complex trusts do not require that all income be paid out to the trust beneficiaries and, as a consequence, the beneficiaries will be taxed on trust income that is distributed to them and the trust will be taxed on trust income that remains undistributed. In grantor trusts, the grantor retains certain set powers that have the effect of causing the trust income to be taxed to the grantor, whether or not it is distributed or retained in trust. Although it would appear that grantor trust status should be avoided, if the physician has the ability to pay the tax, grantor trust status actually permits the equivalent of tax-free growth for the trust fund.

Action Step  Physicians who are establishing trusts in order that the property might grow and not be included in the physician’s estate when he or she dies should consider the powerful opportunities afforded by having the trust drafted as a grantor trust. In order that the obligation to pay tax on the trust’s income never becomes a burden, however, physicians should consider having the trust drafted so that the grantor trust status can be turned on and off so that the grantor can be reimbursed for taxes payable on the trust’s income, if necessary.

Mistake 2  Administering the Trust Improperly
A trust is an agreement between the settlor and the trustee regarding the administration of property for the benefit of identified beneficiaries. Like a contract, a trust’s terms must be respected or else certain adverse consequences are likely. From the settlor’s perspective, if the trust is administered improperly, in contravention of its terms, any tax benefit will likely be lost. For example, if the Internal Revenue Service determines that there was a prearranged plan between the settlor and the trustee such that the trustee’s “discretion” to make
distributions would be exercised only upon the settlor’s “request,” the trust property will be deemed includible in the settlor’s estate. A similar result would occur if a trustee that is also a beneficiary of the trust is found to have exceeded its permissible discretion to distribute property for the “health, education, maintenance, or support” of a beneficiary. From a trustee’s perspective, a breach of the trust agreement, no matter how small or seemingly innocuous, has the potential to expose the trustee to liability to the beneficiaries if a financial loss should result.

**Action Step**  
Physicians should carefully review the terms of all trust agreements in which they are involved in any manner to ascertain and understand their terms. Physicians should also request from the attorney who drafted each trust a written statement setting forth the manner in which the trust is to be administered.

**Mistake 3  Not Using a Qualified Personal Residence Trust**  
Like most Americans, the single most valuable asset of most physicians is often their home. A little known form of trust called a “qualified personal residence trust” (QPRT) can remove the value of the home, together with any future appreciation on it, from the owner’s taxable estate at little gift tax cost. Many physicians, however, fail to even consider using a QPRT because of emotional issues that exist in connection with a person’s home. Yet, the QPRT is one of a very few estate planning techniques that has the potential to significantly reduce estate taxes without unduly affecting the way the settlor lives.

The concept of the QPRT is simple: A homeowner transfers his or her home into trust but retains all right to its use and enjoyment for a set term of years. The “remainder” beneficiaries (e.g., the homeowner’s children) do not have any rights under the trust until the expiration of the set term of years; therefore, the value of the gift is the discounted value of the receipt of the gift many years in the future.

An example illustrates the power of the QPRT. Assume that in May 2004, a 40-year-old settlor transfers a $1 million home to a QPRT with a 35-year term. The settlor will be charged with having made a gift of slightly under $172,000. If the settlor survives the 35-year term, the home (then worth almost $4 million if a 4% rate of growth is assumed) will not be taxable as a part of the settlor’s estate. The only caveat is that the settlor must survive the term of years that he or she chooses or else the transaction is unwound for tax purposes.

Following the expiration of the initial 35-year term, the settlor would still have the right to use the residence as the settlor’s home, but would pay fair market rent to the QPRT for that privilege; thereby transferring even more money to the intended beneficiaries without tax effect (because the QPRT can be structured as a grantor trust both during and after the initial term of years). It is for this reason that all of the benefits incident to home ownership (e.g.,
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mortgage interest deduction, real estate tax deduction, capital gains exclusion) are retained as well.

**Action Step** Physicians who own a home and are likely to have a taxable estate when they die should create a QPRT.

**Mistake 4 Naming Inappropriate Fiduciaries**
Perhaps the most important question that must be answered when creating a trust is whom to name as the trustee. A close friend or family member is often the first choice because of the belief that such a person will accede to the settlor’s wishes in exercising trustee discretion in the trust’s administration. The choice of a close friend or family member as a trustee also has the benefit of keeping costs down, since such persons rarely take commissions for acting as trustee. In contrast, corporate trustees, such as banks or trust companies, will not necessarily accede to the settlor’s wishes under all circumstances and will certainly charge their regular commission schedule for acting as trustee. In exchange for its fee, however, a corporate trustee will provide professional tax and investment services to the trust. Moreover, an individual trustee is much more likely to misappropriate from the trust than is a corporate trustee.

**Action Step** Physicians should carefully consider whom to name as trustee. Relationships with individuals, even family members or close friends, are subject to change, and individual trustees are subject to the possibility of malfeasance in myriad ways that are unlikely to occur with a corporate trustee. Physicians should consider a compromise solution of naming an individual trustee during the physician settlor’s life and a corporate trustee thereafter.

**Mistake 5 Keeping the Trust Local**
Businesses throughout the United States incorporate in the state of Delaware in order to obtain the benefits of Delaware’s corporate law. This type of forum shopping is also available to individuals who wish to “cherry pick” the trust and tax law applicable to their trust, since the law provides that the administration of a trust is to be governed by the law chosen by the settlor as may be set forth in the trust agreement.

There are a number of significant considerations in choosing what state’s law should govern a trust. One is whether the state has repealed the “rule against perpetuities,” which mandates that a trust terminate within a certain set period of time. Another is whether the state imposes a state-level income tax on trust income. For many physicians, one of the most important considerations is whether the physician can also be a discretionary beneficiary of a self-created trust without having the trust remain subject to the settlor’s creditors during life and the estate tax at death.
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Action Step  Physicians should carefully consider their goals when establishing a trust and attempt to coordinate those goals with the vagaries of different state laws. This coordination is best done with the assistance of a competent trust lawyer. Trusts that have already been established but that do not meet all of a physician’s goals may contain a “change of situs” clause enabling the trust to relocate to a more appropriate jurisdiction. If a trust does not contain a change of situs clause, and the state law currently governing the trust is inappropriate, a court proceeding might enable the trust to move to another state.

Mistake 6  Tying the Hands of the Trustee
A trust agreement can be drafted to give the trustee broad discretion, limited discretion, or no discretion. Trusts are often drafted, generally without much forethought, in a manner that limits the trustee’s discretion. This is often later found to be a mistake, since no one knows what the future might hold and the very concept of a trustee is someone the settlor deems trustworthy to make the decisions that the settlor would make under similar circumstances.

For example, a trustee’s discretion to make distributions to a surviving spouse might be limited to trust income rather than trust income and/or principal. While, in general, income might be sufficient for a surviving spouse’s maintenance, returns on investment might fall or the surviving spouse may come to have increased health care costs or other special needs for which the trust income might ultimately prove insufficient.

Action Step  A physician setting up a trust should pick an appropriate (read “trustworthy”) trustee and then have the trust drafted to provide that trustee with the broadest possible discretion.

Mistake 7  Failing to Fund Revocable Living Trusts
In many states, probate (i.e., the process by which a last will and testament is validated by the court) is relatively quick and fairly inexpensive. Moreover, unless the decedent happened to be a celebrity, the fact that probate creates a public record is of little consequence. In other states, where probate is more time-consuming, complicated, and expensive, individuals who are well advised will create a revocable living trust as a will substitute in order to avoid the process entirely. Significantly, however, the creation of a revocable living trust does not avoid probate unless the trust is also funded, during life, with all of the settlor’s assets (other than jointly owned assets or assets, like life insurance, that pass by operation of law). In fact, if even a small bank account, brokerage account, or other asset has been left outside of the revocable living trust, a probate proceeding will be required.

Action Step  Physicians who have revocable living trusts as a will substitute should ensure that all of their assets are properly titled in trust as soon as possible.
Mistake 8  **Leaving Property Outright to One’s Spouse**
In a properly drafted last will and testament, because of an unlimited marital deduction against the value of property left to a surviving spouse, there generally will be no estate tax upon the death of the first spouse to die. This unlimited marital deduction applies whether the property is left to the surviving spouse outright or in a special type of trust called a “qualified terminable interest property” (QTIP) trust. Inasmuch as the tax result will not differ, people commonly leave a large portion of their estate to their spouse outright even though a marital trust would be preferable for several reasons:

- Property left in a marital trust will be protected from the surviving spouse’s creditors.
- Property left in a marital trust will be protected if the surviving spouse remarries and later divorces.
- Property left in a marital trust will be protected from a “right of election.” More specifically, if the surviving spouse remarries and then predeceases his or her new husband or wife, that person will have the right to elect to take a third or more of the deceased spouse’s estate, irrespective of what the surviving spouse’s last will and testament might say. Since a marital trust is not considered a part of the surviving spouse’s estate for this purpose, however, it is protected from any right of election.
- The use of a marital trust ensures that to the extent that the trust is not exhausted in providing for the surviving spouse, any remaining property will pass to the children of the marriage (or the deceased spouse’s other intended beneficiaries, as the case may be), upon the surviving spouse’s death.

**Action Step**  Physicians should review their last will and testament (or revocable living trust) to determine whether property passing to the surviving spouse passes outright or in trust. If outright, the physician should speak with his or her spouse to see if the spouse can agree that the use of marital trusts better serves their respective interests.

Mistake 9  **Not Transferring Insurance Policies Into an “Insurance” Trust**
Most physicians with even a modicum of financial sophistication know that a life insurance policy death benefit is received free from income tax. A much smaller number of physicians know that life insurance is not also received free from estate tax. Under current law, the death benefit can be reduced by almost one half due to estate taxation if no planning is done. The recommended planning, in most cases, is an irrevocable “insurance” trust.

Unlike other types of trusts, insurance trusts generally require that gifts be made to the trust every year so that premiums can be paid. Unfortunately, the $11,000 per beneficiary “annual exclusion” from gift tax does not apply to gifts to a trust unless the beneficiaries have the right to withdraw the gifted amount (called “Crummey” withdrawal rights). It is not enough, however, that this right be drafted into the trust agreement; for the Internal Revenue Service to actually respect the existence of these powers, certain procedures must be followed. First, the trustee needs to provide notice to the beneficiaries each time a contribution is made.
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Second, in order to give the beneficiaries the practical ability to exercise their withdrawal rights, if they should so choose, the contribution should be held by the trustee for some period of time before being used to pay premiums. Finally, the beneficiary should be made to sign a statement acknowledging receipt of the notice, and the notice and the receipt should be retained with the trust records to protect against the possibility of a later estate tax audit.

**Action Step** Physicians should ensure that these procedures are followed so that the existence of Crummey powers will be respected by the IRS and, therefore, that their gifts to the insurance trust will be excluded from gift tax.

**Mistake 10 Keeping the Good News to Themselves**
The law of every state provides that the assets of a “spendthrift” trust are unavailable to a beneficiary’s creditors. This holds true irrespective of how broadly the trustee might choose to exercise its discretion to benefit the beneficiary from the trust fund. The major limitation in the use of spendthrift trusts in this regard is the fact that only six states permit an individual to transfer property to a trust for his or her own benefit and yet have it protected from potential future creditors.

Some individuals, however, will receive an inheritance when their parents, aunts, uncles, or other family members die. If the inheritance is left outright, it will be exposed to existing creditors and will likely remain exposed to potential future creditors. Moreover, to the extent that the inheritance is not ultimately consumed, it will likely be hit with an estate tax when the recipient of the inheritance eventually dies. An inheritance received in trust will be unavailable to creditors and free from future estate tax and is therefore infinitely preferable so long as a friendly trustee is given broad discretion to make distributions to the beneficiary.

**Action Step** Physicians should speak with any one who might leave them an inheritance to suggest that it be left in trust rather than outright. Physicians should also suggest whom they would like to see named as the trustee.

**Conclusion**
Physicians should freely employ trusts in their estate planning for the many benefits that trusts can provide. They should exercise care, however, to ensure that their trusts are first drafted and then administered in a manner that ensures that those benefits are actually obtained.

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12.2 The 10 Biggest Legal Mistakes Physicians Make When Establishing, Funding, and Administering Trusts
By Langdon T. Owen, Jr., Esq.

Executive Summary
Trusts are a legal relationship in which a trustor places legal title to property in the name of a
trustee for the use and benefit of persons named as beneficiaries. They can be revocable or
irrevocable. A revocable trust may be changed at any time by the trustor prior to the trustor’s
death and is very often used in estate planning for physicians. An irrevocable trust is not
changeable by the trustor and is typically used in special situations in which it is desired to
make a gift or otherwise part with control over trust assets. The trustor, trustee, and
beneficiary may be the same person (at least for awhile) but typically are (eventually)
different persons. For example, a typical revocable trust is set up by a trustor during the
trustor’s lifetime (a “living trust”) and during the trustor’s life, the trustor is also the trustee
and sole beneficiary. On death, a successor trustee assumes fiduciary responsibilities to use
the trust for the benefit of the persons the trustor has specified. Trusts are flexible tools that
can be used for many purposes, but unless they are properly established, funded, and
administered, they will not be able to accomplish their intended purposes. There are a number
of common mistakes physicians can make regarding trusts that will limit or eliminate their
benefit.

Mistake 1 Not Funding the Trust Properly or at All
Trusts are only effective as to assets transferred in trust to the trustee. Merely signing a trust
instrument generally does not cause any particular asset to become subject to the trust.
Rather, the trust must almost always be funded by separate transfers of property to the trustee,
which is accomplished through deeds, assignments, beneficiary designations, and other
methods used to transfer assets generally. If this is not done, the trust has nothing to work on.
The physician must remember that the transfer is to the trustee, not to the trust; this is because
a trust is a relationship, not an entity legally treated as a person. To put property into a trust,
the transfer documents typically title property something like this: “John Jones, Trustee under
agreement dated January 1, 2004”; or as abbreviated: “John Jones, Trustee U/A 1/1/04.”
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**Action Step** Physicians should be sure to fund their trust and title assets properly, and ensure that future replacement assets remain titled properly.

**Mistake 2 Using a Revocable Trust to Protect Assets From Creditors**

Some physicians are under the mistaken impression that a revocable trust will protect assets from creditors. This is not so. Certain, rather specialized, *irrevocable* trusts may be used for creditor protection, but a revocable trust is inappropriate for such use. As long as the trust may be revoked by the physician, the assets of the trust will be treated as being the assets of the physician for purposes of being reached by creditors. Revocable trusts provide a number of benefits for a physician in estate planning, but creditor protection is not one of them.

**Action Step** Physicians should use revocable trusts where appropriate for estate planning, but not for asset protection from creditors.

**Mistake 3 Believing That the Use of a Trust Will Alone Save Taxes**

Trusts have no tax-saving magic. Trusts are perhaps the most flexible of the tools in the estate planning lawyer’s toolbox, and as such, most tax-saving plans will sooner or later make use of trusts. However, it is the overall arrangement itself that saves taxes, not the mere use of the trust vehicle. For example, revocable trusts can be drafted with formula clauses designed to maximize the tax benefits against the estate tax of the marital deduction and the unified credit. Other ways to obtain such benefits are also possible; they are just typically much more cumbersome to use. The assets of the revocable trust will be included in the gross estate of the deceased physician for estate tax purposes, but the trust terms can be structured to help achieve tax savings. Irrevocable trusts may be used to achieve tax savings; the key, however, is that such trusts constitute true gifts that irrevocably remove from the trustor physician control over the assets and benefits from the assets. There are other ways to give away assets irrevocably, but the use of a trust can add desirable restrictions with the most ease.

**Action Step** Physicians should use revocable and irrevocable trusts where appropriate to structure transactions for tax savings, remembering that the savings come from the structure, not merely from the use of a trust.

**Mistake 4 Selecting the Wrong Trustees**

One of the most important decisions in setting up a trust is the selection of an appropriate trustee. An inappropriate trustee can cause enormous harm in myriad ways. Trustees must:

- Be impeccably honest and honorable and unwilling to violate their honor, even under strong financial or psychological pressure;
- Have good financial ability, be prudent in financial dealings, and be able to take good financial advice;
- Be willing to follow the trust document and applicable law and seek and take good legal advice concerning the trustee’s duties under the governing instrument;
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- Have strong people skills, including having the trust and confidence of the beneficiaries, having the backbone to say “no” when necessary, not having any interests in conflict with the goals of the trust, and not having any prejudices or family axes to grind that may affect their performance as trustee;
- Be likely to be able to serve through the term of the trust, which may be for a considerable length of time, in order to provide consistency in management and reduce the disruption of transition; and
- Be able to deal effectively and collegially with any co-trustees, including, on the one hand, not having animosity toward a co-trustee and, on the other hand, having the ability to exercise independent judgment not overly influenced by a co-trustee.

If a trustee lacks even one of the necessary attributes or abilities, the physician setting up the trust should probably consider someone else. Where appropriate, trust companies or bank trust departments should be considered. They are highly regulated, and they recruit, train, and supervise people to be responsive to the needs of beneficiaries. Also, they can respond in damages if they do wrong; they have track records and reputations for results and service that can be reviewed; they seldom make significant financial errors; they have experience in tax reporting and providing beneficiary accountings; and they are likely to be around for the long term.

**Action Step** Physicians should carefully select the trustees or co-trustees of any trust. They should consider using a professional trust company or bank trustee department as the trustee or as a co-trustee with an individual as the other co-trustee. In addition, they should avoid unworkable relationships among co-trustees.

**Mistake 5** **Expecting Full Privacy From Use of a Trust**

One reason physicians establish trusts during their lives (rather than by will at death) is to avoid having the terms of the trust made public through the probate of the will. This is a valid reason to use a trust, but the privacy provided will not be perfect. In case of a dispute, the trust will become part of a public court file. At least some information about the trust must be recorded in the real estate records in order for the trustee to take title and effectively exercise trust powers, and must be provided to bankers, brokers, and others dealing with the trust. Fortunately, seldom is the full trust required for these purposes, and bankers and brokers will generally honor the confidentiality of the trust information provided. Perhaps more significantly, beneficiaries generally will be able to see how the trust has been changed by the physician over time. They will see how some benefits have been added and subtracted as circumstances changed. This aspect is something some physicians would rather not have known. However, in the circumstance where a revocable trust has the physician as the sole trustor, sole trustee, and sole beneficiary, restrictions in the latest trust instrument have a good chance of preventing prior trust instruments and amendments from being disclosed.

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Action Step Physicians should not expect full privacy from using a revocable or irrevocable trust. They should have restrictions against disclosure of prior instruments included in amendments to revocable trusts.

Mistake 6 Not Being Aware of the Duties as a Trustee
Physicians sometimes act as trustees to administer trusts established by themselves or others. Trustees have fiduciary duties that are imposed by law and the trust instrument. The physician as trustee must never lose sight of such duties because to do so may lead to costly litigation and liability. The three major duties of a trustee are:

- **Loyalty:** The trustee must be loyal to the beneficiaries under the trust. This means that the trustee must place the interests of the beneficiaries first above his or her personal interest, avoid conflicts of interest with the trust, and not engage in self-dealing with the trust.
- **Obedience:** The trustee must act in accordance with the trusts’ governing instruments, within the bounds of the law. Among other things, the trustee must be familiar with the terms of the trust.
- **Care:** The trustee must in good faith use the care that a prudent person would exercise in a like position under similar circumstances, which includes exercising care in both fiscal and operational matters of the trust.

Generally, the trustee will have the burden to demonstrate that he or she met the applicable standards with respect to these duties. Taken together, these duties require more of the trustee than ordinary business honesty; they require a high degree of honor and integrity and a sensitivity to potential conflicts of interest. Co-trustees generally cannot divide these duties among themselves, but each one is fully responsible ultimately for the administration of the trust, even when certain functions are delegated among co-trustees for convenience.

Action Step Physicians should be fully aware of their duties when acting as trustee and seek and follow competent legal advice when appropriate.

Mistake 7 Not Obtaining and Following Adequate Investment Advice
A physician acting as trustee has the duty to manage and invest trust assets prudently. The standard for prudent investments will vary somewhat from state to state but generally requires consideration of relevant investment factors, such as income, growth, safety of principal, and so on. Few physicians are investment experts and thus will need to have competent investment advice. A trustee cannot simply pick the safest, lowest return investment and then forget about it. Trustees are generally required to actively monitor and manage investments in light of the needs and goals of the trust. Failing to obtain proper advice can be costly to the trust and lead to liability on the part of the physician-trustee.
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Action Step    Physicians should obtain and follow competent investment advice and keep records of having done so.

Mistake 8    Failing to Obtain and Follow Competent Legal Advice When Acting as Trustee
Physicians acting as a trustee of a trust are obliged to follow the terms of the trust and the law. Even a trust drafted in reasonably readable English, rather than in incomprehensible legalese, will be a technical instrument with many nuances and meanings not readily apparent to an untrained reader. Also, the trust needs to be read in the context of applicable law, which is likely to be even less readily apparent to a reader. Thus, any trustee, and particularly a busy physician, should plan on obtaining legal advice any time a substantial matter arises with respect to a trust. A simple telephone call with a knowledgeable lawyer and an hour or two of legal time can save the physician-trustee from endless wasted hours in litigation, the cost of litigation, and the liabilities that can result from litigation. Far better to be safe than sorry. Too often the trustee will, to his or her regret, act without obtaining legal advice.

Action Step    Physicians should engage and obtain advice from competent legal counsel any time they serve as trustee of a trust and any significant issue arises.

Mistake 9    Failing to Obtain Court Approval of Certain Transactions
The physician acting as a trustee may find it desirable to enter into a transaction between the trustee and a person related to the trustee or even with the trustee himself or herself, to take action not clearly authorized by the trust instrument, or to otherwise take action that may produce an issue with respect to the trustee’s duty. In such event, particularly where unanimous consent of all beneficiaries cannot be obtained (e.g., future beneficiaries may be unascertained), it may be wise to have counsel help the trustee seek court approval of the transaction so that the trustee and the trust can be protected. Not all trustees are aware of this possibility. Even when they are aware of it, some trustees are unwilling to submit to court scrutiny. It may be a very serious mistake, however, to proceed with such a transaction without having obtained court approval.

Action Step    Physician-trustees should seek court approval of transactions raising substantial questions about the trustee’s duty.

Mistake 10    Failing to Take Account of Tax Ramifications
Trusts are often used to help save taxes, but even when tax savings are not one of the trust’s primary goals, trusts will have tax implications that can be quite significant. A physician acting as trustee will need to be sensitive to the tax effects of what he or she does or does not do. For example, irrevocable life insurance trusts may be a good way to remove life insurance proceeds from a trustor’s taxable estate by making a gift of the insurance, in trust, when it has a low value. The premiums are also gifts and in order to obtain a gift tax annual exclusion for
the premiums, certain withdrawal powers are often included in such trusts. In paying the premiums on such insurance, the trustee must give notices of such withdrawal rights and the failure to do so can be costly. Also, as another example, trusts reach the highest income tax rates much more quickly than do individual taxpayers. Thus, the trustee may desire to maximize current distributions in order not to incur the higher tax that would result by retaining income in trust. As these two examples illustrate, the physician acting as trustee will need to consult with his or her counsel, accountant, or other qualified tax adviser about the tax implications of the administration of the trust. The failure to do so may cause additional tax expense for the trust or its beneficiaries and may also cause potential liability on the part of the trustee.

**Action Step**  Physicians should consult counsel about the tax implications of trust administration. Where possible and legal, they should try to obtain exculpation from certain tax-sensitive decisions under the terms of the trust instrument.

**Conclusion**

Trusts are very useful tools that must be properly set up, funded, and administered to accomplish their goals. Physicians following the suggested action steps will have gone a long way toward making the trusts, with which they may be involved in one role or another, effective for themselves or others.

**About the Author**

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12.3 The 10 Biggest Legal Mistakes Physicians Make With Regard to Family Limited Partnerships
By James J. Everett, Esq.

Executive Summary
Family limited partnerships (FLPs) are an excellent planning tool for physicians. They allow physicians to give to their children and relatives interests in their estate, including interests in their practice, at a discounted value, while allowing physicians to retain complete control over the partnership. Physicians must realize, however, that although they will maintain control of the assets in the FLP, they are giving away the interest, and no longer have an ownership right in anything they give away. Physicians should also be aware that certain actions can cause the FLP to be disregarded for tax purposes and the entire value to be included in their estate upon death, potentially triggering an estate tax liability. Other errors can cause gift tax liability to donors or recipients of FLP interests. To ensure that the FLP is properly formed and used, a physician should consult an experienced attorney.

Mistake 1  Not Following the Formalities of Partnership Law
Compliance with federal and state partnership rules, including those regarding fictitious names and business registration statutes, is essential to the FLP. The FLP must follow the rules set forth in the Internal Revenue Code, the Department of the Treasury Regulations, and local law. If the FLP does not act like a partnership, it may be disregarded by a court, and the value of the assets in the FLP will be included in the physician’s estate, potentially triggering an estate tax liability.

Action Step  Physicians who establish an FLP should be sure that it maintains separate books, records, and bank accounts, and files the proper partnership tax returns. All assets used by the FLP should be held in the name of the FLP.

Mistake 2  Not Using a Valuation Professional
When fractional interests in an FLP are gifted to relatives, they are subject to a valuation discount—the divided interests are worth less than the FLP as one asset. (In other words, the sum of the parts is not equal to the whole.) A valuation expert can appraise the value of the gift to the relative and determine if it exceeds the annual gift tax exclusion amount, and if so, by how much. Failure to use a valuation expert may result in annual gifts that exceed the allowable limit, and the physician or his relatives will have to pay tax on the excess.

Action Step  Physicians should be sure to hire a separate valuation expert to work in conjunction with their attorney to properly establish the value of their gifts to the limited partners. The attorney should be able to recommend a qualified expert. Physicians should be sure that the attorney who establishes the FLP is not the person who values the gifts.
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Mistake 3  Retaining Incidents of Ownership in Transferred Interests
Physicians may not transfer assets or interests to an FLP and continue using the assets for free. In addition, they should not contribute personal use assets, such as a house, to an FLP and continue to use the assets for personal use. Physicians who contribute assets to an FLP should plan to pay reasonable rent or other value to the partnership for the use of the assets.

Action Step  Physicians should transfer a building or a similar asset to the FLP. They will have to pay a fair rent to the FLP for use of the building, which not only helps to remove additional taxable assets from the physician’s estate (i.e., monthly rental payments), it is also tax deductible.

Mistake 4  Trying to Do It Themselves
Physicians should not try to establish an FLP without the assistance of a qualified attorney. If done improperly, the FLP may not be honored for estate planning purposes. If the FLP is ignored for estate planning purposes, the value of the assets in the FLP will be included in the physician’s estate, possibly increasing his or her estate tax liability.

Action Step  Experienced estate planners are trained in establishing FLPs. They know how to structure them properly, and can advise physicians on how to use the FLP to reduce their estate most effectively.

Mistake 5  Using an Unqualified Professional
Physicians should not use unqualified professionals when forming an FLP. They should use a licensed, qualified attorney who has been practicing for years and knows how to form the FLP correctly. Using an unqualified person to form the FLP can result in the partnership being formed incorrectly and as a consequence, the FLP may be disregarded by the Internal Revenue Service or the courts, and the estate planning benefits negated.

Action Step  Physicians should not follow the advice of an unlicensed, unqualified person when forming an FLP. They should consult a licensed attorney.

Mistake 6  Having Services, Not Capital, Be a Material Income-Producing Factor
Physicians must contribute more to an FLP than just personal services in order for the FLP to be honored. If a physician contributes only services, the FLP will be deemed an “assignment of income” and the entire amount will be taxed to the physician, who earned it. Treasury Regulation 1.704-1(e)(1)(iv) states: “Capital is a material income producing factor if a substantial portion of the gross income of the business is attributable to the employment of capital in the business conducted by the partnership. In general, capital is not a material income producing factor where the income of the business consists primarily of fees, commissions, or compensation for personal services performed by members or employees of the partnership…capital is ordinarily a material income-producing factor if the operation of
the business requires substantial inventories or a substantial investment in plant, machinery, or other equipment.”

**Action Step** Physicians should contribute capital, such as buildings and equipment used in their practice, to the FLP. Services may be contributed to the FLP if capital is also contributed. As such, the Internal Revenue Service and the courts will not disallow the FLP of a physician who contributes his or her entire practice to the partnership, including office space and equipment, and continues to provide services to the FLP.

**Mistake 7 Giving Too Much Control to a Managing Partner without Accountability**
Physicians who are also the general partners in an FLP and transfer junior interests to relatives or children run little risk that the transferred interests will be included in their estate. However, the general partner’s management responsibilities should be fiduciary only. If a general partner is given unfettered control over economic and voting matters, the transferred interests may be included in his or her estate when he or she dies.

**Action Step** Typically, the general partner should be a corporate entity owned and controlled by the physician or another person who is trusted by the physician. An attorney should be consulted for the pros and cons of this method of control.

**Mistake 8 Commingling Assets**
Physicians should keep their personal assets separate from the FLP’s assets. They should not use personal accounts to pay bills of the FLP, nor should the assets of the FLP be used to pay personal liabilities. If assets in an FLP are commingled, the courts may disregard the entity and include the entire value of the FLP in the physician’s estate, potentially triggering an estate tax liability.

**Action Step** Physicians should maintain at least two separate accounts, one for personal assets and one for FLP assets, and take care not to confuse the two or use the assets of one to pay the liabilities of the other.

**Mistake 9 Not Making Pro Rata Distributions**
A physician who is the general partner of an FLP and makes distributions to the general and limited partners must distribute income pro rata with ownership interests. Often, a general partner will try to distribute more to the limited partners, and little or nothing to the general partner, in an effort to increase gifts to children and relatives and reduce the size of the estate more rapidly. This action may result in the FLP being disallowed for estate planning purposes.
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Action Step  Physicians who make distributions must be sure that the distributions are made pro rata with ownership interests in the FLP.

Mistake 10  Waiting Until It Is Too Late
Physicians err if they wait too long to form an FLP. But they also err if they contribute all of their assets to an FLP. Recent cases have disallowed FLPs where the decedent formed the FLP and contributed all of his or her assets to it, and died shortly thereafter.

Action Step  Physicians should visit their attorneys to see if an FLP is appropriate for their estate planning needs; if it is, they should form an FLP as soon as possible. Forming the FLP earlier also allows a physician to donate assets over time, rather than having to donate them all at once.

Conclusion
Although family limited partnerships can be useful planning tools for physicians, there are complications and pitfalls that make an attorney a necessary part of organizing an FLP. When used properly, an FLP can reduce the value of a physician’s estate and result in lowered estate and income tax liabilities. If, however, an FLP is organized improperly, gifts of FLP interests may result in tax to the donor or donee, or in inclusion of the entire value of the FLP assets in the physician’s estate, triggering an estate tax liability. When organizing an FLP, physicians should consult a qualified attorney for the best result.

Additional Resources
- Treasury Regulation 1.704-1(e)

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12.4 The 10 Biggest Legal Mistakes Physicians Make When Preparing Their Wills
By Langdon T. Owen, Jr., Esq.

Executive Summary
Wills are the key instrument to pass property on death in many, if not most, estates, and they should be used at least as a backup even if a physician also uses a living trust. Proper use of a will can provide certainty and security for the family of the physician, and the failure to take full advantage of the protections a will can provide may prove costly and disruptive to the physician’s family at a very difficult time.

Mistake 1 Not Having a Will
Every physician needs a will. It may be the only dispositive instrument needed in some cases. In other cases, it will be a backup to a living trust “pouring over” assets into the trust, where the assets may not have been placed in trust during the physician’s lifetime, either intentionally or unintentionally. It can name guardians for children and specify who is to control the property and the terms on which property is to pass. It can be simple or it can be complex as the physician’s needs, desires, and circumstances dictate. Some physicians, as with other people, shy away from wills because wills are a reminder of mortality, because they are concerned about the probate process, or because of a mistaken belief that a will is not needed if the physician has a trust or power of attorney or if the physician has orally stated his or her intentions to family members. Unless the physician is willing to risk allowing the state legislature to dictate through the intestate succession statutes where his or her property is to go on death, a will is a necessary component of every estate plan. In many states, the probate process is not overly burdensome, but even where a living trust is used to avoid probate, a backup pour-over will is a safety net that also needs to be used. Probate has certain benefits, including a generally very short period to bring claims. This short claim period can protect the physician’s family against potential malpractice and other claims in a way not always achievable with a revocable trust alone.

Action Step Physicians should have an experienced estate planning lawyer help them write a will and advise them to take other action as appropriate.

Mistake 2 Not Sufficiently Considering Who Should Serve as Personal Representative or Trustee
A personal representative, sometimes called an executor or executrix, may be named in a will as the person who will see that the terms of the will are carried out and that the physician’s estate is properly administered: assets collected, debts paid, tax returns filed, and estate and inheritance taxes paid, and property distributed. The job may last from about six months for a simple estate to maybe three years for a complex estate. Trustees, on the other hand, may be
required to administer a trust for many years, perhaps even whole lifetimes. Both a personal representative and a trustee may be named in a will and need not be the same person. However, both jobs require similar attributes and abilities: absolute honor and integrity, the ability to fairly and even-handedly deal with family members or other beneficiaries, the willingness to abide by the terms of the governing documents, the ability to deal collegially with any co-personal representative or trustee, and prudence in dealing with financial matters. All these attributes and abilities must be present; the failure of even one can be disastrous. Thus, selecting a fiduciary, personal representative, or trustee deserves a good deal of thought, but the decision is too often made quickly and so as not to offend someone who may feel honored by being named as a fiduciary. The fiduciary will have a great deal of power in the physician’s family and needs to be able to exercise the power wisely and well. Physicians should bear in mind that family members may otherwise be fine people yet not possess all the necessary attributes and abilities. Professional trustees and personal representatives, such as bank trust departments and trust companies, deserve serious consideration as a sole fiduciary or as a co-fiduciary with an appropriate family member. The cost of a professional fiduciary is always less than the cost of the litigation that will result if the wrong family member or members are chosen.

**Action Step** Physicians should carefully consider who should be the financial fiduciaries and whether it would be best to use a bank or trust company as the sole fiduciary or as a co-fiduciary.

**Mistake 3** **Failing to Name an Appropriate Guardian**

Wills can be, and generally are, used to name guardians for minor children, disabled adult children, or disabled spouses. Guardians are responsible for the personal care of the ward and need not be the same person as the personal representative or trustee. In fact, some physicians are well advised to keep the guardian different from the fiduciary who has the key financial responsibilities in order to provide a check-and-balance system. The guardian must be someone with good people and personal care skills and also able to work well with the financial fiduciary. Selecting a guardian with appropriate skills and values is often the most difficult choice that must be made in writing a will.

**Action Step** Physicians should carefully consider who should be the guardian for minor or disabled persons and name such a person in their will. If possible, physicians should also name a backup in case the first named person is unable to serve.

**Mistake 4** **Failing to Consider Staggered Distributions**

A gift to someone under a will need not be immediate; rather, it can be staggered over time. Such a distribution scheme may be something like: “one third at age 22, one half of the remaining amount at age 25, all the remaining amount at age 27.” For a minor, or for a young adult, when substantial assets are at stake, such staggered distribution dates are often far away.
better than immediate distribution at the physician’s death or when the beneficiary reaches age 21. During the period before final distribution, the property can be held in trust with a trustee who has discretion to distribute income or principal as needed between the scheduled distribution dates. The failure to use such staggered distribution dates has resulted in a great deal of financial and human waste where significant assets become the property of immature and ill-prepared beneficiaries. The assets may be lost to poor financial management, be used in ways harmful to the beneficiary, or both.

**Action Step** Physicians should consider the use of appropriately staggered distribution dates, taking into account the age and maturity of the beneficiary and the size of the gift to the beneficiary.

**Mistake 5 Failing to Consider the Use of “Pot” or “Sprinkling” Trusts**

Far too often, physicians divide their assets equally among their children before the youngest children have had the opportunity to enjoy the benefits the older children have had. However, until the youngest children have had the same opportunity to obtain a basic education and training, “equal” is not truly equal or fair. Consider the case of four children: Two have graduated from college, one is in college, and one is in high school at the time the physician parent dies. An “equal” division at the time of death results in the oldest receiving a full education and a larger inheritance. For many families it is better to hold assets in a single “pot” to be “sprinkled” out as needed (e.g., for education or medical needs) until the youngest child has reached an age (say, 22), when he or she will have had the opportunity to use the sprinkling benefits to achieve the same basic education as the older children. At that time, an equal division can be made, with immediate or staggered distributions as appropriate.

**Action Step** Physicians should consider the use of a pot trust until the youngest child reaches an appropriate age. They should be sure to provide for an alternative disposition if the child fails to survive to the specified age.

**Mistake 6 Not Using Trusts Under the Will Where Appropriate**

Not all trusts are “living trusts” set up while the trustor is alive; trusts can also be set up after death pursuant to a will. Trusts set up by will are called “testamentary trusts.” They may be used for tax planning the same as living trusts can be, for example, by establishing marital deduction trusts for surviving spouses and family trusts for spouses and children designed to take advantage of the unified credit against the estate tax. They may also be used to provide benefits for minors or disabled persons. Where there are minor children, a trust should almost always be used to help the minor beneficiary at least until he or she reaches the age of majority, or some other appropriate later age. It is a big mistake to leave assets to a minor or disabled person outside of trust because then there is no one to manage the property for the minor or disabled person until a court proceeding is brought to name a conservator or similar fiduciary for the child or disabled person. Such a court proceeding can be eliminated by the
use of an appropriate testamentary trust for the minor or disabled person. Further, trusts can be tailored to fit the circumstances, while conservatorships tend to be one size fits all.

**Action Step** Physicians should consider whether the will should contain trust provisions, particularly where there are minor or disabled beneficiaries or long-term restrictions are desirable.

### Mistake 7 Failing to Take Both Sides of the Family into Account
Physicians ordinarily consider how property is to pass to their surviving spouse, children, and further descendants. Too often, however, they leave it at that and fail to specify who is to receive property in the event that no immediate family survives. This throws the matter to the intestacy laws of the state, and in many states, leads to the problem of the “longest liver.” The problem is that the side of the family of the husband or the wife, whichever lives longer, is likely to take all the property where no immediate family survives, while the side of the family of the spouse to die first takes nothing. Many physicians find that such an approach is not fair or appropriate in their circumstances. To avoid the problem, the will needs to specify a division between the sides of the family or some other dispositive scheme fitting to the circumstances. It is generally not a good idea to leave the matter to the intestacy laws of the state.

**Action Step** Physicians should consider what will happen to property on the death of the last spouse to die where collateral relatives (other than direct descendants) may receive benefits. They should also consider whether the families of both spouses are appropriately treated.

### Mistake 8 Failing to Name an Ultimate Charitable Beneficiary
After taking care of a surviving spouse, surviving children and descendants, and other collateral relatives or friends, physicians too often stop. In that event, the physician’s will does not provide for disposition if everyone he or she cares for predeceases. This throws the matter to the intestacy laws of the state. Those laws will typically pass the property to relatives to a certain degree of consanguinity and then, if there are none, escheat the property to the state under its unclaimed property law. By no more than a sentence or two, the physician’s will could provide that if everyone he or she cares about is dead, the property is to pass to one or more charities. This may in large families be a long shot, but the situation does occur regularly even if rarely. The property would generally be better used by a charity chosen by the physician than by unknown or unsatisfactory relatives or the state itself.

**Action Step** Physicians should name one or more charities as ultimate beneficiaries in case all those they care about fail to survive them.
Mistake 9  Failing to Take Into Account Transfer Restrictions
Property may be restricted in one way or another and if so restricted could adversely affect an otherwise well-laid plan under a physician’s will. The areas of greatest concern are restrictions imposed by divorce decrees, business buy-sell agreements, trusts created by others, and retirement plans. The physician could easily assume that particular assets will pass to people as the physician desires pursuant to the physician’s will, only to have the gifts voided or unacceptably changed after death when it is too late to try to cure the problem or at least to take it into account in planning.

Action Step  Physicians should review divorce decrees, business buy-sell agreements, prenuptial agreements, and similar documents that may restrict their assets or their disposition and bring them to the attention of their estate planning attorney.

Mistake 10  Assuming That the Will Passes Everything
Some physicians believe that having a will finishes the estate planning process. Although a will is a necessary component of any estate plan, it is not necessarily the only dispositive instrument. There are many ways to pass property outside of the use of a will, and a will does not change the disposition made under other dispositive instruments. Thus, a will must be carefully coordinated with other dispositions. Other ways property is transferred include trusts; joint tenancies in real estate, or in bank, brokerage, or other financial accounts; life insurance and annuity beneficiary designations; and retirement plan and IRA beneficiary designations. Also, spouses, but only spouses, typically have rights under state law to elect against wills if the will does not provide a certain minimum level of benefits for them. All these sorts of matters must be disclosed by the physician to his or her estate planning attorney so they can be properly taken into account or modified where possible.

Action Step  When preparing a will, physicians should take into account all other forms of transfers, so they may be appropriately coordinated with their will.

Conclusion
Physicians who take the recommended steps will be able to pass their property in the way best suited to their family situation.

About the Author
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12.5 The 10 Biggest Legal Mistakes Physicians Make When Dealing
with Estate Planning Professionals
By Peter J. Parenti, JD, LLM

Executive Summary
Physicians need to respect the board-certified estate planning lawyer as a specialist. Proper
estate planning should always be viewed as a process and not just as an event. Physicians
need to find board-certified estate planning lawyers who are the best and most experienced.
Finally, it is important for physicians to abide by the client protocols established by their
estate planning attorney.

Mistake 1  Failing to Seek Out an Estate Planning Specialist
In the field of medicine, the age of specialization is many decades old. A family practitioner
would not think of referring a patient with a cardiac problem to a hand surgeon. The standard
of care requires that a patient with a specific health problem be referred to a physician who
specializes in that particular health matter. Why then would a physician ever want to visit a
general practice lawyer or a trial lawyer for his or her estate planning needs? The age of legal
specialization is only about 30 years old. To protect the public, many state bar associations
have adopted a system for the board certification of lawyers, and these associations are
usually glad to provide the names, addresses, and telephone numbers of board-certified
lawyers in a particular geographic location.

Action Step  Physicians should call their state or local bar association or seek a referral for
the names, addresses, and telephone numbers of lawyers who are board certified in estate
planning.

Mistake 2  Hiring the Cheapest Estate Planning Specialist
Many physicians spend exorbitant amounts of money for tangible possessions, such as cars.
Likewise, they spend thousands on dubious tax schemes thinking their income tax will be
reduced. However, when it comes to protecting their entire accumulated and future wealth
from lawsuits, estate taxes, and probate, most physicians do not hire an estate planning
lawyer with the proper qualifications but prefer instead to search for the “best deal out there.”
John Ruskin, a 19th century art critic, was famous for the following quote:

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“It is unwise to pay too much, but it is worse to pay too little. When you pay too much, you lose a little money; that is all. But when you pay too little, you stand to lose everything, because the thing you bought was incapable of doing the thing it was bought to do. The common law of business prohibits paying a little and getting a lot; it can’t be done. If you deal with the lowest bidder, it is well to add something for the risk you run, and if you can do that, you will have enough to pay for something better.”

Physicians should follow the example of their patients when it comes to finding a doctor. In their search for a good doctor, they do not go looking for the cheapest doctor. They look for a referral to the best doctor to treat their particular medical problem. When it comes to their health, expertise takes precedence over expense. They want the most experienced doctor, and money is no object. To protect their wealth, doctors would be so wise to find the best lawyer and not the cheapest. If physicians select the lowest bidder for their estate planning purposes, they should ask themselves, why is this lawyer so cheap? Will this lawyer cut corners that could mean losing wealth to taxes, probate, or judgment creditors?

**Action Step** Physicians should seek out a board-certified lawyer who is the best and most experienced and not necessarily the cheapest.

**Mistake 3 Believing That Estate Planning Can Be Completed with a Generic Document**

Occasionally, physicians ask how much it costs for a simple will or a simple living trust. The caller is really shopping for the cheapest lawyer and not for a simple estate plan. As an attorney who is board certified in estate planning, probate law, and tax law, I tell these callers that I feel I would be violating the standard of care by doing a simple will or trust instead of a customized, comprehensive estate plan. The usual response from the caller is, “Don’t you already have standard estate planning documents stored in your computer?” Although I have stored on my computer thousands of estate planning document templates that I have developed over 30 years of practice, until I can ascertain the caller’s needs and desires, I have no idea which template is right for the caller. Estate planning is not a commodity. The documents produced for clients are the result of many hours of discussions about their estate planning goals, which involves exploring their hopes, fears, dreams, values, needs, and desires. Together, the attorney and the client plan their estates for the client and for their loved ones. The analogy of building a custom home applies here. Before a custom homebuilder quotes a fee, the builder would need to spend several hours with the client to discover exactly what kind of home the client desires. Just as one house plan does not fit everyone’s needs, no basic simple will or simple living trust does so either. Brick by brick, hope by hope, dream by dream is how a good estate planning lawyer builds customized estate plans.
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**Action Step** Physicians need to respect the board-certified lawyer as a specialist who customizes their documents.

**Mistake 4  Trying to Do Estate Planning Without Help**
Physicians sometimes find estate planning documents on the Internet or create their own documents and then call an attorney to review these documents for an hourly fee. Legal documents are tools that require a specialist who knows how to use them, and physicians can make a mess of their estate using such boilerplate documents. I respond to such callers by saying that I charge $1,000 per hour to review their estate plan and require a three-hour minimum retainer. These professional fees are based on numerous years of experience and level of expertise. Quality service produces a quality product.

**Action Step** Physicians need to respect the board-certified lawyer as a specialist and not try to do their estate planning themselves. Physicians need to understand the old computer cliché “garbage in-garbage out” also works in reverse when pulling documents off the Internet: “garbage out-garbage in.”

**Mistake 5  Failing to Include the Opinions of a Spouse or Others in Estate Planning**
Sometimes a physician shows up at my office without his or her spouse. When this happens, it is usually the husband who comes in without his wife. The first question I usually ask is: “Will I be creating only your estate plan?” Predictably, he will try to convince me that he has the authority to speak for his wife and that she will do whatever he tells her. My second question is then to ask if his wife believes that estate planning is so unimportant that her input toward the design and creation process is either not needed or not desired. If this question does not convince him to include her in the estate planning process, I usually refuse to plan the estate with only one of the spouses present. I refer to these husbands as estate planning lone rangers. However, I will plan an estate for that spouse if the other spouse is so ill that he or she cannot participate in the design and creation process.

Estate planning lone rangers usually fail to understand that while the husband may be the chief financial officer of the family wealth, the wife is usually the chief emotional officer of the family. It has been my experience that whenever I made the mistake of estate planning with an estate planning lone ranger I usually ended up doing the estate plan twice. This is because when the wife finally does come into my office to review the first estate plan, several problems inevitably are discovered. For example, the spelling of the names and/or the dates of birth of one or more of the children are incorrect or the persons named as executors, trustees, or guardians of the minor children will not be to her liking. Worst of all, she quite understandably feels that the husband and I have conspired against her in designing and creating a plan that did not include any of her input, and she will rightfully refuse to sign anything that did not include her input. It is therefore my policy that when an estate planning lone ranger shows up at my office I give him one of two choices: either we postpone the
meeting until a later date, when the wife can be present, or he will have to immediately write me a check for $500 for the consultation. If he does want to engage my services, I let him know that I will be charging him twice the fee that I normally charge, because I will, more likely than not, have to design and create the estate plan a second time.

If a physician is not married or is a widow or widower, he or she should consider including a significant family member or friend, such as a trusted adult child, in the estate planning design and creation process. This is especially true if this trusted relative or friend is someone the physician usually consults with before making important decisions. By including this trusted person in the process, he or she will be privy to the attorney’s explanation of the estate planning designing and creation concepts, instead of to the physician’s second-hand explanation. Just as physicians are much better at explaining medical matters to patients and family members, attorneys and financial advisers are much better at explaining estate and financial matters to clients and family members.

**Action Step** A happily married physician should always include the spouse in the estate planning design and creation process. An unmarried physician should always include a trusted family member or friend in the estate planning design and creation process.

**Mistake 6  Failing to Disclose All Assets and Personal Information**

Some physicians mistakenly believe that by disclosing all of their assets to their estate planning or financial advisers they will be compromising their privacy or that their advisers will charge them higher fees. Additionally, some physicians may be embarrassed to disclose some vital personal information about themselves or their family, such as a divorce or the existence of a child with a mental, a physical, or an addictive handicap. They might even want to hide the existence of a child who has a criminal record or has been convicted of a crime and served time in prison. What they do not realize is that by withholding vital financial or personal information, they will disempower their advisers, meaning their advisers will not be able to make a proper diagnosis of their planning needs and desires. Furthermore, their advisers will not be able to prescribe appropriate estate planning tools and alternatives. Just as in medicine, if a patient fails to disclose vital information or symptoms, the physician will not be able to make the proper diagnosis or write the proper prescription.

Physicians who believe that certain sensitive financial or personal information needs to be kept private should tell the estate planning attorney that they want this information kept private under the attorney-client privilege and not to disclose this sensitive information to other nonattorney financial advisers.

On the other hand, physicians should seriously consider waiving the attorney-client privilege regarding nonsensitive financial or personal information so that their attorney may share this information with their other nonattorney financial advisers for the benefit of the physicians.
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and their family. It is always advisable for the client and the attorney to include the client’s other financial advisers, such as a certified public accountant and/or financial planner, in the estate planning design and creation process. If, however, it is not possible or practical to include one or more of the other advisers in the process, then the physician needs to give the attorney permission to disclose and explain the estate plan to the other advisers. This is especially important in regard to tax information that needs to be disclosed to the CPA so that the CPA can prepare the proper income, estate, or gift tax returns.

**Action Step** Physicians should always disclose all vital financial and personal information to their attorney. They need to inform the attorney to keep all sensitive information confidential under the attorney-client privilege. All other nonconfidential information should be disclosed to a physician’s other advisers, such as a CPA or a financial planner. It is also a good idea for the physician to disclose any information that he or she may feel is not important or vital and let the attorney decide what is important.

**Mistake 7 Failing to Follow the Attorney’s Client Protocols**

In some practices, prospective clients must complete certain questionnaires and return them to the estate planning attorney before the attorney will schedule a consultation with the prospective client and his or her spouse or other helpful decisionmaker. Estate planning attorneys need this information to evaluate whether the prospective client is suitable for the services they provide. In addition, it is a waste of time to drag out this information during an initial consultation. Physicians should understand these protocol requirements. Physicians require new patients to come into their office at least 30 minutes before their first appointment because patients typically need to complete forms and other paperwork.

In my practice, I explain to prospective clients that if they fully comply with all of these protocols, there is no charge for the first hour. After the first hour, I usually quote a fee range (not an exact fee) for the planning, and they can choose to move ahead with the planning or not. If they choose not to proceed, we end the meeting and there is no charge. If we move on to the second hour and they do not engage my services, there is a fee of $250 per hour after the first hour. If the prospective client tells me that he or she does not want to comply with my protocol but just wants to meet me first, I charge a $500 advanced payment to set such an appointment on my calendar. Experience has shown that clients who do not want to complete my protocols are either going to be difficult to deal with, will waste my time because they are shopping for a cheap lawyer, or are not serious about completing their planning.

**Action Step** Physicians need to fully comply with the attorney’s protocols the same way they expect patients to comply with their protocols.
Mistake 8  **Failing to Include All Advisers in the Estate Planning Process**
I regularly suggest to my physician clients that we consider inviting their CPA and financial adviser to participate in the plan design process. These other advisers are familiar with the client’s financial matters and can contribute valued information and suggestions. In addition, by having them included in the plan design process, the advisers will be fully informed for the planning implementation process.

**Action Step**  Physicians should include their other advisers early in the plan design process.

Mistake 9  **Ignoring Communication From the Attorney and Failing to Follow Up With Periodic Checkups**
Proper estate planning should always be viewed as a process and not as an event. Just as planning for good health is a lifelong process, planning for good wealth is also a lifelong process. After an estate planning vehicle, such as a living trust or a family limited partnership, has been created, the vehicle will need fuel to work. This fuel is the various owned assets that must be retitled into the name of the vehicle. It has been my experience that after the estate plan is created many physicians fail to provide the attorney with the proper documentation to transfer title to their assets into the vehicle. Many times, I have to send two or three follow-up letters to get all the necessary information. Furthermore, over time, as laws change or needs and desires change, I will send several letters to the physician informing him or her to review the plan design in light of these changes. The estate plan funding also must be checked to ensure that all preplanning assets were properly put into the vehicle and that all subsequently acquired assets have been properly acquired in the name of the vehicle. It is critical that these things be done once an estate plan has been created.

**Action Step**  Physicians need to promptly respond to communications from their estate planning lawyer in regard to the funding and updating of estate plans. Physicians need to recognize that proper estate planning should always be viewed as a process and not just as an event.

Mistake 10  **Failing to Get a Second Opinion on the Old Planning**
Many times when I meet physicians in a social setting I ask them if they have accomplished their asset protection estate planning. Whenever they tell me “Yes,” my next question to them is, “How long ago did you get the planning done?” I usually find that it has been five to 10 years ago. Often it is not the physicians’ fault that their planning is out of date, but rather the fault of their estate planning attorney who has simply not followed up on the physician’s planning over the years. Most estate planning lawyers prefer to do planning for new clients rather than following up on previous clients. I usually ask the physicians if they would like to have a free second opinion on their old plan. I have rarely found an old plan that did not need some improving.
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Action Step
Physicians need to keep their estate plans current and remember that estate planning is a process and not an event. If their original lawyer does not follow up on their planning, they need to visit another lawyer and get a second opinion on their plans.

Conclusion
Physicians need to respect the board-certified estate planning attorney as an expert and understand that proper estate planning is a process and not just an event. Complying with the attorney’s protocols increases the likelihood that not only will proper estate planning get accomplished but also a great attorney-client relationship will be established.

Additional Resources
- R. Esperti and R. Peterson, Creating a Loving Trust Practice (LTES, Inc. 1991)
- Esperti, Peterson, and Parenti, Legacy: Plan, Protect & Preserve Your Estate (The Institute, Inc. 1996)

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12.6 The Ten Biggest Legal Mistakes Young Physicians Make When Setting Up Their Estate Plans
By Peter J. Parenti, JD, LLM

Executive Summary
Most young physicians start their medical careers with a lot on their minds. The demands of their profession leave little time for physicians to concentrate on themselves or their future plans. Consequently, estate planning is usually one of the furthest things on their written or
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mental checklists of things to accomplish. They do not fully realize the effect of dying or becoming incapacitated with no written estate plan. If they fail to have a written estate plan, the state in which they are domiciled provides a default estate plan for them known as the laws of descent and distribution or as the laws of intestacy. By having a written estate plan, young physicians can control their property while they are alive; take care of themselves and their loved ones in the event of disability; give what they have to whomever they want, the way they want to, and when they want to; and save every last tax dollar, court cost and professional fee legally possible.

Mistake 1 Failing to Recognize Their Own Mortality
Some young physicians, after dealing day in and day out with the disability and the death and dying of their patients, start to lose sight of their own mortality. A constant concern of others and the placing of others’ health needs before their own have many young physicians putting any thoughts about their own mortality on the “back-burner.” Then again, some young physicians adopt the common misconception of young people in general, that, because of their youth, death or disability is only a remote possibility. The old saying “none of us are going to get out of this life alive” is easily forgotten.

Action Step Physicians need to recognize that death (and maybe disability) is something that will eventually happen to them and that they need to plan for these events.

Mistake 2 Failing to Estate Plan
When an individual dies without a written estate plan, he or she is said to have died intestate. When an individual dies with a written estate plan, he is said to have died testate. When one dies intestate, the state in which the decedent’s domicile is located has its own default estate plan, the laws of descent and distribution or the laws of intestacy. Each state’s legislature decides: (1) who should be considered an “heir” of the intestate individual, and (2) which “heirs” are entitled to receive which portions of the intestate’s assets. Heirs are therefore the default persons who receive an intestate individual’s assets.

On the other hand, when one dies testate, the written estate plan (i.e., a will, trust, life insurance policy, or retirement plan) controls. By having a written estate plan, an individual is expressing his or her legal right to disagree with the laws of descent and distribution or the laws of intestacy and is exercising his or her legal right to leave his or her various assets to the persons that he or she wants to name as beneficiaries.

Action Step Physicians should have a written estate plan so that they can express their desires to give what they have, to whom they want, the way they want, and when they want, instead of depending on the state’s default estate plan.
Mistake 3  Failing to Believe They Have Enough Assets to Do an Estate Plan
In the context of estate planning there are two categories of assets that individuals can own: titled assets and untitled assets. Titled assets are those for which a paper document is needed to prove ownership and a paper document is needed to transfer ownership. For example, real estate is a titled asset because a deed is needed to prove ownership and a deed is needed to transfer ownership. A checking account is a titled asset because an account with a financial institution is needed to prove ownership and a check is needed to transfer ownership from the account. Conversely, a watch, a set of golf clubs, or other tangibles are examples of untitled assets. With untitled assets, the cliché “possession is nine-tenths of the law” is applicable. This is because possession of an untitled asset is needed to prove ownership, and the voluntary transfer of its possession is all that is needed to transfer legal ownership.

An individual’s estate consists of all the assets, both titled and untitled, that he or she owns and possesses during lifetime and upon death. The size of an individual’s estate is irrelevant when it comes to designing and creating an estate plan that meets the definition of proper estate planning. This is true because the size of an individual’s estate may also include assets that his or her estate may acquire after death, such as life insurance proceeds or the proceeds from a lawsuit against a person or entity that may have been responsible for the wrongful death of the individual.

Action Step  Physicians need to have a good understanding of what types of assets they own during their lifetime and what types of assets and the value of such assets their estates will own at their death.

Mistake 4  Failing to Fully Understand the Definition of Proper Estate Planning
The definition of proper estate planning encompasses all of a person’s estate planning hopes, fears, dreams, values, needs, and desires. It is the foundation, and each hope, fear, dream, value, need, and desire are the bricks. A proper estate planning definition builds a proper estate plan from the individual’s unique perspective. It is the prime directive of estate planning and should never be violated. The definition of estate planning is as follows:

I want to control my property while I am alive. I want to take care of my loved ones and me if I become disabled. I want to give what I have to whom I want, the way I want, and when I want. Furthermore, if I can, I want to save every last tax dollar, court cost, and professional fee legally possible.

Obviously, this definition is extremely subjective. If an estate plan ever fails to either fully meet or continue to fully meet any word, phrase, or sentence of an individual’s subjective opinion of the definition of proper estate planning, it will violate the prime directive, and the estate planning should be revoked or modified until the definition is fully achieved.
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To review each part of the definition:

*I want to control my property while I am alive.* The key word is “control.” Any provision of a plan that takes control away from the person doing the estate planning violates the prime directive. Control should not be confused with ownership. One does not need to own an asset to control it. Ownership is what causes the value of an asset to be included in the value of one’s gross estate, for estate tax purposes. Ownership of an asset is what a judgment creditor can easily take away, but a judgment creditor cannot take control of an asset that is not owned. It is not unusual, in the design and creation of an estate plan, to give up ownership but not control, to legally avoid estate taxes or to legally protect assets from a judgment creditor.

*I want to take care of my loved ones and me if I become disabled.* A proper estate plan must include a disability plan for taking care of not only the individual in the event of a mental or total physical disability but also a plan for taking care of the person or persons that the individual was taking care of before becoming disabled. It is extremely important that a plan include written instructions that specifically spell out not only who is to be taken care of in the event of the disability of the individual but also how those individuals will receive that care.

*I want to give what I have, to whom I want, the way I want, and when I want.* Many lawyers refer to this part of the definition as the “golden rule of estate planning.” If you own or control the gold, you have the right to make the rules. Everyone has this right. When a state tells its citizens to whom they must leave a portion of their assets, through its forced heirship laws, it is not unusual for those citizens to transfer their assets to a trust that is governed by the laws of another state, to legally get around the forced heirship laws.

Furthermore, *if I can, I want to save every last tax dollar, court cost, and professional fee, legally possible.* Death taxes, probate court costs, and probate professional fees are optional expenses paid only by the estates of individuals who fail to create plans that can legally avoid these expenses. The living trust is the premier way of legally avoiding these expenses. While some estate planning professionals argue that a will can do just as well at saving estate taxes as a living trust, most wills are poor tools for saving estate taxes (see Mistake 6). Also, a will-based estate plan can never help to save every probate court cost and probate professional fee that is legally possible. It is impossible for a will to avoid probate. In fact, wills guarantee probate because a will is not valid as a title transfer substitution document until the testator dies and the will is admitted to probate by a probate judge. In other words, admitting a will to probate means that the will has been approved by a probate judge as a substitution for a title transfer document, such as a deed or bill of sale that a decedent could have signed while alive.
When a person dies owning titled assets that are titled in his or her name, there is a problem in that a probate court’s assistance will be needed to determine how to get title to a titled asset out of the deceased person’s name. Likewise, when a person becomes mentally disabled and owns titled assets that are titled in his or her name, there is a similar problem in that a probate court’s assistance will be needed to manage or transfer titled assets that are titled in the name of a person who is mentally disabled. Death probate and living probate (also known as guardianship or conservatorship) were established to solve both of these problems. The problem with the probate solution is that it is costly, time consuming, and a matter of public record. Furthermore, probate is a lawsuit that you file against yourself, with your own money, for the protection of creditors and disgruntled heirs. Probate also serves as a legal system that makes sure that the creditors of a decedent or of his or her estate get paid before any beneficiaries and heirs are distributed any assets and that disgruntled heirs get their day in court.

The definition of proper estate planning therefore mandates that the estate plan be designed to avoid probate. A properly designed and created living trust avoids both living and death probate because it owns the title to all of the trustmaker’s titled assets. If the individual becomes mentally disabled or dies, there are no assets titled in his or her name that will need the assistance of a probate court to manage or to transfer out of his or her name. Lawyers usually refer to a living trust that owns the title to all of the trustmaker’s titled assets as a fully funded living trust.

**Action Step** Physicians should plan their estates to meet their own personal definition of proper estate planning regardless of the present size of the estate. Physicians should plan their estates with the assistance of a qualified estate planning attorney, who fully understands the definition of proper estate planning through the use of fully funded living trusts.

**Mistake 5 Failing to Carry Adequate Amounts of Permanent Life Insurance**

Most young physicians, like most young people in general, fail to see the value of any type of life insurance program, let alone the value of a permanent program of life insurance. Young physicians need to look at themselves as if they are “legal money printing machines.” If the U.S. government allowed an individual to own a legal money printing press, that person would be wise to protect it and insure it because it might get stolen or be damaged or destroyed in a fire, storm, or other calamity. Since it makes sense to carry insurance coverage for an occurrence that might happen, it also makes sense to carry adequate amounts of insurance for an event that will definitely occur. At a minimum, a young physician should carry at least $1 million of term life insurance and plan to convert it to permanent life insurance. Life insurers report that they pay death claims on only about 2% of all term life insurance policies. There are three reasons for this low payment rate:

1. The cost of the coverage eventually becomes so unaffordable that the policyholders drop the coverage;
2. When the time period of the term coverage runs out or the temporary need for the term coverage is gone, the insureds drop the coverage (besides the fact that when the term coverage ends, the insureds will be older and possibly uninsurable), and 3. The insureds will convert the term coverage to permanent coverage.

Since all physicians need a permanent plan of life insurance, it makes sense to buy such insurance when they are young and healthy and the premiums are relatively low and affordable.

**Action Step** Physicians should work with an estate planning attorney and a life insurance agent recommended by the attorney to acquire a permanent plan of life insurance that is coordinated with the estate plan created by the estate planning attorney.

**Mistake 6 Failing to Coordinate All Assets Into a Unified Plan**
Among titled assets, there are subcategories. The first subcategory involves assets titled only in one individual’s name or in more than one name, without rights of survivorship. These assets are clearly subject to the living and death probate process in the event of a mental disability or death. In the event of death, these assets will pass under the estate plan created under a will, or by intestacy if there is no will or if the will fails to distribute these assets.

A second subcategory of titled assets is survivorship assets. These assets usually do not avoid the living probate process, but usually do avoid the death probate process. As such, they will not pass under the estate plan of the will. These assets pass by operation of law to the named survivor and include such assets that are titled in joint names with rights of survivorship or in a single name with a payable-on-death designation.

A third subcategory of titled assets is beneficiary designation assets. These assets usually do not avoid the living probate process but usually do avoid the death probate process. As such, they do not pass under the estate plan of the will. These assets pass by operation of law to one or more named beneficiaries. These assets include life insurance and annuity policies and retirement plans, such as pensions, and profit-sharing plans and IRAs.

When an individual creates an estate plan by a will, especially a will that is designed with various testamentary trusts to manage assets for beneficiaries and/or to eliminate or reduce estate and inheritance transfer taxes, assets in the second and third subcategories will not become part of the plan under the will. If an estate plan under a will is intended to be an asset management and delivery vehicle and a death tax elimination or reduction vehicle, the will as an estate plan does not have enough asset fuel to reach the asset management and tax savings destination. An estate plan contained within a fully funded living trust does not suffer from this asset deprivation problem because when a living trust estate plan gets fully funded, the
second subcategory survivorship assets are eliminated, and the third subcategory beneficiary designation assets get coordinated with the living trust estate plan.

**Action Step** Physicians should create fully funded living trust estate plans. Physicians who prefer estate plans through a will need to eliminate the survivorship aspect on all titled assets, even though these assets then have to pass through probate (this assures that these assets become part of the estate plan within the will) and will need to coordinate all beneficiary designation assets with the estate plan within the will. If a physician goes through all that trouble, he or she may as well have a fully funded living trust and avoid probate.

**Mistake 7 Failing to Have the Physician’s Parents or Other Relatives Leave Their Share to a Judgment-Proof Trust**

The trust laws of all 50 states permit the use of what is generally referred to as a spendthrift provision. A spendthrift provision within a trust provides that a beneficiary of the trust is prohibited from alienating his or her interest in the trust (such as by selling it or pledging it as collateral for a loan) and that creditors of a beneficiary are prohibited from invading the assets of the trust to satisfy their claims against the beneficiary. With the exception of five states as of the date of this writing (Alaska, Delaware, Nevada, Rhode Island, and Utah), the trust laws of the remaining 45 states disallow the protection of a spendthrift provision in regard to the interest reserved by the creator of the trust for his or her own benefit. This type of trust is usually referred to as a self-settled trust. However, when someone (such as a parent) creates a trust for the benefit of another person (such as a child), the spendthrift provision of the trust will protect the assets of the trust from the creditors of both the parent and the child. In many states, the protected beneficiary may even be one of the cotrustees of the trust. So long as the trust provides that there must always be at least one trustee who is not a beneficiary of the trust, the beneficiary trustee may even be given the power to appoint a new nonbeneficiary trustee and then remove the old nonbeneficiary trustee.

In addition to the benefits just described, a spendthrift provision may also protect the beneficiary’s interest in the trust assets from divorce, death taxes, and probate. Some of the design features of these asset-protected trusts are discussed further in Mistake 8.

**Action Step** Physicians should encourage their parents and other persons who want to leave them assets to leave the assets to them in a spendthrift trust. The spendthrift trust may be created by a parent or any other person for the benefit of the physician in various ways. The spendthrift trust may be designed as a separate living trust, as a remainder subtrust within the parent’s or other person’s own living trust, or as a testamentary trust created within the last will of a parent or other person.
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Mistake 8  Giving or Leaving Assets Outright to Beneficiaries Instead of in Trust for Life
For the same reasons discussed in Mistake 7, a physician should never give assets to anyone or leave assets to anyone outright. Gifts and inheritances should always be made or left to an asset-protected spendthrift trust for the life of the beneficiary. Distributions of income and principal from the trust must be restricted to distributions for the benefit of the health, education, maintenance, and support of the beneficiary and/or persons supported by the beneficiary. Beneficiaries may be given the limited power to appoint their remaining interest in the trust when they die, in trust to persons of their own choosing. The beneficiary must be prohibited from exercising this limited power of appointment in favor of the beneficiary’s creditors, the beneficiary’s estate, or creditors of the beneficiary’s estate. This “in trust for life” design feature works well to ensure that family wealth is not lost to creditors, death taxes, and those who are not descendents.

Action Step  Physicians should always design and create living trusts that give or leave assets to their loved ones in trust for life, with distributions restricted to the needs for health, education, support, and maintenance of the beneficiary and persons supported by the beneficiary.

Mistake 9  Treating Children Unequally
When physicians raise children, they usually treat each one as an individual. It is rare, however, to have children who are all equal in their needs, desires, abilities, ages, talents, and so forth. Nevertheless, many estate plans say something like this: “I leave my entire estate to my spouse, if my spouse survives me. Otherwise, share and share alike to my children.” If there is no surviving spouse, this form of disposition is not equal, especially if any of the children are minors or young adults and if the parents raised each child as an individual. With this type of dispositive plan, the older children usually profit at the expense of the younger children. There is nothing as unequal as the equal treatment of unequals.

Suppose a physician has three children: Alex, age 24 years; Barbara, age 16 years; and Clark, age 9 years. Alex has just finished his MBA at Harvard School of Business. Barbara has just finished her third year of high school, and Clark is entering the fourth grade. One summer night, a hit-and-run drunken driver kills the physician and his or her spouse. Mom’s and dad’s wills leave everything to the three children to be divided equally. Alex already has had four years of college and two years of graduate school paid for in full, and Alex is now free to make his life’s fortune with his one-third share. Barbara has to use her one-third share to get through her senior year of high school, plus four years of college. Clark has to use his one-third share to get himself through grade school, middle school, high school, and college. If the physician and his or her spouse had wanted to treat their unequal children equally they would have had a plan that kept all of their assets in one common trust, until the youngest child, Clark, attained the age of 23 years or graduated from college, whichever came first.
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The trustees would be allowed to use the funds of the trust for each child’s individual needs for health, education, maintenance, and support, just as if the physician and his or her spouse were still alive.

When Clark attains the age of 23 years or graduates from college, the remaining assets of the trust can be divided fairly into equal shares. In the meantime, while the common trust is being administered, the trustees could make advancements to the older children for such expenses as a first wedding, home, business, or professional practice. On division day, the trustees could offset the shares of the older children by the advancements made to them.

Action Step  Physicians should use a common trust in their estate plans when planning for young children.

Mistake 10  Considering Estate Planning as an Event Rather Than an Ongoing Process

When most physicians visit a lawyer to have their wills created, they view it as a completed process. They sign the wills, bring the originals or copies home, stuff them in a file cabinet or a safe deposit box, and forget about it. This is usually because the will planning event is not very joyous. Living trust planning, on the other hand, can be much more enjoyable. The living trust planning process does not and should not center on death planning but rather focus on planning for the rest of one’s life while living in health, in disability, and then lastly, planning for death. The living trust planning process involves not only the design and creation of a living plan, but also the transfer and future acquisition of assets to or in the name of the living trust. This process requires periodic review, monitoring, and updating. Just as physicians have always recommended annual physical exams to protect one’s health, living trust estate planners recommend a periodic review to protect one’s wealth. Over time, the law, the physician’s needs, desires, and wealth will change, and as such, the living trust plan also needs to be changed.

Action Step  Physicians should view estate planning as a lifelong process that needs to change as the process of life changes.

Conclusion

With a fully funded living trust estate plan, young physicians are able to control their property while they are alive, take care of themselves and their loved ones in the event of disability, give what they have to whom they want the way they want and when they want, and save every last tax dollar, court cost, and professional fee legally possible.
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Additional Resources

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Chapter 13  Hospital Relations

13.1 The 10 Biggest Legal Mistakes Physicians Make in Hospital-Physician Contracting
By Patrick J. Miller, Esq.

Executive Summary
Contracts between physicians and hospitals take many forms to address many relationships. Examples include medical director agreements, professional services agreements, exclusive service agreements, building and equipment lease agreements, management service agreements, contract-based joint ventures, and myriad others. This section discusses 10 mistakes often made in hospital-physician contracting. All of these mistakes find their roots in two broad failures: the failure to have common expectations and therefore an ill-defined relationship, and the failure to appreciate the importance of legal compliance.

Many hospital-physician relationships are of common form and may fit well within pattern agreements, modified to fit the particular situation of the parties. A lease of an office is a good example. While it is vitally important to read, understand, and modify (where appropriate) any such form agreement, it is nonetheless common to have an appropriate pattern or form lease. On the other hand, many hospital-physician relationships are unique. In such cases, it is important not to let the written contract define the relationship, but rather to make sure the relationship the parties want to have is accurately described in the written agreement. Having good legal counsel can help the parties explore their desired relationship and commit it to an enforceable written agreement. The goal is to make sure the parties have a common understanding of their relationship and that the relationship is committed to writing.

The importance of legal compliance cannot be overstated. Many legal principles apply to hospital-physician contracts, but three sets of legal principles are most acute in medical contracting. First is the Medicare antikickback statute (42 U.S.C. §§132a(a), et seq.). This law makes it illegal to solicit, offer, or pay any form of remuneration (e.g., money, property, or services, or items of value) designed to gain influence over the referral of a patient whose care will be paid for by Medicare, Medicaid, or any other government payer program. Sanctions for violations can include criminal convictions (including sentences that impose imprisonment and fines), civil monetary fines, and exclusions from the Medicare program.

The second is the Ethics in Patient Referrals Act, more commonly known as the Stark law. The Stark law, named after Congressman Pete Stark, provides for civil penalties if a physician refers a Medicare patient to an entity with which that physician has a financial relationship for one of 11 designated health care services (e.g., lab, imaging, physical therapy, inpatient or outpatient hospital services), and no exception exists for that relationship.
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Third are principles that apply when a physician contracts with a tax-exempt entity. Many hospitals are exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986. Tax-exempt hospitals must operate for the community benefit, and nonexempt entities or individuals can benefit only incidentally. A contract between a tax-exempt hospital and a physician may benefit the physician, but if the physician is paid fair market value for health care services needed in the community, any such benefit likely is incidental to the tax-exempt hospital’s tax-exempt purpose. With the advent of the intermediate sanctions law in 1997, a physician who is in a position to exert influence over a tax-exempt hospital’s affairs can be subject to excise taxes if he or she and the hospital enter into an “excess benefit transaction.” This essentially means that if a physician who is in a position of influence with a tax-exempt hospital is paid more than fair market value for services or other items of value, without paying fair market value for such services or items, then the physician and hospital executives who approve the transaction can be subject to penalties in the form of excise taxes.

In the context of these basic principles, this section discusses the 10 biggest mistakes physicians make in hospital-physician contracting.

**Mistake 1   Failing to Consult Legal Counsel Early**

Understanding the goals, desires, special interests, and objectives of the parties is important early on in negotiations. Knowing how these objectives fit within the applicable legal parameters can save the parties from negotiating a contract not allowed by the relevant legal principles. In such circumstances, the parties may be prevented from contracting with one another even when their objectives are legitimate solely because they have created a bad paper record or have had discussions that could be interpreted as implying an improper or unlawful purpose. Dozens of legal models have been developed to address the legitimate objectives of hospitals and physicians. Experienced legal counsel with health care regulatory expertise will be able to assist physicians in selecting the right model for the right circumstance.

**Action Step**   Physicians should consult legal counsel experienced in hospital-physician relationships, from both a business and a health care regulatory perspective.

**Mistake 2   Entering an Agreement for a Hidden Purpose**

Although not frequent, entering into an agreement for a hidden purpose is the biggest mistake a hospital and physician can make. Hospitals sometimes think about entering an agreement in which services are described but never performed. A variation is to try to describe services that a physician would perform anyway and pay the physician for those services. The idea behind the agreement is to compensate the physician for his or her “loyalty” to the institution. In other words, the hospital might perceive some intangible benefit associated with a physician’s affiliation with the hospital and want to compensate the physician for that
intangible benefit (e.g., ability to influence referrals of Medicare or other government payer program patients). Such “sham” agreements are plainly illegal. A physician and hospital can make no greater mistake. Such relationships violate the antikickback statute and numerous other laws. In U.S. v. Anderson [85 F. Supp. 2d 1047 (U.S. Dist. Ct. 1999), rev. & remanded, U.S. v. McClatchy, 217 F.3d 823 (Civ. Ct. 2000)], physicians and hospital administrators went to jail because of such relationships.

An area of potential abuse is medical director agreements in which a hospital hires a part-time medical director for a service and the hospital has no real expectation of the service being provided. The implication is that the agreement is entered into to obtain the physician’s referrals. It is unlawful to structure a relationship in which one purpose of the relationship is to gain reason or influence over the physician’s referral judgment. It is appropriate to pay for a physician’s services; it is illegal to pay for his or her referrals. Likewise, if a hospital has a legitimate need for services, it should pay for such services, rather than expecting them to be provided in exchange for referrals.

Action Step  A physician should never enter into a discussion with a hospital in which the intent of the relationship is to influence referrals. Physicians should consult legal counsel early. Many models exist to align the legitimate motives of a hospital and a physician (e.g., improve quality, efficiency, patient access) without being construed as illegal inducements to refer. Physicians should make sure their duties are specified in the agreement and keep a written record of the duties they perform to prevent a later challenge that the duties were just a sham.

Mistake 3  Failing to Understand Market Data
Physicians often leave it to the hospital to obtain relevant market data supporting their compensation to be paid under a contract. Such information is key in hospital-physician relationships because many of the antikickback statute safe harbors, Stark law exceptions, and presumptions under the intermediate sanctions law require any compensation paid by a hospital to be consistent with fair market value. Sometimes hospitals control the data and are negotiating from strength. Other times, hospitals will lack appropriate data or mistakenly use incomplete data and thereby negotiate from a position of ignorance. Survey data may or may not be available or relevant to a particular market and circumstance. As a result of any of these circumstances, the physician will not be able to negotiate the maximum compensation that might otherwise be permissible. To negotiate the maximum compensation, the physician needs to make sure he or she has access to relevant fair market value data and understands the data.

Action Step  Physicians should research the market. They should consult legal counsel or other consultants to determine the compensation being paid in the market, as well as consult their professional society for resources. Also, physicians should consult recruitment firms to
tap into their knowledge base of relevant compensation levels. Isolated examples of what a colleague received elsewhere will not be persuasive, nor will it satisfy a regulator if the relationship is later questioned.

**Mistake 4  Relying on Verbal Assurances**
The legal compliance issues arising in health care are complex. Often, they may appear to be at odds with the short-term business goals of an institution. It is not uncommon to hear phrases such as: “Don’t pay attention to that; that’s in the contract to satisfy the lawyers,” or “I’ll make sure this doesn’t apply to you; upper management says it has to be in the contract, but don’t worry about it.” There are at least two very important reasons never to rely on such statements. First, it may make the contract illegal under the antikickback statute or the Stark law. Both statutes require most contracts to be in writing and do not allow for side deals. Second, the physician will likely not have a legal right to enforce any such oral statements. He or she may well be dealing with an honorable person who is making such statements believing them to be true. But management changes at hospitals, as do circumstances and the motivations of the parties involved. In addition, markets change, and a hospital’s strategic direction will likely change. The person the physician dealt with may be gone, and the next person in charge will likely have every legal right, and may in fact have the legal obligation, to enforce the contract as written.

**Action Step** Physicians should read the contract carefully. They should not let anything stay in the contract if they do not have the full expectation of being bound by such provisions. Likewise, if the contract does not contain an agreed upon provision, they should make sure it is added before they sign it.

**Mistake 5  Relying on the Way Other People Do It**
Often, physicians are tempted to enter contractual relationships that may appear to violate one or more of the previously discussed legal principles. The physician might hear: “They are doing it this way at St. Mary’s. How are they doing it if it is illegal?” Once again, health care law is complex. The facts of other deals may be different. Many transactions held out as examples are in fact not structured correctly. Worse yet, some participants in those other deals may go to jail or face significant liability. Physicians should not be swayed by the actions of others.

**Action Step** Physicians should make their own decisions about what is legal in consultation with their legal counsel. They should make sure their decisions are based on the applicable law at the time their contract is entered into and is based on an analysis of their facts.
Mistake 6  **Failing to Address Term, Termination, and Renegotiation in the Agreement**

Generally, a physician will want to have a long-term agreement. The physician will make financial decisions, such as recruiting partners, based on the expectation of having a continuing contract. This would suggest asking for a longer term. Hospitals may be constrained in the term of agreement they offer because they have tax-exempt bond financing that limits the terms of contracts they can have with others who use their facilities. It is necessary to know these rules and to make sure the hospital is interpreting them correctly because the allowable term varies based on the compensation methodology under the contract. Also, physicians should make sure to begin contract renewal discussions early. In fact, they should consider putting a provision in the agreement requiring early renegotiations. In addition, they should consider further renegotiating a contract early to effectively extend its term. For example, in a three-year agreement, a physician should think about renegotiating a year early so that he or she is never in a position of having only one year left on an agreement. The downside to a longer term agreement may be that the physician is bound to a compensation formula that becomes out of date.

**Action Step** Physicians should identify what the best term is for them. They should note the renewal date on the calendar and be proactive in initiating renewal discussions.

Mistake 7  **Failing to Address Noncompetition Covenants**

Hospitals often seek to impose covenants not to compete that apply during the term and for a period of years after the term. Physicians should not assume that such covenants will be unenforceable. Although noncompetition covenants are not favored in the law, they are enforceable in most states if they are ancillary to an otherwise legitimate relationship. As a general rule, noncompetition covenants must be reasonable in duration and scope (covered services and geographic area). It is obviously best to avoid such covenants altogether, but that is frequently not possible. One should certainly attempt to limit their application. Physicians should try to limit the covenant to the term of the agreement and then only as to certain core services. They should avoid broad “practice of medicine” covenants. The agreement should allow the physician to perform activities that do not harm the hospital (e.g., academic or consulting services). Physicians should also seek to limit any postcontract noncompetition covenant if the hospital terminates the contract or does not agree to renew the contract, or if the physician terminates the contract for cause. If the hospital does not want to extend a contract, then the physician should ask for the right not to be bound by the noncompetition covenant. This can be important leverage at the end of a contract term. The hospital will be more likely to renew the contract if it knows the physician can compete if it does not renew.

**Action Step** Physicians should review noncompetition covenants closely. They should determine whether the hospital’s interest can be protected another way (e.g., nonsolicitation of patients) or by a narrowly defined covenant. Also, they should make sure the covenant
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does not apply if the hospital breaches the contract or if the hospital decides not to renew the contract.

Mistake 8  
**Failing to Analyze Different Compensation Methodologies**

As a result of the increasing complexity of health care regulation, finding legally compliant compensation models can be difficult. Experienced legal counsel can help structure a model that is both compliant and makes business sense. What type of compensation structure will best protect the physician should also be considered. Depending on the circumstances, a physician may be better off with fixed compensation. It provides certainty and removes the risk of business cycles, collection risks, and practice build-up delays. Production compensation methodologies can reward the high producer, but can also put the physician at risk if the hospital’s business suffers for reasons outside the control of the physician. In either event, compensation needs to be structured to compensate the physician for what the physician personally does, not for what he or she refers. A basic tenant of the antikickback statute and the Stark law is that a hospital can pay a physician fair market value for the services the physician provides and not for any other business the physician generates. Recent clarifications to the Stark law make it clear that percentage of production compensation methodologies are appropriate in many circumstances, assuming they can also pass antikickback analysis. Percentage compensation can be useful to align the goals of the parties and still mitigate downside financial risk.

**Action Step**  
Physicians should outline their goals and interests. Are those goals best achieved through a stable payment or are the long-term objectives of the relationship better met by rewarding physician’s personal production? Physicians should consider whether a combination of the two best meet the parties’ objectives.

Mistake 9  
**Failing to Remember Who the Customers Are**

Practicing medicine is first and foremost about the patient. In hospital-physician contracting, however, the physician may not have a direct patient care responsibility or may be in a situation in which he or she is primarily assisting another physician in delivering care. Pathology, radiology, anesthesiology, and, to a lesser extent, emergency medicine are examples in which the physician not only serves patients, but also provides an important consultant or ancillary role. In these cases, other physicians on staff are also the contracting physician’s customers. The hospital, seeking to keep surgeons happy, wants to have timely, services-oriented anesthesia, radiology, and pathology services available to its practitioners. It is therefore important for physicians when contracting to become a service provider to a hospital to make sure those whose care is dependent on their services feel that they provide prompt and high-quality services. The physicians should be proactive in identifying issues. They should not assume that their contract will be secure. They should also be proactive with the hospital and make sure that members of their group serve on every medical staff
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committee. This is a good way to keep informed, as well as to stay in the power structure of the hospital.

Action Step Physicians should identify the important medical staff committees and make sure members of their group serve on these committees. Also, they should meet regularly with the hospital’s CEO.

Mistake 10 Not Paying Attention to Indemnification Provisions
Hospitals often present an agreement that contains boilerplate terms. Physicians should not blindly accept these agreements. An indemnification obligation may expand physicians’ liability for their acts or the acts of those they supervise. A liability assumed by way of an indemnification clause is generally deemed to be a “contractually assumed obligation” and therefore may not be covered by a physician’s professional liability insurance. Often, the correct balance is to provide only that each party is responsible for his or her own acts and agrees to obtain insurance for those acts. Other times, indemnification should not be mutual. A physician may be stepping into a complex set of hospital issues over which he or she has little control, but, as a physician, might be a likely target in any legal action. In such a case, it may be appropriate for the hospital to indemnify the physician but not to have reciprocal indemnification from the physician.

Action Step Physicians should read any indemnification clauses carefully and evaluate fully in light of the entire nature of the relationship. They should not be viewed as boilerplate, but rather carefully tailored contractual provisions based on the circumstances at hand. Indemnification clauses should be reviewed with the physician’s insurer to be certain the physician is not accepting liability for which he or she will have no coverage.

Conclusion
Good physician relations are essential to the efficient operation of a hospital. A well-planned and well-drafted contract can eliminate future misunderstandings and create a mutually beneficial relationship. One should not think of a contract as necessary boilerplate, but rather as a tool to help the parties define their goals and relationship. The goal should be not only to protect the parties in the event of a dispute, but also to avoid the potential for dispute by proactively identifying the essential nature of the relationship.

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13.2 The 10 Biggest Legal Mistakes Physicians Make Regarding Hospital Staff Privileges
By William L. Yocum, Esq.

Executive Summary
Obtaining and maintaining membership on a hospital medical staff is a necessary component of most physicians’ medical practices and livelihood. Physicians are by nature independent and trained decisionmakers, highly intelligent, and feel acute responsibility for their patients. The practical requirements of membership on a hospital medical staff can, however, seem at times to intrude on the doctor’s independent nature. In modern hospitals, membership on a medical staff “involves social, collegial, clinical, and legal aspects in a complicated human calculus that defies simple solution.”¹ This section discusses common mistakes physicians who run afoul of their medical staffs have made, focusing on behaviors and attitudes that get even good practitioners into trouble with their peers on the medical staff, as well as with the hospital administration. In today’s medical and legal practice, a hospital stands at risk for much of what takes place within its walls, including the real possibility of legal liability for the acts of independent medical practitioners. Accordingly, hospitals have a lower tolerance level for disruptive practitioners than ever before.

Mistake 1 Failing to Practice in a Collegial Manner
Failing to practice in a collegial manner is a failing that cuts across most of the topic of this section. A number of cases have been reported of physicians being abusive to other doctors and to nurses, intimidating and even threatening. The American Medical Association considers disruptive behavior unethical.² If others see a physician as rigid, inflexible, and defiant, that physician is probably not practicing in a collegial manner and is at risk of becoming a target for a revocation of staff privileges. Courts have routinely upheld the decision of hospital boards in revoking staff privileges based on abusive, disruptive behavior.

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Action Step  It is the ethical duty of all physicians to conduct themselves in a professional manner in their interactions with other health care professionals and to promote standards of professional behavior among colleagues.

Mistake 2  Impugning the Quality of Care of the Hospital, Nurses, and Other Physicians
Physicians who impugn the quality of care provided by the hospital, nurses, and other physicians believe they are more competent than most, if not all, of the other physicians on the medical staff. They are often intolerant of the mistakes of others, even to the point of yelling at them within earshot of other people, including patients and their families. These physicians treat those who question them, whether or not they are colleagues, derogatorily. It is important that physicians address concerns about clinical judgments with others directly and privately, not in the patient’s room or in the hallway.

Action Step  Dissatisfaction with other physician staff members or nurses should be dealt professionally and through appropriate grievance channels.

Mistake 3  Not Knowing the Hospital’s Policies and Procedures
Every hospital has medical staff bylaws that govern virtually all aspects of a physician’s practice in the hospital. The bylaws contain provisions regarding expectations of committee involvement, professional behavior, interaction with nursing staff and hospital administration, peer review, and procedures to address grievances. Every physician on staff should be provided a copy of the bylaws and should be familiar with their contents. The hospital also has nursing policies and procedures that, while not directly governing physician practice, contain detailed descriptions of certain medical procedures, practices, and limitations on nursing practice at the hospital. Physicians practicing at the hospital need to be familiar with the policies that nurses treating their patients must follow in order to avoid causing conflicts with those policies.

Action Step  Physicians should familiarize themselves with the hospital’s bylaws, policies, and procedures, especially those that address their area of practice and procedures they might order for patients.

Mistake 4  Not Involving Consultants When the Issue Is Out of One’s Specialty
Modern hospital practice requires staff physicians to follow the team concept of treatment. Some physicians find it difficult to admit to themselves or their patients that some aspects of the treatment could be better handled by a consulting physician. This treatment can take the form, for example, of a general practitioner who tries to treat disease conditions alone, when most physicians would bring in an infectious disease consultant. Another example is an orthopedic surgeon who tries to handle all aspects of a joint replacement without involving an internist. While any physician wants to avoid using consultants unnecessarily, physicians who
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find themselves using consultants significantly less than their peers should investigate why, since they risk facing criticism that they are putting their patients’ care in jeopardy.

Action Step  Physicians should practice medicine as a team member. They should request consultations when appropriate and if in doubt, ask for help.

Mistake 5  Not Accepting Constructive Criticism and Suggestions
Often the first inkling indicating that physicians may be at odds with their peers and the hospital administration is when suggestions are made about an issue in their treatment of a patient or some aspect of the treatment is criticized, even informally. When this occurs, some physicians tend to become defensive and argumentative. While there are often different approaches to patient treatment, and physicians can disagree about them, there is a way to disagree without being disagreeable. If the suggestions and criticism are constructive, they should be given due consideration before explaining why a particular treatment decision was made. In some cases, it may be necessary to support treatment decisions with medical studies and literature to cut off an attempt to restrict the physician’s practice.

Action Step  When a physician colleague or a nurse makes a treatment suggestion, physicians should react in a positive manner and be responsive to the feedback being given. They should avoid acting resentful or responding discourteously to the input.

Mistake 6  Failing to Seek Approval Before Prescribing Unorthodox Drugs or Treatment
Failing to follow appropriate channels before prescribing unorthodox drugs or treatment causes much consternation and concern about patient care. This is not to say that physicians should be afraid to try the latest medically supportable treatment, but if the treatment has not been widely accepted, they need to notify the appropriate hospital entity and be ready to support their treatment modality. For example, it is a mistake to simply enter an order for a medication not usually given to treat a particular condition without discussing it ahead of time with the pharmacist or pharmacy committee. The admonition applies more to the administration of potentially toxic drugs than to the use of more benign drugs, but it raises a red flag in any event.

Action Step  Before ordering a medication or treatment modality that would be considered unusual or “cutting edge,” physicians should notify the appropriate committee or department of the hospital of what they are planning and why.

Mistake 7  Failing to Respond Promptly to Inquiries About Care or Behavior
The hospital’s bylaws require the hospital and the directors of the various departments to monitor the care rendered at the hospital. That can result in questions being raised about a physician’s treatment, orders, or behavior. If such a question is raised, it is imperative that the
physician respond promptly and professionally, without being defensive or accusatory. The physician will have a good reason for the treatment decision, but that will get lost if he or she reacts with the attitude that it is none of the hospital’s business or that the way he or she treats nurses is always justified regardless of the complaints.

**Action Step** If a question is raised about the physician’s treatment of a patient or interaction with other health care providers, the physician should respond promptly and professionally. If it is a matter of some seriousness, the physician should request a conference with those involved and be ready to support his or her decision, while being open-minded when listening to what others have to say.

**Mistake 8  Failing to Follow Up on an Agreement Resolving an Issue**
If the physician and hospital have agreed to resolve an issue through changes in practice or through continuing education, for example, the physician must be sure to put the change into effect or get the continuing education, whatever the case may be. Failing to follow through on the agreed resolution invites removal from the medical staff in short order. Extensions of time are not in a physician’s best interest.

**Action Step** When a physician agrees to obtain continuing education or change his or her practice pattern, the physician should implement the change immediately and attend the continuing education promptly. The physician should also report back to the hospital periodically on his or her compliance with the agreement.

**Mistake 9  Acting as Though the Hospital Is Lucky to Have Such a Physician**
Today, a physician cannot always get staff privileges somewhere else. Indeed, being removed from one medical staff can have a detrimental effect on a doctor’s ability to obtain staff privileges elsewhere for a significant amount of time. Physicians should remember that the hospital board has broad discretion in controlling admission to or on its medical staff and is insulated to some degree from legal liability by federal law.

**Action Step** Hospital privileges are a critical part of a physician’s ability to practice medicine and earn a livelihood. Physicians could risk losing privileges at any hospital by taking the attitude that their privileges at that hospital are less important because of opportunities they think they might have at some other hospital.

**Mistake 10  Not Calling a Lawyer When Necessary**
When physicians have peers talking to them about their treatment of patients, a hospital committee looking at their patient records, and are being asked to appear at peer review meetings to discuss their patient care, it’s time for them to call a lawyer. A physician under that kind of scrutiny is at risk of a reprimand, if not summary suspension. A lawyer’s early intervention can sometimes head off some of the more serious disciplinary measures, many of
which are reportable to the National Practitioner Data Bank. This does not mean that physicians should call a lawyer whenever a peer review committee wants to talk to them, but if they are the subject of multiple inquiries, they may need legal advice.

**Action Step** Physicians who are under scrutiny by peers or a hospital committee should seek legal advice from a lawyer. Once matters have progressed that far, the next step might be action against a physician’s hospital privileges. There is a time to fight and a time to mediate or negotiate, but physicians need the advice of a lawyer to make their way through the maze of hospital bylaws and medical staff requirements.

**Conclusion**
Regulating a hospital medical staff involves balancing the interests of both the practitioner and the hospital. When those interests compete, there can be an adverse effect on patient care sufficient for the hospital to consider excluding the practitioner from the medical staff. Avoiding these mistakes and following the action steps suggested should resolve the sometimes competing interests in favor of the practitioner remaining on the medical staff.

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Chapter 14 Immigration

14.1 The 10 Biggest Immigration Mistakes Physicians Make
By Gregory Siskind, Esq.

Executive Summary
The United States has both a critical physician shortage and one of the most advanced health care systems in the world. Those two factors, plus the traditional attractions the country has to offer, make the United States one of the top destinations for the world’s best medical school graduates. But even though the country is not producing enough physicians and even though it will take decades to reach the needed number of home-grown physicians, the U.S. immigration system makes it difficult for international physicians to come to the United States to work. To do so, most international physicians must first secure a visa to work in a residency or a fellowship training program. In fact, more than 25% of the physicians now training in residency and fellowship programs are international medical graduates. Next, these physicians typically need to secure a work visa to remain in the United States and go into private practice or other work opportunities. Securing first the visa to train in the United States and then the visa to work in the country are difficult tasks, and there are many pitfalls along the way that stifle a physician’s aspirations to train and practice in the United States.

Mistake 1 Choosing the Wrong Visa to Come for Medical Training
Most physicians seeking to enter the United States to practice medicine must initially engage in training before they can move into private, academic, or other clinically oriented practice areas. This is largely because licensing requirements in each state require training in the United States, and without a license, a visa is not an option. For the vast majority of international physicians, the first step to coming to the United States involves getting accepted into a residency or a fellowship program. (The American Medical Association has excellent information on this topic on its Web site at http://www.ama-assn.org/ama/pub/category/1554.html. Information is also available at the Web site of the Educational Commission on Foreign Medical Graduates, at www.ecfmg.org. ECFMG is the sole sponsor of physicians coming to the United States for graduate medical training, and plays a role in both the J-1 and H-1B visa process.)

Physicians seeking to enter the United States to engage in graduate medical training can normally enter on either an H-1B or a J-1 nonimmigrant visa. The vast majority (about 90%) enter the country with J-1 exchange visitor visas in a J-1 category specifically carved out for graduate medical training. Most enter on the J-1 visa because that is what they are told they need by their training programs. But that is largely because administratively, programs find it easier to bring physicians over on J-1 visas, since the heavy lifting is done by the ECFMG, the sole sponsor of all J-1 physicians in clinical training. For the last 30 years, physicians entering the country on J-1 visas have had to comply with Section 212(e) of the Immigration and Nationality Act (INA), which requires that J-1 applicants entering the United States to
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engage in graduate medical training in a clinical setting return to their home country or country of last residence for a period of two years. Physicians can seek a waiver of this requirement, but the process is arduous.

From the point of view of the doctor, the H-1B is usually the visa of choice if the goal is to eventually settle in the United States. The avoidance of the home residency requirement under INA Section 212(e) cannot be overstated for many doctors, particularly those pursuing career paths that do not easily lend themselves to a waiver strategy. But obtaining an H-1B visa is not always easy, and even getting H-1B status is not free from problems. For example, H-1Bs are available for only six years, and some training programs last longer than that. Also, there is an annual limit on the number of H-1B visas, and a program that is not exempt from the annual limit may be unable to secure a visa in a timely manner.

**Action Step**  International physicians and their immigration attorney should carefully consider their long-term goals when choosing a training visa. While the training program may dictate the choice of a visa category, many will defer to the request of the doctor.

**Mistake 2**  **Failing to Take All Three Steps of the U.S. Medical Licensing Examination**

To qualify for an H-1B visa, a physician must normally pass Step 3 of the U.S. Medical Licensing Examination (USMLE). Unfortunately, some international physicians, mostly Canadians, do not take the examination because state licensing boards will often recognize the Canadian credentials and not require Step 3 of the USMLE. Physicians can enter a training program in the United States having passed just the first two steps. In these cases, the U.S. immigration requirements are stricter than the state licensing requirements, and a physician will likely be denied an H-1B visa for not having the credentials. And since most J-1 waiver programs require physicians to work three years on an H-1B visa following the waiver of the J-1 home residency requirement, not being able to secure an H-1B visa can be a serious problem.

**Action Step**  Physicians should not skip taking Step 3 of the USMLE.

**Mistake 3**  **Failing to Take a Visitor Visa Application Seriously**

To enter the United States on either a J-1 or an H-1B visa, a physician initially needs to enter the country on a visitor visa in order to take certain credentialing examinations available only in the United States. A physician entering on a J-1 visa must first enter on B-1 visitor status to take the USMLE Step 2 clinical skills examination. This battery of clinical assessments is offered only a few times a year in five U.S. cities. For the H-1B visa, physicians must enter the country on B-1 visitor status to take USMLE Step 3.
Unfortunately, many physicians assume, often erroneously, that getting a visitor visa to come to the United States to take the examination will be easy. Visas can be delayed due to security clearances, and they are often denied because applicants fail to document that they have the funds to support themselves on their trip and that they are not likely to overstay their visa.

**Action Step** Physicians should file for a visitor visa several months before their trip if possible. They should thoroughly document their application and include with it a copy of their round-trip plane ticket showing that the trip is for only as long as necessary to take the examination and leave the country. Applicants should show that they are returning to a job by presenting a letter from an employer documenting leave time. They should present evidence to show they have the funds to cover the costs of the trip. The documentation of registration for the examination should also be presented. Married applicants should apply for a visa only for themselves, not their spouse, since consular officers are then more likely to believe that the applicants will return home because their spouse has remained there. Also, any other evidence showing that the applicant is likely to return to the home country when the exam is completed will be helpful. Finally, it is sometimes helpful to have a lawyer prepare a cover letter explaining why the applicant should be approved. In fact, merely having a lawyer can be helpful in showing that a physician applicant is serious about complying with visa rules.

**Mistake 4 Not Looking for a Job Soon Enough Before Completing Medical Training** To qualify for a J-1 waiver, physicians typically need to find a job in a physician shortage area, the job needs to be with an employer that has recruited extensively for the job, the state has to have a waiver program with slots available or a federal program needs to be available in the area, and the employer has to be willing to go through all of the paperwork necessary to get the physician working. Despite the physician shortage, finding an employer willing to go through all of this is not easy. Physicians who wait too long may find that they are unable to secure a job prior to completing their training. And then even if they find a job, they have not allowed enough time to avoid a gap in the ability to work without disruption.

**Action Step** Physicians should begin their job search early in order to have the time to get a J-1 waiver and an H-1B visa. Ideally, they should allow at least a year to get the paperwork processed.

**Mistake 5 Picking the Wrong Employer** Switching employers after a J-1 waiver is granted is very difficult. The U.S. State Department will adjudicate a waiver only once; after that, only the U.S. Citizenship and Immigration Services (USCIS) has the authority to approve a change of employers. The position of the USCIS is that the proper way to file to change employers is to file for an H-1B change-of-status application. The application must include evidence that the physician will serve the balance of his or her three-year commitment in an underserved area and that there are
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exceptional circumstances justifying the change (e.g., a serious breach of contract by the employer, the shutdown of a facility, or something of similar magnitude). Merely being unhappy in the community or finding a better opportunity elsewhere is not enough.

Action Step Physicians should make sure the employer chosen is one they are willing to remain with for three years and that they thoroughly review their contract before signing it.

Mistake 6 Failing to Pay Attention to the H-1B Cap
Physicians who choose to remain in the United States after completing their residency training will need to plan on filing to change their status to an H-1B work visa. Physicians who are training on a J-1 visa will likely need a J-1 waiver and then switch to H-1B status. Physicians who used an H-1B visa for residency or fellowship training will need to file an H-1B change of employer application. In either case, the availability of an H-1B visa is crucial.

On October 1, 2003, the number of H-1B visas available each year dropped from nearly 200,000 to 65,000 each year. That means that many physicians will not be able to secure a visa when needed and will need to wait for a new quota to become available when a new fiscal year begins each October. Many will be fortunate enough to find a position that is exempt from the H-1B cap. University and nonprofit research institution employers are exempt from the cap, as are other nonprofit organizations affiliated with or related to a university or nonprofit research employer. Also, the USCIS is continuing to treat Conrad 30 waiver positions as exempt from the cap even though arguably that exemption from the cap expired on September 30, 2003.

Congress has been considering legislation to expand H-1B cap exemptions for physicians, but nothing concrete has yet occurred. And physicians need to be reminded that the exemption from the cap is tied to an employer: Physicians who switch from an exempt employer to an employer subject to the H-1B cap again have to have a visa number available. This is particularly a problem for physicians in residency training on an H-1B visa at an exempt hospital. Their programs end in July and if there are no H-1B visas available, they can very well find that they are not able to start their next job until October.

J-1 waivers can take a long time to process. In addition, available slots in the popular Conrad state 30 program can run out quickly, which can mean that the waiver process can easily take more than six months and added to that is the time it can take to process an H-1B application. The H-1B category also has a quota, so physicians may find that they are stuck waiting many more months.

Action Step H-1B applications can be filed up to six months before a job’s start date. Physicians should file as early as possible, and consider positions at a cap-exempt employer if the H-1B quota is seriously oversubscribed.
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Mistake 7 Not Getting an Immigration Lawyer Involved Early in the Job Search
J-1 waiver positions can be difficult to find. But what can be even more frustrating is to go through the interview process and move forward with filing for the waiver only to learn that the position does not qualify for a waiver. There are 49 Conrad 30 physician waiver programs and four federal programs. Each program’s rules are different, and it is easy for someone not fully focused on physician immigration laws to get confused.

Action Step Physicians should discuss physician waiver strategies with an immigration lawyer at an early stage. An immigration lawyer can help to screen positions to determine if the job qualifies and can also review contracts to ensure that they comply with immigration laws.

Mistake 8 Failing to Consider Alternative Waiver Strategies
Many physicians do not realize that the J-1 home residency requirement does not bar them from receiving a nonimmigrant visa without a waiver. They are simply barred from changing from a J-1 to another category within the United States, getting an H-1B visa at a U.S. consulate, or getting permanent residency. But a physician can go to a U.S. consulate abroad and seek other visas aside from the H-1B. The O-1 visa is available for high-caliber physicians demonstrating extraordinary ability in their field. The TN visa is available to Canadian and Mexican doctors coming to work in nonclinical positions. The E-2 visa is available to physicians investing money in setting up a physician practice.

Action Step If physicians find that a J-1 waiver is an option, they should consider alternative visa options.

Mistake 9 Choosing the Wrong Green Card Category
Two major green card strategies are available to physicians. One is the Physician National Interest Waiver, which is available to physicians who agree to serve five years in primary care in a physician shortage area. The regulations surrounding what was supposed to be a straightforward program to encourage physicians to serve long stretches in underserved communities have turned out to be very complicated. The second strategy is the labor certification. Labor certification-based cases require an employer to show that it has been unable to recruit a U.S. or permanent resident physician with the minimum qualifications who is immediately available to fill a job. Given the severity of the physician shortage in the United States, these cases have a high approval rate. The key problem has typically been the length of the labor certification process. In late 2004, the U.S. Department of Labor is expected to introduce an electronic filing system for labor certifications that should dramatically speed up the process. There are some advantages to National Interest Waivers over labor certifications. Spouses can get work authorization documents right away, for example. And the overall processing time on these cases is usually quite a bit faster than the
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labor certification (this advantage will likely diminish when electronic filing for labor certifications becomes available).

**Action Step** Physicians should evaluate their priorities (e.g., getting their green card processed quickly, moving out of an underserved area) when determining a green card strategy. They should also remember that they can pursue more than one green card strategy at the same time (although doing so is more expensive).

**Mistake 10 Taking a Bad Job (or No Job) Instead of Complying with the J-1 Home Residency Requirement**

Many physicians mistakenly believe that if they leave the United States when they complete their home residency requirement, they will have little chance of getting back into the country to work. As a result, physicians will often accept terrible jobs simply to avoid having to leave the country. However, by going home for two years, physicians will be eligible to secure an H-1B visa to work in any kind of position and not just in a shortage area. Given the state of the U.S. physician market, U.S.-trained doctors who can quickly secure a visa to work in any kind of clinical setting are still hot commodities even if they are not currently in the United States.

**Action Step** If physicians cannot find the right job and their home country has opportunities, they should consider going home, satisfying the home residency requirement, and then returning to the United States on an unrestricted H-1B visa that allows for working in any area and not just a shortage area.

**Conclusion**

Foreign physicians looking to train or work in the United States should seek to avoid the mistakes discussed in this section.

**About the Author**

Gregory Siskind, Esq., the founding partner of Siskind Susser in Memphis, Tenn., has been practicing immigration law since 1990. Since he started Siskind Susser in 1994, he has become one of the best-known immigration lawyers in the country. After graduating *magna cum laude* from Vanderbilt University, Siskind went on to receive his law degree from the University of Chicago. For the past several years, he has been an active member of the American Immigration Lawyers Association (AILA). He has chaired the physicians committee and the National Health Care Access Coalition, a group that advocates for physician immigration. He has written several hundred articles on immigration law and is the author of *The J Visa Guidebook* (published by Lexis-Nexis). He writes a technology column for *Immigration Law Today* (published by the AILA) and has written several chapters in the new book *Immigration Options for Physicians*, 2nd edition (also published by the AILA).
14.2 The 10 Biggest Legal Mistakes Physicians Make When Attempting to Immigrate to the United States
By Robert Brown, Esq.

Executive Summary
Each year physicians from foreign countries seek to enter the United States to study in the hope that they will be employed in the United States upon completion of their studies. Often what they perceive as a small violation of U.S. immigration laws or procedural rules may shatter their hopes of employment in the United States.

Mistake 1 Starting the Visa Process Too Late
Foreign physicians often wait until late in their temporary authorized status before they begin to consider their options for seeking U.S. resident status.

Action Step Even if the physician is initially not interested in remaining in the United States, he or she would be well advised to explore at the earliest opportunity the options available for remaining in the country. In particular, the physician should learn the projected length of time needed to meet the requirements for each option.

Mistake 2 Entering the United States under a “J” Exchange Visitor Program
Foreign physicians often enter the United States under an exchange visitor (J) visa. Under the J visa program, meeting the foreign residency requirement in almost all situations involving physicians requires that they return to their home country for two years, unless they obtain a waiver.

Action Step Foreign physicians should explore other visa opportunities before entering the United States on a J visa classification. In particular, they should consider “H-1B” or “O” visa classifications, among others.

Mistake 3 Consulting Legal Counsel Too Late
Foreign physicians often start the visa process on their own, only to find that the process is much more involved and complex than they initially thought it would be. Often, they will not choose the best option, thereby losing significant and critical time or locking themselves into a bad situation.
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**Action Step**  Foreign physicians should confer with experienced counsel before starting any visa process.

**Mistake 4  Moonlighting**
To increase their experience and to augment their income, foreign physicians often obtain employment in addition to their primary employment (moonlight). For many visa classifications, including “H,” working for an employer other than the petitioning employer is not permitted. To work for a second employer, filing a second petition with the Bureau of Citizenship and Immigration Services is often required.

**Action Step**  Foreign physicians should know the limitations of their visa classification. Before taking a second job, they should determine the limitations of their current visa classification.

**Mistake 5  Missing Important Dates**
Foreign physicians often miss important immigration dates, such as passport, status, employment, and visa expiration dates.

**Action Step**  Foreign physicians should keep a log of all of the important dates relating to their authorized stay in the United States, as well as the important dates for their family members. They should initiate action to extend any expiring dates six months before those dates expire.

**Mistake 6  Mistaking an Extension of Stay for a Visa Extension**
Foreign physicians often believe that an extension of stay also extends the validity of their visa. An extension of stay permits a foreign physician to remain in the United States; a visa extension permits the physician to travel to the United States.

**Action Step**  Before departing the United States, physicians should review their passport and visa validity dates. If either has expired, they will not be permitted to return to the United States until those dates have been extended.

**Mistake 7  Entering the United States on a J Visa without Knowing How to Obtain a Waiver of the Home Residency Requirement**
Many foreign physicians enter the United States on an exchange visitor (J) visa or change to it after entering the country without fully understanding the home residency rule (two years abroad in their native country) and the difficulty of obtaining a waiver to the home residency requirement. A diversity (lottery) visa does not eliminate the home residency requirement.

**Action Step**  Foreign physicians should fully explore their future eligibility for obtaining a waiver of the home residency requirement before entering a J visa program. They should
understand their potential eligibility for waiver opportunities afforded under possible persecution, hardship, interested government agency, national interest, or “State 30” status. Foreign physicians should be aware that they are not eligible for a waiver based on a “no objection letter.”

Mistake 8   **Accepting a Waiver for Working in a Medically Underserved Area Without Fully Understanding the Restrictions**

Foreign physicians are often unaware of the requirements and restrictions placed on physicians seeking a waiver of the home residency requirement. To obtain the benefit of this waiver, the following must occur:

- The physician must agree to work full-time in a health professional shortage area (HPSA) or for the Veterans Administration (VA);
- A federal agency or state public health department has to determine that the work is in the public interest;
- The physician must work full-time for an aggregate of five years (not including time on J-1) before he or she is eligible for adjustment of status or an immigrant visa; and
- The five years must be completed within a six-year period from the time the physician is employment authorized (or if the physician is already employment authorized, from the time of the approval of the visa petition).

**Action Step**   

Petitions and adjustment of status applications can be filed before the date that the five-year service is completed. Waivers approved before Nov. 12, 1999, are unaffected; waivers filed before Nov. 1, 1998, are approved if the physician has worked full-time for three years in a shortage area. To support a national interest waiver, a physician must present with the visa petition:

1. A contract of employment (or if self-employed, an attestation);
2. Evidence of employment in an HPSA or the VA and in a specialty designated by the U.S. Department of Health and Human Services as an HPSA;
3. A letter dated within six months of filing the petition from a federal agency or from the department of public health of the state in which the physician will be working attesting that the physician’s work is in the public interest;
4. Evidence that the physician meets the admissibility requirements regarding the United States Medical Licensing Examination; and
5. Evidence to support the waiver, if applicable.

Mistake 9   **Failing to Realize That Many Areas of Specialization Are Ineligible for a Waiver Under National Interest or State 30 Waivers**

Foreign physicians often enter specialized practice without realizing that many national interest and State 30 waivers do not include many areas of specialization.
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Action Step  Before entering into an area of specialization, foreign physicians should consider the effect of doing so on obtaining a waiver under national interest or a State 30 waiver. Usually, waivers are limited to physicians practicing in family or general medicine, pediatrics, general internal medicine, ob/gyn, and psychiatry.

Mistake 10  **Traveling During the Adjustment of Status Application Process**
Foreign physicians often travel abroad during the adjustment of status process. Doing so may, in certain situations, automatically void the pending adjustment application.

Action Step  Before traveling abroad during the adjustment of status process, foreign physicians should ensure that they are fully maintaining status, or they should secure advance parole authorization.

Conclusion
Foreign physicians who are considering employment possibilities in the United States should be aware that U.S. immigration law and procedures are very restrictive. Foreign physicians who intend to seek employment in the United States should become familiar with the nuances of these laws and procedures early in the process.

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14.3  **The 10 Biggest Legal Mistakes Physicians Make Regarding Immigration Issues When Hiring Employees**
By Shoshana B. Tancer, Esq.

Executive Summary
Physicians, as many other business owners, are often unaware that the immigration law affects their employment practices. As a result, they unknowingly violate rules that can lead to significant sanctions for them as an employer as well as possible deportation of the employee. This section alerts practitioners to some of the areas in which they must focus their attention. If a foreigner appears to be the most qualified of those interviewed, the person
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responsible for hiring should contact a qualified immigration attorney to clarify what must be done to ensure compliance with current law and practice in this area.

Mistake 1  **Failing to Require the Completion of an I-9 Form**
Since November 1986, there have been penalties for employers that “knowingly hire” individuals who are not authorized to work in the United States. As part of this law, employers are required, within three business days of the start of employment, to obtain a signed statement from each employee that the employee is authorized to work in the United States. This is true for all employees, even those born in the United States.

**Action Step**  Physician employers should make sure that each employee is required to complete an I-9 form, and that upon completion, they are in a position to decide whether the employee is authorized to work for them without further action on their part.

Mistake 2  **Asking Some Job Candidates and Not Others If They Are Authorized to Work in the United States**
Although sanctions accrue if it is discovered that employees do not have permission to work, it is a violation of equal employment laws and could be deemed discriminatory to ask such a question before hiring an individual. One cannot choose which potential employees to ask about their immigration status.

**Action Step**  Physicians should make sure that if they ask questions about immigration status during the hiring process, they ask those questions of all potential candidates as part of the routine hiring practice.

Mistake 3  **Completing the I-9 Form Improperly**
The I-9 form is constructed in a manner that makes it easy to omit certain information. Among the most common omissions is the failure to include the date of hire, since it is buried in the middle of a paragraph. Every item on the form must be completed, in both the portion for the employee and the portion for the employer, or there will be potential financial liability for the employer. However, the government deems some omissions to be far more serious than others.

**Action Step**  Physicians should assign one individual in their group to have full responsibility for the completion of this form. That person should have the experience to know what is needed and can properly comply with the paper requirements of this law. Physicians who are concerned about prior compliance may choose to have an immigration attorney do an audit of their I-9 files.

Mistake 4  **Asking Employees for Specific Documents**
It is natural for physician employers to ask to see an employee’s Social Security card, birth
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certificate, or another document, but that request is deemed illegal under all circumstances. Even in cases in which there is an expiring employment authorization card, the employer may not ask to see the “new employment authorization document” as such, but rather request only proof that the individual is still authorized to work.

**Action Step** Employees must be shown that the reverse side of the I-9 form lists a number of alternative identification documents. They must choose one item from Category A, which would prove both identity and authorization to work (e.g., a U.S. passport) or one item each from Category B and Category C, each of which would provide the required proof. The documents provided by employees should be carefully referenced, although copies need not be kept. The documents should be described on the I-9 form without using abbreviations or shorthand notations.

**Mistake 5  Failing to Recognize Fake Documents**
To date, employers have not been required to be the guarantors of the validity of the documents received, but judgment should be demonstrated in accepting papers that appear to be blatantly fake.

**Action Step** When presented with documents that appear to be blatantly fake, physicians or the physician’s hiring manager should request additional documents, but again, with no specificity as to what documents the employee should provide.

**Mistake 6  Not Tracking Expiration of Work Authorization Dates**
Many individuals, including foreign spouses of U.S. citizens who are granted work authorization in annual increments, have permission to work for a fixed period only. There are also graduates of U.S. colleges and universities who receive permission to work for one year after graduation. It is essential to ensure that these workers are not working after their authorization is terminated because the employer can be charged with constructive knowledge that such employee is no longer legally working. Also, if the employee has overstayed his or her visa or has been working without authorization, any visa the individual has is automatically voided and the individual from that point on must always return to his or her home country to obtain a new visa.

**Action Step** Physician employers should keep a tickler file of all employees in order to track I-9 forms for reverification of work authorization. In this way, it is possible to check on employees whose authorizations are temporary and must be renewed in a timely fashion. It is also necessary to track the date of hire even for those who are permanent residents or U.S. citizens, since I-9 forms must be retained for either three years from date of hire or one year after termination, whichever is later.
Mistake 7  Keeping I-9 Forms in Personnel Files Located Where the Employee Works

Physicians who have several clinics or offices at separate locations might maintain the I-9 forms at the office at which the employee works. Doing so can create problems if a random audit is conducted by the immigration authorities, since they would require access to all of the I-9 forms at the same time and place. Although the U.S. Citizenship and Immigration Services and the U.S. Department of Labor are required by law to give a three-day notice for such audits, no warrants or subpoenas are required by law; however the federal agencies may obtain them if they so desire.

Action Step  Physicians should create a centralized file separate from personnel files for the I-9 forms. In this way, if an audit occurs, it would be a simple matter to provide the necessary documentation, without using staff time to try to separate out what is needed to comply. If the files are in different locations, it may be more difficult to meet the time requirements; if the entire personnel file is presented, there is always the possibility of additional irregularities or personal information being made available to the agencies, which could create additional problems.

Mistake 8  Not Knowing an Individual Is Eligible for Employment Only by the Sponsoring Employer

The U.S. government has several different visas. Each visa is identified beginning with a letter for those who are permitted to be in the United States but who are not either U.S. citizens or permanent residents. Also, each visa has different requirements, and each has different conditions for compliance. In general, the holder of a particular visa is not able to change employers without first obtaining a new visa. This process can take considerable time and cause a significant delay in hiring.

Action Step  Physicians should make sure that the person responsible for making the hiring decision pays attention to the kind of permission the employee has for working in the United States. A person who already has an employment authorization document (which looks a lot like a driver’s license) may usually work for any employer during the valid period of the document. If, however, a person is able to show only a visa that begins with a letter such as L-1 or J-1, that person is not able to work for a different employer without receiving approval for a new visa. There are special portability rules for the H-1B visa.

Mistake 9  Relying on Organizations That Promise to Bring Health Care Professionals From Abroad

Although it is generally conceded, even by the U.S. Citizenship and Immigration Services, that there is a shortage of nurses and physical therapists in the United States, the ability of such foreign-trained professionals to obtain visas in the United States is fraught with difficulty. There are stringent requirements to be met (e.g., knowing English, passing...
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specified examinations, and being licensed in a state) before an individual may even be considered for a visa by the U.S. government. As a result, many foreign health care givers have been misled and “fleeced,” and many U.S. health care facilities have been misled and charged significant sums for individuals who never arrive.

Action Step Physicians should make sure that if they are seeking to “import” employees, they deal with reliable agencies that have a proven track record. Physicians should check with others in their specialty or in their geographic area to find out if they have had success in such recruitment. Physicians should not be fooled by vague promises. It is very difficult to hire foreign-trained health care providers. In fact, physicians may have better luck hiring foreigners who came to the United States for their education and who will not have to run the gauntlet of all of the necessary requirements, although there will still be many hurdles for them to overcome.

Mistake 10 Not Realizing “J-1” Physicians Are Required to Return Home for Two Years

The United States has responded to charges of brain-drain by permitting physicians and others to enter the United States for educational purposes as exchange visitors, with the understanding that when they complete this education, they will return to their home countries and provide the quality treatment for which they were trained. Even marriage to a U.S. citizen does not waive the two-year requirement. The J-1 visa holders are not eligible to work elsewhere, and the limitations on their ability to work as a physician in the United States are extensive.

Action Step For those who provide services in areas considered by the federal government to be “underserved” and if the J-1 visa holder is a primary care physician or can perform such services, there is the possibility of obtaining a waiver. This is an arduous and expensive process, however, and will result in significant delays in obtaining the services of such a doctor.

Conclusion Immigration law is complicated and ever changing. To ignore it is to do so at one’s peril. A rudimentary understanding of the principles of this field should be required for at least one member of a physician’s office staff.

Additional Resources

IMMIGRATION: HIRING IMMIGRANTS

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Chapter 15 Intellectual Property

15.1 The 10 Biggest Legal Mistakes Physicians Make Regarding Intellectual Property
By David A. Sirna, Esq., and Jeffrey D. Horst, Esq.

Executive Summary
Many small business people, including physicians, often forget about protecting their intellectual property rights until it is too late. Intellectual property is the generic phrase relating to copyrights, patents, trademarks, and trade secrets. With a myriad of other legal issues to address in running a medical practice, physicians do not often consider their intellectual property rights until someone has infringed or is trading on those rights.

Mistake 1 Seeking Assistance of Counsel Too Late
Many physicians are engaged in research and development at hospitals, universities, and corporations. Often, the results of such research and development are copyrightable articles and research reports, patentable processes and inventions, and goods that can be trademarked. For example, although a patent application can be filed only in the name of the individual who has created the invention, in most cases the physician’s employment agreement or contract contains provisions that assign patent and other intellectual property rights to the employer. With respect to copyright ownership, there can be complex factual situations regarding employees and employers, joint contributions to works, and works made for hire. Even if there is nothing specific in a physician’s employment contract, his or her employer may nevertheless have certain rights to the physician’s intellectual property.

Action Step Physicians should consult with an experienced attorney before they negotiate or sign any employment contracts. Specifically, the rights to any copyrights, patents, and trademarks should be clearly defined in the employment agreement.

Mistake 2 Failing to Take Full Advantage of the Internet
As the Internet has flourished in recent years, many of the best “.com” web addresses already are in use and are no longer available. For these and other reasons, the Internet Corporation for Assigned Numbers and Names (ICANN) has developed several new web address suffixes, known as top-level domain names (TLD). Among the newly developed TLD suffixes is “.pro,” which has been exclusively reserved for certain professions, including the medical profession. The .pro domain extension is available only for certain self-certified professionals. Doctors and other health care professionals must undergo a verification process to validate their eligibility to use a .pro name extension. Registration of a .pro domain requires the registrant to supply professional and personal information, which will be used to authenticate the registrant’s professional membership and identity.
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RegistryPro, the company responsible for .pro, expects to launch the .pro domain in 2004 and is currently taking registrations. Initially, there will be only three profession-specific domain names available, one of which is “.med.pro” for medical and health-related services. For example, a physician’s Internet address could be www.johnsmithmd.med.pro. Physicians who already have a .com Internet address can keep it and forward it to their new .med.pro address.

Internet domain names also raise unique trademark issues. One is “cybersquatting,” when someone registers a federal trademark as a domain name for the purpose of selling the domain name to the trademark owner for a profit. In this situation, a physician may file a claim seeking to prevent the domain name registrant from continuing to use the mark as a domain name and to have the domain name registration transferred. The Uniform Domain Name Dispute Resolution Policy (UDRP) defines how disputes over domain-name registrations are resolved, which includes a mandatory, nonbinding, low-cost administrative procedure to resolve claims of abusive, bad-faith registration.

Action Step Physicians should register their website address as a .med.pro early before someone else does. If a physician has a federal trademark and someone else already has registered the mark as a domain name, the physician should file a claim under the UDRP. Although attorney assistance is not necessary to institute a UDRP proceeding, a physician should nonetheless consult with an experienced attorney.

Mistake 3 Failing to Obtain a Registration for Copyrighted Materials
Physicians who write articles or research reports, or create their own marketing materials (e.g., brochures, pamphlets, or newsletters; television, radio, or print advertisements; and Internet websites) automatically have copyright protection in those materials. A copyright exists when original works of authorship—including literary, dramatic, musical, artistic, and certain other works—are fixed in a tangible medium of expression from which the work can be perceived. The term of a copyright, whether or not registered, is the life of the author(s) (if identified) plus 70 years.

Although the law does not require registration of copyrighted work, there are significant benefits to registering copyrighted works with the U.S. Copyright Office in the Library of Congress. The sooner a work is registered, the more protection the owner will receive. Before a person can file a lawsuit to protect his or her copyright from infringement, that person must obtain a copyright registration. If the work is registered within five years of its publication, registration will be prima facie evidence in court of the validity of the copyright and of the facts stated in the registration certificate. Statutory damages (e.g., a fixed amount) and attorney’s fees will be available to the copyright owner in court actions only if registration was made within three months after publication of the work and prior to an infringement of
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the work. Otherwise, only actual damages and profits are available. These damages can be difficult to prove and are often less than the statutory damages.

**Action Step** Physicians should register their original works of authorship either before publication or within three months of publication to place themselves in the strongest position to enforce their rights in the event of infringement, establish the validity of their copyright, and obtain statutory damages. Copyright registration is relatively simple and inexpensive. Although the advice of an attorney is often helpful, it is not a prerequisite to registration.

**Mistake 4 Failing to Place Copyright Notice on Publicly Distributed Copies**

Although a copyright notice is not absolutely necessary, the failure to place a notice of copyright on publicly distributed copies can have dire consequences. Without the copyright notice, an infringer has an “innocent infringement” defense that can potentially reduce any damage award. Copyright automatically exists when an original work of authorship is fixed in a tangible medium of expression from which the work can be perceived. However, physicians should nonetheless place a copyright notice on any copy that is distributed to the public. The notice should indicate a copyright, the year of first publication, and the identity of the copyright owner. Notice can take any of the following forms: “© 2004 John Smith, M.D.,” “copyright 2004 John Smith, M.D.,” or “copr. 2004 John Smith, M.D.”

A different notice is required for a sound recording, such as a radio commercial, that is on a phonorecord (e.g., a CD-RW or a compact digital disk). Notice on a phonorecord must consist of (the letter P in a circle), the year of first publication, and the name of the copyright owner. An example of an acceptable form of notice on a phonorecord is 1999 John Smith, M.D.”

**Action Step** Physicians should place a copyright notice on any copy that is distributed to the public, regardless of whether the copyright is registered. Notice should be placed on each copy such that it gives reasonable notice of the claim of copyright.

**Mistake 5 Failing to Obtain a Federal Trademark or Service Mark Registration**

Physicians who use symbols, logos, or slogans in advertising or promotional materials to identify their practice may have a “trademark” or “service mark.” Although these terms are often used interchangeably, they have different legal meanings. A trademark identifies the source or sponsorship of goods; a service mark identifies the source or sponsorship of certain services, including medical services. Like the copyright, it is not absolutely necessary to federally register the mark. However, there are significant benefits to federal registration, including:

- Providing constructive notice to others of one’s prior right in the mark;
- Preventing others from using or registering confusingly similar marks in connection with similar goods or services;
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- The right to bring suit in federal court;
- Establishing *prima facie* evidence in court of the validity of the mark;
- Establishing *prima facie* evidence in court of the registrant’s ownership of the mark;
- Establishing *prima facie* evidence in court of the registrant’s exclusive right to use the mark in commerce on or in connection with the goods or services specified in the registration certificate; and
- Allowing a prevailing plaintiff to recover certain damages in court, not otherwise available.

To obtain a federal registration, the applicant must demonstrate actual use of the mark in connection with the sale of goods and services “in commerce,” meaning commerce that is regulated by Congress, such as interstate commerce. If the physician’s practice is not in “commerce,” and the physician is unable to obtain a federal registration, he or she may still be able to apply for a state registration, usually through the secretary of state’s office. However, the rights granted by one state will provide protection of the mark only in that state. Physicians who are unable to or choose not to obtain a federal registration for their mark may still seek to enforce their rights under federal law. However, it is more difficult to obtain monetary damages if the mark is not federally registered.

**Action Step** Although anyone can conduct a trademark search, it may be desirable to employ an attorney who is familiar with trademark matters. An attorney can conduct or obtain a clearance search and provide an opinion as to the registerability of the mark. Such a search may reveal a similar mark for similar goods or services, which would potentially be infringed by the proposed mark. The clearance search will help minimize the possibility that physicians will not be able to register their mark or that they will have to change their mark after having expended resources to build goodwill in it.

**Mistake 6 Failing to Make the Mark “Incontestable”**
A trademark or service mark owner may be able to make the mark incontestable under certain conditions. If a physician uses a registered mark in commerce or in connection with goods or services continuously and exclusively for five consecutive years after registration, he or she may file an affidavit and establish certain “incontestable” rights to the mark. Filing a Section 15 affidavit makes the registration conclusive evidence of the registrant’s ownership and provides exclusive right to use the mark. Incontestability also makes the mark immune from attack on the basis of a prior use of the same mark by a third party, and immune from attack by a third party on the basis that the mark is merely descriptive. Currently, the registrant must pay a $200 filing fee along with the Section 15 affidavit.

**Action Step** Although the assistance of an attorney is not necessary for this procedure, a physician should nonetheless consult with an experienced trademark attorney. The Section 15
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affidavit must meet certain conditions set forth under federal law and must be filed within one year after the fifth year of exclusive and continuous use of the registered mark. As always, the physician or his or her attorney should consult the most current fee schedule published by the U.S. Patent and Trademark Office.

Mistake 7  Not Seeking to Patent an Innovative Business Method
With the increased complexity of running a medical practice, including complying with insurance reporting requirements and patient confidentiality regulations, physicians routinely seek new ways to simplify and implement new procedures to ease compliance. A business process or method, such as an information management method, can be patented. Generally, the basic requirements for a patentable process or method (not just the idea) are that the process be new, useful, and not obvious. For example, patents have been issued for e-commerce transactions, such as ordering products through a single click of a mouse and opening a consumer bank account. A physician who has created a new and unique method of implementing his or her idea may be able to obtain a patent. However, Congress has explicitly excluded medical or surgical procedures from patent protection.

Action Step  Physicians should consult with an experienced patent attorney to determine if their innovative business method meets the requirements to be patented.

Mistake 8  Preparing and Filing One’s Own Patent Application
Applying for a patent is a complex process. The application itself is a complex document, and its preparation is governed by a series of complicated laws, rules, and customs. The inventor may believe that he or she is the most knowledgeable person to prepare the application, or that he or she can save money by preparing it. However, independently preparing and filing the patent application may eventually be more costly than simply having an attorney prepare it.

Once a patent application is filed, it must be “prosecuted” in the U.S. Patent and Trademark Office. Prosecution usually involves several correspondences known as “office actions,” which state the reasons for any adverse action, any objection, or additional requirements. Office actions also assist the applicant in determining whether he or she should continue the prosecution of the patent application. It is not uncommon for some or all of the applicant’s claims to be rejected by the examiner on the first office action, and relatively few applications are allowed as initially filed.

It is therefore likely that an applicant who initially declined to hire a patent attorney to save money will need one to repair the self-prepared patent application in response to an office action. If the application cannot be fixed, the inventor may lose the “priority” of his or her filing date or, in a worst-case scenario, the ability to patent the invention altogether. The
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second office action is usually the final determination of whether the patent will be granted and if unfavorable to the patent applicant is generally appealable to a court of law.

**Action Step**  Physicians should obtain an experienced patent attorney or a nonattorney known as a patent agent to draft their patent application and prosecute it through the U.S. Patent and Trademark Office. It should be noted, however, that patent agents cannot conduct patent litigation in the courts if a physician needs to appeal a patent denial in a court of law.

**Mistake 9  Failing to Protect Trade Secrets**
In addition to the patent, trademark, and copyright laws, the law of trade secrets also may provide protection for intellectual property. One substantial benefit of trade secrets is that a trade secret can last forever, as long as its confidentiality is properly maintained. In most states, a trade secret is defined as any formula, pattern, machine, compilation of information, program, device, method, technique, or process that both provides the owner of the information with a competitive advantage in the marketplace and is treated in a way that can reasonably be expected to prevent the public or competitors from learning about it, absent improper acquisition or theft.

To maintain protection for trade secret information, one must use reasonable efforts to keep it confidential. Sensible precautions include marking documents containing trade secrets as “Confidential,” locking trade secret materials away after business hours, installing a security system, maintaining computer security and allowing access to secrets only to those with a need to know. Additionally, it is imperative to require everyone who has access to the secret materials, particularly employees, to sign an appropriate confidentiality and nondisclosure agreement.

A trade secret owner can enforce rights against someone who steals confidential information by asking a court to issue an order (an injunction) preventing further disclosure. To prevail in a trade secret infringement suit, a trade secret owner must show that the trade secret information provides a competitive advantage and that the information is maintained in secrecy. In addition, the trade secret owner must show that the information was either improperly acquired or improperly disclosed by the defendant. Once a trade secret is disclosed, whether intentional or through improper means, it is no longer protectable as a trade secret.

**Action Step**  Physicians should develop procedures and safeguards to keep their trade secrets confidential, allowing access to secrets only to those with a need to know. Most important, physicians should consult with an experienced attorney to assist with the preparation of a confidentiality and nondisclosure agreement before granting anyone access to trade secret information.
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Mistake 10  Failing to Enforce Intellectual Property Rights in a Timely Manner

Obtaining a copyright, patent, or federal trademark registration is only the first step in protecting intellectual property rights. The intellectual property owner must be vigilant in protecting intellectual property from infringement by others. The law requires affirmative acts to protect intellectual property rights.

Failure to take affirmative action to protect intellectual property rights within a reasonable period of time may result in a tremendous loss to the owner. For example, third-party use of one’s trademark may cause dilution to one’s mark, which weakens the mark’s secondary meaning, or its source identifying features. A trademark also can become generic and lose its trademark protection altogether. Physicians who wait too long to enforce their exclusive intellectual property rights may be barred by a statute of limitations, and infringers may be able to raise equitable defenses (e.g., waiver, laches, estoppel, ratification, and abandonment).

Action Step  Physicians should establish procedures to watch for infringement and to take appropriate action to stop such infringement. They should employ a professional “watch” organization or an attorney to monitor filings at the U.S. Patent and Trademark Office and be notified of potential infringement. Physicians should ask their employees and patients to maintain records of confusion about trademarks and other instances of infringement. Also, physicians should ask their friends to report any similar trademarks, articles, commercials, and “knock-off” inventions. Upon discovery of infringement, physicians should have an experienced attorney immediately issue cease-and-desist letters to the infringer. If the demand letter is ineffective, they should initiate an infringement lawsuit to protect their rights.

Conclusion  Physicians make many costly mistakes with regard to intellectual property (such as copyrights, patents, trademarks, and trade secrets), and many of these mistakes can be avoided by consulting with counsel and taking advantage of resources to protect their rights.

Additional Sources

- American Intellectual Property Law Association (at www.aipla.org)
- International Trademark Association (at www.inta.org)
- Internet Corporation for Assigned Names and Numbers (at www.icann.org)
- U.S. Patent and Trademark Office (at www.uspto.gov)
- U.S. Copyright Office (at www.copyright.gov)
- World Intellectual Property Organization (at www.wipo.org)
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15.2 The 10 Biggest Legal Mistakes Physicians Make Involving Patenting
By M. Sharon Webb, MD, PhD, Esq.

Executive Summary
Physicians are natural problem-solvers, often highly creative ones. Solving problems in new and unexpected ways can result in inventions entitled to patent protection. Obtaining a patent, though, is an arcane and formidable process. Physicians who make mistakes in this area may miss chances to protect their inventions and to profit from them.

Mistake 1 Not Realizing That One Is an Inventor
The first step in the patenting process is to invent something. Invention, according to the patent laws, takes place in the mind, not in the laboratory: Physicians have invented something if they have formed in their mind the definite and permanent idea of the complete and operative invention as it would be applied in practice, a process the patent laws call “conception.” Either converting what one has conceived into a working prototype or describing the invention in a patent application filed with the U.S. Patent Office (the PTO) counts as “reduction to practice” in the patent laws. While a physician must reduce his or her invention to practice to obtain patent protection for it, conception makes the physician officially an inventor.

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Action Step Physicians should be attuned to their own creative efforts so that they can recognize when they may have conceived something innovative. Documenting their work in a journal or lab notebook may help them appreciate their own conceptions and distinguish them from reductions to practice.

Mistake 2 Not Understanding Who Owns an Invention
If a physician invents something that becomes patented, that physician owns the rights that the patent conveys, no matter where he or she stands in the medical hierarchy. Others who co-conceive the invention are co-inventors and thus are co-owners of the patent. U.S. patent laws grant each co-owner full rights under the patent, including the power to license or sell those rights to others. Other contracts the physician inventor has signed or policies that bind the physician might obligate the physician, however, to transfer his or her rights of ownership to someone else, for example to an employer as a condition of employment or to a university by virtue of a faculty appointment.

Action Step Once physicians realize that they may have invented something, they should track down and review the agreements or policies that could affect their ownership interest. This may be a good time to obtain advice from an attorney experienced in patents and their ownership.

Mistake 3 Not Giving Credit Where It Is Due
Because inventing something gives the inventor an ownership interest in a patent to that invention, physician inventors should sort out who contributed what throughout the invention’s development. The process of developing a technology may involve many participants, not all of whom are inventors (see Mistake 1). Many members of a technology team may be listed as authors on a scientific paper describing an invention, but such authorship does not imply inventorship or any ownership interest in a patent covering the invention.

Action Step Physicians should identify the contributions of all team members early in the development of an invention, so that their proper roles can be recognized. Lab notebooks or other contemporaneous recordkeeping can be helpful in this process.

Mistake 4 Not Seeking Patent Protection for an Invention
By not seeking patent protection when appropriate, physicians may inadvertently give up the right to do so later. The U.S. patent laws specify what is patentable: The invention must be useful, novel (i.e., not already disclosed, in use, or on sale), and nonobvious (i.e., not apparent to others in the field based on the state of the art). These apparently straightforward terms have sufficient legal complexity that they may not be helpful to the physician inventor trying to figure out if an invention is patentable. Even if the invention appears patentable, the
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inventor may become intimidated by the process of seeking patent protection, thereby losing
the opportunity for patenting.

**Action Step** Physicians who believe that they have invented something potentially
patentable should seek advice promptly about whether to seek a patent. A temporary patent
application, called a “provisional patent application,” can preserve a physician’s rights for a
year while he or she decides whether to file a formal application.

**Mistake 5  Publishing, Then Perishing**
Inventive academic physicians face conflicting obligations: inform colleagues about their
scientific discoveries, or protect their inventions under the U.S. and foreign patent laws.
Publishing an article, posting an online abstract, presenting at a conference, or any other sort
of public disclosure can eliminate foreign patent rights and can start a one-year time clock for
filing a U.S. patent application. Physician inventors need to balance the importance of free
academic communication against the unforgiving barriers that the patent laws impose on such
disclosures.

**Action Step** Physicians should keep their discoveries and possible inventions to
themselves until they have determined that they do not want to patent them or until they have
applied for patent protection, even with a provisional patent application. If in doubt, they
should keep quiet and obtain legal advice.

**Mistake 6  Not Getting Advice Early**
The U.S. and foreign patent laws are highly specialized. Many of the mistakes already
mentioned—along with others—can be avoided if the physician obtains good legal counsel at
the outset. A valued resource for academic physicians is the university’s technology transfer
office, where licensing professionals work with inventors to obtain proper patent protection
and to arrange the commercialization of their technologies.

**Action Step** A patent attorney or a patent agent can advise physicians about their
invention and the patenting process. Physicians who are faculty members may be able to
obtain advice from their institution’s technology transfer office, and those physicians may
have an obligation to inform that office of any inventions they create.

**Mistake 7  Not Pitching in With the Paperwork**
Doctors are generally allergic to paperwork, and the patent world is paperwork intensive.
Still, there are at least two good reasons to be directly involved in the paperwork part of
patenting an invention. First, physician inventors know their invention better than anyone else
and are therefore likely to be the best at describing it to the PTO, using words or diagrams as
necessary. Even if that description is not the final one, they can provide key technical
information for the patent attorney who is writing the application. Second, physician
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inventors know their field, so they can tell which features of their invention are importantly different from the work others have done, work that is collectively termed the “prior art.” Physician inventors may even decide to research the field ahead of time to see if others have disclosed or patented something similar. A good place to start searching for other patents and published applications relevant to a physician’s invention is the PTO database (at www.uspto.gov).

**Action Step** Physicians should take a hands-on role in the paperwork necessary to patent their invention. They will obtain better patent protection that way, and the process will be more economical.

**Mistake 8 Not Reading the Fine Print**
For many doctors, legal documents are nothing but fine print that they do not want to read. But doctors ignore such documents and the contents of those documents at their peril. For example, physician inventors will encounter certain legal documents during the patenting process that they are required to read, understand the contents of, and state officially to the PTO that they have done so. In addition, certain legal documents (e.g., consulting agreements, licenses, and assignments) can affect a physician’s ownership interests in an invention or a patent. Inventors who do not read these documents before signing them may be giving up important rights they could have bargained for had they just been aware of those rights. Physician inventors also become bound by what they have signed in such commercial agreements. Breaching an agreement’s term can have severe economic consequences not offset by the liability insurance that doctors traditionally carry.

**Action Step** Physician inventors must read legal documents before signing them, making sure they understand what the documents mean and how the documents obligate them. An attorney familiar with the patenting and commercialization process can be a useful ally in this regard.

**Mistake 9 Misunderstanding One’s Patent Rights**
Physician inventors might assume that having a patent allows them to make, use, sell, and offer for sale the invention it covers, but they would be wrong. A patent is a negative right, preventing others from practicing someone’s invention. It is not a positive right that allows the inventor to practice it himself or herself. Others may hold patents that prevent a physician inventor from making or using his or her own invention. These patents, called blocking patents, might be extremely broad, pioneering ones that cover the entire technical field, or they might cover an essential component of a physician’s invention. In either case, no one is able to commercialize his or her invention without dealing with blocking patents. It may be necessary to obtain a license from whoever holds them, or it may be necessary to modify the commercial product to design around the blocking patents.
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Action Step  An issued patent sets forth in its claims precise and technical statements of what the patent covers. This is where to look in order to figure out whether a third-party patent covers an invention. By searching for issued U.S. patents that could cover his or her invention and then examining their claims, the physician can determine whether any blocking patents may present problems. The searchable PTO patent database (at www.uspto.gov) is a useful tool for this investigation.

Mistake 10  Not Anticipating the Future
After a physician’s creativity has produced an invention and the physician has been able to patent it and even to reap some commercial benefit from it, that creativity should not stop there. The physician should try looking into a scientific crystal ball to figure out how the invention might evolve and to identify potential opportunities. The more the physician can anticipate, the more possible gains he or she can capture in agreements the physician negotiates. By not anticipating the future, the physician may be missing opportunities that only he or she could identify.

Action Step  Physician inventors should keep their creativity engaged throughout the patenting process, projecting how they or others might develop the technology. That way, they may be able to capture these ideas in a separate patent application or to structure an agreement for commercializing the present invention so that they retain control over how they develop it in the future.

Conclusion
Physicians who make the mistakes described in this section may miss their chances to protect their inventions and profit from them.

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Chapter 16  Litigation

16.1 The 10 Biggest Legal Mistakes Physicians Make in Litigating a Noncompete Agreement
By John G. Browning, Esq.
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Executive Summary
A “covenant not to compete,” or “noncompetition” provision, places certain limitations on a physician’s practice following termination of employment and is a common feature in many employment agreements. Depending on the circumstances, both physician employers and physician employees may find themselves facing litigation over the enforcement of such a noncompete provision after employment has terminated. Therefore, both physician employers and physician employees should consult appropriate counsel, make an early assessment of the evidence needed to support their position, take a realistic look at the enforceability of the noncompete in question, and have an appreciation for the time frames involved in such litigation.

Mistake 1  Making an Unwise Choice of Counsel
The enforceability of noncompete provisions in employment agreements (which also often appear in agreements for the purchase and sale of medical practices) is governed by state law, and consequently can vary from state to state. Given the unique status of physicians in society and the importance of the physician-patient relationship, certain states have placed additional limitations on noncompete agreements affecting physicians (e.g., providing for access to patient records even after the termination of employment). When noncompete issues become the subject of litigation, both physician employers and physician employees should turn to skilled trial counsel knowledgeable in employment law and experienced in dealing with physician agreements. All too often, physicians turn to their transactional attorney who drafted the agreement (in the case of an employer) or reviewed the document (in the case of an employee), regardless of the attorney’s courtroom experience. Due to the ramifications of noncompete litigation, it should be handled by experienced litigators who are familiar with this area of law (and preferably with noncompetes involving physicians).

Action Step  Physicians should consult with experienced civil trial counsel, licensed in the jurisdiction in which their practices are located, and knowledgeable in employment law.

Mistake 2  Not Appreciating the Time Frames Involved
The usual method of enforcing a noncompete is to seek injunctive relief from a court by obtaining first a temporary restraining order and shortly thereafter scheduling a hearing for a temporary injunction, the purpose of which is to obtain an order enjoining the competing physician from engaging in a practice that violates the geographic, time, or type of activity
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limitations contained in the noncompete agreement. An injunction hearing is much like having a full-blown trial on the merits of the case within an extremely compressed time frame, complete with discovery (usually depositions) conducted on an expedited basis. For physicians whose only acquaintance with litigation is a medical malpractice case that might not come to trial for several years, this drastically shortened time frame can come as quite a shock (not to mention a disruption in practice). A case in which injunctive relief is sought can proceed rapidly from initiation to resolution in just a few weeks.

**Action Step** Physicians should carefully consider the compressed time frames often involved in litigating a noncompete agreement and the ensuing implications such a shortened time period will have for their practices.

**Mistake 3 Failing to Make an Early Assessment of the Noncompete’s Enforceability**

Given the fact that noncompete covenants are generally disfavored as unreasonable restraints on trade, unless they comply with certain requirements, physicians would be well advised to assess the enforceability of a noncompete before embarking on litigation. The physician should consult with a licensed, experienced, and knowledgeable attorney about prospects for enforcement of the noncompete at issue. Important questions need to be asked: Was the noncompete supported by adequate consideration or was it simply a case of “sign this and you’ll have a job?” Does the noncompete contain reasonable restrictions on the geographic area to be covered, the applicable time frame, and the type of competing activity to be restrained? Does the noncompete comply with the particular jurisdiction’s requirements, if any, for noncompetes involving physicians (e.g., certain states require a “reasonable buyout” provision, and reasonable access to patient records so that ongoing patient case is not compromised)? A physician employer may be in for a rude awakening if he or she cannot demonstrate the legitimate business interest being protected by the noncompete’s restrictions.

**Action Step** Ideally, physicians should consult with appropriate counsel when first formulating a noncompete agreement. Prior to litigation, physicians should consult with trial counsel about the enforceability of the noncompete’s provisions, and they should be prepared to compromise on the restrictions that are not likely to be upheld (e.g., modifying the geographic area affected by the noncompete).

**Mistake 4 Failing to Marshal the Right Evidence**

Often, physicians fail to look past the most critical witnesses in litigating a noncompete agreement: the physician employer and the physician employee. While such witnesses are clearly the most important to address the terms of the agreement itself, they are by no means the only important witnesses. For example, a physician employer may wish to offer testimony from appropriate hospital representatives, medical society officers, and/or other physicians in the community who can testify to the substantial investment that the practice made in the
departing physician employee and the measures taken to integrate him or her into an established practice and into the local medical community. A physician employee might wish to counter with similar witnesses who can testify as to the shortage of doctors in the community in his or her specialty and the resulting need for such practitioners (a number of cases have been won, and noncompetes held unenforceable, on just such a basis).

**Action Step** Physicians should, in consultation with counsel, consider the significance of witnesses other than the parties to the agreement itself in supporting their cases.

**Mistake 5  Failing to Evaluate the Prospects for Settlement at an Early Juncture**
Physicians should remember that noncompete litigation, while rife with emotional components (such as feelings of betrayal), is no different from other litigation in that the vast majority of cases are resolved through compromise settlement rather than with a final judicial ruling. Moreover, because the enforceability of a noncompete can be highly discretionary with the court, it is not uncommon for judges to “reform,” or modify, the limitations articulated in a noncompete agreement (e.g., reducing the geographic prohibition against a competing practice from 50 miles from the prior employer’s principal office to 20 miles). Because of these factors, it is in the physicians’ best interest to make an early evaluation of the prospects for settlement, including availing themselves of opportunities to have the case resolved by alternative dispute resolution (ADR) procedures, such as mediation or arbitration. Certain states that mandate a reasonable buyout provision for physician noncompete agreements also stipulate that binding arbitration will be used to arrive at a buyout figure if the parties cannot agree.

**Action Step** Physicians should consider at an early juncture the prospects for reaching a mutually agreeable settlement and the potential use of ADR. Early evaluation can minimize the costs associated with litigation and the disruptive effect on the physicians’ practices.

**Mistake 6  Not Being Consistent**
In noncompete litigation, physicians must remember that it is the reasonableness of the business interests sought to be protected that is at issue. Accordingly, the way in which a physician employer reacted to the departures of previous physician employees will be scrutinized. Did the physician employer pursue similar enforcement of a noncompete with regard to others? If not, this failure to be consistent in the protection of business interests can be used to undermine subsequent noncompete litigation and characterize the noncompete enforcement as selective in nature.

**Action Step** Physicians should take care to be consistent in the protection of their business interests, much as a major brand such as Coca-Cola regards any threat to its trademark as serious.
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Mistake 7  Not Being Wary of the Paper Trail
Physicians must be wary of the fact that all kinds of things come out in the discovery that accompanies noncompete litigation, such as personnel files and other documentation. For example, a physician employee who is seeking to break a noncompete but is being characterized as a significant competitive threat to his or her former employer can be greatly helped by internal documents showing that the employee was not yet meeting certain goals of monthly billing or number of patients sought.

Action Step  Physicians should be aware of the significance that otherwise mundane records can have in the course of noncompete litigation.

Mistake 8  Failing to Avoid the “God Complex”
Just as in medical malpractice litigation, a physician’s demeanor during testimony in noncompete litigation can be crucial. Whether testifying in a deposition, an injunction hearing, or at trial, the physician should avoid any appearance of arrogance. A physician employer should keep in mind that he or she is no different from any other employer who has made a significant investment in a key employee and is merely seeking to protect that investment. A physician employee is just like any other individual whose livelihood and career development is being threatened, and who is seeking relief from the courts.

Action Step  Physicians should be wary of how they may be perceived by nonphysicians, especially in the judicial process, and should strive to cultivate a certain level of humility.

Mistake 9  Failing to Anticipate Litigation
Physicians who counsel patients on preventive medicine would be wise to take some of their own advice and plan their employment agreements with the potential for litigation in mind. For example, physician employees could request that their employer add language to the employment agreement rendering the noncompete null and void in the event that they are involuntarily terminated. A physician employer, on the other hand, could make the road to obtaining injunctive relief much smoother by adding to the noncompete acknowledgments by the physician employee that the relief sought by the employer is appropriate, that no adequate remedy exists if the employee were to violate the noncompete, and that the harm in such an event would be irreparable.

Action Step  Physicians should be mindful of the potential for litigation in the first place, and should consult with counsel about appropriate preventive measures.

Mistake 10  Failing to Learn From Past Experience
Surprisingly, even physicians who have been involved in litigation over a noncompete agreement (whether seeking to enforce it or break it) sometimes fail to learn from the past. For example, a physician employer should review all other noncompete agreements—and
LITIGATION: COVENANTS NOT TO COMPETE

revise them accordingly—in the event of certain restrictions being reformed or held unenforceable by a court considering a particular noncompete. While appropriate and competent legal counsel should apprise the physician of statutory or other changes in the law that necessitate revising a noncompete agreement, the physician should be mindful of the lessons learned from ongoing or postlitigation.

**Action Step** Physicians should be proactive and take steps to revise their noncompete agreements in the wake of noncompete litigation in order to incorporate the lessons learned from such an experience.

**Conclusion** Regardless of whether they are the employer or the employee, physicians engaged in or facing the prospect of litigation over a noncompete agreement should consult with experienced trial counsel, consider the greatly compressed time frames involved in such litigation, assess the noncompete’s enforceability at the earliest possible juncture, avoid overlooking important sources of testimony and evidence helpful to their case, and carefully evaluate the prospects for achieving settlement. Just as the requirements for valid noncompete agreements differ from state to state, judicial treatment of noncompete agreements can vary even more widely.

**Additional Resources**
- www.breakyournoncompete.com
- *Medical Practice-Employment Agreement*, 62 ALR 3d 1014

**About the Author**
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Executive Summary
Most physicians will have to testify by deposition in a legal proceeding at least once in their career. A deposition is a question-and-answer session, under oath in front of a court reporter, in the course of a civil lawsuit, or less frequently, in an administrative or criminal proceeding. Physicians are commonly called on to give deposition testimony as treating physicians for patients who are claiming injuries in a lawsuit, such as an automobile accident case. When sued for medical malpractice, physicians are almost always deposed by the patient’s lawyer after the lawsuit is commenced. Physicians who serve as experts in litigated matters are also often required to give deposition testimony. Depositions can be stressful, particularly when the physician is the target of a malpractice claim. Physicians who avoid making the following mistakes will be able to get through a deposition with relatively little pain.

Mistake 1    Ignoring Requests for Depositions
Requests to take a physician’s deposition usually come via a telephone call or a letter from one of the lawyers involved in the case. Physicians who are a party to a malpractice action will be notified by their own lawyer of the deposition request. Physicians sometimes ignore or avoid these requests in the hopes that they will go away. This tactic will not work. A lawyer has the option of serving on a physician a subpoena that requires the physician’s attendance for the date, time, and location indicated in the subpoena. This requirement gives the physician no say as to when and where the deposition will be held, or on what terms. Moreover, failure to obey a subpoena can result in monetary or other sanctions from the court.

Action Step    A physician who is asked to give a deposition should accept the inevitable and cooperate with counsel in scheduling the deposition for a time and place that is convenient for the physician.

Mistake 2    Failing to Seek Advice
Surprisingly, many physicians routinely give depositions without first seeking the advice of a lawyer or a clinic or hospital risk manager. A deposition is a legal proceeding. The physician who is deposed (the “deponent”) gives testimony under oath. Although most depositions are held outside of a courtroom, the proceedings are serious and the consequences of testimony can be significant for both the patient and the physician. Physicians need to know exactly what they are getting into before they raise their right hand, swear to tell the truth, and testify.
LITIGATION: TESTIFYING AT DEPOSITION

Action Step A physician who is requested to give a deposition should consult with a lawyer or, if practicing in a group setting, the group’s designated risk manager.

Mistake 3 Failing to Review Chart Entries
Physicians studying for their board certification examination would not dream of taking the test without preparing for it. Yet physician preparation for depositions is often woefully inadequate. Physicians who are being deposed concerning their medical care and treatment of a patient will be in for a thorough, detailed examination. Common sense dictates that physicians should prepare for this by becoming intimately familiar with their chart entries before testifying. Physicians who show up for depositions without having carefully reviewed the chart beforehand generally do not come across well when testifying.

Action Step It is crucial for physicians to carefully review their chart entries before the deposition to make sure that they know exactly what they did for the patient and why.

Mistake 4 Overpreparing
Although it is important for physicians to carefully review their chart entries before the deposition, there is such a thing as overpreparation. This mistake usually occurs for one of two reasons: spending time analyzing the care provided by other physicians who cared for the patient, and performing extensive literature searches concerning the medical issues in the case. One of the first questions most lawyers ask in a deposition is what the deponent reviewed to prepare for his or her testimony. Anything the physician reviewed is generally considered fair game for the deposing lawyer. A physician who reviews and analyzes another treating physician’s care can be asked if he or she found any problems with the care. A physician who reviews scores of medical articles can be examined on those articles. Too much preparation, or the wrong kind of preparation, can be dangerous.

Action Step When preparing for a deposition, a physician should avoid reviewing information that is not directly pertinent to his or her role in the care of the patient.

Mistake 5 Failing to Address Fee Issues
When physicians give testimony as experts or as treating physicians in nonmalpractice cases, they are generally entitled to compensation for their time. Physicians err when they do not confront this issue before the deposition; neglecting to do so can lead to fee disputes after the fact.

Action Step A physician should discuss fee issues with counsel well before the deposition. Physicians who are represented by a lawyer should discuss the fee issue with their own lawyer. A physician who is a retained expert should discuss fees with the hiring lawyer. Physicians who are not represented by counsel or hired as an expert should discuss fees with the lawyer who makes the deposition request.
Mistake 6  
**Forgetting the Ground Rules**

In normal conversation, it is human nature to interrupt, to nod or shake one’s head rather than respond verbally, and to answer questions with responses such as “uh-huh” or “nope.” Depositions are not normal conversations, however. The court reporter needs to take down the testimony. It is difficult for the reporter to record nonverbal responses or two people talking at once. Lawyers often start depositions by going through the ground rules, which are typically stated as follows:

- Please make sure you understand the question before you answer.
- If you don’t understand the question, ask that it be rephrased.
- Wait until the question is finished before you give your answer.
- Answer verbally rather than with a nod or shake of the head.
- If the question asks for a “yes” or “no” answer, please answer “yes” or “no” as opposed to “uh-huh” or “nope” or a similar response.

Physicians who repeatedly fail to follow the ground rules do not make good witnesses.

**Action Step**  
Physicians should strive to follow the ground rules for depositions so that their testimony can be taken down clearly and accurately.

Mistake 7  
**Guessing or Speculating**

Physicians often get in trouble when they guess or speculate in response to deposition questions. This commonly occurs when a physician is asked whether he or she remembers a specific fact concerning the medical care that was provided to the patient. Physicians often don’t remember the specifics of treatment beyond that which appears in the chart, and many times the charting is less than complete. It is a mistake to guess or speculate based on what a physician thinks he or she may have done. Another common example is when a physician testifies concerning treatment that was provided by another physician or is otherwise outside the personal knowledge of the deponent. If the truthful answer is “I don’t know” or “I don’t remember,” then that should be the response.

**Action Step**  
Physicians should not guess or speculate when answering questions in a deposition. They should stick to their own personal knowledge or, when asked for opinion testimony, testify only as to the opinions they have formed to a reasonable degree of medical certainty.

Mistake 8  
**Volunteering Information Beyond the Question**

Deposition questions should be answered directly and concisely. Physicians can create problems when they wander or ramble into areas beyond the question that was asked. A question that can be answered with a simple “yes” or “no” should not be followed up with a lengthy recitation of the reasons for the answer. It is the lawyer’s job to ask the appropriate follow-up questions, to seek explanations and reasons, to challenge the witnesses’ opinions,
and so forth. Invariably, when physicians volunteer information that is not directly asked, it leads to even more questions, and they often end up being needlessly painted into a corner.

**Action Step** Physicians must answer deposition questions truthfully, but they should strive to keep their answers direct and to the point. They should avoid volunteering information that is not specifically requested by the deposing lawyer.

**Mistake 9 Venturing Outside the Physician’s Area of Expertise**
Lawyers often try to get physicians to comment in their deposition on matters that are outside of their area of expertise. Physicians should not take the bait. If, for example, a lawyer asks a family practice physician to interpret a patient’s MRI scan, the physician will be better served by answering, “You will need to ask a radiologist,” than by taking a crack at an answer, unless reviewing MRIs is part of the physician’s practice and experience. Physicians who testify outside of their area of expertise lose their credibility.

**Action Step** Physicians should avoid answering deposition questions in areas outside of their medical specialty.

**Mistake 10 Becoming Hostile or Argumentative**
Physicians often come under attack in depositions, particularly when they are defendants in malpractice cases. It can easily become a hostile or an argumentative atmosphere. Some lawyers intentionally create that kind of environment, hoping that the physician will say something against his or her better judgment. Although physicians, compared with deposing lawyers, have superior medical knowledge, it is a mistake to fight with a lawyer in a deposition. Physicians risk coming across as arrogant or rude, and worse yet, may say something that will come back to haunt them.

**Action Step** Physicians should strive to maintain a calm, professional demeanor during a deposition, and avoid any temptation to argue with the deposing lawyer.

**Conclusion**
Giving deposition testimony is a difficult task but one that most physicians will need to do during their career. For physicians who avoid these mistakes, the deposition process will be significantly less daunting than it may initially seem.

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Executive Summary
Civil litigation, not involving professional liability claims, often requires the physician to step away from the comfort zone of medical issues and enter the unknown world of contract and nonmedical tort claims. Such claims have the potential of not only being financially ruinous, but also of consuming vast amounts of time and attorney’s fees. The risk, personally and professionally, to physicians who fail to understand the civil litigation process is immense.

Mistake 1  Delay in Contacting Counsel
All too often, physicians will attempt to resolve a business dispute on their own. While that might be appropriate for a relatively mundane manner, counsel should be contacted promptly whenever a dispute seems complex or significant sums are involved. A delay in contacting counsel can result in serious problems at a later stage of the dispute. Statements that a physician may make, orally or in writing, might come back to haunt him or her—a mistake that may have been avoided had counsel been retained promptly. Further, attorneys may be able to view the dispute more objectively and have a greater ability to resolve the matter amicably before tensions escalate. Significant legal expenses might be avoided if the attorney has the opportunity to resolve the matter at a very early stage.

Action Step  When a disagreement arises, careful consideration should be given to involving counsel immediately.

Mistake 2  Making an Error in Selecting Counsel
As with the medical profession, attorneys have widely varying areas of expertise. The physician must make certain that the attorney selected to provide representation has competence and experience with the subject matter of the dispute. The physician must directly ask counsel what his or her experience has been in handling similar disputes.

Action Step  Physicians should conduct “due diligence” regarding their counsel before engaging him or her.

Mistake 3  Failing to Know the Strengths and Weaknesses of Opposing Counsel
The physician must understand that there are, in addition to the parties, other players who will dictate developments in the litigation. First and foremost is the opposing attorney. A
LITIGATION: COMMERCIAL CASES

physician should direct his or her counsel to learn everything possible about the opponent. Has opposing counsel handled similar cases in the past? Does the attorney have a reputation for being reasonable or unduly litigious?

**Action Step** If the physician’s attorney is not already familiar with opposing counsel, the physician should instruct the attorney to make inquiry and to send the physician a report.

**Mistake 4** Not Understanding the Role or Reputation of the Trial Judge
The trial judge will largely dictate the pace of the litigation and play a large role in determining the extent to which settlement discussions will occur. The physician must know whether the judge is experienced in dealing with business disputes. Further, it is important to know whether the judge will move the case expeditiously or if the matter will become one more example of the wheels of justice turning slowly. Finally, it is important to know if the attorney has prior experience with the judge, and whether that experience has been positive.

**Action Step** The physician should learn from his or her attorney all available information regarding the trial judge. That information will be a factor in many important decisions involving discovery, settlement, or proceeding to trial.

**Mistake 5** Failing to Appreciate the Time and Expense of Litigation
Very early in the process, the physician should ask the attorney to prepare a projected litigation budget and timetable. How many depositions will need to be taken and over what period of time? What will the entire matter cost if it proceeds through trial? Obviously, the attorney’s budget can be no more than a good-faith estimate because part of the cost and timetable will be dictated by opposing counsel and the judge. Nevertheless, it is important for the physician to understand as soon as possible what the process is likely to entail. To help monitor the cost, the physician should request monthly, itemized bills.

**Action Step** The physician must not defer a candid discussion of the time and expense of litigation. Those issues will clearly play an important role in evaluating the merits of settlement.

**Mistake 6** Failing to Appreciate that Settlement May Be the Right Choice
Physicians tend to approach business litigation as though it were a malpractice case. This mistake must be avoided. In commercial disputes, physical injuries are not at issue and the physician’s competence is not being challenged. No report to the National Practitioner Data Bank will result from a business dispute. More than 95% of business disputes are resolved amicably before trial, and there is typically immense pressure from the judge to settle commercial lawsuits. Indeed, many courts have mandatory alternative dispute resolution mechanisms, such as mediation, which are designed to resolve matters prior to trial. The physician must review with his or her attorney the risk of an adverse result and the cost of
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trial. The higher the risk or the cost, the greater the need to carefully evaluate settlement options. Only a very compelling business reason would warrant spending more money to try a case than to settle it.

**Action Step**  The dynamics of business litigation are such that settlement discussions will almost always occur. The physician must evaluate the case from a business perspective, not an emotional one, and balance the factors of risk and cost.

**Mistake 7  Failing to Monitor the Proceedings**
Physicians are often so busy that it is difficult to pay careful attention to the progress of litigation. This mistake must be avoided. The physician should regularly communicate with the attorney to understand where the matter stands at any particular period of time. If the trial judge has requested that briefs be filed on any particular issue, the physician should obtain and review copies of them to understand the arguments being made.

**Action Step**  Physicians should make time to know where the case stands and what the next step will be.

**Mistake 8  Failing to Prepare for Depositions or Court Appearances**
The physician must guard against overconfidence and work with the attorney to prepare carefully for any testimony that may be given. The physician must make time for this important work. The physician’s own attorney should be requested to serve as a devil’s advocate, and ask the physician the tough questions that opposing counsel is likely to ask.

**Action Step**  Physicians should never underestimate the importance of preparing for testimony. The physician must review all relevant documents, and work with counsel to understand any potential areas of weakness.

**Mistake 9  Having Unrealistic Expectations of Counsel**
The physician must remember that the attorney was not directly involved in the facts that gave rise to the dispute. An attorney cannot be a mind reader. The physician must carefully explain all relevant facts—good and bad—to counsel so that the attorney may properly evaluate the situation and advise the physician. All such communications are protected from disclosure by the attorney-client relationship, so there is no reason to not be absolutely candid.

**Action Step**  The physician must thoroughly apprise the attorney of all relevant facts.

**Mistake 10  Failing to Appreciate That Tactics and Strategy Are Involved**
While emotions may run high, the physician must guard against the temptation to personalize the proceedings and hope for a measure of vengeance. The judicial process ultimately
resolves matters by an allocation of money, and revenge is a concept best left for movies. Accordingly, the physician must work with the attorney to develop a goal, which will then drive the strategic and tactical decisions that will be made during the process. Litigation must be viewed as a game of strategy, more akin to a game of chess than to a street fight.

**Action Step**  
The physician must work with his or her attorney early in the process to develop a goal and a game plan to achieve that goal. The physician should not personalize the litigation; it is a business dispute and businesslike decisions must be made.

**Conclusion**  
Physicians who adhere to these action steps will maximize their ability to understand the process and make the best decisions possible with respect to settlement issues or trial.

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### 16.4 The 10 Biggest Legal Mistakes Physicians Make in Retaining Counsel for Civil Litigation  
By Lawrence A. Strid, Esq.

**Executive Summary**  
Physicians can often be their own worst enemy when it comes to making a decision about retaining legal counsel in a civil matter. The demands of a busy practice, failing to recognize the significance of legal documents when they are received, and a general distaste for lawyers in general all can lead physicians to ignore the need to retain counsel in a timely manner. What’s more, physicians sometimes make inappropriate decisions in selecting the right attorney for their specific legal problem.

**Mistake 1  **  Failing to Retain an Attorney in a Timely Manner  
The general legal proposition that the law protects the vigilant may prove to be true when physicians become aware that they may have a legal problem or concern. The first tip-off about the need to confer with an attorney should come when physicians receive a legal document or correspondence (including letters from attorneys raising legal issues about a
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Receipt by physicians of certain legal documents (such as a summons or a subpoena) may initiate deadlines for the physicians to meet. By failing to meet these deadlines, physicians could suffer negative consequences thereafter. Physicians should not ignore such documents in the belief that they were improperly served with legal process. Even if this assumption is correct, an unscrupulous process server could still file a verified proof of service attesting to proper service, and such a filing could trigger critical events if not timely responded to.

Action Step  Physicians should promptly consult with an attorney whenever they receive notice of documents of some legal claim or proceeding, even if they believe that the matter is without merit or is inconsequential.

Mistake 2  Equating Quality With Price or the Size of a Law Firm
Some people believe the axiom that “you get what you pay for.” When it comes to retaining an attorney, this axiom means to some that the best ones charge the most and have the largest number of attorneys listed on their letterhead. Sometimes, however, the attorneys charging the most do the least because they only have to look at a client’s file to generate an impressive bill. Many attorneys who charge high hourly rates actually do little work on the matter themselves, unless it is a matter destined for a trial. Usually, they hand off the case to associates or paralegals, who charge less but attempt to “chum” the file as much as possible and thereby generate a respectable bill for the law firm and justify their existence to the firm’s general partners.

Action Step  Physicians shouldn’t presume that the size of a law firm or the amount of the lead partner’s hourly rate guarantees competent legal representation. Many smaller firms have a greater incentive to do a professional job at a more reasonable price.

Mistake 3  Failing to Understand How Attorney’s Fees Work
As a general rule, attorneys handle legal matters for clients in one of three ways, or sometimes with a combination of the three: the contingency fee, the hourly fee, or the flat fee. Most legal matters involve the incurrence of costs, aside from the fee, for such expenses as postage, photocopying, filing fees, service of process, expert witnesses, court reporters, investigators, or other out-of-pocket charges necessary to handle the matter.

The contingency fee, most commonly used in injury cases or possibly in business collection matters, provides that when a recovery is obtained, the attorney will take an agreed-upon percentage of the recovery. Additionally, the client may be responsible for case costs, whether or not a recovery is made, depending on what is agreed to. The contingency fee may
be based on the gross recovery or the net recovery after subtracting the costs, depending on what is agreed to.

In a flat-fee arrangement, all of the work is done for a fixed fee, which may include costs, depending on what is agreed to. In such an arrangement, it is important to define what the work will actually entail (e.g., whether litigation is included and if so whether it covers a trial and an appeal).

In an hourly fee arrangement, the attorney charges an hourly rate, usually in tenths of an hour, for all tasks performed. Most attorneys charge for the time spent on the telephone, preparing letters and documents, reviewing documents, and traveling to and from court and depositions. A lesser hourly rate may be charged for the services of an associate, a junior partner, or a paralegal. It is important that the physician receive a bill from the attorney at least once a month on hourly matters and promptly raise any questions or concerns about the bill.

Many clients are surprised to learn that most often opposing parties are not responsible for their own attorney’s fees if they prevail. In fact, unless specified in a written contract or allowed by statute, most litigants must bear their own attorney’s fees. If a contract or a statute provides that attorney’s fees be charged to the prevailing party in a particular matter, the client needs to clarify with the attorney whether the client must pay fees as they are incurred and will be reimbursed if the client prevails in the action, or whether the attorney will look solely to the opposing party for the fee payment. Most attorneys prefer the former approach, in case the client does not prevail or the losing party is unable or is resistant to paying.

**Action Step** Curiosity is the physician’s best protection in understanding the fee arrangement. Physicians should not be timid in asking their attorney how the fee agreement will work, for exactly what and how they will be charged, and how it may affect the amount of money actually in dispute.

**Mistake 4 Failing to Attempt to Negotiate the Fee**
With few exceptions, the overwhelming majority of attorney-client agreements are negotiable. The physician conferring with an attorney about potential representation should not hesitate to suggest a more economical fee arrangement than that suggested by the attorney.

For example, in an hourly fee arrangement, the attorney may agree to handle the matter on a lesser hourly rate, or with a cap on the total amount to be charged. In addition, depending on the nature of the matter, the attorney may be persuaded to handle it on a contingency fee basis instead of an hourly rate, at least if a legal action to recover an amount of money or damages is contemplated.
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In a contingency or fixed-fee arrangement, the attorney may agree to handle the matter for a lesser amount, or to include costs within the fee instead of charging separately for costs.

**Action Step** Physicians should not hesitate to negotiate with their attorney about the proposed fee arrangement. If the attorney refuses to negotiate, the physician can accept the terms as is or consult with another attorney.

**Mistake 5 Not Obtaining a Written Fee Agreement**
The best safeguard to understanding an attorney fee agreement is to obtain it in writing, signed by both attorney and client. The terms of the written fee agreement are negotiable. Some attorney fee agreements provide for binding arbitration of fee disputes or malpractice claims, which may or may not be enforceable in any given state. Other such agreements may provide for an award of attorney’s fees to the prevailing party in any dispute arising out of the fee agreement. In general, without such language, each party would have to bear his or her own attorney’s fees in any dispute arising out of the agreement.

**Action Step** Any agreement with an attorney should always be in writing, and the writing should be easy to understand, without small print or “legalese.” At the initial consultation, the physician should not feel pressured to sign the agreement, but rather be able to review it at his or her leisure and then contact the attorney later to firm up the deal.

**Mistake 6 Failing to Inquire About the Attorney’s Experience and Plan of Action**
Much like physicians, most attorneys tend to specialize in their profession. The area of civil litigation can cover a wide gamut of legal matters, such as personal injury, malpractice, real estate, collections, business disputes, employment claims, bankruptcy, and intellectual property. In general, familiarity with a particular area of law offers some assurance of the attorney’s expertise.

Potential clients should not hesitate to ask attorneys about their years of practice, whether they have tried the relevant type of legal matter before, how many such matters they have handled, how they would propose to handle the matter if retained, and what their prognosis for the outcome is.

**Action Step** Hiring an attorney should be no different than hiring a receptionist, a physician’s assistant, or a nurse. Physicians want someone who is experienced, qualified, confident, and knows how to put a plan into action. Physicians should ask questions about the attorney’s expertise.
Mistake 7  Being Unaware That Clients Always Have the Right to Discharge Their Attorney

Many clients don’t understand that they have an unqualified right to discharge their attorney, even if the matter is in litigation, and to retain new counsel or to represent themselves in the matter. While clients should avoid representing themselves, especially in litigation, they should not hesitate to retain other legal counsel if they are dissatisfied with their current attorney.

Warning signs of problems or potential problems with an attorney include the failure of the attorney to return the client’s telephone calls, making promises that seem too good to be true, failing to make court or deposition appearances, failing to address questions about the bill, not keeping the client advised about the status or progress of the matter, failing to work on the case, or repeatedly delegating client inquiries or concerns to secretaries or other legal staff.

Especially in litigation, the attorney is considered the agent of the party, such that if the agent takes steps that prejudice the case, the client—and the successor counsel—may be stuck with it.

Action Step  It is incumbent on physicians who do not have confidence in their legal counsel to select new counsel promptly.

Mistake 8  Failing to Know What the State Bar Can Or Cannot Do If a Problem Develops

If a fee or competence problem develops with an attorney, many clients do not know what the bar association can or cannot do for them. Every attorney admitted to practice law in a particular state is subject to the regulations of the state bar for that state.

State bars address problems of attorney regulation and discipline. In general, they do not get involved in fee disputes between clients and attorneys. They do, however, address situations in which attorneys abandon clients, fail to maintain trust funds, commit crimes, or otherwise breach certain fiduciary duties.

Unless intentional misconduct or gross negligence is involved, most state bar associations do not get involved in malpractice claims against an attorney, since the client’s remedy is a civil action for malpractice, and the state bar’s resources are limited. A client who reports a potential malpractice claim to the state bar and then waits for the bar to act may find the statute of limitations running out while the bar association addresses a backlog of other complaints.
Many state bars do, however, require mandatory arbitration over fee disputes if the client so requests, but the fee arbitration program is usually administered by a local or county bar association, as opposed to the state bar.

While all attorneys admitted to practice within a given state must belong to a state bar, membership in local, county, and specialty bars is purely voluntary, and is undertaken for reasons of education, networking, or legal fraternity. Other than the state bar, such voluntary bar associations have no disciplinary power over attorneys.

**Action Step**   Before filing a complaint with a bar association over a fee or competency dispute with an attorney, physicians should consult with another attorney to consider the options that may be available regarding fee arbitration, malpractice claims, or complaints to the state bar.

**Mistake 9**   Not Insisting on Receiving Copies of Correspondence and Documents
Physicians should insist that they be copied on every letter exchanged between parties and counsel on the case (including any documents that are filed or exchanged in litigation), which is something that many responsible attorneys do as a matter of course. This practice keeps physicians advised about the progress of their matter and, for hourly fee cases, allows them to see what they are being billed for and to raise appropriate questions if a concern arises.

**Action Step**   Physicians should advise the attorney they retain on the front end that they expect to be copied on all correspondence and legal documents that are exchanged and filed in the course of the matter.

**Mistake 10**   Not Inquiring If Insurance Will Cover a Claim
Most physicians have several types of insurance: malpractice insurance, business insurance for the office, motor vehicle insurance, workers’ compensation insurance for employees, and homeowners’ insurance on their residence. If a legal claim is made against physicians in their private or their professional capacity, one of these insurance policies may cover the claim and the expense of retaining an attorney to defend the claim as well. While the most obvious example is a claim for professional malpractice, employee claims for work injuries, discrimination, or harassment; injuries incurred at the physician’s office or at home; and tort-related claims for defamation or invasion of privacy may also be covered in an existing insurance policy.

Not all attorneys are especially conversant with coverage law, and some may prefer that physicians pay them to handle the matter rather than make a demand on behalf of the physician for an insurer to provide a legal defense.
LITIGATION: RETAINING A LITIGATOR

Most insurance policies provide that notice of a claim be promptly communicated to the insurer in order to invoke coverage. If the insurance company wrongfully declines to provide a defense or an indemnification on a claim, then that may be the basis for a legal action for bad faith or breach of the insurance contract by the insured.

Insurance is supposed to provide two different components of value: to pay the claim if the claim has merit, and to pay for attorney’s fees and other legal expenses incurred in defending the claim regardless of whether payment is made. Physicians shouldn’t hesitate to get their insurer involved if the subject of dispute involves a covered claim.

**Action Step**   Physicians should ask their attorney about the potential for insurance coverage on the claim, as well as the attorney’s familiarity with coverage issues. If physicians or their attorney suspect the claim will be covered, physicians should provide their attorney with the insurance policy. If necessary, physicians should not hesitate to obtain an opinion from another attorney who specializes in insurance coverage law.

**Conclusion**   When selecting an attorney, it is best to understand how attorneys charge for their services and to ask the appropriate questions at the initial client interview. Physicians should not be intimidated by legal issues. It is the attorney’s task to make legal issues understandable; if the attorney cannot do so, the physician should get another attorney.

**About the Author**

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Executive Summary
Malpractice claims are a fact of life for many physicians today. The sad reality is that it is now difficult to practice medicine without being sued at least once. The reactions of physicians who are named in suits vary: Some treat it as a virtual nonevent, while others decide to leave medicine. Most wish to defend themselves from the allegations if at all possible. In their effort to defend their care, however, physicians often make mistakes that can negatively affect the case. A physician who avoids these common mistakes will have a much better chance for a successful outcome.

Mistake 1  Ignoring the Claim
Some physicians think that ignoring a claim will make it go away. Nothing could be further from the truth; it can only make matters worse for the physician. Physicians who fail to timely report a claim to the insurer may find themselves without coverage, a default judgment may be entered, or a deadline crucial to the case may be missed. Also, memories fade as time passes, making it harder to defend the care at issue. Short-term avoidance of the claim can cause long-term problems.

Action Step  When a malpractice claim is filed, a physician should immediately report the claim to his or her malpractice insurer, and, if the physician practices in a group setting, to the group’s designated risk manager.

Mistake 2  Going Into a Panic
Being hit with a claim can be traumatic, but nothing good can come from a panic-stricken response. Physicians are trained to handle life-and-death situations in a calm and professional manner, yet many seem to lose these skills when a malpractice claim is brought. Panic reactions cause physicians to, for example, admit fault to the patient or engage in other self-destructive behavior. Physicians should realize that a malpractice claim is not the end of the world. Only in egregious and rare situations does a claim jeopardize one’s career or financial position. A physician’s malpractice insurer will provide a defense against the claim. There truly is no reason to panic. The claim should be approached thoughtfully and professionally.

Action Step  Physicians should handle an unexpected malpractice claim much as they would an emergency room code or a complication occurring in the course of a surgery: by being calm and professional and responding appropriately.
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Mistake 3  **Contacting the Patient**
Physicians often are tempted to talk to or correspond with a patient who brings a claim. Doing so is not a good idea. Even the best physician-patient relationship can sour when a patient believes he or she has a claim. It is extremely doubtful that a physician can talk a patient into dropping a claim once it is brought. Moreover, a physician may say words that later could be interpreted as an admission of fault. Once a claim is brought, the physician-patient relationship is forever changed.

**Action Step** Physicians should avoid discussing malpractice claims with patients. If a patient tries to contact a physician after bringing a claim, the physician should respectfully tell the patient that any further discussions need to be with the physician’s insurer, risk manager, or attorney.

Mistake 4  **Talking to Colleagues**
When facing a malpractice claim, it is only natural for a physician to seek another physician’s opinion. That impulse must be avoided, however. During a lawsuit, the patient’s lawyer will likely ask the defendant physician to detail all of the conversations he or she has had concerning the claim. Discussions between a physician and his or her insurer, practice group risk manager, or attorney are generally considered privileged and confidential. The same is true for formal peer review proceedings. However, discussions had in a “curbside consult” with a colleague after a claim is brought are discoverable by the patient’s attorney in a malpractice lawsuit, which can be particularly troublesome if the colleague’s position on the claim is negative. It can be devastating to the defense of a case if it comes out that a physician’s own partner is critical of his or her care.

**Action Step** Physicians should not discuss claims with colleagues. To support the care provided, a physician’s insurer or attorney will seek an outside expert review. If a physician wishes to discuss the case with a colleague, the physician should first check with his or her attorney to see if something can be arranged to preserve confidentiality.

Mistake 5  **Failing to Preserve the Integrity of the Patient’s Chart**
Altering a patient’s chart after a claim is brought or destroying patient records causes ethical and legal problems for physicians. This problem, although exceedingly rare, still bears mentioning. No health care provider is perfect in charting, and in nearly every malpractice case, there are deficiencies in the chart or entries that the physician wishes were not there, but that situation does not justify historical revision.

After a claim is brought, some physicians feel the need to prepare a summary of the patient’s care or other supplement to the chart. This action should also be avoided. If a physician wishes to prepare notes or a summary after a claim is brought, the document should be directed toward the physician’s attorney in order to preserve confidentiality.

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MALPRACTICE: AFTER MALPRACTICE IS FILED

Action Step When a claim is brought, physicians should leave the chart alone. Physicians invariably get themselves into more trouble by adding to or altering the chart than they otherwise would from the claim itself.

Mistake 6 Obsessing About the Claim
Obsessing about the claim is the flipside of ignoring the claim (Mistake 1). As their malpractice case progresses, some physicians let the claim take control of their lives, which can cause both professional and personal problems for the physician. Typically, it takes a long time for malpractice claims to be resolved. In the interim, life goes on. Although physicians should assist their attorney (see Mistake 7), they should not make the claim the focus of their life. Doing so doesn’t help the case, nor does it help the physician personally or professionally.

Action Step Although a malpractice claim is a serious matter, physicians should be careful not to obsess about it.

Mistake 7 Failing to Assist Counsel
Most attorneys are not medically trained. Although the attorney hired to defend the claim by the physician’s insurer will likely be experienced in handling medical malpractice actions, the physician has superior knowledge concerning the medical issues in the case. It is important for the physician to take the time early in the process to review the charting and become thoroughly knowledgeable about the care provided, and to impart this knowledge to his or her attorney. A physician can help counsel understand the medical issues in the case, critique the opposing side’s arguments, and do literature searches. By failing to help the attorney in this manner, the physician is making the counsel’s job more difficult; on the other hand, by helping the attorney, the physician makes the counsel’s job much easier and that assistance can be a key ingredient in a successful outcome in the case.

Physicians also fail to assist counsel when they do not timely respond to telephone calls or correspondence. If a physician’s attorney attempts to contact the physician or makes a request for information, it must be treated as a priority.

Action Step Physicians should carefully review the records as soon as practicable after a claim is brought and help educate their attorney on the medical aspects of the case. Physicians also should provide appropriate research and other assistance to their attorney in closely coordinated efforts. Physicians also should timely respond to all telephone calls and correspondence from their attorney.

Mistake 8 Becoming a “Jailhouse” Lawyer
While failing to assist their attorney in a malpractice claim is a mistake physicians commonly make, physicians who try to do the attorney’s job or second-guess their attorney can be a
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

problem as well. “Jailhouse lawyer” is a term that generally refers to prison or jail inmates who assist other inmates with litigation. These individuals usually know just enough law to be dangerous. The same is true for malpractice defendants who know a little bit about the law. Just as physicians do not want to be told by an attorney-patient how to diagnose a medical condition, attorneys do not need their physician-clients to tell them how to handle the legal aspects of a malpractice claim.

Action Step  It is important for physicians to assist their attorney on the medical aspects of the case. By the same token, physicians should leave the lawyering to their counsel.

Mistake 9  Displaying an Arrogant, Hostile, or Defensive Demeanor
In the 1993 film Malice, starring Alec Baldwin and Nicole Kidman, Baldwin plays a surgeon whom Kidman sues for malpractice. During his deposition, Baldwin states in response to a question from Kidman’s attorney about whether he has a “God complex”: “[I]f you’re looking for God, he was in operating room number two on November 17, and he doesn’t like to be second-guessed. You ask me if I have a God complex. Let me tell you something: I am God.” It is hard to imagine a physician in a malpractice case displaying the sheer arrogance of Baldwin’s character. However, under the stress of a lawsuit some physicians can come across as being arrogant, hostile, or defensive. One of the most important factors behind a successful defense of a malpractice claim is the impression that the defendant physician makes on the patient’s attorney, and if the case goes to trial, on the judge and jury.

Action Step  A physician should adopt a calm, caring, confident, and professional demeanor when facing opposing counsel, the patient, and, if it comes to a trial, the judge and jury.

Mistake 10  Ignoring Reality
Sometimes it is better to admit defeat and make a safe exit on acceptable terms. When a malpractice claim is made, a time will come when a decision has to be made whether to defend the claim all the way through to trial if necessary or to seek an acceptable settlement. Physicians do not do their profession any favors by settling claims that are not meritorious; doing so only encourages more claims. On the other hand, fighting a claim that should be settled can lead to an even bigger settlement or verdict.

Action Step  If a physician’s case will be extremely difficult to win and the physician’s attorney and insurer are recommending settlement, the physician needs to carefully consider the ramifications of proceeding with the defense versus settling. Refusing to settle a “bad” case almost always leads to bad results.
MALPRACTICE: WHEN TO SETTLE

Conclusion
A malpractice case can be a difficult experience for any physician. Unfortunately, physicians often make matters worse once a claim is brought. Physicians who avoid these mistakes will significantly enhance their chances for a successful outcome.

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17.2 The 10 Biggest Legal Mistakes Physicians Make When Deciding Whether to Settle a Medical Malpractice Action
By Barbara DeCrow Goldberg, Esq.

Executive Summary
Nearly 40% of all physicians are sued for malpractice at least once. For obstetricians, neurosurgeons, and others in high-risk specialties, the percentage is even higher. Fortunately, very few of these cases go to verdict, but for those that do, the stakes can be extremely high. The median medical malpractice jury award in 2001, the latest year for which complete data are available, was $1 million, and the largest award was $131,700,000. Whether to settle is therefore a decision of extreme importance. Just as a patient is entitled to sufficient information to give an informed consent to treatment, a physician must have a thorough understanding of the litigation process and the possible consequences of settling or going to trial. The following mistakes ultimately involve a lack of familiarity with the legal system, as well as a reluctance to be objective about the particular case and the possible repercussions of a settlement or adverse verdict.

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4 The Insurance Information Institute, “Hot Topics & Insurance Issues, Medical Malpractice” (Feb. 2004), http://www.iii.org/media/hottopics/insurance/medicalmal/.
5 Whether you have the right to consent to a settlement depends on your insurance policy. Most policies give you an absolute right to approve settlement, at least until the case has gone to verdict. Others contain “hammer” clauses, which provide that if the carrier believes the case should be settled and there is an opportunity to settle for a sum certain, you will be liable for any excess judgment if you withhold your consent.
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Mistake 1  Letting Pride or Sense of Injury Get in the Way
Being sued is a traumatic experience, and some physicians develop symptoms of depression or anxiety. It is natural for a physician to be outraged and feel that he or she has done nothing wrong and will therefore be vindicated at trial. The physician may also want to avoid a report to the National Practitioner Data Bank and the state medical board.

**Action Step**  Physicians should never base the decision to go to trial on their sense of having been wronged. In a worst-case scenario, not settling can lead to a judgment in excess of a physician’s insurance coverage and can potentially expose the physician’s personal assets. Sometimes a settlement is, literally, the best approach to “damage control.”

Mistake 2  Thinking That a Trial Is a “Search for the Truth”
Unfortunately, even if the physician’s treatment and documentation were flawless, the physician will not necessarily prevail at trial. Medical malpractice cases are often decided on the basis of the personalities of the parties, attorneys, and expert witnesses as much as the medicine. If the plaintiff has an obvious injury, and the plaintiff’s attorney and expert have better courtroom skills than the defense team, there is a good chance of a plaintiff’s verdict even if, from a medical perspective, the expert’s theory of departure and causation is questionable.

Even the trial venue and the judge’s personality can make a difference. If, for example, the defendant doctor is an affluent, highly trained specialist who appears somewhat aloof, he or she may not be very well received in a county where the jurors are from different socioeconomic or ethnic backgrounds, particularly if the jurors share the same background as the plaintiff. Similarly, judges’ rulings may tend to favor one side over the other. Both jury demographics and judges’ reputations are well known to experienced plaintiffs’ attorneys, who, to the extent possible, carefully select their venues and even their judges.

**Action Step**  It is essential for physicians to listen carefully to the recommendations of their insurance company, defense counsel, and personal counsel, particularly if they recommend settlement after the jury has been selected. Typically, the attorney who will try the case is a seasoned practitioner who knows the system—including the judge and opposing counsel—and has a good sense of sizing up the jurors and how they will respond to the physician defendant, the plaintiff, and the respective experts.
MALPRACTICE: WHEN TO SETTLE

Mistake 3  **Assuming a Win On Appeal**
Usually, if a decision is made not to settle, the one chance of winning the case is at trial. Physicians should not assume that if they lose at trial, before a lay jury, a wiser appellate court will dismiss the case or grant a new trial. In appropriate cases, appellate courts do dismiss cases for lack of jurisdiction or legally insufficient evidence, order new trials based on erroneous rulings by the trial judge, or reduce damages. It is extremely rare, however, for an appellate court to grant a new trial on the ground that the verdict was “against the weight of the evidence.” Appellate courts typically have a very limited scope of review of a jury’s findings. An appellate court will almost never interfere with a jury determination as to which side’s evidence was more believable, even if the plaintiff’s expert is a “hired gun” who testifies for a living and the defendant’s expert is a preeminent specialist.

**Action Step**   If the physician decides to go to trial, the physician should make sure that he or she has a realistic chance of winning at trial.

Mistake 4  **Assuming That One Can Move on in Life If the Case Is Settled**
Going to trial can take an emotional and physical toll on a physician. It can also be costly in terms of lost income, particularly for a solo practitioner, and there is no guarantee of winning. Therefore, notwithstanding the necessity of a report to the data bank, the prospect of settlement may seem tempting. Again, the issue is analogous to “informed consent.” Physicians must understand all the consequences of a settlement in their particular state, even if this means consulting an attorney specializing in professional disciplinary proceedings.

At a minimum, any settlement will have to be reported to the state’s medical board as well as to the National Practitioner Data Bank, and the state repercussions may actually be more damaging. Some physicians have settled, hoping to “buy their peace,” only to be summoned before their state boards, months later, and given a choice of relinquishing certain privileges or taking remedial education. Contesting the board’s decision may mean hiring attorneys and paying the expenses of a reconvened board meeting. A physician (perhaps nearing retirement) who opts for a limited license may have to explain the “limitation” every time he or she writes a prescription and may be listed in the data bank as having a “license probation.” Finally, the renewal of hospital privileges and membership on managed care panels may be jeopardized.

**Action Step**   Again, a settlement may still be the best resolution of the case, but it is important for the physician to be prepared for a possible investigation by his or her state board. On the other hand, if the case appears defensible, the prospect of settling only to have to defend the same charges again, this time at the physician’s own expense, may tip the balance in favor of trial.

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Mistake 5  Not Recognizing That Certain Cases Should Be Settled
Some cases should be settled, and the sooner the better. Obvious examples include cases of clear liability where a doctor amputated the wrong leg or took out the wrong kidney, or cases involving altered medical records. Altered records will almost certainly be discovered; indeed, plaintiff’s attorneys employ skilled experts to help them find back-dated chart entries. To a jury, even a well-intentioned change in medical records, if not done correctly, may appear as a deliberate attempt to conceal malpractice, and seem morally worse than the alleged malpractice itself. This prejudice may carry over to trial and even to appellate judges, and overwhelm what might otherwise have been a strong defense.

Action Step  If liability is clearly established by the chart, or there is an alteration that can be exploited by plaintiff’s counsel, an early settlement may be the only means of avoiding a verdict in excess of insurance coverage or an award of punitive damages, which, by law, usually cannot be indemnified by insurance.

Mistake 6  Not Being Objective About Inadequate Charting
Settlement may also be advisable even if the care was appropriate and there was no deliberate tampering with chart entries. If the charting is inadequate, it may be the doctor’s word against the plaintiff’s, and if the jury likes the plaintiff better, the plaintiff will probably prevail.

Physicians should be objective in deciding whether the hospital chart or the office records support their position that they rendered appropriate treatment. Perhaps, for example, the physician made a splint for a patient’s broken arm and returned a standard-size splint to the hospital supply room because it did not fit, but the chart shows only that the standard-size splint was sent back and that the patient’s arm was immobilized with a sling because the physician forgot to document the splint he or she improvised. If the plaintiff says the physician used only a sling, and the plaintiff’s expert says the absence of a splint caused the injury, the plaintiff will probably win because the chart does not support the physician.

Action Step  Physicians should discuss any concerns about inadequate documentation with defense counsel. Anything physicians tell their attorney is privileged and cannot be disclosed, without the physicians’ consent, to the medical board or anyone else.

Mistake 7  Underestimating Potential Damages in Catastrophic Injury Cases
Many physicians have primary insurance coverage of $1 million. Some doctors also have excess coverage, which may be provided through the hospitals with which they are affiliated. Even coverage of several million dollars, however, may not be enough in the case of catastrophic injury, as, for example, an infant with severe neurological impairment. Juries in

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3Polacek, op. cit.
such cases typically award damages not only for pain and suffering—which can be in the millions of dollars if the state has no cap on noneconomic losses—but also for long-term custodial care and medical treatment. Projected over the course of an infant’s lifetime, this can add up to tens of millions of dollars.

In such cases, the stakes may simply be too high to gamble on a defendant’s verdict, particularly if there are no codefendant hospitals with multiple layers of excess coverage. This does not mean that every case involving catastrophic injuries should be settled. It is important, however, to understand the worst-case scenario and the physician’s chances of prevailing at trial.

**Action Step** Physicians who decide to go “all the way” may want to consult personal counsel as to the consequences of a judgment in excess of policy limits, including what assets would be subject to seizure and whether the judgment could be discharged in bankruptcy.

**Mistake 8 Not Taking an Active Role Early On**
Perhaps as a form of “denial” or psychological defense mechanism, some physicians have little contact with defense counsel until it is time for depositions and then trial. This can make it more difficult to come to an informed decision about settlement.

**Action Step** To avoid this dilemma, physicians should start taking an active role in their defense almost as soon as the summons or notice of intent is served. For example, they should ask for copies of expert reviews from their insurer, which probably conducted an in-house review soon after the case commenced and may also have obtained an outside review in their particular specialty. If the insurer’s expert reviewers found deficiencies in the treatment, the plaintiff’s expert will almost certainly do so as well.

Similarly, physicians should keep in close contact with defense counsel. Ideally, defense counsel should forward regular reports about the status of the case, depositions, court conferences, etc., but sometimes these reports are sent only to the insurer. Physicians should make it clear to defense counsel that they want to be kept up to date about the case, particularly key events, such as the plaintiff’s deposition and how credible the plaintiff appears, so that they will not have to make a hasty, last-minute decision about whether to settle.

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8According to the Insurance Information Institute, 26 states now have caps on noneconomic damages.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

Mistake 9  Not Getting a Second Opinion If the Insurer Pressures for a Nominal Settlement
Occasionally, the interests of insurer and insured diverge. Perhaps, for example, the insurer wants to settle for the “nuisance value” of a case that does not involve particularly serious injuries. From the insurer’s perspective, a settlement of $10,000 to $15,000 would likely be cheaper than defending the case at trial. Such settlements, however, must still be reported to the data bank and state board, and from the physician’s perspective, the settlement may not be worth the potential repercussions if the case seems defensible.

Action Step  In such a case, it may be worthwhile for the physician to hire his or her own attorney to review the case and give a “second opinion” as to its defensibility. If the personal counsel agrees that the case is defensible, he or she can then put pressure on the insurer to defend the physician vigorously instead of settling for nuisance value.

Mistake 10  Not Getting a Second Opinion If There Are Claims Potentially Outside Coverage
Physicians want personal counsel to give them a second opinion and represent them in their dealings with their insurer if the damages sought are in excess of their coverage or there are certain claims outside their policy, such as claims for punitive damages or intentional conduct. Such claims are particularly common in cases of psychiatric malpractice, in which the plaintiff may assert a claim for what is euphemistically termed “undue familiarity.” Typically, such claims are excluded from the scope of professional liability policies.

Regardless of whether there is any basis for such a claim, it puts defense counsel retained by the insurance company in a difficult position. Ethically, the attorney’s obligation is to the physician as the client, but on the other hand the attorney has been hired by the insurer to defend those claims that are within the policy. As a result, the attorney may not be able to conduct the necessary investigation or retain the necessary experts to defeat the intentional conduct claim.

Action Step  In such cases, physicians should hire personal counsel to advise them as to those claims outside the policy. Depending on the terms of the policy, the insurer may be willing to pay for personal counsel, but even if it is not, a physician should still retain personal counsel at his or her own expense. If liability on a claim outside the policy seems clear, personal counsel may be able to work with the insurance carrier and defense counsel in negotiating a favorable settlement that will dispose of all claims.

Conclusion
Whether to settle or go to trial may seem to pose a “Hobson’s choice” between two equally daunting alternatives. Avoiding these mistakes may not make the choice easier, but hopefully
will enable physicians to make an informed decision that will minimize the effect of the lawsuit on their life, career, and reputation.

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17.3 The 10 Biggest Legal Mistakes Physicians Make When Faced with an Abandonment Claim

By Benjamin Goldstein, Esq.

Executive Summary

When a claim is made against the physician for abandonment, the action the doctor takes can lead to devastating consequences or it can reduce the claim to a minor disruption of the doctor’s practice and lead to a favorable result. Physicians should be aware of the mistakes to avoid and the action steps that lead to a favorable outcome.

Mistake 1  Failing to Segregate the Patient’s Records

When a physician receives notice that a claim is being made or is about to be made, the physician should immediately separate the claimant’s records from those of other patients. Sooner or later a request will be made by a government agency or by a lawyer representing the claimant. The failure to have these records available can lead to separate claims and unfavorable inferences against the doctor for failing to keep records appropriately. This failure can be especially damaging in an abandonment claim, since the physician will be asked to show that treatment was no longer necessary at the time of the termination of the relationship and the physician’s records will be invaluable in that regard. Additionally, the failure to have the patient’s records available will always serve to enhance the claim by making the physician look careless.
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**Action Step** Physicians should segregate a claimant’s records immediately upon receipt or notice of a potential claim.

**Mistake 2  Altering the Medical Records in Any Way After a Claim Is Made**
When a claim is made against a physician for abandonment, there may be a significant temptation to change or alter the records in some way, either to eliminate something in the records or to add to them. Physicians should resist this temptation at all costs. Both sophisticated and unsophisticated tests are available to determine if records have been altered in any way. If a claimant can prove that the records have been altered, everything else that the physician does in the case will be suspect. Also, altering records in any way after a government agency or an attorney has subpoenaed them in a malpractice case is a criminal act. Many cases that were defensible on the part of the physician have been lost once alteration of the medical records is proven.

**Action Step** Physicians should never alter medical records after the fact.

**Mistake 3  Failing to Notify the Insurer Immediately**
Almost all medical malpractice policies contain a clause that requires the physician to notify his or her insurer immediately upon knowledge of facts that could give rise to a claim of abandonment. The failure to do so jeopardizes the physician’s coverage under the insurance policy. A physician may well and truly believe that the claim is frivolous or without merit; nonetheless the insurer must be notified. Where the physician is notified that a government agency is looking into a particular allegation against the physician by a patient, the insurer should be notified even though no malpractice civil case has been filed. An adverse finding by the government agency may lead to a civil case and the insurer may later take the position that waiting until an actual suit had been filed was too late.

**Action Step** Physicians should notify their insurers immediately upon knowledge that a claim might be made against them.

**Mistake 4  Attempting to Speak With a Patient to “Straighten This Out”**
Once the physician receives notice from a government agency or an attorney that an abandonment claim is being made, the physician should not attempt to make any direct contact with the patient or the patient’s lawyer. Tempers can flare, words and conversations can be misconstrued, and in some states it is perfectly legal for the patient or the patient’s attorney to tape the conversation without the physician’s knowledge. At best, such an attempt at communication may be viewed as an admission of liability; at worst, it may be viewed as an attempt to intimidate the patient. If a patient’s attorney attempts to contact the physician, the physician should direct all communication to his or her insurer, advising the patient’s attorney of the name of the insurance company and the claim number.
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Action Step Physicians should not try to contact or communicate with a claimant once a claim is pending.

Mistake 5 Refusing to Turn Over the Patient’s Records When Requested
If a request is made for a patient’s records either by a government entity with an authorization from the patient or by the patient’s attorney with an authorization from the patient, those records should be turned over immediately. Many states provide separate penalties for failing to turn over records within a specific period. Even if there is no sanction for withholding the records, the fact that these records were withheld for an inordinate period of time may later be used against the physician. (See discussion in Mistake 1.) Also, many states have enacted special legislation to protect physicians from malpractice cases as part of tort reform efforts to reduce malpractice premiums. These protections can be lost if the physician fails to provide the legally requested records.

Action Step Physicians should provide copies of the patient’s records upon having them subpoenaed or requested with proper authorizations.

Mistake 6 Failing to Get Personal Counsel If the Claim Has the Potential to Exceed Insurance Policy Limits
When a claim is reported to the physician’s insurer, the company will appoint an attorney to represent the physician. This attorney’s first loyalty is to the physician, not to the insurance company. However, the attorney is not ethically permitted to take action on behalf of the physician that may be against the interests of the insurer. If the claim has the potential to exceed the physician’s policy limits, the insurer will likely notify the physician of this fact and suggest that he or she obtain personal counsel. This is good advice. Although the physician will have to pay for personal counsel, it is a good investment when a claim is made against the physician. The personal counsel should be kept advised as the litigation progresses, should have access to relevant documents and evidence, and should be able to act on behalf of the physician with the insurer in the event personal counsel believes a settlement is in the physician’s best interest.

Action Step Physicians should always obtain personal counsel if notified by their insurer that a claim may exceed policy limits.

Mistake 7 Refusing to Allow the Insurance Company to Settle a Claim Even If Advised to Do So by the Carrier or the Personal Attorney
Many physicians are extremely reluctant to settle abandonment claims for fear of damage to their professional reputation, an increase in their malpractice insurance premiums, and the necessity of reporting the claim to the National Practitioner Data Bank under federal law. Failing to settle can be a mistake that exposes the physician’s personal assets to a judgment. Most claimants’ attorneys explain to their clients the benefits of settling the claim within the
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doctor’s insurance policy limits of liability unless the doctor is seriously underinsured. Insurance is designed to protect personal assets; therefore, when a claim is made and the physician is advised to settle by competent counsel, it is a mistake not to do so.

**Action Step** Physicians should follow the advice of competent counsel when determining whether to settle a claim.

**Mistake 8  Failing to Be Fully and Completely Honest With Attorneys**
The physician who is dealing with a malpractice claim for abandonment and has sought personal counsel needs to be fully honest with both attorneys if they are to appropriately defend against the claim. As with altering records, a defensible case may become indefensible if the physician’s credibility is damaged as a result of having made even an innocent misrepresentation. The physician must be completely forthright with his or her counsel. Very often a claim of abandonment will specifically turn on an issue of credibility, in which a patient will say that the physician did not do that which the physician testifies that he or she did do. It is therefore absolutely critical to keep the physician’s credibility intact.

**Action Step** Physicians should be scrupulously honest with their counsel.

**Mistake 9  Speaking With Colleagues or Staff About the Claim Particulars**
Physicians should not speak to partners, associates, other colleagues, or staff regarding the facts of the claim. Physicians should not do so even to test ideas about defenses that may be used if they can gain support for them. Even complaining to others about the unfairness of the particular claim should be avoided. Unlike conversations with lawyers, these conversations are not privileged. Anyone with whom the physician spoke regarding the claim could be subpoenaed and asked to testify regarding the conversation. Even innocent, fact-finding conversations on behalf of the physician can be made to look like witness tampering. Also, the physician’s credibility can be adversely affected if the witness remembers the conversation differently than the physician does. If the physician believes that a colleague or staff member may have information helpful to his or her claim, the physician should advise his or her attorney, who will interview that person and obtain a statement.

**Action Step** Physicians should not discuss the facts of any claim with anyone except his or her attorney.

**Mistake 10  Failing to Understand the Nature of the Claim of Abandonment and the Defenses Thereto**
While physicians are not lawyers and while it is clearly the attorney’s job to understand the claim and present the appropriate defenses, the physician should have some knowledge of the legal basis for the claim and the defenses available. (Reviewing the section in this book, “The 10 Biggest Legal Mistakes Physicians Make That Lead to Claims of Patient Abandonment,”
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is a good first step.) Additionally, the physician should meet with counsel and have the abandonment claim explained fully and pay particular attention to the law relating to abandonment in the physician’s jurisdiction. Also, the potential defenses should be reviewed so that the physician has an understanding of what they are. Eventually, the physician will be called on to give testimony under oath before a government agency, in a deposition, or in court. Having an understanding of the legal nature of what the claim is about as well as the defenses being raised on the physician’s behalf will be invaluable in that circumstance.

**Action Step** Physicians should become familiar with the legal nature of the claim and the available defenses.

**Conclusion**
When a claim is made against the physician for abandonment of the patient, the physician should review these mistakes and obtain competent counsel as soon as possible. Avoiding these mistakes can greatly increase the chances of a favorable outcome.

**Additional Resources**
- Seak, *How to Be an Effective Medical Witness* (video distributed by the AMA)

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THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

17.4 The 10 Biggest Legal Mistakes Physicians Make When Reporting and Not Reporting Cases to Malpractice Insurers
By James C. Goodwin, Esq.

Executive Summary
One of the more troubling situations physicians face during their careers is that inevitable day when they must decide whether to report a potential claim to their malpractice insurer. The fact that this question often arises on the heels of either a patient problem or a patient conflict only makes matters worse. After all, physicians practice medicine out of a desire to help people. When they fail in that endeavor, or are at least perceived to have failed, they are emotionally affected, and potentially so is their livelihood. After all, reporting can sometimes trigger review by those who grant hospital privileges, credentialing with health insurance networks, or even self-reporting obligations to state licensing agencies. But many physicians let their emotions or their fears about the resulting effect on their medical practice get in the way of a rational reporting response. These 10 commonsense recommendations may just help keep physicians out of trouble.

Mistake 1 Not Reading the Policy
Instead of wondering whether to report, physicians should pick up a copy of their policy and spend a minute reviewing it. Does the policy require them to report certain things but not others? Most, but not all policies, have a requirement to report potential lawsuits, insurance claims, and sometimes even patient complaints or threats. Some policies even require that physicians report in a specific manner, such as in writing or verbally. Many policies have requirements that physicians report within a certain amount of time.

Action Step Physicians who do not understand the requirements of their policies, and perhaps even if they think they do but are not quite sure, may want to meet with an attorney to have their questions answered or call their insurer for guidance.

Mistake 2 Thinking “Ignoring It Will Make It Go Away”
Ignoring it will not make it go away. If something happens that is atypical enough to cause a physician to fret over it or to want to avoid dealing with it, then that physician is dealing with exactly the type of issue that should be reported to the physician’s insurer. Sometimes it may be a bad outcome resulting from bad care. More often, it is simply a bad outcome, which can occur even when the physician thinks he or she did everything right. Patient dissatisfaction is a simple fact of life and learning how to deal with it appropriately is an entirely different topic all together.

Action Step The goal here is simply to figure out when that dissatisfaction is serious enough to warrant reporting to the insurer. In general, if a patient has taken time to write
down his or her concerns, then they are serious and the physician should report. If a patient has taken time out of a busy schedule to see the physician without making an appointment, the physician should report. If a patient has telephoned multiple times or continues to express concerns even after the physician has explained the situation to the best of his or her ability, the physician should report. If a patient’s attorney calls, the physician certainly should report. Conversely, if a patient merely expresses some grumbling after a procedure but has not followed up, then depending on the situation, the physician may be okay not reporting. In situations in which the physician is personally concerned that he or she may have been negligent, the physician must analyze the degree of any resulting harm. If it was something as simple as not charting appropriately, but without resulting harm, then the physician probably does not need to report. On the other hand, if a patient’s health was affected, the physician probably should.

Mistake 3 Thinking “Reporting Will Cause My Rates to Rise”
Malpractice insurers recognize that mistakes are inevitable. They are in the business of paying money to compensate for those mistakes. The earlier they can get involved in the process of evaluating errors, the better financial decisions they can make. Physicians also will be better off personally in situations in which a report leads to the determination that counsel should be appointed for you. Attorneys who represent doctors always want to represent them as early as possible.

Action Step Having knowledgeable legal counsel on board from the start can help avoid the types of mistakes that can quickly turn a precautionary matter into full-blown litigation. In addition, it is a fact of life that attorneys cost a lot of money, so the sooner a bad case can be identified and settled, the better it is for everyone. Conversely, if it is not a bad case, but the physician is confronted by aggressive patients, their family members, or their attorneys, then all the more reason for the physician to get help from his or her malpractice insurer quickly. (See Mistake 2.) Physicians should leave the legally maneuvering to the experts; in doing so, they will avoid a lot of personal stress.

Mistake 4 Thinking “Not Everything Needs to Be Reported”
While there certainly is a time for putting the right spin on things, and revealing only what absolutely must be revealed, this is not one of those times. Again, malpractice insurers are on the physician’s side.

Action Step To assist a physician, insurers need to know the full extent of the problem and the resulting possible harm. There is a caveat, however. Most insurance policies have clauses that permit malpractice insurers to deny coverage if the physician has intentionally engaged in wrongful behavior, such as in a criminal act, or perhaps by altering evidence to cover up potential mistakes. Although rare, physicians who find themselves in such a position should make their first telephone call to an attorney. (See Mistake 1.)
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Mistake 5  Thinking “I Can Handle This Myself”
Some physicians believe they can give a patient a personal check and settle the issue without having to report. The idea, apparently, is to settle for a few thousand dollars in order to avoid a potential huge increase in malpractice rates. Those physicians should remember that they are doctors not salesmen. Even worse, some physicians find themselves in a position of having done something that causes them concern that they may be denied coverage. These physicians need an attorney not only to help evaluate how best to deal with the insurer, but possibly how best to defend them in a potential criminal action. Even if the issue is not that serious, physicians absolutely must avoid any urge to try and alter prior negligence by modifying records or covering up evidence. The accidental “loss” of a chart, a page from a chart, film, and so on can actually prove more damaging than the contents of it would have been in the first place. In most jurisdictions, if evidence is lost or destroyed, jurors may be told that they can presume that it contained damaging evidence. Even records that still exist but have been altered can prove to be a physician’s downfall.

Action Step  Medical charts get copied repeatedly and distributed to many different entities, including other health providers, health insurance networks, and the patients themselves. Good trial attorneys track all those copies down and compare them. Good trial attorneys hunt documents for a living; physicians do not. Good trial attorneys know handwriting experts; physicians do not. In such situations, physicians would be well advised to seek a good trial attorney.

Mistake 6  Not Cooperating After Reporting
Physicians should not presume that, without their assistance, their insurer will be able to handle everything after they report. Even the best claims representative is almost never a physician, and if medicine were easy, everybody would do it. The insurer and the attorneys it hires need the physician’s expertise, advice, and time. Often, they also need the physician’s records, and that may mean all of the records. They may need films, consultations, billing statements, and phone records, and they may need the physician to take the time to help explain all of those records to them. A physician cannot just stick it all in an envelope with a sticky note on top saying “deal with this,” drop it in a mailbox, and then walk away. In such situations, if a physician is lucky, a simple telephone call may suffice, and the report of a potential problem will simply end up in the files and computer systems of the malpractice insurer until the statute of limitations passes and everything is purged.

Action Step  If a physician is unfortunate enough to be the recipient of a lawsuit stemming from an incident that he or she reported, that physician will certainly have to make time to work with his or her insurer and the counsel that they retain to represent the physician. The physician is a critical member of that team, and even if it is not convenient, easy, or pleasant, the physician’s personal participation in the process can make all the difference in the world.
MALPRACTICE: REPORTING TO INSURERS

Mistake 7  Blaming Another Provider
Physicians often get lulled into thinking that they can avoid litigation or medical board complaints if they can simply make a patient or a patient’s family (or even the patient’s attorney) understand that the problem was the result of something someone else did. Typically, the only result is that the “someone else” is now going to be confronted and possibly sued too, and then that person is going to be inclined to point the finger right back at the one originally blamed. Even if a physician is not targeted, arguments that he or she controlled the actions of others are fairly common, and even if such an argument is not raised, then someone is probably going to claim that the physician should have discovered the error and done something to fix it.

Action Step  When the subpoena to appear at deposition arrives at a physician’s door, even if it is only about the care he or she provided to a patient who happened to have received negligent care by someone else, the physician should call his or her insurer. Doctors who are not represented by an attorney at deposition are at risk of saying something that may come back to haunt them. While the insurer may not be guaranteed to provide courtesy counsel to appear at a deposition such as this, most of the time the carrier will choose to hire counsel for the physician. The hour or two the physician spends with an attorney preparing for a deposition may save the physician many hours of grief later.

Mistake 8  Thinking That Making a Mistake and Reporting it Will Be Ruinous
Many doctors are still practicing medicine who have settled claims and/or received verdicts resulting in payment of policy limits of their malpractice insurance, with a resulting report filed with a credentialing agency. Those physicians are still practicing because everyone knows mistakes are inevitable but recognize that it is often how physicians address those mistakes that makes all the difference.

Action Step  Even if a physician’s first inclination is to beg for forgiveness from a family, a patient, or an attorney who wants to sue, the physician should start by making a report to his or her insurer. The insurer can help the physician determine the best way to deal with the problem and get an attorney if necessary. Physicians should remember that telling someone that they are sorry for their loss is vastly different from telling someone that they are sorry because they caused their loss. Expressing sympathy and compassion is natural and generally a good thing to do, but before confessing responsibility, a physician should make a report to his or her insurer.

Mistake 9  Not Reporting All Problems
Just because a physician has had multiple reports in the recent past does not mean that the next report is any more or less worrisome than the underlying facts it is based on. Sometimes the only reason for having to make multiple reports is because the physician ran into a particularly ornery group of patients, or a particularly litigious attorney who represents them.
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**Action Step** Some attorneys intentionally try to sue a doctor multiple times in a serial fashion knowing that the pressure of defending multiple lawsuits tends to be cumulative and may lead to a doctor eventually throwing in the towel. Insurers recognize this strategy and are good at evaluating each claim on its own merits, and physicians should recognize this in making their decision whether to report.

**Mistake 10 Reporting Everything** Physicians should not be nervous about every potential problem. Just as they cannot go about admitting into the hospital every patient who stubs a toe, they need to evaluate how serious the issue is before reporting to an insurer.

**Action Step** Physicians who are waffling about whether there is a need to report should refrain from discussing the matter with a colleague to get a second opinion because such conversations may later be admissible as evidence. Instead, the physician should consider calling a knowledgeable malpractice attorney for advice. When in doubt, the default should probably be to pick up the phone and call the malpractice carrier. Most malpractice insurers will not actually open a report file unless they also deem the matter to be sufficiently worrisome.

**Conclusion** Physicians pay a lot of money to obtain malpractice insurance, but they do not always make the best decisions when it comes time to decide how to deal with a potential claim. It is inevitable that they will need to decide how best to respond to a potential claim and must resist the urge to simply ignore potential problems. Malpractice insurance is there for a reason, so if physicians take the time to report the claims that should be reported and participate in whatever process that ensues thereafter, they will be much more satisfied with the outcome.

**About the Author**

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Executive Summary
It is an unfortunate fact that physicians increasingly face litigation alleging medical negligence. One of the most important phases of medical negligence litigation is the deposition of the defendant physician. Deposition testimony often sets the stage for the rest of the litigation process, and deposition mistakes can be both difficult and sometimes impossible to overcome at trial. Deposition testimony will serve as part of the foundation for experts testifying on behalf of the plaintiff as well as the defendant physician, and can often severely limit the effectiveness of defense theories.

Mistake 1  Failing to Be Familiar With the Details of the Medical Record
There are many reasons physicians may give deposition testimony without having first closely read the entire relevant record. These include constraints on their time, their belief that they can remember the file and deal with questions on the record at the time of the deposition, and the tendency of physicians to concentrate solely on their portion of the relevant records. In most instances, plaintiff’s counsel will have invested considerable money and time in the case before the physician is deposed. In fact, plaintiff’s counsel will be intimately familiar with every detail of the record, and will usually question the physician on the entire record, not just the portion the physician completed. It is often these details that can make or break a case, and if the details have not been studied and considered, the testimony given without this forethought can be disastrous. For example, a physician may list several reasons a particular differential diagnosis was not considered, only to learn that these reasons are not supported by the entire record, which can and has led to physicians inadvertently agreeing that they did not meet the standard of care in a patient’s treatment.

Action Step  Physicians should understand and appreciate that their deposition testimony is one of the most important phases of the litigation process, and they should take the time to become familiar with the details of the entire record and to consult with counsel regarding all areas of concern raised by such review.

Mistake 2  Failing to Understand or Appreciate the Plaintiff’s Theory of the Case
One of the biggest mistakes a defendant physician can make is to go into his or her deposition with blinders on as to the plaintiff’s theory of a case. Plaintiff’s counsel will have both a broad theory of the case and specific theories about the medicine and the standard of care. A physician who makes the mistake of not considering the plaintiff’s position will not be fully prepared to give deposition testimony. It is impossible to fully and adequately prepare for a deposition without examining the plaintiff’s theory, what support there may or may not be for
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that theory, and what the defense or response will be to the theories put forth by plaintiff’s counsel.

**Action Step** Physicians should not narrowly focus on only what they believe the case is about, but also should give thought to the medical evidence the plaintiff might rely on and what medical evidence exists to refute the plaintiff’s theories.

**Mistake 3  Trying to Talk or Explain a Way Out of the Lawsuit**
Often, physicians will believe strongly that the care and treatment provided were appropriate and that they can explain why a certain course of treatment was taken and the medicine behind the decisions in such a way that plaintiff’s counsel will surely see that the plaintiff has no case and give up. This scenario will not happen. What will happen is that the physician will fail to understand or appreciate the plaintiff’s theory of the case (Mistake 2), and will talk too much and volunteer information that almost inevitably leads to results that are less than satisfactory (Mistake 8).

**Action Step** Physicians should not assume that if they educate plaintiff’s counsel on the medicine involved, the case will be dropped. They should listen to and follow counsel’s advice and save this educating for the jury.

**Mistake 4  Blaming the Patient or Other Health Care Providers**
While it may sometimes be appropriate to place fault on the patient or another health care provider, it is rare that this is an appropriate defense of a physician’s conduct. In medical negligence cases, the plaintiffs are often suffering from a significant illness or condition, and the jury will be sympathetic to their illness or condition and with their position of being in a subjective role to the physician from whom they sought treatment. When another health care provider is faulted, the physician can count on that health care provider to fault him or her in return, and when defendants point fingers at each other, both defendants lose.

**Action Step** Except in rare circumstances and upon the advice of counsel, physicians should concentrate on explaining and defending their care and treatment, and not blame others.

**Mistake 5  Being Less Than Honest About the Facts or Records**
When someone is blamed for causing injury or damages to another person, it is human nature for the person being blamed to search for every possible explanation for why the claim is false. While rare, this situation sometimes results in physicians taking liberty with the facts. An even rarer occurrence, but one that does happen, is when a physician who becomes aware of potential litigation seeks to alter the medical records in his or her favor. When this impulse to defend one’s self rises to the level of dishonesty or falsifying records and is discovered, the physician will lose, regardless of the quality of care and treatment provided to the patient. If
the jury believes that a physician is lying, or even thinks the physician might be lying, the physician will lose and the jury will punish the physician with a verdict that is worse than what might have otherwise occurred. In addition, such actions by a physician may jeopardize his or her insurance coverage.

**Action Step** Physicians should zealously defend their care and treatment, but should never lie or falsify records.

**Mistake 6  Failing to Pay Sufficient Attention to Questions**

One of the most important rules about giving deposition testimony is: Listen to the question, make sure you understand the question, and answer only the question. Plaintiff’s counsel will often change the facts of the case when he or she asks a question, and failure to pick up on this kind of questioning will result in the wrong answers. Often a question will leave out sufficient information for the physician to give an answer, but the physician who is not paying attention will answer anyway. For example, plaintiff’s counsel may ask the physician what the proper treatment is for a certain condition, but fail to include in the question necessary facts, such as the severity of the condition, comorbidity conditions, and the patient’s age. Responding to such questions without requiring more details will often result in a suggested treatment that does not correspond to the treatment given in the case at hand or an incomplete suggested treatment, which will leave the physician open for impeachment later in the deposition or at the time of trial. In addition, failure to pay sufficient attention to the question will often result in information being unnecessarily volunteered, which results in the problems discussed in Mistake 8.

**Action Step** Physicians should always make certain before answering a question in their deposition that they heard and understood the question that they are answering, and that they do not respond to questions that contain incorrect factual recitations or insufficient facts.

**Mistake 7  Arguing With Plaintiff’s Counsel**

As a general rule, physicians know more about medicine than the plaintiff’s lawyer. It is likewise true that no physician is happy to be the subject of a medical negligence lawsuit and to have his or her competency called into question. For this reason, and for no doubt numerous other reasons, physicians often will be confrontational with plaintiff’s counsel during their deposition testimony. Plaintiff’s counsel essentially argues for a living, and the more successful plaintiff’s counsel is, the more likely it is that he or she is very good at arguing. The general rule is that if a physician argues with plaintiff’s counsel, the physician will lose the argument (this is hard to accept) and end up making Mistakes 3, 6, 9, or 10.

**Action Step** Physicians do not have to agree with plaintiff’s counsel and should firmly disagree when appropriate, but they should avoid engaging in arguments with plaintiff’s counsel during their deposition testimony.
Mistake 8  **Volunteering Information**  
Volunteering information is a mistake that 90% of all physicians make when giving testimony on their own behalf but it is a mistake that is 100% avoidable. The deposition is not the time for the physician to present his or her case. Each question asked by plaintiff’s counsel should be answered fully and completely, but no additional information should be volunteered. There are some very good practical reasons for this advice:

- If plaintiff’s counsel does not ask for the physician’s explanation, the counsel may not know the explanation until he or she hears it for the first time at trial;
- If the physician divulges information to plaintiff’s counsel in the deposition when it was not asked for, the physician will provide plaintiff’s counsel with all of the time between the deposition and trial to prepare a response;
- If plaintiff’s counsel does not ask for and receive the physician’s explanations for the way the physician treated the patient, plaintiff’s experts may make erroneous assumptions, which can then be challenged at trial; and
- When information is volunteered, it may lead to further questions that may not have been asked otherwise, to damaging testimony that would not have been otherwise elicited, and will always result in a longer deposition.

**Action Step**  
Physicians should fully answer each question, but not volunteer information beyond what is needed to answer the question.

Mistake 9  **Being Too Defensive**  
While concentrating on defending themselves in a deposition, physicians will often cross the line in answering questions from giving well-reasoned and thoughtful responses to becoming too defensive. This sometimes results from the physician reading too much into the questions being asked and interpreting almost every question as some form of trick question. When this happens, physicians become overly cautious in responding to even simple questions, which should readily be answered. For example, when asked whether he would agree that his number one priority is the patient’s health and well-being, an overly defensive physician, thinking that this a trick question or not wanting to be seen as “agreeing” with plaintiff’s counsel, may hesitate or not give a direct answer. When this pattern of answering pervades the deposition, it will result in the physician not agreeing with very obvious things or giving poor answers to straightforward questions, which will often cause the jury to doubt the physician’s testimony or credibility on all of the issues in the case.

**Action Step:**  
Physicians should avoid being overly defensive, since doing so will affect their credibility on all aspects of the case.

Mistake 10  **Failing to Consider the Overall Presentation**  
Like it or not, a trial is at least in part like the theater. If the jury does not like a physician or thinks the physician is arrogant, sloppy, or insufficiently familiar with the medicine, the
physician will likely lose. Many depositions are videotaped and played to the jury, so the jury will not only hear the physician’s words in the deposition but will also see the physician’s presentation. Physicians must remember that, by their presentation, they are leaving an impression with the jury. The impression should be that the physician is competent, confident but not arrogant, and caring. Anything that detracts from that impression, including the clothing and personal hygiene of the physician, can harm the physician’s case.

**Action Step** Physicians should consider their overall presentation and should groom, dress, and act in a manner that leaves everyone involved with the impression of competency, confidence, and concern for the patient’s welfare.

**Conclusion** Physicians who are giving a deposition on their own behalf and avoid these mistakes and listen to and follow the advice of experienced counsel will optimize their chances of obtaining a favorable outcome.

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17.6 The 10 Biggest Legal Mistakes Physicians Make in Dealing with Their Appointed Malpractice Attorneys
By Steven I. Kern, Esq.

**Executive Summary**
When confronted with a medical malpractice complaint, physicians rely on their appointed malpractice attorneys for their first line of defense. But the lawyer appointed by the malpractice insurer may not always have the physician’s best interests at heart.

**Mistake 1 Thinking That the Insurer Has the Same Interest as the Physician in Winning the Case**
The existence of the physician’s insurance company is predicated on its ability to remain profitable. While it is often true that making money means winning cases, that is not always so. Sometimes the cost of defending a case can far exceed the cost of settlement.
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**Action Step** When purchasing malpractice insurance, physicians should look for policies that require their consent before an insurance company can settle a case (even if it means an additional premium). Physicians should keep in touch with their appointed counsel, and make sure he or she is pursuing an aggressive defense. Physicians who start to get pressure to settle should seek a second opinion, preferably from an experienced health care attorney who truly understands all of the consequences of a settlement.

**Mistake 2  Thinking That the Insurer’s Appointed Attorney Will Devote All Necessary Resources to the Defense**

A corollary to Mistake 1 is assuming that the insurer’s appointed attorney will have available all necessary resources to properly defend the physician. Often, the costs of mounting an “aggressive” defense are far greater than the costs of mounting a modest defense, and the increased risks of loss to the company do not warrant the increased expenditures necessary to provide that aggressive defense. Most times, an appointed lawyer must ask for permission to perform even the most basic tasks, such as hiring an expert, pursuing legal research, filing discovery motions, or conducting surveillance of a patient thought to be exaggerating injuries. When the costs of these tasks are thought to be greater than the perceived economic benefit, permission is denied and the attorney must do without. Additional experts, more research, heightened investigation, and extra discovery may be rejected in favor of a less expensive, quick settlement.

**Action Step** If a physician’s attorney has been denied permission to do what the physician believes the attorney should be doing to properly defend him or her, the physician should hire personal health care counsel to analyze the defense. If the personal health care attorney decides that things haven’t been done that should be done, the physician should have the personal health care attorney demand that the necessary actions be taken. The insurer and the appointed lawyer have a fiduciary duty to the physician to provide a zealous and full defense. Through active involvement by the physician and the physician’s own counsel, the physician can ensure receiving all that he or she is entitled to receive.

**Mistake 3  Thinking That an Appointed Malpractice Attorney Has Only the Physician’s Interests to Consider**

Another corollary to Mistake 1 is to assume that the appointed attorney has only the physician’s interests to consider. As discussed in Mistake 1, while the appointed malpractice attorney is ethically obligated to put the physician’s best interests first, he or she is still being paid by the insurer. Appointed counsel understands the philosophy of the insurer and its desire to control costs, and will often, as a matter of practice, not even consider certain avenues of defense, knowing that the insurer will not approve them. Since an appointed malpractice attorney is financially dependent on the insurer and understands and accepts its defense philosophy as a prerequisite to being appointed, corners may be cut without the physician ever knowing.

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Action Step
If the initial actions taken by the physician’s appointed defense counsel do not result in the kind of defense the physician believes he or she deserves, the physician should consider having the personal health care counsel directly augment the defense, either by assisting appointed counsel or by taking over the case. This step may require the insurer’s permission. In certain cases when such permission has been denied, physicians have brought a separate action against the insurer to pay for personal counsel due to its failure to provide adequate defense.

Mistake 4 Thinking That the Insurer’s Push to Settle Won’t Affect the Physician
In today’s environment, payment of a malpractice claim triggers, by law, mandatory reporting to the National Practitioner Data Bank and in many states reports to other government entities. Settlements can also affect state-operated Internet physician profiles, hospital privileges, and participation with managed care companies, and will almost certainly increase malpractice insurance premiums in the future.

Action Step
Physicians should not allow their malpractice insurer to settle a case without their careful consideration. The decision to settle can affect a physician’s career for years to come. Physicians should discuss the issues not only with their malpractice attorney, but with other advisers as well, including their personal health care counsel, insurance agent, and partners.

Mistake 5 Thinking That the Interests of All the Defendants Are Aligned, So That Having the Same Appointed Lawyer Makes Sense
It may be that early on in litigation every defendant’s interests appear to be the same. Everyone may be convinced that no malpractice occurred and that the plaintiff’s case is frivolous. Unfortunately, as cases get closer to trial, as discovery progresses, and as plaintiffs become more inventive in their ability to create a “villain,” difficult decisions must often be made. Fingers start pointing in every direction and the unified front that existed at the beginning of the case can rapidly degenerate into a blame game. At that time, appointed counsel’s primary interest may be to limit total liability. In so doing, the interests of any individual defendant are likely to become secondary.

A physician is entitled to have an attorney who places that physician’s interests above those of any other defendant and who will be ethically able to maintain the physician’s confidences. When one attorney is assigned to represent multiple defendants, the potential for conflict always exists. The physician’s recollection of events may be slightly different from another defendant’s recollection. More serious conflicts exist when another defendant tells the “shared” attorney something in confidence, which the attorney is ethically unable to share with the physician but which could adversely affect the physician’s defense. An even more serious conflict can occur when an opportunity arises to dismiss the physician from the case, but to the prejudice of other defendants represented by the same attorney. By representing
multiple defendants, the attorney may be unable to take advantage of that opportunity for the physician. In many states, when an attorney represents multiple defendants, the attorney-client privilege ceases to exist with respect to communications among the attorney and the multiple clients. Thus, the physician’s concerns, strategies, and secrets may become known to the other defendants.

**Action Step** A physician should demand that his or her insurer appoint an attorney who represents only him or her. Defense attorneys are usually good at working together in everyone’s interests when those interests are the same. When interests diverge, however, a physician needs to have an attorney whose interests are aligned with his or hers, even at the expense of other defendants.

**Mistake 6 Thinking That the Physician’s Interests Are the Same as Those of the Hospital at Which the Physician Is Employed**

Hospitals are always interested in protecting their names and their image. As such, even though the hospital (or its insurer) may be responsible to pay a claim, regardless of whether the fault lies with the hospital or with the physician, there is a strong interest in moving responsibility away from the hospital. When malpractice occurs at a hospital, it is usually a result of systems errors rather than one individual’s mistake. When systems errors occur, they tend to reflect badly on the hospital’s administration. Therefore, hospital administrators prefer to find an individual to blame. The most obvious target is usually a physician.

**Action Step** Physicians should never assume that a hospital’s interests are aligned with their interests. They should demand that an attorney be provided to represent only their interests. At the first sign that the hospital is being protected at the physician’s expense, the physician should retain personal health care counsel to protect his or her interests.

**Mistake 7 Thinking That Because the Appointed Lawyer Does Medical Malpractice Defense Work, He or She Must Know the Medicine**

A lawyer who does medical malpractice defense most often has no medical training. He or she went to law school, not to medical school. Most often, the medicine that a malpractice lawyer knows, he or she learned from trying individual cases. Physicians should assume that even the most experienced medical malpractice lawyer generally has less medical knowledge than the average first-year medical school student. This does not mean that the attorney is unable to provide a superb defense. It does mean that a physician must help educate the lawyer so that the lawyer knows all that must be known to appreciate what the physician did, why the physician did it, and how the physician can support it. The lawyer also needs to know how the physician’s adversary will attack the physician, the questions to ask, and how to answer the attack.
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Action Step At the earliest opportunity, physicians should help their lawyers understand the medicine, the literature that supports their decisions, and the basis for any criticism that may be directed against them. When appropriate, physicians should suggest renowned experts who may aid in their defense.

Mistake 8 Thinking That a Settlement Will Be Apportioned Equally Among All Defendants
When the same insurer represents multiple defendants, it may wish to end the case by engaging in a global settlement on behalf of all defendants. When it does so, it needs to report the settlement to the National Practitioner Data Bank and may also have to report it to various state authorities. The rules of the National Practitioner Data Bank require that payments be apportioned among all of the defendants, whenever possible. Since some insurers do not want to have to determine the relative “guilt” of each of their insureds, they simply report the total amount paid and the names of all of the participants. This can make it appear that any individual is responsible for the entire payout, and certainly works to the detriment of a minor defendant and to the advantage of a significant defendant.

Action Step When the insurer wishes to settle a case on behalf of a physician and on behalf of other defendants, the physician should demand that his or her portion of the settlement be separately apportioned, especially if the physician’s role in the case was minor. In such cases, the physician should demand that the apportionment be made based on the respective potential liability of each defendant, and not simply divided equally among all settling defendants.

Mistake 9 Assuming That the Insurer Appoints Only the Best Lawyers
Insurance companies are for-profit entities. A major cost to any insurance company is the cost of defense. Some insurers treat their appointed attorneys much like HMOs treat their physicians: bargain for the lowest fee and then renegotiate each bill. As a result, many of the best and the brightest lawyers have ceased working for insurance companies. Sadly, many have shifted to the plaintiff’s side because it is so much more lucrative. Those who remain often seek to leverage their time by using inexpensive, young attorneys to handle much of the work on a file. As a result, a physician may find inexperienced attorneys attending depositions, drafting discovery responses, or even appearing at oral arguments on motions. Even the lead attorney may be overworked and underpaid.

Action Step If at any stage of litigation the physician suspects that appointed counsel is not paying sufficient attention to the case, is allowing inexperienced junior associates to handle significant aspects of the case, or is simply not as qualified a trial lawyer as he or she would like, the physician should obtain a second opinion from a health care attorney with malpractice litigation experience. If necessary, the physician should retain his or her own counsel to assist in the defense.
Mistake 10Thinking That, as the Physician in Charge, It Is Necessary to Take Full Responsibility for Everything That Went Wrong

The “captain of the ship” doctrine that makes the physician or surgeon in charge of the case responsible for all that goes wrong has been discredited in most jurisdictions. Courts today recognize that delivering medical care and performing surgery are collaborative enterprises, requiring team effort and coordination. More often than not, medical errors do not result from isolated acts of individuals, but from systems failures at multiple levels. Simply stated, failsafes fail. Nurses misunderstand or misinterpret physician orders. Test results fail to arrive at their intended destination. Systems, procedures, and policies break down. Despite these facts, lawyers, especially those appointed by the hospital to represent physicians, may urge a physician to take the blame.

Action StepPhysicians should not blithely accept responsibility for acts that take place “on their watch.” Doctors cannot be responsible for that which they cannot control. In a hospital, physicians’ ability to control their environment is limited. They do not control the hiring or diligence of staff, the quality of systems, or the competence of other departments, such as laboratory, pathology, and radiology.

ConclusionPhysicians who have been sued should be proactive in making sure appointed defense counsel is zealously representing their best interests.

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MALPRACTICE: Defending a Malpractice Claim
By Angela Elsperger Lord, Esq.

Executive Summary
Good physicians are sued every day. In general, a medical malpractice lawsuit challenges a physician’s medical care and treatment as a deviation from the standard of care, which is interpreted in most jurisdictions to be the skill and care ordinarily possessed by a reasonable physician under the same or similar circumstances. Although a lawsuit can be stressful and, at times, unpredictable, there are several steps that a physician can take in his or her practice to make the process more manageable and to increase the likelihood of a successful resolution.

Mistake 1 Failing to Give Notice to the Insurer
Physicians sometimes choose to ignore allegations of medical malpractice or demand letters seeking compensation for medical malpractice. Even if a physician believes the claims or demands are frivolous, they cannot be ignored. Most insurance agreements require a physician to give notice of the claim or occurrence to the insurer within a limited period of time according to the insurance policy, even if a formal lawsuit has not been served on the physician. By giving notice to the insurer as required by the insurance policy, the physician is on the right course for receiving the benefits of the insurance agreement, which may include an assignment of legal counsel and payment of legal fees.

Action Step
When a claim is made, physicians should promptly notify the insurer as required by the terms of the insurance contract.

Mistake 2 Failing to Retain Records
Medical records are a key component to most medical malpractice lawsuits. For example, many physicians do not have an independent memory of a particular patient, a discussion about informed consent, or a differential diagnosis. Indeed, most lawsuits are not started until several months after the medical care was given. As a result, retention of medical records is important because the medical records will be the most important exhibits at trial and may provide the most critical information to defend the lawsuit. Both state and federal laws impose retention requirements for medical records. If the applicable retention requirement is shorter than the statute of limitations for a medical malpractice claim, the medical records should be retained for the statute of limitations period so that the medical records will be available in case of a lawsuit.

Action Step
Physicians should retain medical records as required by federal and state laws. If the applicable retention period is shorter than the statute of limitations period for a medical malpractice claim, the medical records should be kept for the longer statute of
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limitations period so that the medical records will be available for use at trial in case of a lawsuit.

**Mistake 3  Having Inadequate Documentation**
Medical records are only as good as the physician’s documentation. A physician who fails to document the medical considerations or treatment in the medical record opens the door for the patient to argue at trial that it was not done. A phrase often used by plaintiffs’ attorneys at trial is “if it isn’t documented, it wasn’t done.” Good documentation assists the defense of a medical malpractice claim.

**Action Step** Physicians should document the medical care and treatment provided to patients, consistent with medico-legal training and practice.

**Mistake 4  Having Inconsistent Documentation**
Physicians often have a routine practice for documentation or use forms to make documentation more efficient. If a routine practice for documentation or forms are used, it is important to follow the routine practice consistently. Consistent documentation practices assist the defense of a medical malpractice claim.

**Action Step** Physicians who have a routine practice for documentation or use forms for documentation should consistently follow the routine practice.

**Mistake 5  Failing to Document Informed Consent Consistently and Completely**
Physicians can be sued for failing to obtain informed consent for a medical procedure. As a general matter, physicians are required to explain the risks, benefits, and alternatives to a patient in order to obtain informed consent for the medical treatment or procedure. A patient is often in a better position to testify about a discussion with a physician because the patient will claim to have a specific memory of the physician’s deficient discussion with him or her. In contrast, a physician most likely will not independently recall the specific discussion with the patient. Rather, the physician must rely on his or her documentation of the discussion and routine practice in discussing the risks, benefits, and alternatives with a patient. Accordingly, it is helpful in defending a medical malpractice claim that alleges lack of informed consent for the physician to have a routine practice for documenting informed consent that the physician follows consistently.

**Action Step** Physicians should consistently obtain and document a patient’s informed consent for the medical care and treatment.

**Mistake 6  Discussing a Medical Malpractice Lawsuit With Others**
As a general matter, physicians should not discuss a lawsuit with others after a claim has been made. In a typical medical malpractice lawsuit, the patient’s attorney will depose the
physician. With the exception of privileged conversations, such as discussions between the physician and his or her legal counsel, conversations that the physician has had with others, including treatment providers within the same medical facility, will be discoverable by the patient’s attorney.

**Action Step**   A physician should not discuss a medical malpractice lawsuit with others, aside from his or her legal counsel and those authorized by the attorney to discuss the case with the physician.

**Mistake 7   Second-Guessing Other Physicians**
In a medical malpractice lawsuit, a patient’s attorney may depose or call as witnesses other physicians who treated the patient. Indeed, it is not uncommon for several physicians to see a patient at the same medical facility or for subsequent treatment providers to see the patient at other facilities. A physician should be cautious about criticizing the care provided by other physicians when the physician has been influenced by hindsight. Often, a subsequent treatment provider has more information than what was available to the physician who is being sued for medical malpractice. In a medical malpractice lawsuit, a physician’s medical care and treatment are prospectively evaluated without the benefit of hindsight. Accordingly, it is important for subsequent treatment providers not to jump to conclusions when testifying about another physician’s medical care and treatment.

**Action Step**   Physicians should not second-guess each other after being influenced by hindsight. When a physician is being asked about another physician’s decisions or medical care, it is important to consider the effects of hindsight.

**Mistake 8   Expecting a Quick Resolution**
A typical medical malpractice lawsuit is not resolved overnight. After a patient starts a lawsuit, the physician has a period of time to respond to the claims. After the initial pleadings have been served, both sides may spend several months gathering information about the claims. It is not uncommon for a lawsuit to take up to two years or more before the case is resolved. This can be frustrating for a physician. A physician who has been sued should work with legal counsel to resolve these frustrations and to keep apprised of the status of the case.

**Action Step**   Physicians should be prepared for a lawsuit to last several months before any resolution and should work closely with legal counsel to resolve frustrations with the process and to keep apprised of the status of the case.

**Mistake 9   Failing to Prepare for the Physician’s Deposition**
A physician defendant in a medical malpractice lawsuit will be deposed during the discovery phase of the lawsuit. Physicians may be tempted not to prepare for the deposition testimony, since a deposition is not in front of a judge or jury. The only people typically present at a
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deposition are the attorneys, a court reporter, and the parties. But a deposition is sworn
testimony and will be admissible at trial to impeach or cross-examine the physician.
Accordingly, it is imperative that the physician prepare for the deposition as if it were trial,
since everything that is said at the deposition could be introduced at trial in front of the jury.

**Action Step** Physicians should prepare for deposition testimony with the same mindset as
if they were preparing for trial.

**Mistake 10  ** **Showing Poor Demeanor in Front of the Jury**
At trial, physicians can forget that they are constantly being watched by the jury. Even when
a physician is not testifying on the stand, the jury is keeping a watchful eye on the physician’s
demeanor, presence, and reactions to other testimony. A physician should be attentive,
respectful, and conscientious when at trial, even when the physician is not on the witness
stand.

**Action Step** At trial, physicians must be aware that they are being scrutinized by the jury
even when they are not on the witness stand. Accordingly, they should be conscientious of
their actions and reactions at trial.

**Conclusion**
Physicians who have been sued for medical malpractice are not alone. They should work
closely with defense counsel to resolve the case. If physicians have taken or take these steps,
they will be in a better position to defend the lawsuit.

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MALPRACTICE: TESTIFYING ON DIRECT EXAMINATION

17.8 The 10 Biggest Legal Mistakes Physicians Make When Testifying on Direct Examination Before a Jury
By Steven M. Maslauski, Esq.

Executive Summary
The direct examination of the physician is the time when both attorney and client need to shine. This is the only point in the trial when important facts affecting liability are set forth before the jury in a systematic, factual fashion. The properly prepared team of lawyer and physician client can score points in a persuasive presentation that is both precise and concise. But costly mistakes made by the physician while testifying can detract from the presentation, and these mistakes must be minimized, if not completely avoided.

Mistake 1 Playing Excessively to the Jury
The physician must not speak directly to the jurors. Doing so can create an overly rehearsed, pandering feeling. Eye contact with individual jurors is fine, but it should be blended with eye contact with the attorney questioning the witness. The physician mixing his or her interaction with both a jury and his or her attorney maximizes impact and persuasion.

Action Step Physicians should intersperse eye contact with individual jurors and the questioning attorney.

Mistake 2 Dressing Inappropriately
The physician must not dress in an overly formal or overly casual manner. Therefore, a two-piece pinstriped suit is not the dress for trial, where a doctor’s reputation is on the line, nor are an open-collared shirt with blue blazer and khakis. Donning a conservative blazer with a solid white or blue shirt, dark slacks, and subdued tie will enable the physician to present to the jurors as a relaxed, confident professional with integrity. This clothing strikes the desired balance between casual and formal. For female physicians, the same general rules apply: conservative, understated, and traditional (perhaps a conservative two-piece suit or a conservative dress devoid of flashy jewelry or accessories).

Action Step Physicians should dress sharply but conservatively, and opt for a trial clothing ensemble of blazer, shirt, tie, and slacks in traditional colors and patterns (for men), and a two-piece suit or conservative dress (for women).

Mistake 3 Having a Pompous Demeanor
A physician comes to a jury trial with most jurors respecting his or her career and avocation. However, the jury must find the physician likeable and friendly and be able to relate to the physician. The physician should smile often, but make the smile genuine. The physician should sit up straight and not cross his or her arms. The physician should aim for a feeling
that the physician and his or her attorney are having a relaxed but important conversation in a living room. They should invite the jury to eavesdrop on the conversation.

**Action Step** Physicians should sit up straight, smile when appropriate, keep their arms uncrossed, and be relaxed and conversational during the examination.

**Mistake 4  ** **Turning Answers Into a Narrative**
The conscientious, competent trial attorney representing the physician will have spent countless hours designing the direct examination plan and rehearsing the testimony with the physician. With few exceptions, the physician will be expected to give relatively brief, direct answers to questions. Rambling on with a narrative answer will bore the jury, depart from the direct examination plan, and give nonresponsive information that opposing counsel can then use to cross-examine. In addition, the trial judge may cut off the physician and admonish him or her. Opposing counsel may object on the basis that the answer is becoming a narrative.

**Action Step** Physicians should listen to the question and answer only that question.

**Mistake 5  ** **Not Responding to the Trial Judge’s Questions**
Judges can interrupt at any point during direct examination and ask questions. These questions rarely bring objections and are vitally important, since the jury will feel that a judge’s questions might be more significant than an attorney’s questions. Therefore, the physician must answer them and appear as if he or she is eager to respond completely to the inquiry. It is desirable to keep the judge happy at all times, and answering questions like a guest on* Meet the Press* will not do the job. Physicians should make eye contact with the judge when answering, turn toward the judge, address the court as “Your Honor,” and give the desired information.

**Action Step** Physicians should respond to the judge’s questions as completely as possible, and act happy that the court asked the question.

**Mistake 6  ** **Referring to Notes or Written Materials**
Some trial judges allow the physician’s chart to be used without limitation. Alternatively, the parties may stipulate that the doctor may refer to the chart at any time. Technically, however, the witness may refer to the chart or other materials only to refresh his or her recollection. Therefore, the doctor should be prepared to answer questions without looking at anything for assistance.

**Action Step** Physicians should commit their chart and progress notes to memory in order to allow good answers to questions without the need to reference any written materials.
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Mistake 7  **Volunteering Information**
The physician’s attorney should have designed the direct examination to elicit limited information in response to questions. Volunteering information not specifically requested by the question can only lead to trouble. Physicians should fight the urge to give any answers that are not directly responsive to the question.

**Action Step**  Physicians should answer questions with only the requested information and volunteer nothing extra or superfluous.

Mistake 8  **Using Cumbersome Technical Language**
Medical malpractice cases necessarily involve technical medical terminology. But this information must be conveyed to the jury in language they can understand and process. Although the physician will rehearse this communication with his or her attorney, it is very easy to use jargon that overwhelms and confuses lay people.

**Action Step**  Physicians should use simple words and terms whenever possible, and define medical terms and concepts so the jury can understand them.

Mistake 9  **Allowing Verbal Idiosyncracies to Distract the Jury**
“Um,” “uh,” and “you know” haunt everyone’s conversations. Even the most polished speakers can have these verbal mannerisms creep into planned discourse. Such mannerisms must be completely eliminated, or at the very least kept to a minimum.

**Action Step**  Physicians should keep “um” and “uh” out of their answers if at all possible.

Mistake 10  **Speaking Rapidly**
Most medical malpractice trials have a court stenographer who transcribes the trial testimony into a written record. Speaking too rapidly makes transcription impossible, and either the stenographer or the court will tell the physician to slow down. This admonishment breaks the cadence of quality testimony and could impair the physician’s credibility if it occurs often.

**Action Step**  Physicians should give their answers in a clear, deliberate fashion with good pacing.

**Conclusion**
Direct examination should be powerful and persuasive. A sound presentation by the physician and his or her attorney can severely limit or even eliminate opposing counsel’s cross-examination. Keeping these 10 common (and very human) mistakes to a minimum will go a long way toward that coveted defense verdict.
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17.9 The 10 Biggest Mistakes Physicians Make While Testifying on Their Own Behalf
By Celeste K. Poteat, Esq., and Holly D. Sass, Esq.

Executive Summary
Physicians often make numerous mistakes while testifying on their own behalf. This involves being unfamiliar with the medical record and with their own deposition, speaking before they think, thinking too long, volunteering information, withholding facts, failing to prepare properly, using medical jargon, not maintaining eye contact, and losing their temper. It is important that these mistakes be avoided.

Mistake 1 Being Unfamiliar With the Medical Record
Often, physicians take the stand at trial without having read the plaintiff’s medical records just before testifying. They may review the chart upon learning that an investigation is being conducted or that a lawsuit has been filed, and they may also review the medical records before or during a deposition. Because it can take a couple of years for a case to come to trial, and despite the fact that they have reviewed the medical records on previous occasions, it is crucial that physicians familiarize themselves with the records just before testifying. Recalling the details in the chart is not required, but they must refresh their memory of the plaintiff’s overall course of care and treatment.

Action Step Physicians should always thoroughly review the plaintiff’s medical records a couple of times immediately before taking the stand and testifying under oath.

Mistake 2 Being Unfamiliar With One's Own Deposition
Physicians often testify to certain facts during a deposition, but later at trial testify to facts that appear to be or are inconsistent with those they gave at the deposition. Defense attorneys know that this can result from the environment and pressures the physicians feel or simply from recalling different or additional information at a later date; however, uncovering such inconsistencies can make a plaintiff attorney’s day and will be used to impeach a physician’s
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testimony. Consequently, it is imperative that physicians be familiar with their deposition testimony. If they discover that testimony is inaccurate because of facts or information as the physicians now know them, they should be frank about the facts and inconsistencies at trial. Physicians will take the wind out of the plaintiff attorney’s sails if they are up-front and honest about the inconsistencies.

**Action Step**  Physicians should always reread and familiarize themselves with their depositions in order to remember the details of their testimony and to avoid being caught off guard if the plaintiff’s attorney attempts to impeach their testimony at trial.

**Mistake 3  Speaking Before Thinking**
Often, physicians answer a question without thinking about what the questioner is truly asking. On direct examination, they may respond to a question without listening to the entire question because they are anticipating what is being asked. On cross-examination, they may answer a question without fully understanding it. It is important that physicians listen to the entire question, think it through thoroughly, and respond accordingly. If the physician does not understand the question or if the attorney has not articulated it in a comprehensible manner, the physician should not respond before obtaining clarity.

**Action Step**  Physicians should always think through the question being asked and their response to it before speaking.

**Mistake 4  Thinking Too Long**
On the other side of Mistake 3, many physicians think too long and hard before responding to a question. While it is important to think before speaking, it is also necessary to do so in a timely manner. Physicians tend to be very methodical in their thinking, which can be a positive characteristic, but during trial testimony may create suspicion in the jury. Juries may view such caution in answering as an indication that a physician is withholding information or trying to formulate a response that portrays him or her in the best light.

**Action Step**  Physicians should always think before speaking, but not so analytically that they think too long and cause the jury to doubt the accuracy and completeness of their answer.

**Mistake 5  Volunteering Too Much Information**
Physicians often volunteer more information than is required from a question. Candidness is crucial, but they should not provide information other than that sought by the question. Physicians tend to speculate when they are unsure of an answer, which causes them to voluntarily testify to unnecessary information. If an answer is unknown, they should indicate so.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

**Action Step**  Physicians should always answer only the question being asked. They should never speculate.

**Mistake 6  Withholding Facts**
On the other side of Mistake 5, physicians withhold from an answer facts that may appear to be unfavorable. It is imperative that they answer each question completely and truthfully. Physicians may withhold information out of fear that the information will damage their case. However, candidness is essential, since the truth will come out at trial. A jury will be more understanding of and receptive to a physician’s testimony at trial if the physician is upfront and honest about the facts. It is more damaging to the physician’s case for the plaintiff’s attorney to point out to the jury the facts that were withheld.

**Action Step**  Physicians should always tell the whole story, even facts that appear to be unfavorable, when such information is required by the question.

**Mistake 7  Being Too Prepared for Direct Examination But Unprepared for Cross-Examination**
Often, physicians are overprepared for direct examination and underprepared for cross-examination. While this mistake falls mostly on the attorney, it is important for physicians to be aware of it. Attorneys want to ensure that the physician is well prepared to testify. Unfortunately, the focus of such preparation is often on the direct examination when it should be on the cross-examination. When too much emphasis has been placed on the direct examination, a physician’s testimony sounds rehearsed and scripted, and the physician may come across to the jury as being insincere. Because the plaintiff’s attorney on cross-examination can really cause trouble for a physician, the physician’s preparation for cross-examination with his or her attorney is critical. It is important that the potentially problematic areas in the physician’s case be acknowledged and that time be spent responding to the tough questions that plaintiff’s attorney will likely pose on cross-examination.

**Action Step**  Physicians should always take time to thoroughly prepare for testifying at trial. They should know the types of questions their attorney will ask on direct examination, but should also emphasize and be well prepared for cross-examination.

**Mistake 8  Using Medical Terminology**
Physicians often testify at trial using the medical jargon that has become second nature to them. However, it is important for them to remember that the jury is likely to consist of people who do not have the extensive medical knowledge and training that they have and that some members of the jury may not have a college education. Physicians may unintentionally use medical terminology, at which time the attorney should ask for clarification or an explanation from them. While it is necessary that physicians speak knowledgeably and
intelligently, overusing medical jargon can confuse and make the jury members feel as though the physicians are belittling them.

**Action Step** Physicians should always use common language when possible so the jury can understand. They should never speak over the jury’s head so as to make jury members feel inferior. Educating the jury on complex medical concepts through diagrams or models will be beneficial for the jury, as well as for the physician and his or her case.

**Mistake 9 Not Making Eye Contact With the Jury**
Physicians often testify to the attorney asking the questions, as opposed to the jury, which is responsible for deciding their case. Out of habit, physicians may look at the person speaking to them when responding. It is important, however, that their testimony be directed at the jury. The jury will be more involved in the testimony and will likely pay closer attention to what they have to say. Making eye contact with members of the jury will put them on a more personal level with a physician.

**Action Step** Physicians should always make eye contact with members of the jury.

**Mistake 10 Losing One’s Temper and Confidence**
Physicians often and understandably take offense to questions asked on cross-examination. However, it is imperative that they remain calm while the plaintiff’s attorney attempts to grill them. Physicians may start to lose their temper and respond aggressively in an attempt to defend the care and treatment they provided. Despite feeling as though he or she is being attacked, such action reflects poorly on the physician and will not be looked at favorably by the jury. Physicians may also lose their confidence. It is important that they express confidence in themselves, as well as in the services that were provided.

**Action Step** Physicians should always remain calm and confident on the witness stand, even when being cross-examined by the plaintiff’s attorney.

**Conclusion**
Physicians who are attentive to these mistakes and follow through with the recommended actions will be well prepared and successful in testifying on their own behalf at trial.

**About the Authors**
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Physicians have very little control over their involvement in malpractice litigation. This section describes a limited means of control that includes the benefit of making a physician a better doctor. There is beauty in its simplicity: Treat staff fairly. Beyond the avoidance of stupid unethical behavior, physicians should set a goal of treating staff as physicians think they themselves deserve to be treated. By doing so, physicians will make more money, heal more patients, fare better in malpractice litigation, and sleep better at night.

Mistake 1 Mistreating Staff
The biggest mistake physicians can make that involves malpractice is to mistreat staff. When it is time to testify, a disgruntled employee will damage a physician’s malpractice case.

Action Step The employee’s motivation to damage a physician’s malpractice case is easily understood, and a physician should do these things at a minimum to prevent this from occurring: Pay a fair wage, do not date staff members, supply them with proper equipment, avoid sloppy hiring and firing practices, and consult with an employment lawyer to promote strong staff retention. A physician’s staff should view the physician as a benevolent dictator rather than a tyrant getting his or her due at malpractice time.
MALPRACTICE: STAFF AS WITNESSES

Mistake 2  Overdelegating
If physicians burden their staff with too much work, mistakes are likely and their testimony
describing their practice will make them look bad. Also, a physician who delegates work to
staff who are not qualified to do it risks a regulatory action that jeopardizes his or her license.
Physicians are vicariously liable for the mistakes of their staff.

Action Step  Physicians should not overdelegate work to their staff.

Mistake 3  Excluding Staff from Informed Consent Discussions
The standard of care necessitates that physicians should use written informed consent forms
for certain treatment. Malpractice liability can also arise from the absence of verbal informed
consent. Physicians will benefit from the help of their staff in a dispute on the issue of verbal
informed consent. Their staff will affirm their routine practice of reciting the elements of
informed consent prior to treatment, which gives physicians help in the swearing match
between them and the damaged patient about what was covered during the informed consent
discussion.

Action Step  To obtain the support of their staff requires that physicians allow them to be
present during verbal informed consent discussions with patients.

Mistake 4  Suggesting Deposition or Trial Testimony to Staff
Once a physician has been sued, it is natural for the physician to think about his or her staff
defenses. Also, it is tempting to think out loud, particularly in front of staff, because the
physician fears that he or she screwed up. When that staff is scheduled to give testimony, the
physician will think about talking about their recollection of the facts. The opposing lawyer
will ask if the physician has talked to the witnesses about the case. The physician will look
bad if a staff member has to admit that the physician tried to influence his or her testimony.
Even the most innocent comment the physician makes can look inappropriate when taken out
of context.

Action Step  Physicians should talk to no one but their lawyer.

Mistake 5  Running the Practice as a Business Rather Than a Profession
Despite the indignity of being a defendant in a malpractice suit, a physician remains a
respected and trusted professional. The physician’s staff follows his or her lead if the
physician practices as a professional rather than primarily as a business person. Doing so
allows the physician to receive the benefit of the doubt from patients and staff.

Action Step  Physicians who treat their staff as production workers in a factory rather than
as team members in a profession will find that the staff’s testimony will not be supportive of
their treatment of patients.
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Mistake 6  Letting Staff Alter Records
People cannot think clearly when they panic. Nearly all professionals, lawyers included, have a panic denial response initially when accused of malpractice. Far too many doctors resort to alteration of records. This problem has created a booming business for handwriting expert analysts. A doctor who understands this is felonious behavior may induce staff to do this dirty work.

Action Step  Asking staff to alter records is a no-win proposition: A staff member who says no will have to testify to the physician’s dishonesty, but if he or she says yes, the physician becomes a criminal who will probably lose the malpractice case. The bottom line: Don’t ask.

Mistake 7  Disciplining Staff After the Malpractice Suit Has Been Filed
After a sentinel event occurs, physicians can expect a malpractice suit to follow. They may consider blaming a scapegoat on their staff to avoid being a victim themselves. This is a natural thought process that should be ignored. As fear turns to anger, physicians will select a target. At this point, a common mistake is to discipline staff, which is usually not justified and unfavorable to the physician in the ensuing malpractice case. The physician will still be sued, and will be found vicariously liable for the acts of the person who was disciplined.

Action Step  Physicians should control their emotions and consult their malpractice lawyer.

Mistake 8  Skimping on the Training or Supervision of Staff
A physician might have a good staff because he or she is lucky. More realistically, physicians must carefully train and supervise their staff. Physicians must see the patient care provided by their staff as an extension of their own duty to the patient. The patient deserves treatment by staff members who know what they are doing.

Action Step  It is a law everywhere that physicians are legally and financially responsible for the acts and omissions of their staff. Since their mistakes can put a physician out of business, it would be a mistake to have to concede in a malpractice case that the physician failed to properly train or supervise his or her staff.

Mistake 9  Blaming Staff for One’s Own Mistakes
Blaming staff for a patient’s bad result is a form of mistreatment and only worsens a physician’s case. It is natural, but unprofessional and counterproductive. Even if true, it was a mistake. The most productive finger pointing by a doctor in a malpractice case is at a patient. Even a gravelly damaged or dead patient can be effectively blamed for a bad result if the patient did not follow medical advice or failed to mitigate damages. Also, theoretically, the
physician’s defense can rely on blaming another doctor who saw the patient before or after the physician did.

**Action Step** Under no circumstances are physicians better off blaming their staff for mistakes for which they are responsible. The legal effect of the doctrine of vicarious liability (or *respondeat superior*) is that blaming the staff is no different than blaming oneself.

**Mistake 10** *Being Afraid to Spend Money on a Criminal Lawyer to Protect an Employee*
A particularly egregious action by an employee involved in an event that could give rise to malpractice could also result in criminal prosecution. That possibility is a matter of prosecutorial discretion and the degree of outrageousness of the conduct of the employee. When it happens, a physician should consult with an experienced malpractice lawyer for advice on the need to act proactively by retaining a criminal lawyer for damage control. There are obvious advantages to making that move before the employee is formally charged with a crime in which the physician will be involved as a matter of civil liability. Sometimes as a matter of prudent risk management, a physician’s malpractice carrier will offer to take control of the matter by selecting and retaining criminal counsel for the employee on the physician’s behalf.

**Action Step** If the malpractice carrier decides it is not worth the expense to take control of the matter, the physician should weigh the pros and cons of spending his or her own money as a means of indirectly protecting his or her own interests. The theoretical possibility of a conflict of interest in doing so is an issue physicians should discuss with their malpractice lawyer.

**Conclusion**
Physicians should realize that their office staff may become witnesses in a malpractice case against them, therefore physicians should avoid the mistakes described in this section.

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17.11 The 10 Biggest Legal Mistakes Physicians Make Regarding the Breakdown of the Doctor-Patient Relationship

By Terry Anne Woodward, Esq.

Executive Summary
How can physicians best protect themselves in a litigious society? Clearly, it seems as though this instant-fix, immediate gratification society has relegated physicians to a class of professionals in which perfection is not only expected, but demanded. Medicine is fraught with risks and there are no guarantees. For many physicians, that factor—the immediacy of the situation—was perhaps the great attraction that brought them to medicine: the challenge to fix what, by nature, shouldn’t be fixable. When a physician fixes what was broken, he or she would expect gratitude, not “why wasn’t it done sooner or why wasn’t I told?”

There is no doubt that the practice of medicine in the United States is fraught with risks and dissatisfaction among physicians. Los Angeles Times Magazine (July 11, 2004) published an article entitled “Medicine on the Brink,” which addresses why many physicians find it more satisfying to practice medicine in less developed countries where they can focus on patient care; where they are revered not demonized; and where the world of managed care, litigation, and malpractice do not exist.

Doctors in the United States, over the past 30 years, have become disillusioned and demoralized. It is not difficult to understand why. Managed care, decreased compensation, malpractice lawsuits, uninsured patients, and rising premiums, sometimes topping $200,000 per year, have perverted the nation’s health care system. So, what can doctors do to protect themselves, besides leaving the country?

This section provides a list—a trail map, so to speak—of the biggest mistakes physicians make where the physician/patient relationship is concerned and how to rectify and avoid some of the numerous, sometimes not so obvious, pitfalls that are inevitable precursors to litigation. This is in no means a guarantee, as those inextricably involved in the practice of medicine realize that there are none. If only everyone really understood that—right?

Mistake 1 Spending Inadequate Time with the Patient and Having an Abrupt, Impersonal Manner
It isn’t a coincidence that the number one item doctors identify as being the most satisfying part of their job—spending time with patients—is the one thing that, when lacking, combined with a bad result, leads to inevitable litigation. The scene for the patient has become all too
familiar: the packed waiting room, the uncomfortable chairs, the poor magazine choices (leftovers from the doctors’ personal life of golf and travel, luxuries most patients can’t afford). This environment is often punctuated by rude, impersonal, insensitive staff. The *coup de grâce* for most patients is the visit by the harried, exhausted, time-constrained physician, who barely has a foot in the door before departing.

The breakdown between many physicians and their patients starts with a packed, impersonal waiting room, a rude staff, and a “quick” visit. First impressions combined with illness make that breakdown easy to understand. It is difficult to be patient for answers when someone is ill with a fever and sleep deprived. A person who is ill and has to wait wants to be heard.

While recognized that in the world of managed care and rising insurance premiums there exists the necessity to do more in less time, whatever physicians can do to rectify this opening scene will be worth it. Instead of getting an exhausted, ill, angry patient, they will increase their odds of getting a patient open to suggestion, health care options, and recommendations. The patient will be less likely to begin the relationship by questioning the doctor. It’s perhaps best explained as a respect issue: You give it, you get it.

**Action Step**  Physicians should do whatever they can to make patients comfortable in the waiting room, if it applies to their specialty. If it doesn’t, and the physicians are referral physicians or emergency room doctors, they should do what they can to lobby and control their preevaluation environment. They should ensure that patients are comfortable and that their questions are answered respectfully and directly by knowledgeable personnel before they are evaluated by a physician. When a physician sees the patient, the physician should introduce himself or herself on a first name basis, such as, “Hello, I’m your doctor, John Hopkins.” A physician who introduces himself as “Dr. Hopkins” and addresses the patient by his or her first name widens the preexisting gap between physician and patient. Physicians should let their patients know that their care matters and that the physicians are receptive to hearing their patients’ complaints. Simply put, physicians should make their patients feel valued and heard.

**Mistake 2  Failing to Chart Appropriately**

Given Mistake 1, inadequate time, Mistake 2 seems an inevitable, natural consequence. The harried physician, rushed in people interaction, necessarily rushes through charting. Charting occurs at a critical time, after the physician has seen the patient (while conversation, diagnosis, and recommendations are fresh in the physician’s memory), but before the next patient is to be seen, waiting, less than 10 feet away. Physicians are trying to get out one door and into the next, more than aware that they are behind and need to move on.

**Action Step**  This is when physicians should be spending crucial time documenting what they have discussed with the patient, what they have recommended, what the diagnosis is,
and what the plan is for follow-up. It is important to remember that what isn’t charted is subject to recollection, speculation, and vagary, which all too often results in a credibility contest between the physician and the patient. The physician testifying as to his or her custom and practice and the patient ultimately testifying to an entirely “Greek” set of facts. Significantly, what is documented, is usually perceived to be what happened and believed. It is a “written” defense. Physicians should take the time to chart what happened and chart the referrals. And physicians who are among the unfortunate to have a noncompliant patient should document this as well. All this documentation is worth its weight in gold to confirm what really transpired during that brief, important visit.

**Mistake 3**  **Failing to Recommend, Perform, and Diary Necessary Follow-up**

Suppose a physician is confronted with a situation that demands follow-up: a 54-year-old man with signs and symptoms of colon cancer, which could also be hemorrhoids, irritable bowel syndrome, or colitis. The physician just isn’t sure. Or suppose the physician sees a 43-year-old woman with fibrocystic breast disease, who periodically develops lumps, but now has a persistent one. What does the physician do? In such cases, Action Step 2 and Action Step 3 are inextricably related.

**Action Step**  Physicians should refer, refer, refer, and document, document, document. They should diary the follow-up and diary the subsequent conversations with the patient. The physician doesn’t necessarily have to do this, but can instead have the office manager “tickle” or “diary” important follow-up appointments. The physician should make sure that either the office manager or the physician follows through with either a telephone call or a written reminder.

Physicians may assume that a patient will act on his or her health care. They assume that the patient appreciates the risks as they do, which is generally not the case. Lawsuits are lost over much less. Physicians should diary the discussion regarding follow-up, and diary the follow-up and put it in the patient’s chart. Whether the follow-up telephone call comes from the physician or the office manager doesn’t matter. It shows the physician cared enough to attempt to get to the bottom of what is really going on. If it is documented, and the importance of follow-up is discussed and charted and the patient doesn’t follow through, the physician has done everything but drag the patient to the specialist. The physician is in good stead and in a good defensive position if the worst occurs and he or she is sued.

**Mistake 4**  **Failing to Call In a Consult**

This mistake dovetails nicely with Mistake 3, and little needs to be said about it other than this: If an area of medicine is over a physician’s head, or in a different field, the physician should call in a consult. Many cases involve physicians who have read their own slides (they are not pathologists), read their own X rays (they are not radiologists), and interpreted their
own test results. Physicians should not do so unless they are truly qualified (board certified to do so) or are certain of their finding.

If a physician ordered the test, scan, or study, the operating premise is that he or she did it for a reason. The physician should make sure that the reason for ordering it—to rule out the more serious conditions—isn’t hiding somewhere he or she can’t or wasn’t trained to see. Physicians who insist on reading their own scans, ultrasounds, films, or slides should have them read again by another physician to ensure that their findings or conclusions are accurate. It is a small price to pay.

**Action Step** When a physician lacks the education, background, and expertise to diagnose and/or interpret a patient’s condition, the physician should call in consults to confirm suspicious findings or in areas of medicine in which he or she has not been specifically trained. The physician should document each and every referral.

**Mistake 5 Failing to Hospitalize Questionable Cases**
Many situations do not lend themselves readily to a quick diagnosis, whether it be in an office setting or in an emergency room. Many cases require follow-up, consultation, further diagnostic testing, and perhaps hospitalization in the interim. What should a physician do in a case where hospitalization would be the best, safest option, pending further diagnostic testing? Hospitalize and document/diary the reasons for doing so. Physicians should not let managed care issues dissuade them.

**Action Step** Whether a patient presents in the emergency room or in the office, if the physician feels that the patient has a questionable diagnosis that could potentially prove serious or fatal, it is always best to err on the side of caution and admit the patient. While it is recognized that preferred provider contracts have their provisions and contracts are hard to come by, the physician is best served by acting in the patient’s best interest (and ultimately the physician’s as well) than by hoping for the best while awaiting diagnostic tests. When a bad result or fatality occurs, it is hard to sell to a jury the argument explaining why the physician decided to send the patient home while awaiting diagnostic test results.

**Mistake 6 Continuing to Care for the Noncompliant**
The *Los Angeles Times Magazine* article discussed in Mistake 1 addresses the issue of how many physicians are becoming “gun shy” about whom they treat: “Every patient who walks through their door is a potential plaintiff.” This is sad but true, and physicians must do what they can to protect themselves.

**Action Step** While it is acknowledged that emergency room physicians may not have a choice, certainly physicians in the private arena do. Simply put, the current litigious environment demands that physicians evaluate each patient as a potential risk, as cynical as
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that may sound. Physicians with patients who are repeatedly noncompliant with the recommended course of care such that they jeopardize their health should politely and directly tell those patients that they cannot continue to care for them if they won’t care for themselves. Physicians should document the file and discharge those patients from their care if necessary. Of course, it is incumbent on the physicians to recommend and chart all necessary referrals and diagnostic tests that the patients refused while under their care and treatment. In other words, physicians should make sure that they have done all they can to ensure the good health of, and an appropriate and accurate diagnosis for, their patients.

Mistake 7 Basing Decisions on Financial Considerations
Decisions based on insurance concerns are never in a patient’s best interest and that is what medical malpractice cases and the standard of practice is all about. Specifically, what would a reasonably prudent physician do, recommend, or diagnose under similar circumstances, irrespective of financial considerations? The verbiage “cost effectiveness” is not part of the legal definition of what is medically appropriate under the circumstances, and juries don’t want to hear this term because it puts finances over a patient’s well being. Therefore, while it may occupy some part of a physician’s cerebral cortex in making recommendations and follow-up diagnostic tests, physicians should not let it sway their gestalt sense of what is appropriate for a patient under a particular set of circumstances.

Action Step Physicians who feel that a patient needs to be hospitalized, that a further consult needs to occur, or that further diagnostic testing or medical treatment needs to proceed should tell the patient and document it in the file. Insurance considerations must not affect their recommendations as to what is appropriate under a particular set of facts and circumstances. The patient’s well being is always first and foremost over financial considerations.

Mistake 8 Failing to Avoid Liability During Weekend Calls/The Phone Zone
Quoting Dr. Jack Lewin, chief executive officer of the California Medical Association: “If you’re a doctor who’s willing to take care of really sick patients, particularly a poor person you don’t know, or you’re an obstetrician who does a delivery and something goes wrong, it’s guaranteed you’re going to get sued.” (Emphasis added.) Unfortunately, this is generally true.

The causative factor here is the aura of suspicion that attaches to a physician one doesn’t know, combined with a bad result. For the on-call physician, called in to handle an emergency involving a patient he or she doesn’t know, this is an all-too familiar scenario.

Action Step Physicians who are called in on an emergent or consultant basis where exigent circumstances exist, or potentially exist, should evaluate the patient. Once a physician has been contacted and receives information regarding a particular patient and agrees to get involved, the physician is potentially on the hook and liable for an adverse outcome if he or
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she doesn’t act. For example, the physician is much better off to get out of bed and evaluate
the patient in the emergency room prior to discharge than to do so from home based on the
assurances of hospital staff. Similarly, a physician who is acting as a primary care physician
for a patient who needs further consult is much better off legally to go to the hospital and
look at the patient and then call in the consult, rather than merely accepting responsibility for
the admit over the telephone and simply calling in a consult. This is important because it
shows the jury that the physician who was called cared enough to show up and evaluate the
patient, rather than simply relying on the assessment of others for his or her own convenience
and expedience.

Mistake 9  Not Being Familiar With the Records, and Having an Attitude at
Deposition
When physicians are defendants in a medical malpractice action, their deposition is key. It
cannot be emphasized strongly enough how important this process is. Physicians should find
out from their attorney if their deposition will be videotaped.

Action Step  Physicians should take time to meet with their attorney to talk about what to
expect and to familiarize themselves with the liability aspects of the case. They should review
their records of the patient whose medical care is at issue well before the deposition. They
should be prepared to explain their recommended course of treatment and any gaps in care or
lack of charting. Their testimony, confidence, and demeanor at deposition are key to what the
case is worth. Cases are won and lost at deposition. Juries find for the party they believe.
Physicians who are credible, sincere, and honest; present as a good witness; and have an
expert in their camp are more likely to be successful at trial.

Mistake 10  Failing to Listen Objectively to One’s Attorney
Granted, it is difficult for a physician to feel close to an attorney when he or she is being sued
by one. However, it is important that the physician remember that the defense attorney is
representing him or her, not the plaintiff and not the physician’s insurance company. The
defense attorney’s primary job is to evaluate the physician’s case objectively and assess
liability. While the attorney will be the physician’s advocate at deposition and trial, his or her
most important job is to assess the physician’s exposure if the case proceeds to trial in order
to enable the physician to make an informed decision as to whether to settle or try the case.

Action Step  Physicians should remember that their attorney’s job is to assess potential
liability. While it may be uncomfortable for a physician to hear that a jury may find against
him or her, the attorney is merely the messenger. In medical malpractice actions, independent
experts are relied on in consultation and trial to explain what similarly placed physicians
would do under similar circumstances.
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If the physician’s attorney tells the physician that a jury is likely to find against him or her, the physician can rest assured the case has been reviewed by experts on behalf of the insurance company, or independent experts, who are seeing the case as one of liability. An experienced medical malpractice attorney who tells a physician it is in his or her best interest to settle genuinely believes that the physician has more to lose by going to trial. While the physician may not agree with the message, he or she should listen and make sure to understand why the attorney feels the case to be one of liability. Only then can the physician make an informed decision as to whether to resolve the case or proceed to trial and assume the risk of an adverse verdict.

Conclusion
Avoiding mistakes in the doctor-patient relationship is critical to avoiding liability for medical malpractice.

About the Author
Terry Anne Woodward, Esq., was admitted to the bar in 1989, and spent the first portion of her career defending large teaching hospitals, HMOs, and private doctors and hospitals, including at trial and in binding arbitrations. She obtained her law degree from Loyola Law School and also attended the University of San Diego Institute on International and Comparative Law. Her trial skills were first identified in 1987, when she earned the American Jurisprudence Award in Trial Advocacy. She is currently working as a trial attorney practicing medical malpractice defense with Moore, Winter, Skebba and McLennan, in Glendale, Calif. Woodward can be contacted by telephone at 818-240-2600.

Chapter 18 Managed Care

18.1 The 10 Biggest Legal Mistakes Physicians Make in Managed Care Contracting
By Maria B. Abrahamsen, Esq.

Executive Summary
Physicians who are presented with a proposed provider participation agreement by a managed care organization (MCO) often look only at the fee schedule or capitation rate (as applicable) in deciding whether to sign the agreement. However, there are many other important provisions in MCO contracts that will determine whether the contract ultimately is favorable to the physician. Even if the individual physician does not have sufficient bargaining power to cause the MCO to change the terms of its standard contract, it is still essential that the physician analyze the contract carefully in order to decide whether to sign it.

Mistake 1 Having Insufficient Knowledge About the MCO
The financial health and “provider-friendliness” of MCOs vary widely. Physicians should be familiar with the fiscal strength and claims processing history of an MCO before contracting with it. Information on an MCO’s solvency, timeliness of claims processing, and claims denial rates is often available from state insurance agencies and health care trade associations. If the physician identifies the MCO’s weaknesses and areas of likely conflict before negotiations begin, the physician may be able to negotiate contract terms that will adequately protect the physician’s interests. In some cases, the physician may decide not to pursue a contract with a particular MCO based on the results of such “due diligence.”

Action Step Physicians should research the MCO’s financial strength and business practices before deciding to contract with the MCO.

Mistake 2 Failing to Understand the Meaning of “Covered Services”
The typical MCO-physician contract requires the physician to provide (or arrange for) “covered services” to the MCO enrollees who seek service from the physician. A physician cannot understand what commitment he or she is making unless the term “covered services” is clearly defined. The definition of covered services is particularly important in capitation contracts in which the physician agrees to provide all covered services the enrollee needs in exchange for a lump sum (capitation) payment from the MCO.

Physicians should be alert to any language that allows the MCO to change the definition of covered services during the term of the contract without the physician’s consent or bases the definition of covered services on another document, such as the patient’s employment benefit plan. Such clauses are particularly dangerous in a capitation contract because they permit the
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MCO to expand the scope of the services the physician is required to provide, with no guarantee of a corresponding increase in the capitation payment.

Some MCO contracts include in the definition of covered services, goods and services that the physician cannot personally provide (e.g., eyeglasses, services of physicians in other specialties or of nonphysicians, and even facility services such as nursing homes). It is essential that physicians understand what services they are required to arrange for and whether they have any control over the source and price of those items. In some cases, the physician may be financially at risk for these other items or services.

**Action Step** Physicians should scrutinize the definition of covered services and analyze whether the services are the types of services they typically provide, and whether the compensation offered by the MCO is acceptable in light of the services the physician is obliged to provide (personally or through others).

**Mistake 3 Paying Insufficient Attention to Payment Formulae**

Physicians focus on the dollar amounts in the MCO’s fee schedule or capitation rate in deciding whether the proposed MCO contract is a good deal. However, these rates may tell only part of the financial story. Many contracts state that the capitation or fee schedule payments to the physician are subject to interim reductions (withholds) that are ultimately paid only if the physician meets certain quality and/or utilization targets.

It is also common to reduce physician payments to fund deficits in MCO accounts that are used to pay for pharmaceuticals or facility or specialty services used by the physician’s patients. Such payment reductions can be particularly frustrating if the physician has limited or no control over the patient’s use of specialist or facility services or the source or cost of these services. Legal counsel can assist the physician in deciphering complex compensation formulae and identifying situations that could cause the physician to be paid at less than full contractual rates.

The deadline for payment is another important element of the payment formulae. No matter how favorable the payment rate, the overall effect of the contract may be unfavorable unless it specifies a reasonable deadline for the MCO to pay claims, reconcile risk arrangements, and refund withholds.

**Action Step** Physicians, with the assistance of experienced counsel, should carefully analyze all elements of the compensation formulae stated in the contract.

**Mistake 4 Signing a Blanket Agreement to Comply with MCO Policies**

Most MCO contracts include a seemingly benign requirement that physicians comply with all MCO policies and procedures. This provision locks physicians into complying both with
existing and new MCO pronouncements. Physicians should review all existing MCO policies before signing a contract because the policies may substantially affect their right to payment (e.g., preauthorization procedures and medical necessity standards). Physicians should also attempt to negotiate contract language that:

- Obligates the MCO to provide the physician with advance written notice of new policies
- Allows the physician to terminate the agreement early and without penalty to avoid an unacceptable new policy
- Exempts the physician from complying with any MCO policy that is inconsistent with the terms of the physician’s contract with the MCO.

**Action Step** Physicians should understand the contents of the MCO’s existing policies before agreeing to comply with them and should not make a blanket agreement to comply with all future MCO policies.

**Mistake 5 Making a Broad Indemnification Commitment**
MCO agreements often contain a broad commitment by the physician to indemnify and defend the MCO. Such a clause typically obligates the physician to indemnify the MCO for liability (including settlements, judgments, and litigation costs such as attorney’s fees) that the MCO incurs as a result of the physician’s actions (and perhaps also the actions of others). Physicians should delete indemnification clauses, if possible, since even without the indemnification clause the MCO can sue the physician for damages caused by the physician’s actions. Physicians should confirm whether their professional liability insurance covers indemnification commitments; often it does not.

**Action Step** Physicians and their counsel should consider carefully before including any indemnification clause in the MCO contract, particularly if the obligation to pay under the clause is not covered by insurance.

**Mistake 6 Having No Assurances of Timely Reporting by the MCO**
If the amount of payment the physician receives from the MCO is affected by utilization, it is essential that the physician receive timely utilization reports. For example, if a primary care physician receives a monthly capitation payment from an MCO, it is common for all or part of the cost of drugs and specialist and facility services the physician’s patients use to be deducted from the capitation. The primary care physician can determine if utilization problems exist (and analyze and solve them) only if the MCO provides the physician with timely, meaningful, and reliable reports of the “outside services” that are charged against the physician’s capitation.
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**Action Step**  If utilization rates affect a physician’s payments from a MCO, the physician should ensure that the contract requires the MCO to provide timely and reliable utilization reports.

**Mistake 7  Allowing the MCO to Amend the Contract Unilaterally**
Physicians tend to ignore contractual “boilerplate” provisions (usually located near the end of the agreement) on the assumption that they do not really affect the parties’ rights. This approach can result in nasty surprises. A key boilerplate provision defines the process for amending the contract. Some MCOs reserve to themselves a right to amend the agreement at any time simply by giving the physician written notice of the change. This means the MCO could change key terms of the agreement (such as payment rates, term and termination, and scope of covered services) without the physician’s consent.

Alternatively, the contract may authorize the MCO to send the physician a written notice of proposed amendments, which become effective automatically unless the physician objects in writing within a specific number of days. This is a dangerous approach because of the risk that the notice will not be received, the notice will not be reviewed by a knowledgeable individual in the physician’s office, or the deadline for objecting to the amendment will be missed.

**Action Step**  A high priority for physicians when negotiating managed care contracts is requiring that all amendments to the contract (including any reductions in payment rates) be agreed to in writing and in advance by both parties.

**Mistake 8  Having No Effective Penalty for the MCO’s Breach**
A typical contract allows either party to terminate the agreement if the other party breaches the contract and fails to correct (cure) the breach within a specified number of days after receiving written notice of the problem. The most likely breach of a provider agreement by the MCO is failure to make full and timely payment to the physician. Under a typical termination provision, the physician would notify the MCO of the MCO’s breach. The MCO could then avoid termination of the contract by paying the delinquent sum to the physician just before the termination deadline. Unless the MCO is penalized for making late payments, the MCO has no incentive to improve its performance.

A fairer result for the physician can be obtained if the contract requires the MCO to pay the physician interest on overdue amounts or increases the rate paid to the physician for services that are performed while the MCO is delinquent.

**Action Step**  Physicians should include in MCO contracts an effective penalty to motivate the MCO to make prompt payment of the full amount due.
Mistake 9  Having No Right to Terminate
A physician can afford to accept many “imperfections” in an MCO contract so long as the physician has a right to terminate the agreement without cause and without penalty on relatively short notice. Conversely, if the physician is locked into a contract and is able to terminate only if the MCO clearly breaches, then the physician needs to be certain he or she is well protected by the contract terms.

If a physician insists on a right to terminate the contract without cause on short notice (e.g., 30 or 60 days), the MCO likely will insist on having the same right. Therefore, the physician needs to weigh the benefits of being able to terminate the contract easily against the risk the MCO could abruptly terminate the physician’s participation without cause.

Action Step  Physicians, with advice of counsel, should consider the benefits of negotiating a right to terminate the agreement easily without cause, and the disadvantages of granting the MCO an equivalent right to end the agreement easily.

Mistake 10  Not Paying Attention to the Post-Termination Obligation to Treat MCO Enrollees
A real trap for the unwary is a contract clause that obligates the physician to continue to treat MCO enrollees after the physician’s contract with the MCO is no longer in effect. Physicians should consider the following issues in analyzing such contract language:

- Which enrollees must the physician continue to treat? The contract should clearly address this point; the answer likely will be different for primary care physicians (who have long-term relationships with specific patients) and for specialists.
- How long is the physician obliged to continue services? Physicians should avoid open-ended commitments, such as continuing to treat the MCO’s enrollees until they can find another physician, until the MCO arranges for a replacement physician, or until the patient’s treatment is complete. Such commitments could require the physician to treat noncompliant and otherwise difficult patients or patients with chronic illnesses indefinitely, while not receiving the benefits of full participation with the MCO.
- At what rate will the physician be paid for post-termination services?
- Are the physician’s post-termination obligations reduced (or eliminated) if the contract was terminated because the MCO failed to pay properly? Physicians need to avoid long-term commitments to continue treating an MCO’s enrollees in cases in which the contract ended because the MCO was unable or unwilling to pay the physician.

Action Step  Physicians and their counsel should focus on any proposed obligations by the physician to continue treating the MCO’s enrollees after the parties’ contract has ended. In some states, MCOs are obliged to include in their provider agreements specified language
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regarding post-termination services; physicians should be familiar with any such requirements in their state.

Conclusion
Physicians undertake major financial and service commitments by entering into a participation agreement with an MCO. It is essential that they understand the common pitfalls in such contracts and attempt to avoid them.

Additional Resources
- Medical Management Institute, *Negotiating Managed Care Contracts* (Practice Management Information Corp., 2004)

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18.2 The 10 Biggest Legal Mistakes Physicians Make in Dealing with Managed Care Contracts
By Neville M. Bilimoria, Esq.

Executive Summary
Unsuspecting physicians should be careful when teaming up with managed care companies (MCCs) to provide care for MCC enrollees. Failure of physicians to be on guard when it comes to dealing with MCCs can lead to costly results, including payment of recoupment amounts to MCCs and denied claims or untimely paid claims. Physicians should be very careful in how they negotiate their contracts with MCCs and should not merely sit by the wayside, hoping that MCCs will be looking out for their interests. Unfortunately, MCCs have
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become increasingly sophisticated in their contract negotiations with physicians. On the flipside, physicians often believe that if they “go with the flow” and sign up with various MCCs to provide care like all the other physicians, that they somehow will be protected. Such mistakes can lead to costly results and make the practice of medicine for physicians frustrating and often altogether unrewarding.

Mistake 1 Consulting Counsel Too Late
Many physicians do not realize that virtually every contract provision is “negotiable” and that they can negotiate with MCCs. Unfortunately, many physicians wait by the wayside until a problem occurs in the relationship and then involve counsel to try to save a poor result. Waiting for problems to arise often results in the problem taking hold, sometimes leaving little chance of escaping an untoward result. Consulting with counsel before entering into contracts with MCCs is a must in today’s health care environment. Counsel can assist physicians in negotiating key terms in MCC contracts that can help to avoid problems in the future; counsel can also educate physicians on the reality of the arrangement they are about to enter into.

Action Step Physicians should consult with counsel at the earliest point possible, well before signing a contract with an MCC, to prevent problems in the physician-MCC relationship.

Mistake 2 Believing That Getting Lawyers Involved Only Leads to Strained Relationships with MCCs
Many physicians purposely avoid consulting counsel to make their dealings with MCCs less contentious or to avoid confrontation with MCCs. After all, many physicians believe that being part of an MCC as a provider will further their practice and enable them to flourish. However, consulting with counsel does not mean that the physician necessarily is being confrontational with the MCC. Appropriate counsel can foster the relationship between the physician and the MCC by ensuring that both parties fully understand the rights and responsibilities being placed on each of them. Physicians need to understand that the contract being placed in front of them has been drafted, amended, and continually reviewed by the MCC’s counsel. So, attorneys have already been involved in the process by the time they receive the agreement.

Action Step Physicians should not be afraid to negotiate contracts with MCCs for fear that such negotiations may alienate them from the MCC. Consulting with counsel can have a beneficial, rather than a deleterious, effect on the relationship.

Mistake 3 Believing That Managed Care Contracts Are Boilerplate
Physicians often think that MCC contracts are the same for all physicians, perhaps because they feel that the MCCs they are dealing with are so large and make no room for any
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negotiation. As a result, many physicians will not take the time to even read the MCC contracts before signing them. Physicians fail to realize that MCC contracts are drafted strongly in favor of the MCC and against the physician. By law, managed care contracts must be negotiated and cannot be boilerplate. Physicians may realize too late that the key is looking at the details of the contract, not the goodwill, verbal assurances, or marketing of the MCC.

**Action Step**    Physicians should always negotiate their managed care contracts, never accepting them as boilerplate or standard contracts that will somehow favor them.

**Mistake 4  Failing to Identify External Sources to the Contract**
MCC contracts almost universally attempt to refer to performance obligations of the physicians in various MCC policies or procedures that are not contained directly in the contract. For example, an MCC contract may state: “Provider shall comply with all policies and procedures established or modified by payer from time to time.” Only in the health care world would a party to a contract be asked to sign an agreement without having read, let alone read and understood, many of the terms that the provider will be subject to. More recently, MCCs have been placing certain performance obligations on their websites for physicians to access readily. While this may seem like a good way to provide easy access to the MCC’s policies and procedures, physicians have virtually no ability to determine when changes are made to those policies on the website or to even verify that they are looking at the correct external source. Physicians should not be obligated to check MCC websites to make sure that they are complying with their ever-changing policies and procedures.

It is important that all of the obligations placed on physicians be known to them and preferably attached to a single document. Physicians can also insist that the external sources referred to in a contract be asked to sign an agreement without having read, let alone read and understood, many of the terms that the provider will be subject to. More recently, MCCs have been placing certain performance obligations on their websites for physicians to access readily. While this may seem like a good way to provide easy access to the MCC’s policies and procedures, physicians have virtually no ability to determine when changes are made to those policies on the website or to even verify that they are looking at the correct external source. Physicians should not be obligated to check MCC websites to make sure that they are complying with their ever-changing policies and procedures.

**Action Step**    Physicians should make sure that they check all external sources and the contract accordingly to make sure that external sources referred to in the contract are not altered without their consent, and are attached to the contract that is actually signed by the parties.

**Mistake 5  Failing to Properly Define Medical Necessity**
MCC contracts often attempt to limit payments to providers by maintaining ultimate responsibility for medical necessity decisions on claims according to vague standards that allow the MCC to override a physician’s clinical judgment. When defining “medical necessity” in an MCC contract, physicians should make sure that the definition accounts for
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relevant practice standards in the area in which the services are provided. Often, the definition of medical necessity in contracts includes “the most cost-effective services or level of care that can safely be provided to an enrollee.” This least-cost standard serves only to compromise the art of medicine and to unnecessarily allow MCCs to deny claims that are properly performed and medically necessary consistent with professional standards of medical care.

**Action Step** Physicians should make sure that the definition of “medical necessity” in their contracts does not include a least-cost standard and that it is instead based on generally accepted practices in the field of medicine that they serve.

**Mistake 6 Failing to Strengthen Prompt-Payment Provisions**

Physicians know that delayed MCC payments are standard in today’s medical practice. Ironically, physicians experienced with late payments from MCCs do not take the time to negotiate promptness of payment with MCCs. Because delayed payment is a chronic problem in dealing with MCCs, physicians should be given a contractual right to prompt payment of all claims. For example, a naïve physician may think that the following provision is acceptable and would not cause problems for the physician in the MCC-physician relationship:

Late Payment. Payer shall make payments as provided above within an average of thirty (30) days after receipt of a timely and properly completed and submitted invoice. The thirty (30) day calendar shall not apply when there is an issue related to payment, in which case, any such issue shall be resolved by Payer.

While on its face, the 30-day time frame is sound, that time frame, as indicated, can, and often will, be delayed by the MCC. Physicians should insist that “clean” claims be paid promptly. Furthermore, contracts should also require MCCs to return claims that lack the necessary information within a certain number of days of receipt, and pay the claims within a certain number of days of receipt of the additional information requested. Physicians should also make sure that they attempt to negotiate interest on delayed payments to avoid chronic payment delays from MCCs or, more preferably, that claims not paid in a timely manner be paid at charges.

**Action Step** Physicians should clearly define prompt payment and force clean claims to be paid quickly and uniformly and make sure there are no gaps for MCCs to delay payments according to the terms of the contract.

**Mistake 7 Failing to Account for Termination of the Contract**

Physicians often do not pay attention to termination clauses in dealing with MCCs. Managed care contracts should include a statement of the parties’ continuing obligations after
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termination. The MCC should be obligated to pay the provider for services rendered to enrollees after the termination date at charges. Continuation of benefits is regulated in many states, and contract provisions should closely match state law requirements. Physicians should also be wary of patient abandonment upon termination of their relationship with an MCC. Concerns over physicians abandoning patients is receiving heightened attention in the courts, and unwary physicians without appropriate provisions in termination clauses could find themselves being sued for patient abandonment.

**Action Step** Physicians should pay close attention to termination clauses and make sure that continuity of care is provided even after the contract ends with the MCC.

**Mistake 8 Failing to Enforce Agreements with MCCs**

Many physicians are left powerless by breaches of MCCs—if they even know about the breaches. Physicians should be careful to monitor and track MCC activities. For example, physicians should track the timeliness of MCC payments. Often, physicians do not realize that each and every payment made by an MCC over the course of a year may, in fact, be late and in breach of the contract provisions. Physicians should promptly notify MCCs when they are delinquent in making timely payments to avoid late payment pile-ups. Physicians should also be aware of individual state late payment statutes.

When there is a problem in the relationship with the physician and an MCC, the physician should immediately seek to quantify the scope and cause of the problem. The physician should then meet with the MCC to resolve the issue informally. This is the most cost-effective route to dealing with problems with MCCs. After analyzing the situation and meeting with the MCC, the physician needs to determine whether to demand compliance from the MCC or whether to negotiate revisions to the contract.

**Action Step** Physicians should monitor, monitor, and monitor their relationship with their MCC and promptly notify the MCC when it is breaching contract terms or acting unfairly under the contract.

**Mistake 9 Defining “Covered Services” Inappropriately**

MCCs may require that providers furnish all basic health care to enrollees. The definition of “covered services” should, however, limit a provider’s obligation to the services it customarily provides at the time the contract is signed. The definition should also acknowledge changes in codes relative to existing services, as well as new services, and the reimbursement that will be paid for such services.

**Action Step** Physicians should be mindful of “covered services” definitions in their MCC contracts to prevent MCCs from unilaterally changing these definitions, which could result in denied claims.
Mistake 10  Failing to Allow Physicians to Audit MCCs
Typically, MCC contracts have detailed and lengthy provisions allowing MCCs to have access to physician records with respect to payments received by the physician. However, physicians often fail to have a reciprocal clause in their contracts allowing the physician access and audit procedures against the MCC. Usually, MCCs have rights to inspect, review, and make copies of records maintained by a physician and to conduct periodic audits of physician records whereby the MCC will unilaterally notify the physician of the audit results. MCCs will also sneak in a clause requiring that all amounts that the MCC deems owing as a result of an audit should be promptly paid by the physician. A more beneficial provision would allow both parties to have access to the audit procedures of the other party. Identifying a standard for audits, such as the National Health Care Billing Audit Guidelines, is often beneficial in that such a standard prevents physicians from being subject to onerous or burdensome audits by the MCC. Physicians should also require that the parties negotiate in good faith to resolve any disputes identified in the audit. Finally, any audit disputes that cannot be resolved should be submitted to arbitration for prompt resolution.

Action Step  Physicians should seek to make audit procedures reciprocal and take steps to audit questionable practices by the MCC in an effort to maintain fairness in the MCC-physician relationship.

Conclusion
Physicians who become aware of these mistakes will be better equipped monetarily, psychologically, and legally to deal with MCCs in everyday practice. Failing to understand these mistakes can lead to expensive problems for physicians and an altogether unwieldy relationship with an MCC.

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Executive Summary
For most physicians and physician group practices, success in negotiating managed care contracts is a vital factor in overall practice success. To avoid common contracting mistakes, successful negotiation with a managed care organization (MCO) requires both thorough preparation and careful attention to the specific terms of the contract. Because of the magnitude of what is being undertaken, no managed care contract should ever be signed unless and until the contract has been carefully reviewed and its implications are fully understood.

Mistake 1  **Not Adequately Specifying the Precise Services to Be Covered or the Exact Compensation to Be Paid**
Physicians and group practices regularly enter into managed care contracts that do not clearly specify the precise services that are to be covered under the contract or the exact compensation that is to be paid for the services provided under the contract. Often, covered services are either poorly defined or not defined at all. Similarly, managed care contracts often provide that reimbursement will be made pursuant to the MCO’s fee schedule then in effect, or pursuant to a fee schedule attached to the contract that is incomplete or lacks specificity. Physicians also commonly fail to consider whether new procedures will be covered or how catastrophic cases and technologically advanced services or products will be reimbursed, if at all. Also, when providers are risk bearing, they occasionally fail to ensure in the contract that they will have adequate access to the financial information maintained by the MCO that is needed to verify proper reimbursement. Providers sometimes even unintentionally consent to participate with respect to “all products” of the MCO.

**Action Step**  Physicians should insist that separate schedules be attached to the managed care contract identifying the precise services covered under each of the MCO’s plans or products. Likewise, for each of the MCO’s plans or products, separate schedules should be attached to the managed care contract identifying the exact compensation that is to be paid by the MCO for each covered service.

Mistake 2  **Agreeing to Be Bound by Policies and Procedures That Have Not Been Reviewed and That Are Not in the Contract**
Many physicians and group practices enter into managed care contracts that state that the provider will be bound by the MCO’s policies and procedures as they exist from time to time. Often, such policies and procedures are never actually produced for the provider or reviewed
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by the provider until after a dispute has arisen. Also, physicians and group practices often cede to the MCO the ability to change policies and procedures unilaterally at will, regardless of any adverse effect such changes may have on providers.

Action Step  Physicians should insist that any policies or procedures be attached to the managed care contract and that no changes to the policies or procedures will be binding on the provider without the provider’s written consent.

Mistake 3  Allowing the MCO to Hide the Devil in the Definitions
On a regular basis, physicians and group practices enter into managed care contracts without fully comprehending how efficiently MCOs can in effect take back in one portion of the contract what they appear to be giving away in another portion of the contract. For example, MCOs have become extremely adept at using definitions to restrict their liability to providers or to otherwise shift the contract in a way that does not comport with the provider’s reasonable expectations:

- “Medically necessary”—Often defined in a manner that allows the MCO’s medical director to second guess clinical decisionmaking after the fact using vague standards
- “Emergency medical condition”—Sometimes defined in a manner that allows the MCO to deny payment using a standard other than the “prudent layperson” standard
- “Payer”—Often defined in a manner that allows inappropriate third-party access to physician discounts (e.g., “silent PPOs” and “renting” of discounts); also, when an MCO is administering a product for a self-funded employer plan, “payer” is commonly defined in a manner that absolves the MCO from any payment obligation, even when the managed care contract does not provide an adequate enforcement mechanism against the self-funded employer plan, which usually has no direct contractual relationship with the provider.

Action Step  Physicians should carefully review the entire managed care contract, including the definitions, and seek professional legal advice before signing the contract if they have any questions about the parties’ respective duties and obligations.

Mistake 4  Failing to Insist Upon Contract Provisions That Ensure Prompt and Fair Reimbursement
Unfortunately, physicians and group practices often enter into managed care contracts that do not contain provisions necessary to guarantee prompt and fair reimbursement. For example, some important provisions that are often omitted include the following:

- Uncomplicated procedures for efficiently obtaining from the MCO (or other payer) a binding advanced verification of a patient’s enrollment 24 hours a day, seven days a week, and 365 days of the year
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- Detailed coding standards and requirements that prohibit bundling and/or downcoding by the MCO (or other payer)
- Clear claim submission procedures and deadlines, together with an easy process for obtaining from the MCO (or other payer) a binding acknowledgment of claim receipt
- An unambiguous definition of “clean claim” placing the burden on the MCO (or other payer) to timely (e.g., 10 days) return any allegedly insufficient claim with a detailed written description of the specific purported deficiency. If the MCO (or other payer) fails to timely do so, the claim should be deemed a “clean claim” for all purposes.
- A prompt payment provision specifying how many days the MCO (or other payer) has after claim submission to make payment on clean claims and providing for a significant penalty (e.g., total billed charges) and interest on untimely payments
- A clear coordination-of-benefits clause providing that the MCO (or other payer) is obligated to make payment unless, within some reasonable time frame (e.g., 72 hours following claim submission), the MCO (or other payer) can document to the provider’s satisfaction that the MCO (or other payer) is secondary, and further providing that the MCO (or other payer) is not relieved of its payment obligation if the primary payer has not made payment within a specified time after claim submission
- A provision providing that the MCO (or other payer) is obligated to timely pay the provider’s claims, notwithstanding the pursuit of subrogation rights against potentially responsible third parties.
- An exclusive list of all approved “payers.”
- An effective enforcement mechanism against “payers” that are self-funded employer plans, and against any other “payers” that do not have a direct contractual relationship with the provider.

Action Step  Physicians should insist on inclusion of contract provisions (such as those described in this Mistake) that ensure prompt and fair reimbursement.

Mistake 5  Not Restricting the MCO’s Ability to Make Retroactive Adjustments

Physicians and group practices commonly enter into managed care contracts that allow MCOs to make refund requests and/or adjustments long after the underlying claims were originally processed and paid. As a result, an MCO may determine that it has paid the physician more than it should have and unilaterally decided to offset the alleged “overpayment” against future reimbursement due to the physician.

Action Step  Physicians should reject any general clause in a managed care contract permitting the MCO to unilaterally make offsets or adjustments, and should instead insist on contract language allowing the MCO to request an adjustment only during the first 90 days...
after the physician’s receipt of payment. Any request for an adjustment should be required to be in writing and to detail the specific basis for the requested adjustment. If the physician disputes a requested adjustment and the MCO wants to pursue the matter further, the MCO should be required to follow the dispute resolution procedures in the managed care contract.

**Mistake 6 Agreeing to Inefficient and Costly Internal Grievance and Dispute Resolution Procedures**

When entering into managed care contracts, physicians and group practices regularly agree to be bound by inefficient and costly internal grievance and dispute resolution procedures that result in unnecessary delay. Often, multiple levels of appeals are required to be exhausted while there are no clear deadlines for the MCO to act, or penalties if the MCO fails to act timely. Similarly, many managed care contracts provide unreasonably short time frames for internal appeals of adverse claim determinations and have overly burdensome procedural requirements for making such appeals. Often, claim determinations and payments are deemed final for all purposes if the physician fails to comply with the MCO’s inefficient internal grievance and dispute resolution procedures.

**Action Step** Physicians should insist that any mandatory grievance or dispute resolution procedures be efficient and cost-effective, and should reject any unreasonable or overly burdensome dispute resolution procedures.

**Mistake 7 Limiting in Advance the Ability to Seek a Satisfactory Remedy If the MCO Fails to Perform**

Physicians and group practices often enter into managed care contracts that contain unreasonable restrictions on the provider’s ability to seek a satisfactory remedy if the MCO fails to fulfill its obligations. Some of the limitations often encountered include the following:

- Restrictions on when a claim may be asserted (e.g., contractual statute of limitation clauses)
- Restrictions on where a claim may be asserted (e.g., binding arbitration clauses and mandatory venue provisions)
- Restrictions on recoverable damages (e.g., limitations or caps on direct or indirect damages, attorney’s fees, costs of litigation)
- Failing to specify the circumstances under which the physician can collect from individual patients (e.g., noncovered services, ineligible patients)

**Action Step** Physicians should avoid contractually limiting their ability to seek a satisfactory remedy if the MCO fails to perform, and should attempt to remove from the contract any unreasonable limitations proposed by the MCO.
Mistake 8  Permitting the MCO to Make Unilateral Changes At Will, and Failing to Provide a Prescribed Mechanism for Periodically Renegotiating Reimbursement Rates

When entering into managed care contracts, physicians and group practices often agree that the MCO can unilaterally make changes to the contract and/or to the governing policies and procedures. Unbelievably, advance notice of the changes is sometimes not even required to be provided to the physician by the MCO. Also, physicians and group practices regularly sign managed care agreements containing no efficient mechanism for periodically renegotiating reimbursement rates (e.g., an inflation index and/or a prescribed annual review process).

Action Step  Physicians should insist that no changes to the managed care contract and/or policies or procedures will be binding on the physician without the physician’s written consent, and should ensure that the contract contains a prescribed mechanism for periodically renegotiating reimbursement rates. Physicians should also attempt to ensure that the contract contains a provision allowing the physician, at his or her option, to terminate participation with respect to individual plans or products of the MCO without terminating the entire contract.

Mistake 9  Neglecting to Adequately Consider Post-Termination Obligations and Restrictions Under the Contract

Physicians and group practices sometimes fail to give adequate consideration to post-termination obligations or restrictions contained in proposed managed care contracts. For example, some MCOs ask physicians to agree to provide care for patients for certain periods of time after termination, regardless of whether the patient is under a course of treatment at the time of termination, yet make no provision for compensating the physician for such services.

Action Step  Physicians should carefully analyze any proposed post-termination obligations and restrictions under a managed care contract, and should seek professional legal advice before signing the contract if they have any questions about the parties’ respective post-termination duties and obligations.

Mistake 10  Accepting Too Much When Agreeing to Indemnify and Hold Harmless the MCO

Far too often, physicians and group practices enter into managed care contracts that contain overly broad and unreasonable “indemnification” and “hold harmless” provisions that make the provider liable for assorted losses and expenses that may be incurred by the MCO.

Action Step  Physicians should insist that any overly broad or unreasonable “indemnification” and “hold harmless” provisions be deleted from any managed care contract before they sign the contract.
MANAGED CARE: NEGOTIATING CONTRACTS

Conclusion
By avoiding these mistakes, physicians and medical groups can help ensure successful negotiation of managed care contracts, and can increase the likelihood that their practices will succeed within the managed care arena.

Additional Resources
- Fontenot, Managed Care Contracts: What Do You Need To Know? (June 2002), http://www.sma.org/resident/manage_care.htm
- Medical Management Institute, Negotiating Managed Care Contracts (2003)

About the Author
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18.4 The 10 Biggest Legal Mistakes Physicians Make in Pay-for-Performance Programs
By Alice G. Gosfield, Esq.

Executive Summary
Pay for performance (P4P) is a new phenomenon intended to motivate physicians to improve the quality of the care they provide by paying them more money for meeting certain targets. Some programs get their money to pay physicians directly from employers (e.g., Bridges to Excellence (BTE), at www.bridgestoexcellence.com), while other programs are sponsored by the managed care companies themselves (e.g., the Integrated Health Association (IHA), at www.iha.org). Although these initiatives are new and there is little national experience with them, physicians should be aware of the potential legal issues involved when they consider participating in these programs.

Mistake 1  Not Understanding How the Determination to Pay Is Made
In a number of P4P programs, the BTE for example, determination as to whether to pay is based on a threshold of performance. Whether the physician qualifies is evaluated based on data reported by the physician to another entity, such as the National Committee for Quality Assurance. NCQA certifies an appropriately performing physician as a “recognized diabetes physician” or a “recognized heart and stroke physician” in accordance with the standards set forth in NCQA’s physician recognition programs. This certification qualifies the physician for a single payment (e.g., $100) per patient per year for each condition for which the physician is certified. The number of patients that determines the total payment is based on the managed care payers’ data. In other programs, all participating physicians are divided into tiers, based on their performance in comparison with each other. In these programs, whether any payment will be made depends on the behavior of the other physicians who are participating and not just on the actions of the physician hoping to be paid.

Action Step  Before physicians decide to participate in P4P programs, they should make sure they understand whether they will be paid if they meet the targets or whether their payment will depend on how they rank in comparison with other physicians whom they do not know and may never know.

Mistake 2  Not Knowing If a Legal Right to Access the Comparative Data Exists
Most P4P programs are take-it-or-leave-it propositions. They are not set forth in a contract or an amendment to an existing contract. As a result, a physician may disagree with the

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determination as to whether or how much he or she will be paid, but there is no legal right for
the physician to see what other physicians have done or how they performed in order to
ascertain how the physician ranked or whether he or she should have qualified in comparison
with others.

**Action Step** Physicians should ask for and review all the descriptions of the program,
including any contract addenda or amendments to see whether they have a right to review the
data upon which their pay will be based. Physicians might also look at their state managed
care reform legislation to see whether there are generic provisions that were enacted or
regulations that were published before P4P existed that could be used to get access to the
data.

**Mistake 3 Not Figuring Out What It Will Cost to Get the Money**
The amounts paid in P4P programs are quite variable. Some are enhancements to the
capitation rate the physician is already being paid. Some are a flat amount per patient once a
physician qualifies. Some programs do not just pay more, they lower administrative burdens
by giving the participating physicians personal digital assistants or permitting them to
prescribe off formulary. Still, the point of P4P programs is to change physician behavior.
Therefore, physicians may incur costs as they put themselves in a position to get the
additional money. Staff time to cull data from medical records is estimated at 15 minutes per
chart reviewed for NCQA’s diabetes physician recognition program. Some physicians report
their staff having to spend time validating health plan data upon which the physicians are
paid. Physicians who have not been providing enough of the evidence-based services that the
P4P program rewards may incur additional costs in time, equipment, and personnel to get up
to the targets for payment. For physicians who have been overutilizing services, some of their
revenue may decline. So will some of their costs associated with the services they no longer
will provide, but whether these are equal amounts is the real question.

**Action Step** It is important that physicians analyze as closely as possible what it will take
in their practice to reach the P4P targets. Costs in terms of new equipment, supplies, and staff
time should be evaluated. This evaluation will show whether the additional revenue will
translate into improved profit rather than just more revenue.

**Mistake 4 Assuming the Payer Has a Legal Obligation to Pay**
Astonishingly, many P4P programs are not documented in any contractual provision. BTE,
for example, does not use any contracts with the physicians involved in the program. This
means that while the physicians may work hard to reach the targets, there is no legal
obligation on the party with the money to pay them the enhancement pay they expected. On
the other hand, in some cases, such as some payers in California that are part of the IHA
initiative, there is an amendment to their basic contract that establishes the program.
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**Action Step**  It is critical for physicians to know before they get into the program whether they will have any right to assert that the plan or payer has breached the contract if they are not paid or are not paid as much as they think they earned.

**Mistake 5  Assuming a Right to Appeal the Enhanced Payment Determination Exists**

Even when they use a contract amendment to establish the payment system, several of these programs have stated explicitly that physicians have no right to appeal the determination that they qualify for payment or the amount they will be paid. This means that the physician’s decision to change his or her behavior on the expectation of being paid should be seen as a gamble. These programs may end up functioning just fine, but there is also good reason to believe that some of them will end up not operating as advertised.

**Action Step**  Groups that are big enough might have enough clout to ask for contract amendments that give appeal rights. Otherwise, physicians should make the decision regarding participation with the understanding that doing so is not without risk.

**Mistake 6  Not Knowing If Others Are Being Paid to Influence the Care That Determines the Basis for Payment**

The health conditions that are often the subject of P4P programs (e.g., diabetes, congestive heart failure, asthma, and coronary artery disease) are also sometimes the subject of the disease management programs of an important managed care plan. Whether the disease management is performed by an outside company or by the plan itself, these programs are also designed to improve outcomes, utilization, and patient compliance, and the outside vendor is often paid based on improved savings. In no discussion of P4P programs has information been provided about the interaction of these programs.

**Action Step**  Physicians should ask if there is also a disease management program in place at the managed care companies in which the P4P program is being rolled out in an area that is important to their practice. If so, they should try to determine what the disease management program is trying to accomplish. In some instances, physicians may find that the presence of such a program may help them; in other instances the disease management program may present additional challenges.

**Mistake 7  Not Understanding the Relationship Between the P4P Program and Existing Contractual Obligations**

Physicians must comply with the standard provisions in managed care contracts involving the

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managed care programs of the plan (e.g., quality improvement, utilization
management, NCQA accreditation). If a cardiologist, for example, seeks to be an NCQA
recognized diabetes physician, the cardiologist’s ability to get the outcomes of his or her
patients to the levels that qualify for payment (e.g., diagnostic test results) might require
increased numbers of office visits. If the plan compares the cardiologist to his or her peers
and finds that the cardiologist has a higher number of office visits, or if payment for the
additional visits is denied because the norms used in the utilization management program
differ from the P4P expectations, what will happen to the cardiologist? These issues are also
generally unaddressed. Further, when the P4P money comes from the employer, as in the
BTE program, but the basic managed care contract uses different standards, inconsistencies
may result.

**Action Step**  Physicians should be sure to review their basic participation agreement and
provider manual to clarify which programs may have an effect on their behavioral changes
made to produce the appropriate results. They should try to obtain an amendment to their
contract such that the plan’s utilization management program cannot penalize them for
actions they may take in furtherance of the P4P program.

**Mistake 8 Not Appreciating the Potential Effect of Adverse Selection**
One of the fundamental principles of P4P programs is “transparency,” increased data on
quality performance made available to patients, as suggested in the principles set forth in
*Crossing the Quality Chasm*,¹¹ the Institute of Medicine study that led to the creation of many
of these programs. To the extent that a physician who is performing well under these
programs is seen in a health care report card as an excellent provider, the result may be that
sicker patients with the condition for which the physician is receiving additional money may
flock to his or her practice. If the physician is being paid on a capitated basis, the resulting
“adverse selection” would produce a patient panel profile most likely quite different from
what the actuarial assumptions were when the capitation rate was set. As a result, that
physician will have to provide more services to a sicker population for the same amount of
money. The paradoxical financial effect may be that by performing effectively in a P4P
program, over the long run the physician may significantly disadvantage himself or herself.

**Action Step**  Physicians who are paid on a capitated basis while participating in a P4P
program should seek the ability to limit the numbers of patients with the disease condition
addressed in the program. Alternatively, participating physicians might bargain for an
increase in the capitation rate if their proportion of the target patients increases by some
predetermined amount (e.g., 10%) over a defined period of time.

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Mistake 9  **Not Recognizing Potential Liability in Self-Reporting Data**
Some P4P programs are predicated on data reported by the physician. If a physician overstates or even misstates data upon which additional payment would be made, insurance fraud liability may result. False claims liability extends to any statement made to secure reimbursement, even in private insurance and not just the public programs of Medicare and Medicaid. In general, to prove liability, intent is important, depending on the circumstances; however, this new form of data production may increase a physician’s liability.

**Action Step**  Physicians participating in P4P programs should include monitoring of the accuracy of data before it is submitted as part of their general compliance efforts.

Mistake 10  **Not Recognizing a Potential Shift in the Standard of Care Even If Not Participating in the P4P Program**
According to some predictions, even if a physician chooses not to participate in a P4P program, the standard of care that is represented in the targets that the P4P programs are looking to produce may, over time, emerge as the expected standard of care within communities where these programs exist. Since the programs are predicated on the principles of evidence-based medicine, they may, impliedly at least, speak to the standard of care under any circumstances. Plaintiff’s attorneys may seek to use these programs as a new basis for malpractice liability when physicians do not do what the P4P programs require.

**Action Step**  Physicians who choose not to participate in P4P programs would be well advised to think carefully about what they are doing in their own practices, whether or not they are being paid for behavior that differs from that of their colleagues. While not currently an issue, it is not difficult to predict that it might become one in the near future.

**Conclusion**
Pay-for-performance programs are a new phenomenon with potential legal and operational pitfalls for physicians. Still, they represent an important recognition that not all physicians should be paid the same way, and that more evidence-based medicine deserves enhanced payment. While the final story will unfold over time, these programs should be examined carefully by those who would participate. Physicians should consider other potential approaches to increasing their profit margins and improving their clinical outcomes as well.

**Additional Resources**
MANAGED CARE: PAY-FOR-PERFORMANCE PROGRAMS


About the Author
Alice G. Gosfield, Esq., has a national law practice that has been limited to health law since 1973, emphasizing representation of physicians and physician organizations. A past president of the National Health Lawyers Association (1992-1993), she also was chairman of the board of directors of the National Committee for Quality Assurance from 1998 to 2002, and served as a board member for 12 years. Gosfield’s practice addresses issues related to Medicare reimbursement, fraud and abuse avoidance (including the Stark and antikickback statutes), contracting, managed care issues, hospital medical staff concerns, and quality improvement, among others. She has been listed in every edition of The Best Lawyers in America (Health Law). She may be contacted at Alice G. Gosfield and Associates PC, 2309 Delancey Place, Philadelphia, PA 19103; by telephone at 215-735-2384; by fax at 215-735-4778; or by e-mail at www.gosfield.com.

Chapter 19 Medicaid

19.1 The 10 Biggest Legal Mistakes Physicians Make When Dealing with Medicaid Patients, Claims, and Issues
By William F. Sutton, Jr., Esq.

Executive Summary
Medicaid is the state-administered health care program for welfare recipients, indigent individuals who meet state eligibility requirements, and certain people who meet the federally specified poverty guidelines. Medicaid is financed with state and federal funds and is operated by the individual states in accordance with certain federal laws and regulations. The entity that administers the Medicaid program in a particular state is commonly known as “the single state agency,” which is a state government entity. Typically, the single state agency will contract with a private company, commonly known as a “fiscal agent,” to receive, process, and pay claims received from health care providers who elect to participate in the Medicaid program.

To ensure that there is an adequate number of health care providers available to treat people eligible for the Medicaid program, single state agencies must contract with health care providers interested in participating in a state’s Medicaid program. As a result, health care providers interested in participating in a state’s Medicaid program are required to enter into a contract with the single state agency in order to provide services to Medicaid patients. These contracts typically provide terms and conditions that the health care provider must abide by while participating in the Medicaid program. If the provider breaches one of these conditions, the provider will be deemed by the state agency to be in violation of the contract, resulting in termination of the contract in addition to other sanctions. To avoid such sanctions, physicians who elect to participate in a state Medicaid program should learn to avoid the following mistakes.

Mistake 1 Making Enrollment Errors
As part of the Medicaid provider contracting process, physicians are required to answer questions on Medicaid provider enrollment forms prepared by the single state agency. Due to a lack of attention to detail, physicians often fail to answer or fully respond to questions on these forms, resulting in a rejection of the enrollment packet by the single state agency or its fiscal agent. Also, inaccurate information may result in a subsequent termination of the physician’s contract, in addition to punitive actions by the single state agency based on false statement allegations.

Action Step During the provider enrollment process, it is critical that physicians carefully review the provider enrollment forms and answer all questions completely and accurately. There can be no guessing or conjecture. Before completing the enrollment application,
physicians should be sure that their licensure information is current and correct, that they are in compliance with all regulatory requirements for their specialty, and that all licensed personnel employed by the group are properly credentialed, since the enrollment application will likely cover these issues. A properly completed Medicaid provider enrollment application will eliminate significant administrative obstacles and avoid the possibility of subsequent civil or criminal charges stemming from allegations based on false responses to provider enrollment questions.

Mistake 2  **Failing to Read the Medicaid Provider Handbooks**  
After enrolling in the Medicaid program, participating physicians receive a copy of what is typically known as the Medicaid Provider Handbook. This handbook covers issues relating to covered services, proper billing and coding, and (on occasion) standards for treatment.

**Action Step**  It is critical that participating physicians obtain and carefully read the Medicaid Provider Handbook to determine what the program expects of them. They should contact the single state agency if they have any questions about any matter covered in the handbook. Failure to abide by the guidance in the handbook could result in administrative sanctions by the single state agency, including recovery of money previously paid to the physician or termination from the Medicaid program.

Mistake 3  **Failing to Check Medicaid Recipient Eligibility**  
After enrolling in the Medicaid program and beginning to see patients, it is incumbent upon physicians to ensure that the patients they are treating are, in fact, eligible Medicaid recipients. Normally, Medicaid recipients are issued recipient identification cards containing their identification number, which is the number physicians need to submit a claim for payment to Medicaid. When patients present for treatment claiming to be Medicaid-eligible, the physician’s staff should ask for their Medicaid identification card and, if possible, some other form of identification. This is necessary to ensure that the people presenting for treatment are, in fact, who they say they are and are eligible for Medicaid benefits.

**Action Step**  Verifying a patient’s Medicaid eligibility is the best way for physicians to ensure that they are not expending time and effort for services that may not be reimbursed. Treatment rendered to ineligible recipients will not be reimbursed by Medicaid and, in some instances, the single state agency may attempt to recover from the physician funds that were paid for the treatment of ineligible patients. These problems are easily avoided by instituting simple processes to verify patients’ Medicaid eligibility before rendering services, which include asking patients to produce their Medicaid identification card or other item issued by the single state agency establishing eligibility for services.
Mistake 4  **Allowing Unqualified or Incompetent People to Handle Coding and Billing**

Allowing unqualified or incompetent people to handle their coding and billing is perhaps the most catastrophic mistake that physicians make as participants in the Medicaid, or any other government health care, program. It is absolutely critical that the billing and reimbursement functions, including preparation of the claim forms, be handled by people who are knowledgeable and sufficiently skilled in coding medical claims. At a minimum, claims that are incorrectly coded or lack the necessary supporting documentation will be summarily denied for payment. Moreover, claims that are incorrectly coded and result in a higher level of reimbursement than warranted will expose the physician to sanctions, penalties, and, in some situations, criminal prosecution.

**Action Step**  As participants in a government-funded program, physicians are responsible for ensuring that all claims submitted for payment are medically necessary and properly billed. Accordingly, participating physicians must either employ or contract with people or entities experienced in coding and billing claims, including claims for services rendered to Medicaid recipients. While doing so will result in an investment of additional practice resources, it is a sound investment given the consequences associated with improper billing of services. There simply is no substitute for competent medical coding and billing of claims.

Mistake 5  **Assuming That All Government Health Care Laws and Regulations Apply to the Medicaid Program**

Although the Medicaid program is administered by single state agencies under guidelines set forth by the federal government, state Medicaid programs are often allowed to fashion their own regulations and guidelines that differ, and in some cases differ materially, from other health care program regulations. For example, a single state agency may define “physician supervision” more stringently than the federal Medicare program for a particular type of service.

**Action Step**  Physicians who participate in Medicaid should never assume that other government laws, regulations, or guidelines automatically apply to Medicaid. This is particularly true for covered services, coding and billing, and reimbursement. It is therefore absolutely critical for participating physicians to become familiar with the Medicaid Provider Handbook for their specialty and provide all services rendered to Medicaid recipients in accordance with those guidelines.

Mistake 6  **Failing to Take Immediate Action After Identifying Problems With Claims**

Often, upon receiving notice from the Medicaid fiscal agent that a series of similar claims will not be paid, physicians fail to take immediate action to investigate or identify the nature of the problem. Typically, the problem involves a small administrative error that is easily
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corrected. Some physicians, however, put the problem off until a significant backlog of unpaid claims builds up, compromising their financial position. Moreover, the failure to immediately address this problem may result in untimely resubmission of claims once the problem is identified and corrected.

**Action Step** When a series of claims is being denied, it is critical that the physician take immediate action. The physician or his or her staff should immediately contact the single state Medicaid agency or fiscal agent to receive a clear and concise explanation as to why the claims are being denied for payment. A participating physician who, in good faith, has been treating Medicaid patients is entitled to receive, and the single state agency is obligated to provide, an explanation of the billing problem. Once the problem has been identified and corrected, the physician may timely resubmit the previously denied claims for payment and avoid having similar errors in the future.

**Mistake 7 Failing to Properly Maintain Patient Charts and Related Records as Required**

Without exception, state Medicaid programs have requirements for maintaining patient records, including patient medical charts and related billing records. These requirements stem, in part, from the single state agency’s need to conduct periodic audits of participating physicians. If a single state agency conducts an audit and determines that the patient charts do not support the services that were billed, the agency could seek recovery of the payments made for those services. Moreover, the failure to produce records or charts will likely result in program sanctions. The Medicaid agencies routinely conclude that if a service is not properly documented, the Medicaid program should not pay for it.

**Action Step** Physicians participating in Medicaid must develop a systematic process for retaining patient records that complies with Medicaid’s record retention requirements. If the single state agency initiates an audit, physicians will be expected to produce records and related documents. Accordingly, physicians who enroll in their state’s Medicaid program should, as an initial step, identify the program’s record-retention requirements and set up internal policies and procedures that comply with these requirements.

**Mistake 8 Failing to Conduct Periodic Medicaid Billing Reviews**

A comprehensive health care compliance program normally requires physicians to conduct periodic claims reviews. These reviews ensure that physicians are billing in a compliant manner or identify any potential billing problems. Ordinarily, such problems are easily and quickly corrected. Left unchecked, however, even the smallest billing error can create a catastrophic financial problem, particularly if the physician typically submits a high volume of claims for payment. Also, physicians may face significant program sanctions if the government later determines that the billing problems were the result of reckless conduct or gross indifference.
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**Action Step** Each physician who elects to participate in Medicaid must have a periodic claims review system. Ideally, such a review would be conducted by an independent organization sufficiently skilled and experienced in government medical coding and billing. Such organizations typically select a random sample of a physician’s paid claims to determine if the physician is correctly coding for the services rendered. If the initial sample of claims demonstrates compliant billing, the review will stop. If the initial random review reveals problems, a more comprehensive review will be required. Under either scenario, billing problems will be identified, thereby allowing the physician to control the process for implementing compliant Medicaid billing.

**Mistake 9 Ignoring or Failing to Cooperate in Medicaid Audits**
Participating physicians should understand that single state Medicaid agencies typically enjoy significant police powers regarding their program. As part of these policing activities, single state Medicaid agencies often audit the records of individual physicians, especially physicians who receive significant Medicaid dollars in a particular specialty. The initial step in these audits normally involves a written request from the single state agency to a physician requesting the physician to produce records and related information pertaining to Medicaid services that were previously paid. In some cases, the Medicaid single state agency may elect to conduct a review of the physician’s claims at the physician’s office. Even under the best of circumstances, these on-site reviews are disruptive to the physician’s office staff and, if possible, should be avoided if another method of producing the records is available.

**Action Step** When approached by state Medicaid auditors, physicians should be cooperative, since the agency will eventually obtain the records they are requesting. Accordingly, physicians should be prepared to produce all records related to services rendered to Medicaid recipients. If a physician refuses, without legal justification, to produce records or cooperate in these audits, it is likely that the physician will face program sanctions, including termination of his or her Medicaid contract and recovery of payments made for services. It is therefore important that physicians not ignore any document requests from the Medicaid single state agency, since a simple oversight could lead to harsh sanctions based on a breach of the Medicaid provider contract.

**Mistake 10 Seeking a Fight, Not Information, When Audited by the Single State Medicaid Agency**
A Medicaid audit exit conference occurs after the audit is completed. During this conference, the physician has an opportunity to be educated about the auditor’s findings. Though there will be a time for the physician to contest the auditor’s findings, the exit conference is neither the time nor the place to do so. Starting a verbal confrontation with the Medicaid auditor will not improve the situation, and will quite likely make the situation worse.
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Action Step  If presented with an adverse audit result, physicians should use their time with the Medicaid auditor to learn more about the case. For example, what standards did the auditor use to make his or her findings? What laws, regulations, or program guidelines were used as a basis to evaluate the claims? Were these claims reviewed by a peer of the physician? If so, what are the peer physician’s credentials? Again, much more is to be gained from the Medicaid auditors by engaging, as opposed to combating, them. Physicians will always have an opportunity to contest the audit findings, with or without the assistance of legal counsel. The purpose of the Medicaid audit exit interview is to gain as much knowledge as possible.

Conclusion
While many of these mistakes seem simple, the demands of a busy physician’s schedule often result in these problems being overlooked. With the assistance of a good independent review organization and competent office staff, many of these mistakes are easily preventable. Physicians must remember, however, that no matter who handles the coding and billing of services, retention of patient charts, or verification of Medicaid recipient eligibility, it is the physicians who are ultimately responsible for ensuring compliance with Medicaid laws and regulations. With this in mind, physicians should carefully evaluate whether they want to participate in their state’s Medicaid program or, if they are already enrolled as a participating provider, whether they want to remain.

About the Author
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Chapter 20  Mergers and Acquisitions

20.1  The 10 Biggest Legal Mistakes Physicians Make When They Acquire Another Practice or Business
By Mark A. Coel, Esq.

Executive Summary
The day when a physician could leave residency or a fellowship, hang up a shingle, and begin practicing are, for the most part, long gone. Managed care, increased competition, and rising costs have made start-up medical practices a rarity. In general, physicians who are not interested in associating with an existing medical practice (that is, buying in as a partner of a multiphysician group, usually after spending several years as an associate) will find an easier point of entry through the acquisition of an existing practice. This option, nevertheless, comes with its hurdles and pitfalls.

Mistake 1  Not Reaching Out to Advisers at the Outset
Too often, physicians attempt to negotiate the terms of an acquisition without the benefit of counsel at least from an attorney and/or an accountant. Critical deal points and legal issues may be ignored, inadvertently given away, or made more difficult to negotiate in connection with the preparation of final documents.

Action Step  Physicians should bring in competent advisers at the outset so that the transaction can be properly framed, which can in turn yield savings both in the short run and long after the transaction has closed.

Mistake 2  Not Spending Time at the Practice
The acquisition of a medical practice is likely to be one of the largest investments that a physician will make. Even so, the decision to acquire a practice is often based simply on the verbal and written representations of the seller, as opposed to an on-site evaluation of the day-to-day operations of the practice.

Action Step  In general, physicians who spend as much time as possible in a practice before making a commitment will have fewer disappointments than those who spend little or no time evaluating the practice.

Mistake 3  Not Entering Into a Formal Letter of Intent
Not entering into a formal letter of intent is a mistake that ordinarily follows from Mistake 1. Too often, clients approach their counsel and state: “This is what I agreed to, draw up a contract.” Under the best of circumstances, the negotiation of the terms and conditions of a formal acquisition document can take many days and sometimes weeks. This time lag can be
extraordinarily dangerous for a buyer, who may discover that the seller is out “shopping” the buyer’s offer to other interested parties.

**Action Step** Physicians should be sure to enter a carefully drafted formal letter of intent when negotiating an acquisition. A carefully drafted letter of intent will take the business “off the market” for an agreed upon period of time. A letter of intent will also outline the key terms and conditions of the acquisition that will serve as a road map for the preparation of formal agreements.

**Mistake 4 Not Properly Evaluating the Purchase Price**

“That sounds like a fair price, right?” Determining the purchase price for the acquisition of a medical practice should not be based on hunches, intuition, or what a colleague paid for another practice two years ago. Determining the purchase price for a medical practice should be based on hard data, which should be obtained as early in the process as possible. At a minimum, the purchaser of a medical practice should obtain three years of tax returns and financial statements, billing and collection records with receivables aging reports, and copies of third-party payer contracts with applicable reimbursement rates.

**Action Step** Enlisting the services of an accountant well versed in evaluating medical practices early in the process is critical. A qualified accountant will not only be able to determine a value based on the practice’s historical data, but also help forecast the practice’s performance in the hands of the new owner.

**Mistake 5 Not Conducting the Appropriate Level of Due Diligence**

Many purchasers view the term “due diligence” as a mere scavenger hunt for liabilities. The due diligence process goes well beyond this view and should include a careful analysis of all agreements to which the seller is a party and which the buyer wishes to assume.

**Action Step** Physicians should conduct a thorough level of due diligence that includes seeking answers to the following questions: How much time is left on the practice’s lease? Is the lease assignable or assumable? Are there other contracts in place for associate physicians and other personnel? Are these contracts assignable or assumable? Are key terms of these contracts (most important, restrictive covenants) assignable or assumable?

**Mistake 6 Not Being in a Position to Bill Services to Third-Party Payers**

In a time when control of the patient is less a function of the relationship with the doctor and more a function of which insurance plan the patient has, it is critical for any purchaser of a medical practice to determine how he or she will retain the patient. Considering that most third-party payer contracts are not assignable, the physician acquiring a practice that depends on these types of contracts will have to plan in advance to be able to retain the revenue of the practice.
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Action Step  The advanced planning involved in being able to retain the revenue of the practice may mean attempting to effectuate an assignment of the contracts, securing provider contracts well in advance of closing, or considering a stock acquisition. A stock option would potentially carry along with it all of the practice’s contracts and allow for a change of control provision, which may treat a stock sale in the same manner as an outright transfer of the contract. It also imperative that the physician buyer make sure to be properly enrolled with Medicare, Medicaid, and other applicable governmental programs as early in the process as possible.

Mistake 7  Not Protecting Against the Seller’s Liabilities
Very often the buyer of a medical practice will find himself or herself fending off a claim brought by one of the seller’s creditors. The determination of the price to be paid for the acquisition of a medical practice is typically based on either the assumption of none of the practice’s liabilities or only certain agreed upon liabilities. Consequently, any other liabilities, whether known or unknown, should expressly be made the responsibility of the seller.

Action Step  The physician buyer should insist on an asset acquisition. If the stock in the medical practice is acquired, all of its liabilities, known and unknown, follow the buyer. In an asset acquisition, it will be much more difficult for a third-party creditor to pursue the buyer for the seller’s liabilities. The physician should be sure to include a clear indemnification and hold harmless statement for any liabilities that the buyer will not assume, making sure the indemnification extends to attorney’s fees. In many cases, it can cost as much in attorney’s fees to defend a claim as the amount of the claim itself. The physician buyer should also make sure there is a person or entity to which the buyer can seek recourse if a liability arises. Ordinarily, shortly after the last dollars have changed hands, the seller, if a separate legal entity, will be liquidated. Accordingly, it is advisable to obtain a guarantee from the seller’s owners. In addition, the physician buyer should consider installment payments so that there is a source of funds from which to effectuate a setoff.

Mistake 8  Not Considering the Tax Ramifications of the Transaction
Improperly structuring an acquisition can often lead to disastrous results from a federal income tax standpoint. For example, aside from the liability issues, acquiring the stock of an existing medical practice has a significant drawback from a federal income tax standpoint. In a stock acquisition, no portion of the purchase price may be deducted or amortized. In an asset acquisition, depending on the tax allocation of the purchase price, much of what is paid can be depreciated or amortized over a given period of years. While the allocation of the purchase price weighted more heavily toward hard assets is beneficial to the buyer (these types of assets can be depreciated more quickly), such an allocation is less favorable to the seller because these types of assets have likely been fully depreciated and such allocation will result in “recapture” (which may treat a portion of the gain as ordinary income). On the other hand, an allocation of the purchase price toward “goodwill” is more favorable to the seller.
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(recapture not being an issue) but less favorable to the buyer, who must amortize this portion of the purchase price over 15 years.

**Action Step**  Physician buyers must carefully consider all of the long-term tax consequences when structuring an acquisition.

**Mistake 9  Not Having the Seller Around to Transition the Practice**
Consider this scenario: A patient of a medical practice that has changed hands did not receive the announcement notifying her of the sale of the practice. She shows up for an appointment that she booked six months earlier only to find that Dr. Smith has retired and the practice is now being run by Dr. Jones.

**Action Step**  Although many states require physicians who are selling their practices to notify patients of the sale, there is no substitute for an in-person, face-to-face introduction of the patient to the incoming physician by the outgoing physician. Depending on the type and size of the practice, the transition period can be as short as 30 days or as long as one year. Therefore, the buyer may want to arrange to have the selling physician stay involved to help smooth the transition.

**Mistake 10  Not Getting a Restrictive Covenant**
Not getting a restrictive covenant can lead to the following situation: A physician has just acquired a medical practice, a portion of the purchase price includes a “goodwill” factor. The seller is liquidated, the physician who ran the practice takes the sales proceeds and opens up an office down the block.

**Action Step**  Physician buyers should be sure that the purchase agreement or a separate document includes a carefully drafted restrictive covenant that prohibits the seller (and its owners, agents, and employees) from competing with the buyer for a specified period of time and within a given geographic area. State laws vary regarding the enforceability of restrictive covenants.

**Conclusion**
The purchase of a medical practice can be an extraordinarily complex transaction. With the proper counsel, guidance, and consideration of various issues, the purchaser of a medical practice is far less likely to have an undesired outcome.

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20.2 The 10 Biggest Legal Mistakes Physicians Make When Selling a Medical Practice
By Helena G. Francus, Esq.

Executive Summary
At some point during their career, many physicians will face the prospect of selling their medical practice. Whether the result of a voluntary decision (such as a well-earned retirement) or a less happy situation (such as illness), the sale of a medical practice needs to be structured and carried out so as to best realize the selling physician’s two main goals: maximum profit and minimum postsale liabilities. The following are mistakes to avoid and action steps to take to ensure that these twin goals are met.

Mistake 1 Agreeing on Price Before Consulting a Valuation Expert
An appraisal of the practice by a qualified valuation expert is critical in both getting a fair price for the practice and dispelling any unrealistic notions of what that price may be. Few people would ever consider selling their home without consulting an experienced real estate broker or appraiser to determine a reasonable listing price, yet sellers of professional practices often take a do-it-yourself approach to valuing their practices based on criteria that may have no applicability to a given situation. This approach often results in either selling the practice for considerably less than it’s worth or scaring away potential qualified buyers.

Action Step Before the practice is offered for sale, physicians should hire a professional valuation expert qualified to appraise medical practices in their specialty and geographical area.

Mistake 2 Agreeing on Terms and Conditions Before Consulting an Attorney
A typical scenario in the sale of a practice is two parties, neither represented by counsel, agreeing on the essential terms of the transaction. One party, usually the seller, then goes to an attorney to “draw up the documents” based on the agreed terms. Unfortunately, by that time it may be too late to implement any changes recommended by the attorney to better protect the seller, since the prospective buyer has, in his or her mind, already reached a binding agreement. The sale is then either scuttled or carried out against the advice of counsel; worse, the disappointed buyer may sue based on the parties’ “napkin” agreement.

Action Step Once the decision is made to market their practice, physicians should have a qualified business transactional attorney prepare a draft “seller-oriented” agreement, which can then serve as a starting point for sale negotiations.
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Mistake 3  Making Representations and Warranties That Cannot Be Supported
Sometimes the buyer approaches the seller with a draft purchase agreement in hand, either before or after sale negotiations have begun. In this case, the draft agreement usually includes a laundry list of seller’s representations and warranties, everything from “no pending litigation proceedings” (a reasonable warranty) to “no unknown liabilities” (an impossible warranty). Selling physicians may skip over this “legalese” to focus on more interesting issues, such as payment amount and terms, only to have an unsupported representation come back to haunt them in the form of a fraud or deceit claim.

Action Step  Physicians should carefully scrutinize each requested representation and warranty and agree only to those that they know they can reasonably make.

Mistake 4  Failing to Require Certain Representations and Warranties From the Buyer
While buyers typically need to make fewer representations and warranties than sellers, certain ones are critical if the selling physician is to have some peace of mind after the practice changes hands. Key among these are warranties that the buyer is licensed to practice medicine in the state in question, is in good standing with that state’s medical board, and is not subject to any actual or threatened discipline. While representations and warranties may not ensure against the selling physician being named in a malpractice suit or an administrative action arising solely out of the buyer’s conduct, they will form the basis for additional remedies in the event they turn out to have been false when made.

Action Step  Physician sellers should include in the terms of sale specific buyer’s representations and warranties regarding qualification to practice and absence of disciplinary action, along with a duty of indemnification from third-party suits or other proceedings.

Mistake 5  Not Reviewing the Assignability of Key Third-Party Contracts
It sometimes comes as a surprise to selling physicians when they discover, usually well into the sale process, that their office lease, or an equipment lease or service contract, is not freely assignable to a new owner of the practice. In most cases it is not difficult to obtain a new lease or contract from the third party, but where the deal was particularly attractive to the buyer because of a below-market, long-term office or equipment lease or service contract, a failure to discover limitations on assignability beforehand can result in delays, reduction of the sale price, cancellation of the sale, or other problems.

Action Step  Physicians should review the assignability provisions of each third-party agreement that is to be assigned in the sale. When assignment is restricted and the third party refuses to give its consent, physicians should expressly exclude the lease or contract from the terms of the sale.
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Mistake 6  Getting Inadequate Security for Seller Financing
Sometimes financing by the selling physician is required to reach a deal, usually because commercial financing is too expensive, but sometimes because a buyer is considered by commercial lenders to be a poor credit risk. Most selling physicians are savvy enough to review a prospective buyer’s credit history before extending financing, but often they either fail to secure the loan altogether or secure it by the transferred practice itself (a costly mistake if the practice fails to thrive in the hands of the new owner).

Action Step  Physicians should insist on security that is unrelated to the practice (e.g., a lien on the buying physician’s residence or other real estate).

Mistake 7  Agreeing to an Unrestricted Noncompetition Clause
The enforceability of noncompetition clauses (essentially, terms that limit the right of the selling physician to continue practicing medicine after the sale) varies from state to state, but these clauses are generally valid if they are restricted in terms of duration (e.g., five years), location (e.g., no competition within the same county or within a 25-mile radius of the transferred practice), or both. It would be a costly mistake, however, to wait until an actual controversy arises sometime later and then rely on the courts to interpret and limit the scope of an overbroad noncompetition clause.

Action Step  Physicians should be sure that the precise duration and geographical scope of a noncompetition clause (if one is agreed to at all) are spelled out in detail in the sale agreement.

Mistake 8  Not Providing for an Express Assumption of Liability by the Buyer
When the sale is structured as an “asset purchase” rather than a “stock purchase” (because the practice is unincorporated or for some other reason), it is critical to expressly provide that the buyer will assume the liabilities of the practice, prorated as of the closing date. Many physicians forget that what they are hoping to gain from the sale is not only profit, but also relief from ongoing financial obligations and other liabilities.

Action Step  Physicians should include a detailed list of liabilities that the buying physician will assume and a duty of indemnification from those liabilities.

Mistake 9  Agreeing to Buyer-Controlled “Holdbacks” From the Purchase Price
Sometimes a seller will not meet a certain condition to closing before the projected closing date, and the buyer may attempt to “hold back” part of the purchase price, usually in some type of escrow arrangement, until the condition is satisfied. Another use of holdbacks is to add “teeth” to a noncompetition clause by providing that any breach by the seller will result in forfeiture of all or a certain portion of the holdback amount, which would otherwise be released to the seller upon expiration of the noncompetition period. When the use of a
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Holdback cannot be avoided, it would be a major mistake to give the buyer unilateral control over disposition of the escrowed funds.

**Action Step** Physicians should ensure that any holdback arrangement provides for the joint consent of buyer and seller to any disposition of the funds, along with a dispute resolution procedure in the event the parties cannot agree.

**Mistake 10 Not Including Termination Provisions in the Agreement**

Sometimes, despite the best of intentions, a sale cannot be consummated by the projected closing date. It is certainly reasonable to extend the closing date upon mutual consent of the parties, but where the buyer is having trouble raising the necessary cash or financing, or either party finds it cannot meet some other preclosing obligation, it makes sense at some point to terminate the transaction and remarket the practice for sale. However, in the absence of clear termination provisions, the buyer might be able to hold up the sale indefinitely, or, where it is the seller who is having trouble closing, the buyer may seek to hold the seller to the agreement.

**Action Step** Physicians should specify a clear “drop dead” date by which the sale must close unless the parties otherwise consent in writing, with a provision for return of funds and documents and a release from further obligations under the agreement.

**Conclusion**

Many of the potential mistakes in the sale of a medical practice can be avoided through proper planning and documentation, proving that, in law as well as in medicine, an ounce of prevention is worth a pound of cure.

**About the Author**

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20.3 The 10 Biggest Mistakes Physicians Make When Their Practice or Other Business Is Being Acquired

By Michael Jordan, Esq.

Executive Summary
Selling a practice or other business is one of the most important decisions a physician will make. All too often, however, the excitement of closing the deal results in not paying enough attention to the important details of the transaction. Just as good fences make good neighbors, good legal documentation minimizes the likelihood of postclosing disputes between the parties. While this section focuses on selling a medical practice, the fundamentals are equally applicable to the sale of any business.

Mistake 1 Failing to Learn Enough About the Individual or Entity Making the Acquisition
More often than not, simple inquiries before the sale can prevent considerable problems later. For example, the physician should request personal financial statements, credit reports, and references to verify that the prospective purchaser has the resources to consummate the transaction. Efforts should be made to determine if the purchaser has acquired other practices or businesses and, if so, the physician should contact the sellers to determine if the purchaser has satisfied all obligations. The physician’s attorney should search the court docket to determine whether any lawsuit is pending against the purchaser and, if so, evaluate the nature of the proceeding to determine if it has any bearing on the purchaser’s business acumen or honesty.

Action Step A physician who fails to learn about the purchaser may be entering into an agreement with an entity that has neither the willingness nor the ability to honor the agreement.

Mistake 2 Failing to Carefully Consider All Ramifications Resulting From the Structure of the Transaction
All acquisitions will be of either the stock or the assets of the entity being acquired. Behind that facile statement are a myriad of issues that must be carefully evaluated by the physician’s attorney and accountant, including tax effects, an indemnification agreement concerning postclosing claims, assignments of leases for property or equipment, employee obligations (including employee benefit plans), among others. The failure to have experienced counsel structure the best transaction possible may have long-lasting adverse consequences.

Action Plan The physician must review thoroughly with counsel how a proposed sale should be structured to maximize financial benefit while minimizing adverse tax consequences and liabilities.
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Mistake 3  Failing to Ensure Adequate Security for the Purchase Price
If any part of the purchase price is to be paid postclosing, care must be taken to provide adequate security for the physician. In the medical practice setting, security options may include personal guarantees, an interest in the accounts receivable of the practice, or both. In the nonmedical practice setting, this might entail obtaining security interests in the assets transferred.

Action Step  The physician must always remember that circumstances change. The most financially secure buyer, with the best business plan, may for a variety of factors be in a dramatically different financial situation in a short period of time. The failure to ensure proper security for postclosing payment obligations could result in severe financial loss.

Mistake 4  Agreeing to an Overly Broad Noncompete Provision
When enforceable under state law, a buyer is likely to request a noncompete provision in the agreement. This request may not seem particularly consequential at the time of sale, but unforeseen opportunities may arise after the sale that will require careful interpretation of any such provision. The duration and scope of any noncompete agreement must be carefully scrutinized, and the selling physician should attempt to limit the agreement as much as possible. This is particularly critical where the physician has been engaged to provide further medical or other services by the purchaser. If that relationship sours, and the physician has not intended to retire, a covenant not to compete can prove extremely troublesome.

Action Step  The physician should carefully review the scope and duration of any noncompete agreement, particularly if the physician does not intend to stop working after the sale of the practice or business.

Mistake 5  Not Carefully Discussing and Negotiating Post-Transaction Employment or Consulting Obligations
Often, a hospital will acquire a physician practice and employ the physician to provide medical or business consulting services. The same types of relationships might be structured in other commercial, non-health-care settings. These ongoing obligations may present real problems if they are not carefully negotiated at the time of sale. For example, what will patients or customers be told about the new relationship, and by whom? What will be the terms and conditions of employment (e.g., call coverage for the physician)? Who will comprise the support staff and who will have authority over the staff?

Action Step  The physician should not wait and trust that postclosing employment or consulting obligations will develop naturally. The parties may, in fact, have very different expectations, and the only way to prevent future disagreements is to address these issues before the sale.
Mistake 6  **Failing to Consider How Postclosing Payments Will Be Calculated**

Often, part of the consideration paid for the purchase will be a percentage of future profits of the business. Similarly, in the physician setting, a purchasing hospital may employ the physician and establish a bonus formula that will depend partly on collections. In either setting, efforts should be made to have such payments calculated based on gross, not net, collections. Manipulating net collections is a game mastered by some accountants. If forced to agree to payments based on net, the physician should negotiate exactly what will be included in deductions from gross. Physicians might understandably apply their own experience in billing and collection to extrapolate what they expect to collect as a hospital employee. All too often, these expectations will vary wildly from reality. The physician must carefully explore who will be performing billing and collection functions after the practice is sold and ask some hard questions during the negotiation process. For example, what is the historical collection percentage of the acquiring hospital? Which specific hospital employee or employees will be responsible for billing and collection of the physician’s practice efforts, and how much experience do these individuals have? If at all possible, the agreement should guarantee a minimum collection percentage.

**Action Step** The closing documents must specify how postpayment obligations will be calculated, leaving as little room as possible for uncertainty in this respect. A failure to properly consider this issue may lead to actual payments far below the selling physician’s expectations.

Mistake 7  **Failing to Define Events of Default**

In any case, where there are any postclosing obligations, the agreement must define under what circumstances the purchaser will be held to be in “default” of such obligations. For example, if the purchaser must make a certain payment by an agreed upon date, will the failure to make payment by that date be an automatic default or should a grace period be agreed upon? If the purchaser agrees to assume responsibility for certain obligations and fails to do so, the consequences of that failure must be addressed.

**Action Step** The physician and his or her counsel must review any postclosing obligations and consider the potential consequences of the purchaser’s failure to honor such obligations. The agreement must be tailored to define events of default and the consequences that will flow from the default.

Mistake 8  **Failing to Carefully Delineate Dispute Resolution Provisions**

It is common for a practice acquisition agreement to specify that disputes will be resolved by arbitration. If so, the provision must be reviewed carefully. All too often, arbitration provisions provide for extended discovery or extended time periods to resolve any dispute. Such provisions can significantly increase the time and expense of an arbitration proceeding. Further, the agreement should specify a mechanism to govern disputes that relate to billing
and collection matters during the course of the relationship. It is very common for physicians and hospitals to disagree regarding amounts billed or collected, and a mechanism should be agreed upon (e.g., a review of the relevant documentation by an independent accounting firm) that would provide a method of resolving such disputes without litigation or a full-blown arbitration proceeding.

**Action Step** One goal of negotiation should be to provide an efficient and relatively inexpensive method of resolving disputes.

**Mistake 9  Not Spending Enough Time Determining How the Relationship May Be Terminated**

The decision to sell a medical practice is, obviously, a career-altering step. Once sold, many established relationships will be affected and new ones created. A physician who is employed by the purchaser must be careful to spend considerable time in negotiating and understanding how the new relationship might be severed. A “for cause” provision, specifying that the physician cannot be terminated unless there is some “good cause” is obviously preferable, but care must be given to defining what will constitute “good cause.” Conversely, what “causes” might a physician use to terminate the relationship? Routinely, hospitals will also insist on a “no cause” provision, typically in addition to the provision that would afford cause to terminate. For example, after specifying the “causes” pursuant to which the agreement may be terminated, the agreement might then specify that it may, in any event, be terminated for no cause “upon notice.” In this respect, it is important to insist on an extended “notice” provision, of at least 90 days, to allow the physician to begin to reestablish his or her independent medical practice.

**Action Step** During the negotiation process, careful thought must be given to how and when a postclosing relationship may be terminated.

**Mistake 10  Failing to Consider Where Disputes Will Be Resolved**

In cases where the practice is sold to a multisite hospital, or another commercial venture is sold to an out-of-state entity, real problems for the physician can arise if the venue to resolve a dispute is inconveniently located. For example, a hospital system might specify that any litigation will be resolved in the city of its corporate headquarters, which could be hours away. If the physician has agreed that venue and jurisdiction are proper in that locale, the provision will likely be enforceable. Obviously, provisions of this nature impose financial and practical burdens on the physician.

**Action Step** The physician should work to negotiate an agreement that specifies that litigation or arbitration will occur where the physician provides services for the purchaser, or where the physician’s practice or business was located. If that provision cannot be negotiated, efforts should be made to compromise on a location that is not unduly burdensome.
Conclusion
While it is understandable for a physician to focus on “getting the deal done,” a failure to consider the details of a transaction may have significant adverse consequences. By following the steps outlined here, a physician can minimize the likelihood of such consequences and complete a productive business transaction.

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Chapter 21  Professional Discipline/Licensing

21.1 The 10 Biggest Legal Mistakes Physicians Make in Responding to a Notice of Disciplinary Investigation
By Edwin A. Bayó, Esq.

Executive Summary
Receiving a formal notice of an investigation is one of the most stressful events in a physician’s career. Although in some cases, the physician may have an inkling that he or she may be the subject of an investigation, in many cases, such notices come as a total surprise. The shock of being notified of a pending investigation and possible disciplinary action may result in a hasty and unprepared response.

Mistake 1  Failing to Respond
Not responding is a form of response. In some cases, the nonresponse is due to the fact that the physician has moved and not updated his or her address with the appropriate agency. In many jurisdictions, failing to maintain a current practice or residence address on file may itself constitute grounds for disciplinary action. Whether intentionally or unintentionally, not filing a response creates the appearance of carelessness or disregard for the possible consequences of the action. Even in the worst possible scenario, a brief response that simply acknowledges receipt of the notice of investigation is preferable to no response.

Action Step  Physicians should maintain a current practice and/or residence address with the regulatory board at all times. Any notice of investigation should be reviewed and timely responded to.

Mistake 2  Filing a Handwritten Response
Coming second to not filing a response, a handwritten response also creates the appearance of carelessness and disregard for the seriousness of the proceedings. It immediately sets the wrong tone.

Action Step  Any response submitted by a physician should be typewritten, and if submitted directly by the physician, on his or her letterhead.

Mistake 3  Not Being Familiar With Applicable Laws and Regulations
Physicians are too often unaware of the applicable statutes and regulations relating to disciplinary actions and investigations. Such statutes and regulations may control the time allowed to submit a response, the availability and timing of subsequent or supplemental responses, and the ability to obtain copies of the documents and related information that caused the investigation. The opportunity to provide a response or to receive the benefit of procedural safeguards may be waived or lost.
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**Action Step** Physicians should become familiar with the laws and regulations that govern investigations and disciplinary actions in their jurisdiction.

**Mistake 4  Failing to Thoroughly Investigate Before Providing a Response**
Depending on the jurisdiction, the applicable statutes and regulations relating to disciplinary investigations may provide certain due process rights, including the right to obtain copies of documents related to the investigation. In some jurisdictions, the physician may have the right to obtain copies of the expert reports and opinions used by the agency to support a finding of negligence or failure to meet applicable standards of practice, as well as witness statements. The physician may have the opportunity to submit his or her own expert’s opinion in rebuttal.

**Action Step** All available documentation should be examined closely before formulating a response.

**Mistake 5  Failing to Take Advantage of Available Impairment Programs**
Most jurisdictions have impaired practitioner programs to assist physicians with substance abuse and other impairment issues. In some cases, a physician who voluntarily reports to and abides by the requirements of such a program has the right to an alternative disposition under the disciplinary statutes. If the matter under investigation concerns impairment, voluntarily entering into the impaired practitioner program may result in an alternative disposition, and can always be cited as a mitigating factor. Physicians must understand that entry into such programs carries significant burdens of compliance, and before taking such a step they should consult with counsel.

**Action Step** Physicians should be familiar with the impaired practitioner programs in their jurisdiction.

**Mistake 6  Attacking the Complainant, Agency, or Process in the Response**
The tone of the response is an important factor. Any flaws in the complainant’s version of the events should be pointed out factually, but without gratuitous speculation as to bias or motives. Those matters may be developed and pursued at the appropriate time. A response that takes issue with the agency conducting the investigation or the process is simply unprofessional. The threshold for sufficiency of a complaint is very low (i.e., if the allegation is true, would it constitute a violation?). Although a significant number of complaints end up being unfounded, the process requires that they be investigated. Antagonistic responses or those that point out that “everybody does it” are not conducive to an early resolution.

**Action Step** Physicians should avoid gratuitous attacks on the complainant or the investigating agency in their response.
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Mistake 7  **Failing to Pursue and Implement Remedial Measures**
The proper response at the right time may make the difference between a formal administrative action and a lesser disposition, such as a letter of caution. In many “borderline” cases, a significant deciding factor in the lesser disposition is implementing remedial measures and describing them in the response. For example, if the investigation concerns an allegation of deficient recordkeeping or a minor error, the response should describe the steps taken to improve recordkeeping or reduce the possibility of the error, such as additional continuing education in the subject area, enactment or amendment of written operating procedures, and/or training of staff.

**Action Step** Physicians should consider any possible remedial measures and either implement them or commit to their implementation as part of their response.

Mistake 8  **Talking to Investigators**
The notice of investigation is often accompanied by a request for an interview by the investigator. In many cases the nature of the investigation or its full scope are not clearly defined at this stage. The investigator is not required to advise the physician that any statements provided during such interview may be used against him or her. Such interviews do not allow for the opportunity to carefully consider the question or review pertinent documentation before providing a response. Physicians may reveal incriminating matters inadvertently, or without comprehending the full scope of potential ramifications.

**Action Step** Physicians should decline requests for interviews with investigators.

Mistake 9  **“Correcting” Records or Creating Exculpatory Documentation**
In the stress resulting from a notice of investigation, a physician may be tempted to “correct” a patient record or to add a notation regarding the recommendations the physician clearly recalls having made to the patient during a visit but which were not written down. In just about every case, the potential disciplinary penalties for such actions greatly exceed those available for the underlying problem.

**Action Step** No alteration should be made to any document once the physician has been notified that there is a pending investigation.

Mistake 10  **Consulting Counsel Too Late**
Not making this mistake should ensure that the other nine mistakes are not made. Investigations that may result in a disciplinary action are “penal” in nature, and the subject of the investigation has due process rights that are similar to (but less extensive than) those of a criminal defendant. Although the investigating agency has the burden of proving matters that are grounds for a disciplinary action, a response that is hasty or not well thought out may result in the admission of critical elements, thereby making any possible disciplinary action
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far easier to prove. By consulting counsel too late in the process, a physician may have given up significant substantive and procedural rights. Furthermore, having counsel involved at the beginning of the investigatory process increases the chances that the case may be resolved at the investigatory stage, or in a reduction in the number of eventual charges pursued.

**Action Step** Physicians should consult with experienced counsel before they respond to a notice of investigation.

**Conclusion**
Physicians must avoid errors when responding to notices of disciplinary investigations.

**About the Author**

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### 21.2 The 10 Biggest Legal Mistakes Physicians Make in Their Attitude and Demeanor During Disciplinary Proceedings

*By Bruce V. Hillow, Esq.*

**Executive Summary**

A significant number of physicians will at some point during their careers have a complaint lodged against them before a professional disciplinary board, whether a state licensing board, a medical society ethics committee, or a hospital panel. Dealing with a complaint is a difficult process, made more so if the physician’s attitude and demeanor create or compound problems. Some mistakes are caused by ignorance, but many are caused by the emotions aroused when professional judgment is questioned and professional status is at stake.

**Mistake 1  Denying That a Problem Exists**

A complaint to a disciplinary board creates a serious problem for a physician. But in wishing it away, the problem can become worse. Putting it aside and forgetting it for awhile, thinking that it can be resolved in a quick conversation with the investigator, or just sending off the medical records that the board is requesting are hasty and ill-considered actions that may
cause harm. A response within a short period of time, often 30 days, is usually required. To retain an attorney and prepare a response take time. The investigator has the role of a detective charged with gathering evidence. The investigation will not be aborted by anything the physician says in a preliminary telephone conversation (but anything the physician says “can and will be used against him or her”). It is best for the physician to have his or her attorney review any request for records, since investigators will sometimes ask for records to which they are not entitled. In any event, it’s best to have a second set of eyes make sure that all of the documentation that is necessary is being sent; to try to add records later to those that were already sent invites an allegation of falsification.

**Action Step** Physicians should acknowledge that a complaint to a disciplinary board is a problem that requires assistance and must be dealt with promptly and responsibly.

**Mistake 2 Acting on Feelings of Panic**
“I have heard that disciplinary proceedings are kangaroo courts and are out to get doctors.” “I’m going to be disgraced and publicly humiliated.” “I’m going to lose my profession and livelihood.” Panic is irrational anxiety that feeds on itself. The antidote consists of time, reflection, and consultation. Actions that emanate from panicky feelings are almost invariably counterproductive. Physicians should not telephone and berate the complainant or try to persuade him or her to withdraw the complaint. Such action might be seen as an attempt at coercion, undue influence, or deprivation of a right. And, again, anything the physician says might be used against him or her. Physicians should never change any medical record. Although a physician may be sorely tempted to do so if a record is suggestive of an omission or error, alterations are often discovered and will only make matters worse. Physicians should remember that the majority of complaints are dismissed without disciplinary action being taken.

**Action Step** Physicians should not act on initial anxiety. They should consult with an attorney to plan a course of action.

**Mistake 3 Being Passive**
Passivity is caused by feeling overwhelmed and helpless when one is the focus of a potentially punitive legal procedure, and it sometimes takes the form of leaving everything to one’s lawyer. But physicians must play an integral part in planning and executing their defense, which will require their medical expertise as much as their attorney’s legal knowledge. Indeed, the lawyer should insist on the physician’s active participation and, in fact, on the physician taking the lead in some situations (e.g., during the initial interview by the investigator). Good defensive lawyering is creative and active, not only reactive; of course, allegations of wrongdoing must be countered, but an alternative and more compelling “story” must be advanced as well and as early in the process as possible. Fearful passivity may lead to the hiring of an inexperienced and usually overly aggressive attorney. It is
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incumbent on the physician to find an attorney specifically experienced in handling disciplinary proceedings involving physicians. Experience exclusively with medical malpractice (or any court litigation) does not adequately prepare an attorney to handle an administrative disciplinary proceeding in which rules of evidence are relaxed and at least superficially, a more open, academic, and collegial atmosphere prevails.

**Action Step** Physicians should be actively involved in their own defense, as well as in finding, choosing, and working with an experienced attorney.

**Mistake 4 Looking for Reassurance in the Wrong Places**
Physicians should be careful in whom they confide about the complaint. In their ignorance, colleagues may assume the worst, gossip, or cease making referrals. If a malpractice lawsuit is also initiated, then anyone in whom the physician confides becomes a potential witness. Physicians should restrict their confidences to their attorney, their spouse (if he or she is not made unduly anxious), and perhaps a trusted mentor. If someone further is needed to help with troubling feelings about the process, physicians should consider consulting a psychotherapist (to whom communications are privileged).

**Action Step** Physicians should check with their attorney before confiding in anyone about the complaint.

**Mistake 5 Acting Arrogant**
It’s uncomfortable for professionals to have their judgment questioned. Most private practitioners are their own overseers. As professionals, physicians sometimes have to operate “by the seat of their pants” without the opportunity to fully plan and reflect, a luxury that academics, by contrast, usually have. So being closely questioned, especially by academically oriented practitioners who usually populate disciplinary boards, may lead to defensiveness that sounds like arrogance. Arrogance is anathema to disciplinary board members because it suggests an inability to learn from mistakes. Penalties are harsher when a respondent-doctor appears unable to question his or her actions and acknowledge the possibility that an error might have been made.

**Action Step** Physicians should avoid acting arrogant and defensive; they should acknowledge by their attitude that they know they are not perfect and are willing to objectively examine their conduct.

**Mistake 6 Expressing Anger Toward or Insulting the Complainant**
Sometimes the complainant is unknown to the physician, other times the source of the complaint is clear or can be easily surmised. Complainants have a right under law to complain about the conduct of professionals. They also have either an absolute or a qualified privilege when they do so (i.e., they are protected from prosecution for libel unless they
The purpose of licensing laws and disciplinary proceedings is to protect the public (collectively, complainants). Anger or insults directed toward a complainant reflect badly on the physician (the respondent). If the complainant is lying or distorting the truth, has malicious or hidden motivations, or had unrealistic expectations, then the physician’s factual statements can counter them. (Factual statements are corroborated and made credible by supporting documentation; there is no substitute for a well-maintained medical record in building a defense.)

**Action Step** Physicians should avoid *ad hominem* attacks on the complainant.

**Mistake 7 Expressing Anger Toward or Insulting Investigators, Board Members, or the Disciplinary Process**

Investigators and board members are generally hard working, responsible, and honest. They take seriously their role as public guardians. Their job is a necessary one. To suggest that they are incompetent or biased can only hurt the physician. (This does not preclude the physician’s attorney from ensuring that investigators and board members have no conflicts and possess the appropriate credentials for the case.) To suggest that the system of which they are a part is unnecessary or prejudiced can only hurt the physician. If the physician wants fairness from them, his or her best chance of getting it is to expect it. It may be especially hard to act in a civil manner toward the prosecutor because if the case goes to a hearing, then the prosecutor will be advocating for the physician’s guilt; therefore it’s best for the physician to avoid any direct contact with the prosecutor.

**Action Step** Physicians should not attack the disciplinary system or its agents.

**Mistake 8 Becoming Confessional**

While not being defensive (see Mistake 5), physicians also must try to avoid giving too much information. This approach is sometimes taken by respondents who have an overly trusting, deferential, or timid attitude toward authority. They may be overly harsh in criticizing themselves, perhaps to forestall criticism from authority figures. Physicians can avoid taking this approach by anticipating questions and reviewing with their attorney how best to phrase and limit their responses.

**Action Step** With their attorney, physicians should anticipate questions and the content and limitations of their responses.

**Mistake 9 Trying to Hurry the Process**

Some physicians, usually out of anxiety about the uncertainty involved, will press their attorneys to try to resolve the investigation and charges, if any, as quickly as possible. Most often when charges are brought following an investigation, the matter is resolved through negotiations. The party most desirous of a quick resolution is usually at a disadvantage in
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negotiations. In legal proceedings, delay is almost always beneficial to the defense. Complainants can lose interest or become unavailable, emotions abate, a record of rehabilitation or lack of risk to patients can be established, and so on.

**Action Step**  
Physicians should let their attorney, not their anxiety, set a schedule for resolution of the legal process.

**Mistake 10  Losing Faith**  
Losing faith is sometimes hard to avoid in a system of justice that depends on fallible human beings and at times may appear inefficient and even arbitrary. Some of the safeguards afforded to criminal defendants and even civil litigants are lacking in administrative proceedings. As a respondent (defendant), facing the power of a state, professional society, or hospital is daunting. Losing faith may lead to prematurely accepting an overly severe penalty. Resignation may be mistaken by the board for culpability, and cynicism for hostility. With the physician’s cooperation and an experienced competent attorney as an advocate, a physician will have the best chance of being treated fairly and as leniently as possible. Most often the system does result in some approximation of justice.

**Action Step**  
Physicians should not despair of a fair result being achieved.

**Conclusion**  
Having the proper attitude and demeanor goes a long way toward resolving a disciplinary complaint successfully.

**About the Author**  
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DISCIPLINE AND LICENSING: TESTIFYING ON OWN BEHALF

21.3 The 10 Biggest Legal Mistakes Physicians Make in Testifying on Their Own Behalf in Hearings for Professional Discipline
By Bruce Lamb, Esq.

Executive Summary
Professional disciplinary actions are increasing throughout the United States. In most instances, physicians have the opportunity to litigate the allegations against them in an evidentiary hearing. Because evidentiary hearings are similar to trials, counsel should represent physicians in such proceedings. Typically, a physician testifies via direct examination by the physician’s counsel and is cross-examined by the prosecuting attorney. Physicians who testify need to be prepared for and rehearse such testimony and heed the advice of counsel familiar with presenting evidence in hearings and trials; they must not attempt to control the proceedings themselves. Many physicians make serious mistakes in their own testimony; some of those mistakes could result in an adverse outcome.

Mistake 1 Proceeding to Hearing Without Competent Counsel
Physicians often believe that they will be exonerated if they are given the opportunity to explain the circumstances of the care that was rendered. Many believe that they can adequately explain their treatment decisions as they would to their colleagues. They fail to recognize that hearing procedures involve a means of communicating information that are different from those used in their practices or in their educational processes. Some physicians make the critical mistake of not retaining counsel to assist them in the hearing.

Action Step Physicians should consult with counsel experienced in disciplinary hearings. Such counsel should prepare their clients thoroughly for examination and cross-examination.

Mistake 2 Failing to Allow Counsel to Control the Flow of Direct Testimony
Direct testimony is best presented in an organized fashion developed by the physician’s counsel. Many witnesses, including physicians, tend to volunteer additional information when responding to questions or to exceed the scope of the anticipated response to the question prepared by counsel. Doing so interrupts and disorganizes the flow of the question-and-answer process and reduces the effectiveness of direct examination.

Action Step Physicians need to understand and accept the concept of presenting evidence in a controlled manner. To present direct testimony effectively, physicians must listen to the preparation efforts of their counsel and be patient with the flow of the questions and answers.

Mistake 3 Attacking the Patient
Physicians may believe that the patient is responsible in whole or in part for any adverse outcome or difficulties the patient may have suffered. Noncompliance by a patient certainly
may be relevant. However, the physician must understand that a direct attack on the patient by the physician can be counterproductive. In most instances, counsel must handle evidence of noncompliance and issues relating to the credibility of the patient in a manner that addresses the issues without rising to the level of a personal attack. The physician must listen to the attorney’s plan for presenting evidence of noncompliance or evidence that could affect the patient’s credibility and abide by that plan. A direct attack on the patient by the physician can place the physician in a poor light before the trier of fact (the judge or hearing panel).

**Action Step** The physician must participate in, understand, and agree to counsel’s plan to develop issues of patient noncompliance or credibility and not resort to personal attacks.

**Mistake 4 Attacking the Prosecutor or the Prosecutor’s Theory of the Case**
Physicians may be frustrated that criticisms have been developed and have resulted in disciplinary action. Sometimes a physician will vent this frustration in testimony by attacking the prosecutor’s theories of the case, the prosecutor’s expert witnesses, or the prosecutor individually. Such attacks can adversely affect the physician’s credibility.

**Action Step** Physicians must understand the tactics attorneys will employ to present the evidence against them and must always respond in a professional manner. Physicians must avoid any emotional outbursts and must appear to be calm and reasonable before the trier of fact.

**Mistake 5 Overstating the Facts**
Physicians must avoid overstating facts. Overstatement or improper embellishment of recollections of events may present an opportunity for effective cross-examination. Physicians should avoid using such terms as “never” and “always” when communicating recollections of their interactions with patients or common practices.

**Action Step** Physicians should discuss in detail with counsel any testimony that will be presented. They should not testify in a manner that may give rise to additional areas of cross-examination or rebuttal testimony.

**Mistake 6 Embellishing the Interpretation and Description of Medical Record Entries**
Physicians may tend to embellish or overstate the significance of medical record entries. Brief (and sometimes inadequate) medical record entries can give rise to significant criticisms of physicians. Physicians must avoid attempting to overstate the meaning and significance of entries in patient charts to minimize the opportunity for effective cross-examination or the use of rebuttal witnesses.
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**Action Step**  When discussing entries in medical records, physicians must testify candidly and in a controlled fashion without embellishment or overstatement.

**Mistake 7  Failing to Be Responsive**
During cross-examination, the prosecution will attempt to identify and exploit weaknesses in the physician’s position. Like most witnesses, the physician does not want to make concessions and may attempt to avoid pointed questions by providing nonresponsive answers. Typically, these efforts adversely affect the physician’s credibility.

**Action Step**  Physicians must understand that nonresponsive answers adversely affect their credibility, and they must be able to provide responses to pointed questions that will increase their credibility rather than detract from it. Thorough preparation for testimony is essential.

**Mistake 8  Arguing With the Prosecutor**
Physicians may view cross-examination by the prosecuting attorney as an opportunity to engage in a debate with the prosecutor. Such responses can adversely affect a physician’s credibility, and the trier of fact may interpret such answers as an attempt to avoid being responsive to questions.

**Action Step**  Physicians must follow through with the trial strategies formulated by counsel and understand that responding to questions in an argumentative fashion detracts from their credibility.

**Mistake 9  Using Nonverbal Communication**
Typically, the trier of fact observes only one witness during the entirety of the proceeding: the physician. The physician needs to control nonverbal communications throughout the proceeding and must understand that glaring at adverse witnesses or shaking his or her head in disagreement with testimony is not typically conducive to establishing a good rapport with the trier of fact.

**Action Step**  Physicians must act in a controlled manner throughout the proceeding and avoid nonverbal communication.

**Mistake 10  Volunteering Information at the End of Testimony**
It is not unusual for physicians to volunteer a final statement or comment at the conclusion of testimony. Typically, such statements give rise to a new series of questions by the prosecuting attorney and may allow the prosecuting attorney to present a rebuttal witness.

**Action Step**  Physicians must understand the trial strategies of their counsel in the presentation of evidence and testimony and must avoid volunteering additional statements or comments.
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Conclusion
Preparation of the physician for testimony, including rehearsal, is essential to an effective presentation. Physicians must understand that a hearing or trial involves a different means of communicating information than the means used in their training and practice. To avoid surprises in litigation, physicians must understand and support the tactics of counsel.

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21.4 The 10 Biggest Legal Mistakes Physicians Make After a Licensing Board Complaint Has Been Filed Against Them
By Kevin O’Mahony, Esq.

Executive Summary
Licensing board complaints may be filed by patients, their family members, other health care providers, employees, or anyone who interacts with a physician. Increasing awareness of this fact, aided by consumer groups and state laws that require posting patients’ rights in waiting rooms, has led to more medical board complaints being filed and sanctions being imposed. Disciplinary action can include:

- A reprimand
- Restrictions on a physician’s practice
- Continuing medical education or monitoring requirements
- Probation
- License suspension or revocation.

Moreover, the adverse consequences of a board complaint do not necessarily end with a disciplinary action. Doctors generally are required by contract to report disciplinary actions to their professional liability insurers, managed care plans, and patients’ health insurance plans.
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Federal law also requires that discipline be reported to the National Practitioner Data Bank, which hospitals must check before granting or renewing medical staff privileges. Thus, a cascade of negative effects may flow from a single board complaint. Depending on the alleged offense and the board’s conclusion, a physician’s reputation and livelihood may be destroyed. The importance of responding properly to a licensing board complaint cannot be overstated. Nonetheless, many physicians make critical mistakes after a board complaint has been filed, needlessly exposing themselves to additional professional risk.

Mistake 1    **Taking the Complaint Lightly or Going Into Denial Mode**
Upon receiving a licensing board complaint, physicians often dismiss the allegations (regardless of merit) as frivolous, groundless, or the fabrications of a delusional patient. Or, they go into denial mode, pretending nothing has happened. Physicians may be outraged at being wrongly accused of unprofessional conduct. They may assume that once they explain what happened, the medical board will see the complaint as not worth the paper it’s written on. But even in situations in which a complaint lacks merit, physicians are well advised to take any complaint seriously.

**Action Step** Physicians should treat any formal complaint as a serious matter, warranting immediate and thoughtful action. They should immediately plan a thorough and respectful response.

Mistake 2    **Ignoring or Missing the Response Deadline**
When a complaint is filed with a licensing board, the board generally sends a notice of the complaint to the physician. In that notice, there almost always is a deadline for the doctor to file a written, narrative response to the allegations, and a deadline to produce all of the patient’s records. Physicians are busy people. Gathering the relevant information, obtaining the necessary advice, and preparing an appropriate response are time-consuming tasks, most of which cannot be delegated. It is also human nature to put off dealing with unpleasant tasks. Consequently, the deadline for producing records and filing a response often creeps up before the physician has done what is necessary to prepare a proper defense. Unfortunately, failure to respond in a timely manner can at best harm the physician’s credibility and at worst result in sanctions being imposed.

**Action Step** Physicians should immediately make a note of the due date for their response. They should determine as soon as possible whether an extension of time to respond will be needed and if so, request an extension well before the deadline arrives. Physicians should promptly gather and obtain certified copies of all the patient’s records, and see that they are furnished to the medical board on time, consistent with the privacy regulations under the federal Health Insurance Portability and Accountability Act (HIPAA) and under state privacy laws.
Mistake 3  **Failing to Consult With Counsel Promptly and to Fully Disclose All Important Facts**

It is important for physicians to find an attorney licensed to practice in their state who is familiar with the state’s licensing board procedures. Because of pride, cost concerns, professional rivalry, or a belief that they can handle the matter themselves, physicians often do not consult legal counsel until significant damage has been done to their professional reputations. Knowing how to practice medicine and being superior doctors do not mean physicians are equipped to defend themselves in a licensing board proceeding, where legal rules of procedure and evidence apply. Even attorneys abide by the maxim that “a lawyer who represents himself in a case has a fool for a client.” This is because even the best advocate can fill only so many roles without losing effectiveness. In all but the simplest of cases, it is far better to have someone else defend the physician and if necessary criticize the complainant than it is to have the doctor—who is the target of the complaint—be his or her only advocate. The damage that can be done to a physician’s reputation and livelihood by a professional complaint far outweighs any legitimate concerns the physician may have about retaining the services of an attorney experienced in this area of the law.

**Action Step**  Physicians who know an attorney in their community who has successfully handled these types of cases should call that attorney immediately. If not, they should contact colleagues and physician organizations for referrals. Next, physicians should promptly provide counsel with all pertinent information and documents and any known grounds for defending the allegations. They should not omit any important or potentially damaging information because they hope it will not come out. They should include all facts that may be relevant, so their attorney is fully informed and not unpleasantly surprised by damaging facts when it is too late to minimize their effect. Physicians should consider asking their attorney to retain a consulting expert. Doing so will allow the physicians to get an objective opinion after a full discussion of the matter protected by the attorney-client privilege or work product doctrine.

Mistake 4  **Failing to Notify the Malpractice Insurer or Risk Manager**

When a complaint is filed, most physicians are not anxious to broadcast that fact. Especially if the charges include serious or embarrassing allegations, doctors may avoid notifying even those who may help them. Doing so can be a serious mistake for several reasons. First, under most malpractice insurance policies, physicians have a duty to notify the insurer of any claim or potential claim that might require coverage. Second, unless the physician is a sole practitioner, he or she often is required by contract, bylaws, or organization policy to notify a risk manager or someone within the organization about the claim, no matter how embarrassing or meritless the charge. Failure to provide timely notice of formal complaints to such parties can jeopardize insurance coverage, a physician’s employment, ownership interest in an organization, and the physician’s career. Moreover, the malpractice insurer or entity with which the physician is affiliated may provide or pay for assistance, including
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experienced counsel to represent the physician before the board. Therefore, keeping a board complaint secret from these parties is not in the physician’s best interest, professionally or economically.

**Action Step** Physicians should review their malpractice insurance policy. They should also determine whether they have a duty to notify the insurer, and whether there is coverage for board complaints. If so, they should notify their carrier of the complaint as soon as possible. They should also notify appropriate risk management personnel where they practice and provide pertinent documents. In addition, they should request any legal and other assistance that may be available under the policy, contract, or organization bylaws.

**Mistake 5 Trying to Dissuade the Complaining Party From Pursuing the Complaint**
Trying to dissuade the complaining party from pursuing the complaint is a tactic that almost never works. Worse, it can lead to damaging evidence being admitted against the physician. And the physician may be portrayed as having tried to intimidate the complaining party. After getting a telephone call from a seemingly friendly investigator, physicians should not assume that they can simply explain away the complaint. Although some complaints can be resolved quickly without adverse action, physicians shouldn’t be lulled into a false sense of security by what may initially be a friendly or supportive approach by a board investigator. Often, the investigator’s attitude will change. And statements the physician made at the outset, without adequate reflection, can become a problem later. Physicians should avoid having conversations with third parties, including potential witnesses, that may damage their defense and are not protected from disclosure by the attorney-client privilege or some other legally recognized privilege. In short, saying the wrong thing or something in the wrong way to anyone (except the physician’s attorney) can significantly inhibit a physician’s defense and lead to unfavorable consequences.

**Action Step** Physicians should involve legal counsel in all substantive discussions about the case. If asked, they should politely decline to discuss the matter with anyone without their attorney present. Doing so will help ensure that their counsel is fully informed, and that their conversations are protected under the attorney-client privilege or work product doctrine.

**Mistake 6 Responding Angrily or Emotionally**
A physician’s first reaction to a complaint may be to respond angrily or emotionally either as a result of righteous indignation or fear about the effects such a complaint may have on the practice. Another reaction may involve blaming other health care providers for less than optimal outcomes or for getting the physician involved in a complaint.

**Action Step** Before writing or speaking to the medical board, physicians should think, take several deep breaths, and think again. They should remember that board members are
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medical professionals; they know that many complaints are brought without merit and that physicians can be falsely accused, regardless of their competence or ethics. On the other hand, licensing boards are under increased scrutiny by the media and consumer groups and are often graded on the percentage of doctors they discipline. Their job is to police the medical profession and to protect the public. Thus, while they should not be predisposed to find against the physician, board members are unlikely to be impressed by shrill or emotional protestations of persecution or by a physician who blames the patient or other providers for problems. Physicians should resist any temptation in that direction, and omit extraneous information and personal attacks. Physicians should take the high road, no matter how infuriating the allegations. They should, if appropriate, indicate how the patient or complaining party might be mistaken (rather than be mean-spirited or deranged), and demonstrate sympathy or understanding for how such a mistaken impression might be formed. Physicians should be factual, responsive, and persuasive, addressing the board’s concerns, expressing a willingness to cooperate, and reaffirming their intention to comply fully with all applicable laws and ethical rules. In short, physicians should show complete respect for the board and the important job it does.

Mistake 7  Needlessly Admitting Fault
In medicine, as in everything else, things do not always happen as they should. In some cases, a frank acknowledgment that a mistake was made, an apology or an expression of remorse, and a promise to do better next time is the best response. In most cases, however, the issue of fault is not clear. Rare is the case in which a physician’s conduct cannot be explained, or at least cast in a better light than is done in a complaint or an investigator’s report. Therefore, except in irrefutable cases, it is a mistake for a physician simply to admit fault and hope the board will reward the doctor’s candor with a slap on the wrist or a minor sanction. In general, unqualified admissions are likely to lead to more severe sanctions being imposed, greater exposure to malpractice liability, and fewer career options.

Action Step  Physicians should be candid and forthright with the board. They should express concern for the patient’s problem, if appropriate. They should not needlessly accept blame, however, when their conduct is defensible, can be explained, or can be characterized in a less blameworthy fashion. Consistent with the truth, a physician and his counsel should carefully analyze all possible ways of defending or explaining the doctor’s conduct before simply admitting fault. Even if an admission is the only credible option, the best possible terms should be sought before conceding.

Mistake 8  Responding as If Speaking to Physicians Fully Versed in the Specialty
Although medical board members are usually physicians or health care professionals, they are not trained in every medical specialty. Therefore, an individual member or panel may know little about the particular medical specialty in which the physician who is the subject of the complaint practices. Consequently, the physician responding to a board complaint should not
respond in so technical a manner or with such specialized jargon that only an expert in the particular field would understand the response. Conversely, the physician should not respond as if educating an audience with no medical training or background whatsoever or in a condescending manner that insults the board.

**Action Step** Physicians should strive to achieve a middle ground between these two extremes. They should respectfully inform or educate board members about unique or peculiar aspects that may be involved in their particular practice, specialty, or the procedure at issue. In cases in which medical records are voluminous, it is best to cite key portions that support the physician’s defense. If the medical records do not clearly and obviously support their position, they should consider retaining an expert witness to render an opinion. To demonstrate that other authorities support their position, physicians should cite medical treatises, other treating or consulting physicians, and experts whose findings or opinions support the diagnosis, care, or treatment at issue.

**Mistake 9  Failing to Respond to Every Charge in the Complaint**
Often, a physician’s written response will address some, but not all, of the charges made in a patient’s complaint. While the response should be no longer than necessary, it is a mistake to ignore an allegation or assume the board will, on its own, deem a charge so lacking in merit that it does not warrant even a denial by the responding physician.

**Action Step** A physician’s narrative response should address each allegation or charge made in the complaint. Otherwise, the board may infer that the allegation or charge is true. Conversely, a physician’s narrative response should involve no more than is necessary to address each allegation and the board’s stated concerns.

**Mistake 10  Hiding, Altering, or Destroying Records**
Revising or destroying records is perhaps the easiest way for physicians to lose their license. Under no circumstances should a health care provider ever hide, alter, or destroy a medical record even if he or she believes such an alteration would make the record more accurate.

**Action Step** Physicians should never revise records after the fact. Instead, they should promptly gather or obtain certified copies of all the requested records, and see that they are furnished to the medical board in a manner consistent with the Health Insurance Portability and Accountability Act’s federal privacy rules and state privacy laws. To the extent there may be material errors or omissions in an original record, the record should be supplemented—but only in accordance with previously established record-keeping policies. Physicians should produce the original record in its unamended form and clearly note the date and reason for any supplementation, amendment, or addendum. Physicians and their counsel must be prepared to explain the reasons for any omission or error in a record, and any amendment, supplementation, or addendum.
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Conclusion
Physicians who avoid the mistakes discussed in this chapter and take the steps suggested will be best able to ward off disciplinary action and other adverse consequences that may result from a licensing board complaint.

Additional Resources

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21.5 The 10 Biggest Legal Mistakes Physicians Make in the Collateral Consequences of Disciplinary Proceedings
By Jon M. Pellett, Esq.

Executive Summary
Unfortunately, many physicians facing disciplinary action before their respective state licensing boards fail to recognize that actual discipline is only one small step in the overall disciplinary process. Certain violations will be considered of such a nature as to result in immediate or long-term collateral effects on a physician’s health care provider status, staff privileges, other staff memberships, disciplinary status with other states, and practice. While certain violations may not cause the physician to suffer severe or long-term consequences, others can cause disruptions of the physician’s practice or changes in the nature and structure
of the practice due to the collateral effects of the disciplinary event. Even the existence of an investigation may cause further action by these other entities. The key to surviving a disciplinary event is to know the full ramifications of license discipline and, where available, take proactive steps to minimize the effect of any discipline that might be imposed. A failure to recognize and appreciate the effect discipline can have on the physician’s practice can have severe repercussions for the physician and his or her livelihood.

**Mistake 1  Maintaining Multiple State Licenses**
Often, physicians retain a license to practice medicine in multiple jurisdictions or forget that at one time they held a license in another state or believe that it expired long ago through nonrenewal. Also, licenses in other states are often held in an inactive status or are simply still present despite years of nonrenewal. Many times physicians retain these multiple state licenses even though they have no intention to practice in these states.

When a disciplinary event occurs in one state, a physician with multiple licenses often finds that he or she will be disciplined not only by the state in which the event occurred, but also by one or more of the other states in which the physician holds or once held a license. This is true even if the license in the other state had not been renewed for several years.

**Action Step**  Physicians should check with all the states in which they have held a license and know the status of each license they have held. They should also know whether each state considers the license to have been permanently issued. Physicians should assess whether it is in their best interest to maintain multiple state licenses and where possible, they should consider whether it is in their best interest to relinquish unnecessary licenses before an investigation begins. If prompted to consider the issue by a pending proceeding in one state, they should consult with an attorney on whether relinquishment of other state licenses will be in their best interest.

**Mistake 2  Failing to Report Discipline by State Licensing Boards**
After a disciplinary event has occurred, physicians often forget that the disciplinary event may need to be reported to the various certification boards, entities, hospitals, insurance plans, and organizations to which they belong. They also fail to recognize that these entities and organizations often take additional adverse or corrective action for their having been disciplined by their respective state licensing boards.

Upon receiving an independent report of the disciplinary event from the state licensing board, these entities often seek to take adverse or corrective action against the physician for not only having been disciplined by his or her state licensing board, but also for failing to have reported the discipline or the earlier disciplinary investigation to the entity. In turn, the adverse action or corrective action taken against the physician by these entities may itself be a
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basis for additional state board action against the physician or additional action by the other entities and organizations to which the physician belongs.

**Action Step** Physicians should know the membership and reporting requirements for all of the various entities to which they belong. If a physician finds himself or herself under investigation for possible disciplinary action, the physician should gather together all of the bylaws, contracts, and rules of the entities and organizations of which the physician is a member and determine what must be reported and when it must be reported.

If disciplinary action is possible or is initiated, the physician should seek counsel on how to handle the aftermath of the disciplinary event and should confer with counsel on the possible penalties or structure of any order imposing discipline to attempt to minimize the penalties and collateral consequences of the discipline taken by the other entities of which the physician is a member.

**Mistake 3 Delegating Responsibility for Reporting of Disciplinary Events Without Proper Follow-up or Supervision**

Often, a physician will delegate to his or her office staff or to the credentialing staff of the practice where the physician is employed the responsibility for reporting to other entities pending investigations and disciplinary events concerning the physician’s license and then put the whole matter out of his or her mind. Many times, the office staff or credentialing staff of the practice will overlook the requirements of other state licensing bodies, professional organizations, insurance providers, malpractice carriers, medical staff organizations, and other entities and fail to report pending investigations or disciplinary events or fail to timely do so in accordance with the bylaws and requirements of the various entities and organizations to which the physician belongs. Also, if any of these entities or organizations take an interest in the disciplinary event, the staff will fail to appreciate the need to update other entities or organizations of the action taken, which in turn causes a “snowball” effect.

**Action Step** Physicians should take a more active role in ensuring that disciplinary events are properly and promptly reported to other entities. If disciplined by one of their respective state licensing boards, physicians should personally review the reporting requirements for all entities or organizations to which they belong. If a physician delegates responsibility for reporting disciplinary events, he or she should follow up with the staff to be sure the reports were made timely. In addition, the physician should review all reports sent by the staff before they are forwarded to the various entities to which he or she belongs, correcting for any errors or inconsistencies in the reports. Once a report is made, the physician should use the same report for all other entities.
Discipline and Licensing: Collateral Consequences

Mistake 4  Failing to Recognize That Disciplinary Events May Be Reported to National Data Banks

All public action taken against a physician may be reported to the Healthcare Integrity Protection Data Bank, one of the three main national data banks to which physician disciplinary actions are reported. The other two databanks are the Federation of State Medical Boards and the National Practitioner Data Bank (a separate component of the Healthcare Integrity Protection Data Bank). Each of these databanks has specific requirements for what action must be reported. In turn, these databanks are queried by many health care organizations, state licensing boards, malpractice insurance plans, and credentialing organizations.

If disciplinary action has been taken against a physician, he or she may fail to recognize that the action will be reported to the various databanks and from the databanks, reported to other state licensing boards or organizations to which the physician belongs.

Action Step  Physicians have the right to conduct a self-inquiry to determine what information has been reported to the various national databanks and should query the databanks periodically, once every six months, to determine whether derogatory information has been reported. If permitted to submit a statement of explanation to the databank, physicians should prepare a concise statement explaining the disciplinary event. When discipline is taken and notice is given to the physician of the report made to the national data bank, the physician should review the report for accuracy, challenge any inaccuracy in the report, and prepare a concise statement for inclusion with any report made to the data bank.

Mistake 5  Failing to Explore Alternate Penalties When Facing Disciplinary Action

Certain disciplinary penalties (e.g., suspension, revocation, probation, or any encumbrances placed on the physician’s ability to practice medicine) can result in exclusion, decertification, or sanction by certification boards, insurance plans, hospital staff organizations, federal- and state-funded programs, and the Drug Enforcement Administration. Some penalties may actually prevent the physician from supervising certain physician extenders or from working in certain capacities or for certain providers.

Action Step  Physicians facing disciplinary action should confer with counsel on exploring alternate penalties in any disciplinary event. They should obtain help in dealing with disciplinary events and seek to minimize the effect discipline can have on their membership in other organizations and their practices. If alternate penalties are not available, physicians should assess their practices and their professional memberships and make plans for possible additional action by certification boards, insurance plans, hospital staff organizations, federal and state programs, and the Drug Enforcement Administration.
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Whenever possible, physicians should seek to be proactive in addressing the possible collateral action by the organizations to which they belong and seek specific guidance on dealing with each organization and the changes that might need to be made to their practice.

Mistake 6  **Failing to Respond Truthfully When Questioned About Pending Disciplinary Actions**

Regardless of the status of a physician’s disciplinary case (confidential or public), in today’s health care climate, many entities, insurance providers, and other organizations will ask physicians whether they have been the subject of an investigation or a disciplinary action by a licensing authority, board, or other regulatory body. Typical questions include “Are you the subject of an investigation in any jurisdiction, state, or county or have any disciplinary actions been initiated or are any pending against you?” “Have you ever been involved in any disciplinary action by any hospital, medical society, or state licensing agency?” and “Have you ever had any adverse action taken or is any adverse action pending with respect to … a state license?” These questions render any confidentiality afforded to the investigative process by the state licensing board essentially null and void. The entity making the request will expect truthful responses to its questions.

A failure to truthfully respond to the questions could result in further discipline by state licensing boards or other sanctions (e.g., exclusion from participation in insurance plans, delay in admission to an entity, delay in issuance of a new license, or a delay in the renewal of a license with a state licensing board).

**Action Step**  If in doubt about how to approach answering a question posed about pending investigations or disciplinary events, physicians should consult with legal counsel on the best way to approach answering the question. Physicians should always ensure that their answers to questions about pending investigations or disciplinary events are considered truthful.

If an event is considered confidential, physicians should ensure that any disclosure of the event in response to a question contains a statement that they are not waiving their right to confidentiality by making the disclosure to the entity asking the question.

Mistake 7  **Approaching License Discipline Without the Benefit of Counsel**

Many physicians have never faced a disciplinary event and may not understand the nuances of a disciplinary proceeding. They may not fully appreciate the ramifications of the disciplinary event. Many physicians believe they can respond to a notice of investigation without the benefit of the assistance of competent counsel. Often, they believe that the event can be explained, that the physicians on the state licensing board will understand their point, and that they will not face adverse consequences as a result of the notice of investigation or the disciplinary event if they respond rather than having competent counsel assist them.
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**Action Step** Whenever a physician faces disciplinary action, whether by a state licensing board or other entity, the physician should obtain the advice of competent counsel and the physician should always evaluate the effect of the disciplinary event on his or her practice and membership in other organizations.

**Mistake 8** Not Obtaining Coverage for the Practice When a Disciplinary Event Disqualifies the Physician From Supervising Physician Extenders

Under the requirements of some state licensing boards, the placement of a physician on probation or suspension will affect the ability of that physician to supervise physician extenders, such as physician assistants or nurse practitioners. Often, as the investigation is progressing, physicians will not make plans for the possibility that they may be disqualified from supervising physician extenders during the period of discipline or will continue to supervise physician extenders during the period of discipline in violation of their state’s requirements.

**Action Step** Physicians who are facing possible disciplinary action should evaluate their practice to determine whether coverage may be necessary to ensure that physician extenders are properly supervised during the period of discipline and that the physicians are acting in conformity with state requirements during the period of discipline.

**Mistake 9** Failing to Know the Requirements of Employment

Having had discipline imposed against a physician’s license may also exclude a physician from service as a medical director for a clinic or other entity during the period that disciplinary conditions were imposed or subsequently. Some states require a free and unencumbered license as a precondition for the physician to serve as a medical director and/or to be employed by a medical clinic.

**Action Step** Physicians should be aware of any preconditions for their continued employment in various settings. They should seek counsel if they become the subject of discipline, including planning for the effect of any discipline on their employment status.

**Mistake 10** Failing to Appreciate the Importance of Maintaining Board Certification

As with other professional organizations, many certification boards make routine inquiries as to a physician’s license status. Many also require that physicians self-report any problems or discipline. Physicians could see discipline, exclusion, or other sanction by their certification boards as a result of the state disciplinary action. Often, if the action taken by the state board results in impairment of the physician’s ability to practice free and unencumbered, the certification boards may act to decertify the physician’s status with their organizations. This typically happens where the action is one of suspension or restriction of the license or a
privilege associated with the license, such as the ability to prescribe controlled substances, but it can also be based on other considerations.

Loss of board certification can affect medical staff memberships and status in participating insurance plans or cause increases in malpractice insurance premiums or termination of coverage.

**Action Step** Physicians should know the requirements of their certification boards and be proactive whenever they face discipline by a state licensing board.

**Conclusion**
Physicians should always consider the potential effect of a disciplinary proceeding on their professional license and practice. They should seek ways to minimize that effect and be aware of the interrelationship of discipline to employment, malpractice insurance premiums, staff and other professional memberships, and insurance provider status.

**About the Author**
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21.6 The 10 Biggest Legal Mistakes Physicians Make That May Lead to Professional Discipline
By T. Lawrence Tabak, Esq.

**Executive Summary**
This year, thousands of physicians will be disciplined for professional misconduct. The vast majority of these physicians will not lose their licenses, but their discipline and penalty will become a matter of public record . . . permanently. Having a disciplinary sanction on one’s record makes it difficult to maintain a successful career in medicine and the effect can be severe. Aside from the financial devastation, one’s health and personal relationships can be affected as well. Therefore, it is critical that physicians avoid serious mistakes in the first
place in order to dramatically reduce the chances of becoming the subject of a disciplinary investigation.

Mistake 1  Engaging in Negligent Medical Practice
Physician negligence is the main source of disciplinary complaints and investigations against doctors. A physician will be found to have practiced the profession negligently if he or she fails to exercise the care that would be exercised by a reasonably prudent physician under the circumstances; in other words, when the physician fails to meet applicable medical standards. The standard of care will be tested based on the behavior of other physicians practicing the same specialty in the same type of setting. Unlike a medical malpractice action, a guilty finding of negligence in the context of a disciplinary matter does not require the element of damages to the patient as a result of the alleged negligence. The most frequent allegations of negligence include the following:

- Surgery--management of postoperative complications
- Failure to diagnose--cancer
- Improper treatment--insufficient therapy
- Improper treatment--birth related
- Surgery--inadvertent act
- Improper treatment--during examination
- Failure to diagnose--infection
- Improper treatment--drug side effect
- Failure to diagnose--fracture/dislocation
- Improper treatment--infection

Action Step  The overwhelming majority of disciplinary complaints are filed by patients or relatives of patients. Therefore, maintaining a good physician-patient relationship is crucial and frequently has more influence over whether a complaint is made than the actual course of medical treatment or the outcome of that treatment. Studies have shown that patients are much less likely to file a complaint against a physician who has taken the time to establish a good rapport and engender the feelings of concern over the patient’s well-being.

Mistake 2  Improperly Altering the Medical Record of a Patient
Physicians should never even contemplate revising a note once it has been written in a patient’s medical record. Sometimes, it is possible to make minor clarifications along the way, but they must be made in an appropriate and above-board manner that leaves no doubt that the physician’s intentions were honest. Improper alteration of a medical record will adversely affect the credibility of the medical record and the physician and can amount to prima facie evidence of fraud. In some states, if a misleading alteration of the medical record is made intentionally or willfully, it is a felony. A physician who has improperly altered a medical record can expect an investigation by the state board of medicine.
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Action Step  Physicians should never alter a medical record to conceal its original content. If an addendum is necessary, it must be labeled as an addendum, must include the date and time it was written, and must be signed by the physician.

Mistake 3  Engaging in an Improper Relationship With a Patient
It is considered improper for a physician to undertake any self-gratifying behavior (including sexual intercourse, touching for a sexual purpose, sexual conversation, dating, or suggestions of sexual involvement or sexual romantic contact) during the course of the physician-patient relationship. Sexual interactions between physicians and their patients detract from the goals of the physician-patient relationship. Bringing sexual conduct into the physician-patient relationship may exploit the patient’s vulnerability, obscure the physician’s objective judgment, and be detrimental to the patient’s well-being. Almost every medical board’s position regarding sexual relationships with patients is clear and unequivocal: It will not tolerate a physician entering into a sexual relationship with a patient, consensual or otherwise. Such behavior and conduct are viewed as unprofessional and provides a basis for suspension or revocation of a physician’s license.

Action Step  Physicians should always respect the physician-patient relationship and adhere to strict boundaries.

Mistake 4  Keeping Poor Records
“Medical records are often written in haste, repented at leisure”—the leisure, unfortunately, of the long and unpleasant litigation process or investigation by a state medical board or government agency. Records should convey an impression of consistently competent, attentive, thoughtful patient care. They should be legible and complete. Progress notes and other records that demonstrate a high quality of patient care do not happen by accident. The investment of time, effort, and practice of maintaining good documentation can pay for itself many times over.

Action Step  Physicians must maintain complete, timely, and accurate documentation of the care rendered to a patient. Following the acronym SOAP (subjective findings, objective findings, assessment, and plan) is a good charting method.

Mistake 5  Being Impaired by Drugs or Alcohol
Physicians are not immune to the diseases of alcoholism and chemical dependency. In fact, there may be an even greater risk of such problems among physicians due to the availability and accessibility of drugs in the workplace and the work-related stresses to which most physicians are exposed. Substance abuse exposes the physician to an alarming risk of malpractice claims and, in turn, misconduct proceedings. In their efforts to protect the public, state medical boards will make certain that physicians suffering from alcoholism or substance abuse are removed from practice until they are proven to be rehabilitated.
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**Action Step**
It is imperative that physicians in a position of responsibility, whether for patient care or in other areas, should not have their performance impaired by drugs, alcohol, or other circumstances. This is true even when the physician is not on call.

**Mistake 6  Having a Criminal Conviction**
Once a physician is convicted of a misdemeanor or felony, the state medical board can and will commence an action against that physician based on the criminal conviction itself, regardless of whether the conviction was related to the practice of medicine or the ability to practice medicine. In such cases, the physician does not have the opportunity to dispute the underlying facts that led to the criminal conviction, but will be allowed only to put forth arguments related to mitigation and sanction. These disciplinary actions are becoming ever more popular as the state medical boards gain increasing cooperation from federal and state law enforcement authorities.

**Action Step**
Physicians must consider the consequences of their actions, whether or not they are related to the practice of medicine, and the potential detrimental effect on their medical license.

**Mistake 7  Failing to Disclose Information on Credentialing Applications**
Recently, many physicians have been caught off guard by the requirement to answer questions regarding legal actions, including any past criminal convictions, on a state-mandated “physician profile” or hospital credentialing application. Failing to disclose this information can lead to a misconduct charge of fraud with the intent to deceive. Many physicians are finding themselves the subject of investigations not realizing that questions about 20-year-old DUI convictions and misdemeanor convictions for student pranks during college require a “yes” answer, if applicable.

**Action Step**
Physicians must answer all questions on any professional application honestly and diligently. They are advised to seek the assistance of experienced health care counsel if they are confronted with a question that they are unsure about how to answer.

**Mistake 8  Writing Prescriptions for Friends and Relatives**
Physicians are often cautioned not to prescribe medications for themselves, family members, colleagues, or friends with whom they do not have a physician-patient relationship. However, many physicians do so despite the risks involved. A physician who prescribes for people without knowing their medical histories opens up the possibility that they could experience negative drug interactions from medications that they never mentioned to the physician or prolong the diagnoses and treatment of a serious condition. While writing prescriptions may have no negative effect, the state medical boards will not be concerned with the outcomes if they are investigating a physician’s prescribing practices. Every prescription issued by a
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physician creates a physician-patient relationship and requires the same protocols and procedures that a physician would provide for any of his or her patients.

Action Step While it may present personal challenges for physicians to refuse a social request for a prescription, it is essential to be able to say no. If a physician feels he or she must prescribe for a friend, relative, or colleague, the physician should remember that the law imposes very specific requirements before doing so. These include taking a thorough medical history, conducting any and all necessary physical examinations, and always creating a proper and complete patient record.

Mistake 9 Engaging in False Advertising
Physician advertising is yet another way physicians are being scrutinized by state medical boards. Although physicians are permitted to advertise, they must do so in conformity with the state laws or face potential charges of professional misconduct. In sum, physicians may engage in advertising or solicitation so long as the communication is not materially false or deceptive. Specifically, making claims of special skills or training without proper credentials constitutes fraudulent conduct and can be grounds for revocation of a professional license. Physicians in most states are also prohibited from using testimonials or guarantees of any service and must keep copies of any advertisements on file for one to two years.

Action Step Whenever an advertisement is used, the physician must possess information that substantiates the truthfulness of any representation made in the advertisement.

Mistake 10 Failing to Consult With Experienced Health Care Counsel
Perhaps the most important self-protective strategy to avoid a disciplinary sanction is retaining the services of an attorney who “practices before the board”—someone who is experienced in handling professional misconduct cases, knows the law, and understands the consequences for the physician. Experienced legal representation levels the playing field and involves not only the skills to defend the physician, but also skilled communication and collaboration.

Action Step Physicians should consult with experienced health care counsel before they have any contact with the state licensing board.

Conclusion
It is impossible to anticipate every situation that can lead to a professional discipline investigation. However, avoiding these mistakes can dramatically reduce a physician’s chances of facing such an investigation.
DISCIPLINE AND LICENSING: CREDENTIALING

About the Author
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21.7 The 10 Biggest Legal Mistakes Physicians Make in the Credentialing Process
By Michael A. Cassidy, Esq.

Executive Summary
Physicians often ignore the crucial steps to be taken when early warning signs appear in the credentialing process. They also may ignore the fact that the credentialing process, although sometimes informal and often performed solely by health care personnel in health care institutions, is nevertheless a structured legal process that can trap the unwary and penalize the careless.

Mistake 1 Misrepresenting or Attempting to Hide Prior Adverse Peer Review Actions
By far the most serious credentialing mistake any physician can make is the “cover up.” Failing to disclose a prior adverse peer review action, especially when that fact will be discovered through a National Practitioners Data Bank (NPDB) query or a reference check, creates almost insurmountable problems. This mistake is serious for several reasons:

- In a profession in which ethics are both important and valued, the cover up itself is a negative event.
- A misrepresentation is an objective, clear-cut violation of the credentials application process. Most applications have a statement or series of questions concerning prior adverse peer review actions. If a physician fails to disclose, then that nondisclosure is itself a violation. The incident happened: The physician was asked about it and lied. There are no subjective issues, and no defenses.
- Lying about his or her record taints a physician’s credibility and therefore the physician’s explanation of any underlying events precipitating the peer review action.
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The underlying event cannot then easily be portrayed as politics, or professional disagreement, or retaliation by competitors because the veracity of the physician’s position is now in doubt.

- Because of the NPDB, the Joint Committee for Accreditation of Healthcare Organizations (JCAHO) emphasizes quality credentialing, and in the “small world” of the medical community, deception is almost always discovered.

**Action Step**  Physicians should answer the questions on medical staff applications correctly, and they should not adopt unreasonable definitions of the questions just to provide a questionable excuse for nondisclosure.

**Mistake 2  Failing to Report Adverse Peer Review Actions**

Many medical staff bylaws and third-party participation agreements require physicians to report adverse peer review actions (e.g., revocation, suspension, or voluntary relinquishment of medical staff membership, clinical privileges, or state or federal Drug Enforcement Administration licenses, and exclusion from third-party programs). Although not as serious as affirmatively or actively concealing adverse peer review actions, the failure to report these adverse actions when required to do so is still a serious mistake for two reasons. First, although perhaps inadvertent, it nevertheless smacks of the dreaded cover-up. Second, the failure to report is itself an independent, separate, and easily established clear and objective violation of the bylaws or agreements. It taints a physician’s reputation. In situations in which the “old MD’s network” or the new CEO is looking to remove a physician, or when the alleged subjective violation is difficult to prove, some disciplinary action for this type of violation is an easy determination. Although the violation itself may have nothing to do with quality of care or the physician’s professional ability, it could still result in the physician’s loss of membership or reduction of privileges.

**Action Step**  When an adverse peer review action occurs, physicians should review the medical staff applications and participation agreements they have signed. Better yet, they should have a list of the applicable requirements. They will receive a copy of the NPDB report. If appropriate, the physician should submit a supplemental statement (see Mistake 3). In some situations, a physician is best served by sending a brief notice that may convey just the NPDB report and the supplemental statements. There is no harm in sending the report; all queriers will see it anyway, and the voluntary production of it makes it appear as if the physician has nothing to hide. If the reported incident is a serious problem, the physician may want to have a full explanation prepared, with supporting exhibits and maybe letters of reference, to diffuse the situation.

**Mistake 3  Failing to Monitor or Respond to Data Bank Reports**

Reports to the NPDB should be monitored and contested when appropriate. Data bank procedures permit physicians to request the reporting entities to correct erroneous reports, use
the administrative procedures of the federal Department of Health and Human Services to challenge incorrect reports, and file an individual supplemental statement.

**Action Step**  When notified of an adverse NPDB report, physicians should use all of the procedural safeguards available.

**Mistake 4  Believing “Collegial Intervention” Is Collegial**

Collegial intervention can be a trap for the unwary. Whenever physicians are approached by an “official” member of the medical staff to discuss quality assurance or quality improvement issues, especially in relation to a physician’s cases or conduct, the physician should both embrace the opportunity as a professional and suspect the worst. Collegial intervention can be used as an excuse by the medical staff/hospital to initiate or conduct an investigation before a physician even knows it is happening and without providing any of the due process protections provided by the bylaws with respect to formal investigations. What the physician perceives as just a series of casual conversations could, in retrospect, be portrayed as a concerted effort by the organized medical staff to correct a problem the physician did not even realize he or she had.

**Action Step**  Physicians should be careful. They should ask the inquiring medical staff or hospital representatives if this is an “official visit.” Also, they should check their medical staff and credentialing file (see Mistake 9).

**Mistake 5  Neglecting the Opportunity to Secure Corroborating Witnesses**

Collegial intervention as well as initial investigations usually start with a meeting of some type. This is not the place to “lawyer up”; that is both unprofessional and unnecessarily adversarial, and usually prohibited by the bylaws (see Mistake 10). The intent of the bylaws is usually to provide a professional and a nonadversarial environment to address minor issues before they become major problems. However, the physician should request to be accompanied by another physician (e.g., a partner or another department member) just to have a witness who can corroborate the facts if necessary. If the physician can’t have a witness, then he or she should either record the meeting (with mutual consent) or prepare a written memo immediately after the meeting and send a copy to the person responsible for conducting the meeting to confirm the facts. Using a professional and nonaccusatory memo to confirm the facts is especially helpful when done before the battle lines harden.

**Action Step**  Physicians should secure potential witnesses and keep accurate records so they are not “unarmed” in future confrontations.
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Mistake 6  **Failing to Appreciate That Any Peer Review Activity Should Be Taken Seriously**

Physicians have an unfortunate tendency to dismiss the seriousness of the initial stages of peer review investigations as unnecessary and unwelcome administrative intrusions that will be resolved when the real doctors become involved. While this *may* have been true at an earlier time, it is certainly not true now. Liability for negligent credentialing and JCAHO medical staff standards make credentialing a serious business all the time, not just when the controversy erupts into a medical staff hearing. Credentialing professionals take their responsibility seriously, and these “professionals” are now well trained professionals. Gone are the days when the credentialing was just another bookkeeping duty of the medical staff secretary. By the time the credentialing professionals first raise the issue with the physician, their homework will have been done; they will have facts, witnesses, and medical records. Unless the physician investigates and prepares his or her position and defense with the same diligence and zeal as the “prosecutors,” the physician will find himself or herself at a significant disadvantage. The physician will be starting with a handicap that he or she may well not overcome. Physicians should do their homework.

**Action Step**  Physicians should appreciate the possible adverse consequences of any peer review action.

Mistake 7  **Whistleblowing in Retaliation Is Generally a Bad Idea**

Physicians sometimes confuse patient advocacy with disruptive behavior, sometimes intentionally. It is almost never effective, on a long-term basis, to threaten exposure of quality assurance concerns or issues as a means to justify their own problem cases. First and foremost, other bad outcomes do not change a physician’s outcomes. However, one clear exception to this policy is when a physician is being held to a different standard. But even in this situation, the identity of other physicians need not be disclosed if the critical facts can be discussed without identification. Second, a physician’s conduct could create unwanted liability for him or her, such as slander or defamation. The peer review statutes of most states immunize the participants, although some states may have overlaying good-faith requirements. This immunity against liability for participation in the peer review process usually applies only to charges and disclosures made as an integral part of the peer review process, such as statements or written communications to a quality assurance committee. Immunity may not apply to unprotected communications, such as impassioned speeches in the doctors’ lounge. Finally, there is no surer way to precipitate retribution than to cast the first stone.

**Action Step**  Physicians should follow their mother’s advice: “People who live in glass houses should not throw stones.” And, “If you don’t have anything nice to say, don’t say anything.”

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Mistake 8  **Conspiracy Theorists Win Only in Movies**
A variation of the misguided whistleblower’s mistake is maligning the motives of others. The best defense might be a good offense on the gridiron but unless one has solid facts, blaming the situation on scheming competitors, jealous physicians, and clueless hospital staff is not a winning strategy. Although truth is always an exception to any warning, and there are a significant number of medical staff cases in which the conspiracy and the liability have been proven, all cases are unique.

**Action Step**  Physicians should not create an entire class of adversaries and undermine their legitimate defenses by making unfounded accusations.

Mistake 9  **Neglecting to Monitor One’s Own Medical Staff Records**
Physicians should not wait until a peer review action is threatened to inspect their medical staff or credentials file. When their reappointment application is being filed, they should go to the medical staff office and request to review the file, and the explanation can be simply that the physician heard that it was a good idea to review his or her record at the times of each reappointment. Some medical staff offices might keep separate credentials and peer review files, and physicians should ask to see both. The hospital might object to allowing a physician to review the file, arguing that “peer review laws” make such information confidential. Depending on the state, this may or may not be true. Many peer review protection acts, including the federal Health Care Quality Improvement Act of 1986, which established the NPDB, provide immunity for those who participate in the peer review process, but they do not make the records confidential from the physician. If this claim is made, the physician should ask his or her medical staff to formally review this issue with separate counsel.

**Action Step**  Physicians should regularly monitor their medical staff and credentials files.

Mistake 10  **Refusing to Retain an Experienced Lawyer**
Refusing to retain an experienced lawyer is a mistake that falls into the general category of being unprepared. When investigations or inquiries begin, physicians mistakenly believe that legal counsel at this early stage is inappropriate or unnecessary. That’s how some of the other mistakes happen. Even if a physician cannot be represented by a lawyer in the meeting or during the interview process, that does not mean the physician should not know his or her rights. There would not be a list of “the 10 biggest mistakes physicians make” in this area if physicians were effectively represented by counsel.

**Action Step**  By the time a physician thinks he or she needs legal advice, it may already be too late. Physicians should consult counsel as soon as they realize that anything unusual is happening. Too early is an inconvenience; too late is a serious problem.
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Conclusion
Physicians are best served by avoiding these 10 legal mistakes in the credentialing process.

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Chapter 22  Real Estate

22.1 The 10 Biggest Legal Mistakes Physicians Make in Negotiating Leases with Landlords
By Deborah A. Green, Esq.

Executive Summary
Negotiating a favorable lease is of critical importance to any medical practice. Physicians need to recognize the common problems that arise in medical leases and should retain experienced counsel to help them negotiate the most favorable terms. Failure to negotiate a lease or failure to fully comprehend the terms of the lease can lead to serious problems.

Mistake 1 Failing to Understand the Patient Demographic
Renting commercial space is different from renting a residential apartment and should never be approached in a casual manner. Once physicians have decided on the nature of their practice and the type of patient they want to attract, they must decide whether to be located in an urban, suburban, or rural environment. In an urban environment, physicians want to make certain there is ample, convenient parking, or if they are located in a large city such as Chicago, that they are located close to public transportation. Physicians who want a cash practice need to be located in a wealthy neighborhood and in a building with upscale amenities, while physicians who treat mostly patients with workers’ compensation claims would want to locate their office in a neighborhood where their patients are most likely to live.

Action Step Before physicians begin reading newspaper ads or making the rounds with brokers in search of their practice location, they must first decide the type of clientele they want to treat.

Mistake 2 Being Unaware of the Different Types of Leases
Leases come in a variety of flavors, but all leases tend to favor the landlords, since they are usually written by landlords. Just because the terms are written on a preprinted form does not mean that they cannot be changed. Physicians should feel free to have their attorney negotiate the terms for them.

Gross Lease. A gross lease is sometimes referred to as a “pass-through lease” or a “full-service lease.” The lessee pays only the base amount for the duration of the lease. Occasionally, the lessee may be required to pay certain additional costs. Consider, for example, the following scenario:
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Dr. Rimilov has entered into a five-year lease. He has rented 1,500 square feet in an 18,000 square foot building. He pays $14 per square foot, so his base rent is $21,000 per year, or $1,750 per month. This rate includes utilities, maintenance, taxes, and janitorial services.

In some gross leases, Dr. Rimilov will pay only $1,750 per month for five years. At the end of five years, the term of his lease will end or the lease will be renegotiated. In other instances, all or certain cost-of-living increases and building expenses will be added to the rent after the first year of the lease and he will be responsible for payment.

_Graduated Gross Lease._ A graduated gross lease is a good idea for physicians who are starting out in practice, since it keeps costs lower initially. Consider, for example, the following scenario:

Dr. Rimilov has entered into a five-year lease. He has rented 1,500 square feet in an 18,000 square foot building. He pays $14 per square foot, so his base rent for the five years is $105,000 (which includes utilities, maintenance, taxes, and janitorial services), as in the previous example. Over the five-year lease, he will pay $1,000 per month the first year, $1,500 per month the second year, $2,000 per month the third year, and $2,125 per month the fourth and fifth years. At the end of five years, he will have paid the same amount as in the previous example, but because he was able to make lower payments initially, it will be easier for him to manage the finances of his practice when he is first starting out.

_Adjusted Gross Lease._ The adjusted gross lease is the same as the gross lease but gives the lessee more control. For instance, newer buildings generally permit the lessee to control the amount of air conditioning or heat in the lessee’s office. This works to the lessee’s advantage if the lessee’s hours are fairly standard and works against the lessee who has evening or weekend hours. Again, consider the following scenario:

Dr. Rimilov maintains a 1,500 square foot practice. His hours are Monday through Friday, from 9 am to 5 pm. He seldom has emergencies. Dr. Rimilov’s neighbor, MicroWare, is a 1,500 square foot software company, with office hours Monday through Saturday, from 7 am to 11 pm.

In a gross lease, the heat and air conditioning costs would be split equally between Dr. Rimilov and MicroWare because each has the same amount of gross footage. The amount of time that each used the air conditioning unit would not be considered. In such a scenario, MicroWare would obviously benefit: Dr. Rimilov would be paying for air conditioning he was not receiving. In an adjusted gross lease arrangement, MicroWare and Dr. Rimilov each would have a meter and neither would benefit to the detriment of the other.
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The Net Lease. Under a net lease, the lessee pays for all utilities, maintenance, taxes, and janitorial services. As a result, the base lease payment should be lower than it would be under a gross lease. The lessee has more control over expenses (except for taxes and increases for common areas) because the lessee decides which vendors to use and to what extent.

Action Step Unless they are sophisticated in leasing medical practice facilities, physicians should consult with a health care real estate lawyer to negotiate a lease. Activities that are perfectly legal and make excellent business sense in a nonmedical setting can subject a physician to severe penalties and possible jail time in a health care setting.

Mistake 3 Personally Guaranteeing the Lease
Most landlords require that the lessee sign a guaranty of the lease. This document is extremely important. It means that the lessee is personally liable for payment of the rent on the premises. If the physician’s practice is unsuccessful and must be shut down, the physician will still be liable for payment of the balance of the lease term unless he or she finds another tenant for the space. Even in such an event, the lessee will most likely not be relieved from payment until the original lease expires. Even if the physician signs a guaranty with a partner, the physician will be primarily liable for the entire amount that is due. For instance, if a physician has assets and the partner does not, the landlord may go after the physician alone for the entire amount due. The physician may in turn sue the partner but if the partner does not have assets, the physician is out of luck (and out of money).

Action Step If the landlord insists on a personal guaranty, the physician should seek to limit the duration. For instance, the physician should try to have the personal guaranty limited to one year or 18 months if he or she is negotiating a five-year lease. If the landlord will not negotiate the term, perhaps the landlord will negotiate a limitation on the amount of the guaranty.

Mistake 4 Entering into a Percentage Lease
In a percentage lease, the lessee pays the landlord a percentage of the lessee’s gross income. Although perfectly acceptable in a retail setting, it is not permitted in health care. For a physician, giving a landlord a percentage of his or her gross income may be construed as fee splitting.

Action Step Physicians should not even think about making this mistake.

Mistake 5 Failing to Understand “Pass-through” Expenses
Many leases have a cost-of-living increase included. This increase is generally based on the Consumer Price Index (CPI) for the area where the space being leased is located. Physicians should be sure to have the type of CPI clearly described in their lease and that the increase is capped by a certain percentage of the lease. Physicians should also request that the amount of
rent be decreased if the CPI falls. In addition, when physicians receive their yearly statement showing their increases, they should make certain to review these increases with their accountant immediately. Also, if the building is not fully leased, physicians should be sure they are not paying for the shortfall. The lease should state that expenses will be adjusted as if the building were fully occupied.

**Action Step** Physicians should examine their leases carefully to find out whether they will be responsible for payment of pass-through expenses. If they are responsible for payment, they should make certain that they know the exact pro-rata share of the building that they are leasing. They should not take the landlord’s word for it. Physicians should measure the office space themselves (which can be easily done by counting ceiling tiles). Also, physicians should find out whether their leased area includes just their office space or also part of the common areas, such as the hallways or the lobby of the building (the “load factor”). Physicians may wind up paying for the pretty atrium on the eighth floor when their office is on the third floor.

**Mistake 6** **Failing to Get the Lease in Writing**
There are many types of leases, and each has its pros and cons. The one thing to remember is that the lease controls a physician’s ongoing relationship with the landlord.

**Action Step** All leases should be in writing, even if it is a close friend who is leasing the office space. Life has its ups and downs. That close friend could get divorced and lose the property in the divorce settlement, allowing the spouse, as owner of the building, to evict its tenants.

**Mistake 7** **Failing to Include All Important Terms in the Lease**
The lease should contain all terms that are important to the physician. For instance, if a physician has a lease with an option to renew in five years, he or she should make certain that there is a formula in place in the lease terms to determine the price to be paid in five years. If the neighborhood in which the practice is located becomes fashionable, the increase could be 200% to 300%. On the other hand, if the price is tied to the rate of inflation or other objective criteria, the physician will probably be able to handle an increase more easily.

**Action Step** Physicians should never leave issues to be determined at some later date. The issues never get resolved until an answer is needed, and by that time a physician is subject to the landlord’s whims.

**Mistake 8** **Failing to Read the Lease**
The lease may be one of the most important documents that physicians ever sign, so they should be sure to read and understand it. Even when the lease is long and in very small typeface, physicians should read it anyway.
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**Action Step**  When a physician cannot understand the lease, he or she should be sure to get a written explanation from the landlord. The explanation should be attached to the lease. In addition, the physician should make sure the language that was not understood is crossed out and that the landlord puts his or her initials near the changes.

**Mistake 9  Failing to Tailor the Lease to the Needs of a Health Care Facility**

Leases are often drafted by landlords; other times, a retail, standardized form is used. Although these forms are useful in certain situations, they will not be applicable to a health care practice.

**Action Step**  Physicians should make sure that the following points are covered in their lease:

- Is sufficient storage available for their supplies both within the office and in storage bins (if available) in the building?
- What provisions will be made for signage?
- Are there restrictions on having certain types of equipment in the office, either as a result of the weight of the equipment or the use of such equipment? Will such restrictions affect the physician practice, either now or in the foreseeable future?
- Is the space Medicare approved?
- Is there emergency access to the office space? Are the elevators (if any) operational 24 hours a day?
- Are there facilities for the handicapped? Physicians should refer to local codes to ascertain the types of facilities required for the handicapped and not take the broker’s or landlord’s verbal representation for compliance unless the landlord is willing to provide a signed statement that the office facility is in compliance with the codes regarding access for the handicapped and if the facility is not in compliance, the landlord will make the office facility compliant within 30 days or pay the cost of having the physician do so. Making an office compliant with regulations regarding access for the handicapped can be expensive, so if a physician is not prepared to bear the brunt of paying for such improvements, he or she should get the landlord to agree to make the necessary improvements.
- Are the exam rooms sound-proofed to maintain patient confidentiality?
- Will other doctors practicing in the physician’s specialty be permitted to lease space in the building?
- What are the conditions, if any, that would permit the physician to sublet or assign the premises? Physicians should get those conditions in writing even if they think they will never want to sublease or assign the office. A physician may outgrow the office and require additional space elsewhere or may find that until his or her practice office grows it would be in his or her financial self-interest to lease part of the space to another practitioner when the physician is not there. Physicians should
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*never* agree to “working it out” when and if the time comes. It usually does not work out in their favor.

- Is the lease between only the landlord and the physician’s practice or is the physician personally liable under the terms of the lease?
- Is there access to parking 24 hours a day? If the building has parking, are discount parking validations available for patients?
- Is there sufficient space in which to expand the practice? If the physician is adding office space, is the physician required to use the lessor’s space planner or permitted to use one he or she chooses? If the physician is permitted to use his or her own planner, the physician should make certain the planner is experienced in the medical field and get references and visit offices that the planner has created. If the physician must use the landlord’s planner, the physician should make sure to obtain a written representation from both the landlord and the planner that the planner is experienced in planning medical offices and will be responsible for anything built that is not in accordance with customary medical space. Often, specialized medical equipment, such as x-ray machines, requires specialized wiring and lead lined walls, ceilings, and doors. Physicians should make sure that the planner has this information as soon as possible so that the space can be built to suit the requirements.
- What utilities are provided during which hours? For example, in Florida, a physician would want the air conditioner on before the office opens and kept on until the last person in the office leaves.

**Mistake 10   Failing to Provide an “Out” If Needed**

Physicians who need a loan to start their practice but are unsure whether they will qualify for one should make certain that the lease provides them with an escape clause.

**Action Step** The following clause would give a physician an “out” if he or she fails to qualify for the loan: “This lease is subject to Tenant obtaining a written commitment within ____ days of the date hereof for a loan in the principal amount of ______ at an initial rate of interest not to exceed ____ percent for a term of ___ years. Tenant will make application therefore within five days from the date hereof and use reasonable diligence to obtain the loan commitment and to satisfy the terms and conditions of the commitment and to close the loan. If the Tenant fails to obtain the commitment or fails to waive Tenant’s rights hereunder or after diligent efforts fails to meet the terms and conditions of the commitment, then either party may by written notice to the other cancel this lease and tenant shall be refunded his deposit.”

**Conclusion** A physician will likely spend most of his or her life in the office. Moving can be stressful, expensive, and deleterious to patient care as files have a way of getting lost and computers tend to develop strange maladies when moved. Physicians should not let a broker negotiate
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the lease for them. The broker’s commission is generally tied to the amount of money to be paid as rent so the broker has an inherent conflict. Also, the broker will most likely not have an understanding of health care law. Even when working with a lawyer, physicians should make sure that they understand their rights and obligations from a business perspective. It is the attorney’s job to protect their clients legally, not make business decisions for them. Finally, physicians should develop a lease that permits them and their landlord to co-exist happily for a long time.

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22.2 The 10 Biggest Legal Mistakes Physicians Make in Negotiating Subleases from or to Other Doctors
By Deborah A. Green, Esq.

Executive Summary
Physicians should address the following issues in the lease if they will be subleasing space in an existing health care office. Both the sublandlord and the subtenant should consider these issues.

Mistake 1 Failing to Review the Lease
Sublandlords often assume that they are permitted to sublet a portion of the premises in question. If the lease contains a prohibition against subletting (and most leases do), and the leaser sublets without first getting the landlord’s permission, the leaser may be required to evict the new subtenant or at least pay a sum of money to the landlord. If the leaser is required to evict the subtenant, the subtenant could sue the leaser for damages sustained (e.g., loss of income and the cost of having to get new office space).

Action Step Physicians should be familiar with the terms of the lease.
Mistake 2  **Failing to Get a Copy of the Underlying Lease**
The sublandlord and the subtenant often enter into a short written agreement (if they enter into any written agreement at all) concerning the terms of the tenancy. The subtenant is unaware of any of the terms involving the sublandlord and the landlord. The subtenant should review the existing lease (often referred to as the underlying lease) between the sublandlord and the landlord because the subtenant should know whether the sublandlord is permitted to sublet space. Even if the sublandlord is permitted to sublet the space, the subtenant’s lease will be subject to the terms of the lease between the sublandlord and the landlord. Therefore, it is in the subtenant’s best interests to find out exactly what those terms are. If the subtenant is evicted because the sublandlord had no right to sublet the premises without first obtaining permission, the subtenant may sue for damages but would still be out of business for a period of time. Also, the subtenant would need to find adequate space again.

**Action Step**  When it comes to real estate, physicians should always get the terms of the deal in writing.

Mistake 3  **Having a Lease That Fails to Clarify What Services the Sublandlord Will Provide the Subtenant**
A common term in short subleases between doctors is that the sublandlord will provide customary services to the subtenant. A problem could arise when the subtenant and the sublandlord have differing opinions about what constitutes customary services. Therefore, each party to the transaction should ensure that both the sublandlord and the subtenant agree to the following issues:

- Will the sublandlord take telephone calls and book appointments for the subtenant?
- Where will the subtenant’s charts be kept?
- Does the subtenant have sufficient storage for supplies both within the office and in storage bins (if available) in the building?
- What provisions will be made for the subtenant’s signage?
- What security is provided for the subtenant’s records, supplies, and other materials? Keeping records secure is imperative under the Health Insurance Portability and Accountability Act (HIPAA).
- Does the subtenant have access to a waiting room?
- Is the space Medicare-approved?
- Is there emergency access to the office space?
- Are the elevators (if any) operational 24 hours a day?
- Is there access to parking 24 hours a day? If the building has parking, can the subtenant obtain discount parking validations for patients?
- Are the exam rooms soundproofed to maintain patient confidentiality?
- Will other doctors be permitted to lease space in the office?
- Is the subtenant personally liable under the terms of the lease?
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Action Step Physicians should make no assumptions about the services to be provided.

Mistake 4 Failing to Comply With Federal and State Self-Referral Rules
The federal government and most states have rules against self-referrals. To avoid a self-referral violation, physicians should make sure the lease is in writing, has a period of no less than one year, and the rent that is being charged is fair market value. “Fair market value” rent is rent that is commonly charged in the community for the type of space being renting. Under no circumstances should the amount of rent charged be based on the volume or value of referrals. A self-referral violation does not require intent. This means that even if the physicians never intended to be involved in a self-referral situation but it turns out that they are, the parties could be liable to pay a substantial fine.

Action Step Physicians should have an attorney ascertain whether there is a prohibition against self-referral in their state. If there is such a prohibition, they should find out if there are any safe harbors; if there are any safe harbors, they should make sure that the lease is in compliance with them.

Mistake 5 Failing to Comply With Federal and State Self-Anti-Kickback Rules
The federal government and most states have rules against kickbacks. To avoid a kickback violation, physicians should make sure that the lease is in writing, has a period of no less than one year, and the rent being charged is fair market value. This safe harbor is essentially the same as the safe harbor for self-referrals described in Mistake 4. Again, under no circumstances should the amount of rent charged be based on the volume or value of referrals. Unlike self-referral violations, however, an anti-kickback violation requires “intent.” Intent means that a person who had no intention to pay or be paid a kickback cannot be found liable; if, however, that person is found guilty, he or she could be subject to jail time.

Action Step Physicians should have their attorney determine if there is a prohibition against kickbacks in their state. If there is such a prohibition, they should find out if there are any safe harbors and, if so, make sure that the lease is in compliance with them. Since an anti-kickback violation is very serious, physicians should make sure that the lease does not inadvertently place them in such a situation.

Mistake 6 Failing to Investigate
When subletting space to or from another doctor, physicians may neglect to find out who the other doctor is. They should make sure to do so: If the doctor has been in trouble with state or federal authorities, it is most likely that these authorities would take a close look at the subletting physician too. The subletting physician may have nothing to hide, but why invite such scrutiny?
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**Action Step** Many sites on the Internet provide information about whether a doctor has been excluded from a federal program or has been censured by a state regulatory agency. Physicians should make use of these sites before they enter into the lease.

**Mistake 7** Failing to Describe the Fee for Management Services If Provided Under the Lease
If the sublandlord is going to provide management services, physicians should make sure they are paying fair market value prices for such services and try to get a breakdown for each service provided.

**Action Step** Physicians should call a management company in their community and ask how much it charges for such services. Then, they should compare this amount to the price the sublandlord is charging.

**Mistake 8** Failing to Describe the Fee for Billing Services If Provided Under the Lease
If the sublandlord is providing billing services, physicians should make sure these services are paid for at fair market value and not a percentage of the total, particularly if the billing company is determining the codes that are billed. Physicians should remember that they are ultimately responsible if billing or coding is done incorrectly.

**Action Step** Physicians should conduct a random review of the billing company, as well as have an independent coder check the bills to make sure that the bills being sent to third-party payers accurately reflect the services being provided.

**Mistake 9** Failing to Provide for a Secure Environment
Many doctors leave files unattended on desks, have signature stamps out in the open, keep checkbooks in unlocked drawers, and use unsecured computers. Such behavior in an office that has subtenants and other workers who are not part of the staff is an invitation to trouble. Physicians should make certain to have an area to which only they have access and that they keep their valuables there when they leave the office.

**Action Step** Physicians should get keys to their file cabinets; keep signature stamps and checkbooks under lock; use their own computer, and make sure that their password is not easy to guess.

**Mistake 10** Failing to Personally Inspect Bank Records
Subtenants often let the sublandlord’s office manager or bookkeeper handle bank records. This is an excellent way of having funds embezzled. Physicians should make sure to check each statement that arrives. If they discover a discrepancy, the bank will be liable if it is notified immediately. If there have been discrepancies over a period of several statements and
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the bank has not been notified, the physician would be considered negligent and the bank
would not be required to make good on the loss.

Action Step Physicians should keep control over the checking account. They should
review statements monthly, check signatures on checks, make sure that they are familiar with
the names of their vendors and what they usually charge.

Conclusion Physicians who are involved in a sublease should avoid these mistakes. Failure to do so could
result in serious trouble.

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22.3 The 10 Biggest Legal Mistakes Physicians Make When Buying Real Estate
By Robert J. Horvat, Jr., Esq.

Executive Summary
Their earning ability allows many physicians to invest in the real estate market and own
interests in land, office buildings, retail properties, and single- and multifamily developments.
When making those investments, physicians, because of the enormous time constraints many
of them are under, often focus almost exclusively on the bottom line return they hope to
achieve and fail to pay adequate attention to details. Inattention to details can, at a minimum,
cause an investment to underperform and, in certain circumstances, spell financial disaster for
the physician.

Mistake 1 Not Reducing the Purchase Agreement to Writing
Physicians are extremely busy and, as a result, sometimes fail to ensure that all of their
agreements are reduced to writing, relying instead on a handshake. In the real estate
investment world, however, all promises and discussions should be reduced to writing
because of the amount of money and risk involved. A well-drafted purchase agreement
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should cover topics such as purchase price, earnest money, contingencies, closing, prorations, title insurance, representations and warranties, and casualty and condemnation.

**Action Step** Physicians should not make any assumptions or believe any assurances. Even the best intentions can be misinterpreted. If it is not in writing, the seller can easily argue that it does not exist. Physicians should have a purchase and sale agreement prepared that covers all of the important issues and allows them an out if the results of their due diligence are not acceptable.

**Mistake 2  Investing Blindly**

Even though real estate is one of the few investments in which risk is directly proportional to knowledge, physicians often invest in real estate based on questionable advice or without doing any real investigation at all of the property. Since the rule in commercial real estate is still largely *caveat emptor* (“let the buyer beware”), performing adequate due diligence is extremely important.

**Action Step** Physicians should avoid unpleasant surprises. They should not rely on puffery that the property is a “steal” or “hidden gem.” As needed, they should hire professional inspectors, engineers, and environmental and other consultants. It will be money well spent.

**Mistake 3  Buying Into an Unknown Location**

Even though the principal real estate maxim is “location, location, location,” physicians often invest in real estate without knowing much about the area in which the property is located. A “good” location depends on the real estate sector involved. For example, the corner of two major streets may be an ideal spot for a shopping center, but not for a single-family residential development.

**Action Step** Physicians should research the property’s location carefully. Are the demographics (i.e., population and income) sufficient to support the use to be conducted on the property? Are zoning changes planned? Is the site well suited for the intended use?

**Mistake 4  Not Doing a Realistic Financial Analysis**

Not doing or having done a realistic financial analysis of the proposed investment property can lead to financial disaster for physicians. One of the biggest mistakes first-time investors make is paying too much for a property whose rental income stream cannot support the price. Physicians should not rely on the seller’s statements regarding value and income.

**Action Step** Physicians should always thoroughly analyze the financial situation of a potential investment property. They should have the property professionally appraised and have their accountant review the property’s books and records. One way to determine an
acceptable purchase price for the property is to use the income capitalization approach. This can be done by estimating the net operating income for the property (gross annual rents minus operating costs such as taxes, insurance, maintenance, and utilities) and dividing that number by the rate of return experienced by real estate investors in the area (the capitalization or “cap” rate).

**Mistake 5**  **Making an Inadequate Title Investigation**
Physicians often assume that title to the investment property is merely a perfunctory legal issue that need not concern them. Nothing could be further from the truth. The title documents, which constitute liens on the property, could be critical to the physician investor’s ability to develop and operate the property. Things such as easements, licenses, reciprocal operating agreements, and covenants, conditions, and restrictions may impose significant financial and nonfinancial obligations on the investor.

**Action Step**  Physicians should have the state of title carefully reviewed by an experienced real estate lawyer before agreeing to the purchase.

**Mistake 6**  **Ignoring Section 1031 of the Internal Revenue Code**
Many physicians are unaware that Section 1031 of the Internal Revenue Code enables them to defer taxation and effect a tax-free exchange if they exchange an existing investment or business property for like-kind property. This enables them to dispose of an unwanted property and acquire a different property without a tax effect. Doing so, however, involves very strict timelines within which a replacement property must be identified and closed on.

**Action Step**  Physicians should determine upfront whether their transaction might qualify for Section 1031 treatment. If so, they should consult an expert to ensure that the transaction is structured and carried out in a manner that complies with that section.

**Mistake 7**  **Using the Wrong Ownership Structure**
Physicians sometimes invest in real estate in their own names, even though there are a variety of much more advantageous investment vehicles available to them. When deciding whether and which entity to use, the two major issues physicians should consider involve tax and liability. Ideally, depending on the circumstances surrounding an investment, an entity should be selected that provides the physician with both limited liability and a pass-through of the profits and losses generated by the property (i.e., no tax at the entity level), such as a limited liability company or a subchapter S corporation. However, each entity has advantages and disadvantages that must be weighed before deciding which best satisfies the physician investor’s need.
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**Action Step** Physicians should not invest in property in their own name without first obtaining expert advice about the other structures available to them. Those structures may enable them to realize significant tax and other benefits.

**Mistake 8** Having an Inadequate Capital Structure
Physicians often invest in property without first ensuring the availability of reasonably priced financing or without having enough capital to sustain themselves if there is a market downturn or unexpected vacancies. To stay in real estate for the long term, cash reserves are needed. Operating from a lack of cash puts pressure on the physician to defer maintenance, do substandard repairs, accept less-than-qualified tenants, and give in to tenant demands for fear of vacancies.

**Action Step** Physicians should explore financing alternatives as early as possible with reputable lenders and then finance conservatively. They should ensure that they have sufficient cash reserves to survive in case the unexpected occurs.

**Mistake 9** Not Spelling Out Details When Purchasing With Others
Physicians often enter into common ownership investments with other physicians and friends without spelling out each owner’s rights and responsibilities with respect to the property. Most deals that go sour have this in common: The investors/co-owners did not have a clear understanding of what they were buying. They didn’t think through the details and potential downside of their relationship and how to deal with those issues.

**Action Step** Physicians should prepare an agreement that clearly spells out each co-owner’s rights and responsibilities. They should deal specifically with issues such as ownership interests, financial responsibilities, management, repairs and maintenance, the death of a co-owner, and the desire of a co-owner to sell his or her interest.

**Mistake 10** Procrastinating
Some physicians try to time their real estate investments by waiting for the “perfect” market or situation. There are no such markets or situations. History proves that the prices of good commercial real estate will increase, regardless of when one buys, as long as the owner holds on to the property for a reasonable period of time. Hoping that a better deal may be out there if one waits may very well mean missing out on market upturns.

**Action Step** Physicians should act now by identifying their goals, the kind of property they want, the areas that have such properties, and everything for sale in those areas. They should continue to do so until they find a deal.
Conclusion
Physician investors who take these mistakes into consideration when acquiring investment real estate and take steps to avoid them will be able to take advantage of the tremendous opportunities and upsides available in the U.S. commercial real estate market.

Additional Resources
- L. Manning, Commercial Real Estate: The Ins and Outs of Making Money in Investment Properties (Cypress Publishing Corp. 2002)

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22.4 The 10 Biggest Legal Mistakes Physicians Make When Selling Real Estate
By Robert J. Horvat, Jr., Esq.

Executive Summary
When deciding to sell investment property, physicians often pay too much attention to the asking price and too little attention to other factors that can have an effect that is just as important on the profitability of the transaction. By focusing more on these other factors, the overall ease and lucrativeness of the deal can be greatly enhanced.

Mistake 1 Selling When a Property Is Down
Physicians are often passive absentee owners who may not necessarily be intimately familiar with a property’s physical and financial condition at the time they decide to sell. The only way to maximize the sale price is to ensure, if at all possible, that a property is sold at the top of its performance peak, and that there are no issues involved, such as excessive vacancies or deferred maintenance.
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**Action Step** If necessary, physicians should spend money to make money. They should make sure that the property is in its best physical condition before it is put on the market. Also, to the extent possible, they should try to time the sale to coincide with maximum occupancy of the property by long-term tenants.

**Mistake 2  Failing to Consult a Tax Adviser Before Selling**
Physicians often fail to consult their tax adviser before selling their investment property and learn of their tax mistakes only after the sale is complete. One of the biggest tax mistakes that can be made in this context is failing to take advantage of Section 1031 of the Internal Revenue Code, which allows physicians to exchange their property for a like-kind property without any tax effect whatsoever.

**Action Step** Physicians should be sure to consult with their tax attorney or accountant before listing their property for sale.

**Mistake 3  Not Requiring Enough Earnest Money**
Physicians sometimes do not realize the importance of the earnest money deposit. The purpose of the deposit is to show the buyer’s good faith while the seller takes the property off the market and to provide the seller physician with a source of reimbursement if the buyer defaults. The higher the deposit, the greater the incentive for the buyer to go through with the deal and the greater the likelihood that the physician will be adequately compensated if the buyer nevertheless does default.

**Action Step** Physicians should require a deposit of not less than 10% of the purchase price in the sale agreement.

**Mistake 4  Overpricing the Property**
One of the biggest mistake physicians and other sellers make is overpricing their property. They believe that some foolish or unsophisticated buyer will fall in love with the property and pay the full asking price without knowing its true fair market value. That just doesn’t happen very often. Most investment property buyers are both cautious and knowledgeable. What is more likely to happen if property is overpriced is that it will simply languish, even in a hot market.

**Action Step** Physicians should do their homework and set an appropriate sales price for the property (which is something the real estate broker should do for them).

**Mistake 5  Being Inflexible**
By adopting a rigid “take it or leave it” attitude, physicians may lose buyers who would otherwise have been willing to give them very close to what they wanted in the first place. Selling investment real estate is a give-and-take process. Even if a buyer’s initial offer is not
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what the seller physician wanted, the buyer may later return with a better offer.

**Action Step** Physicians should be flexible and not alienate any potential buyer. They should decide up front what they want and what their bottom line is.

**Mistake 6   Failing to Use an As-Is Clause**
The general rule in commercial real estate transactions is “let the buyer beware.” The law in most states does not require the seller or its agent to reveal anything about a property, including its defects. Therefore, since alleged breaches of representations and warranties concerning a property’s condition are a great source of litigation, seller physicians should attempt to limit any representations and warranties regarding the property and simply give the buyer broad rights to make whatever inspections it desires and then decide if it wants to proceed.

**Action Step** Physicians should limit their representations and warranties regarding the property’s condition to the maximum extent possible. In any event, they should include a clause stating that the buyer is purchasing the property as is, without any representations and warranties whatsoever, except as expressly set forth in the sale agreement. Over the long term, limiting representations and warranties could prove as critical to the profitability of the transaction as the selling price itself.

**Mistake 7   Selling by Owner**
To save a sale commission and attorney’s fees, some physicians attempt to sell their investment property themselves. While doing so in a residential setting might sometimes make sense, it rarely does in a commercial setting. There is nothing simple about selling investment real estate. Tax, zoning, title, property condition, environmental, entitlement, and other legal issues must be addressed in almost every deal. If they are not dealt with correctly, the physician could suffer extremely adverse financial and legal consequences.

**Action Step** Physicians should retain a first-rate real estate broker and real estate attorney. This team can then assist them in evaluating the market, providing exposure for the property, negotiating business and legal terms that protect the physician, and creating a strong bargaining position.

**Mistake 8   Wasting Time With Unqualified Prospects**
Physicians often spend a great deal of time and effort with a prospective buyer, only to then find out that the buyer is not qualified. A qualified buyer is one who is ready, willing, and able to buy the property. An unqualified buyer is “just looking,” does not have the necessary financial resources to actually purchase the property, or both.
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**Action Step**  As soon as a potential buyer expresses an interest in the property and before wasting any time and money on negotiations, the seller physician should make sure that the buyer is actually ready to purchase and has the financial wherewithal to do so. A good real estate broker will ensure this is the case before an offer is even submitted to the seller physician.

**Mistake 9  Selling Just to Finance the Next Project**
Physicians sometimes forget that real estate is a long-term business. Holding on to real estate increases net value, creates collateral, and increases bargaining power with lenders. Because the media often gives coverage to the occasional person who makes money from the rapid appreciation of a property within a short period of time, many investors do not understand that buying real estate solely for short-term appreciation is a big gamble, and that selling one property just to acquire another may very well deprive the investor of significantly greater gains that could have been realized simply by holding on to the original property.

**Action Step**  Physicians should not flip properties simply for the sake of flipping. Unless they are convinced that the existing property is a bad long-term investment, they should consider carefully whether they might be better off simply holding that property.

**Mistake 10  Financing the Sale Alone**
Many physicians, because they might not have an immediate need for the proceeds from the sale of their property, are willing to finance a portion of the purchase price for the buyer in return for an above-market rate of interest. While doing so might sometimes make sense, it often will not because such financing places the physician in the shoes of a lender and requires the physician to be concerned with issues such as maintenance, waste, ongoing operations, and assignment and subletting in order to ensure the continued integrity of the property in case the buyer defaults. Many physicians simply do not have the time to do so adequately. Moreover, the mere fact that any buyer requires seller financing in the first place should raise a red flag that the buyer may not be completely financially solvent.

**Action Step**  Unless the seller physician can devote adequate time to monitoring the property or is willing to pay a third party to do so (the cost of which may completely negate the value of any above-market interest received) and is willing to take back the property if the buyer defaults, he or she should not agree to finance all or any portion of the purchase price.

**Conclusion**
Physicians who pay attention to these issues and take the recommended actions will be in an excellent position to maximize the return from a sale of their property.
Additional Resources


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Chapter 23  Risk Management

23.1  The 10 Biggest Legal Mistakes Physicians Make Regarding Risk Management
By Linda J. Hay, Esq.

Executive Summary
The benefits of using risk management in the medical setting are clear. The education, prompt identification, and investigation of problematic issues through a risk management process can be implemented at the institutional, the individual, and the practice group levels. Educating all providers and staff on the proper documentation and identification of problem areas may help to avoid claims or lawsuits. While these techniques will not always prevent a claim, they will help provide the best possible defense against a claim.

Mistake 1  Failing to Recognize Problem Patients
Recognizing problem patients early on is an important component of risk management. Problem patients may exhibit traits that include a lengthy history of care from many different physicians, a course of care dominated primarily by emergency visits, constant complaints about past and/or current care, ongoing failure to pay for services, and consistent noncompliance with medical advice and instructions. These types of traits are commonly seen in plaintiffs or litigious individuals. The prudent practitioner, by identifying these traits early on, may decide to discharge or not accept such patients. By making such a decision, the practitioner can often save time, money, and aggravation in the long term. If, on the other hand, such patients are cared for, the practitioner should document in detail their care and the issues involved.

Action Step  Physicians should develop systems that will alert them to problematic patients early on in order to determine if these patients are worth the long-term aggravation.

Mistake 2  Pursuing Collection Actions for Patients Where Care May Be an Issue
Many malpractice claims arise when a physician pursues a collection claim. Once a malpractice claim is filed in response to a collection claim, a defense must be made. Although the decision to pursue a collection action rests with the physician, once a malpractice action is filed, much of the physician’s control over the situation is lost. Any decision to pursue a collection matter (by letter or action) should therefore be carefully evaluated before it is pursued. If a claim is made, the physician must weigh a number of factors—including whether he or she is prepared to defend all of the care given to the patient, the nature and traits of the patient (i.e., is this a problem patient?), and the amount of money involved—against the risk of a claim. If a claim for collection is asserted, physicians should be sensitive to the manner of collection and to the personality of the person seeking the unpaid monies in further attempts to avoid a malpractice claim.
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**Action Step** Physicians should perform a risk-benefit analysis before each and every collection attempt is made.

**Mistake 3  Failing to Keep Consistent, Accurate, and Complete Documentation**
A well-documented chart is, in all respects, the best witness in a lawsuit: It is made contemporaneously with events, it has no memory to fade over time, and it has no bias or prejudice. Ensuring that all aspects of patient care are documented in a timely, chronological, consistent, and legible manner is key to proving that good, quality care was rendered. The first action a potential plaintiff’s attorney will take to determine whether to file a lawsuit is to obtain and review a copy of the chart. A well-documented chart documents the care and provides a clear chronology of the potential basis for a claim, with no gaps within which a plaintiff’s expert can claim “if it is not documented, it was not done.” Every staff person who writes in the chart must be aware of these issues as well. Timed, dated, contemporaneous entries detailing the action, care, communication, prescriptions, telephone calls, missed appointments, instructions, and refusals with consistent, approved abbreviations make a good chart.

**Action Step** Physicians and their staff should document, document, document.

**Mistake 4  Failing to Maintain a Good Bedside Manner**
Patients who like and respect their providers are less likely to file a lawsuit. The manner and method in which physicians and their staff render patient care have a significant effect on decreasing or increasing this risk. Even when quality care is delivered, patients who must wait 45 minutes for every appointment, never get an apology, and are greeted by brusque and unfriendly staff may become angry at the physician or group. Staff who cannot maintain a good attitude with patients should not deal directly with patients. If a bad or unexpected injury or illness occurs, a patient who feels that he or she has a poor relationship with that doctor or staff will not hesitate to talk with a lawyer and pursue a claim. A good relationship with the patient can serve to overcome that risk. If a suit is filed, a good patient relationship always works to the physician’s benefit in terms of receiving a favorable testimony by the plaintiff, keeping damages down, and keeping the plaintiff reasonable.

**Action Step** Physicians and their staff should maintain a good bedside manner with patients and always be professional with other providers; doing so goes a long way in the long run.

**Mistake 5  Failing to Designate a Point Person to Oversee Risk Management**
Early identification of problem areas or trends that may result in claims can be very beneficial, especially if corrections can be made before problems result. Methods and procedures to identify and sort issues and spot trends must be instituted for prevention. The best way to identify problems is to designate a key person to whom problems are to be
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reported. Similar to the incident reporting system at hospitals, physician offices or groups should designate a person to whom an informal report is made. Staff must be educated to report events that occur in an office setting; such reports should be verbal only. For example, if a patient who is scheduled for a procedure states that he or she does not understand the procedure or its risks, that fact should be reported to the point person. Such identification may show a trend that one of the group’s physicians is not following the informed consent process. Before a claim arises, steps can be taken to educate that physician on the need to follow protocol or additional double-checks can be instituted. Problems that are identified early may be resolved before a claim is made.

**Action Step**  Physicians should designate a point person to oversee risk management and identify potential problems.

**Mistake 6  Making Negative Comments About Other Providers**
No medical provider, physician, or staff person should ever be critical of other providers in front of a patient or in the chart. Facts may be and should be documented, but critical opinions or comments, if heard or viewed by a patient or his or her attorney, could foster potential litigation and may serve as the basis for expert opinions in a lawsuit. Criticism of prior treatment will serve to involve the criticizing provider in a suit against the provider who gave the prior treatment. In addition, physicians should beware of patients who attempt to elicit criticisms. They may have already considered or instituted a lawsuit against another provider. Physicians are well served in rendering treatment recommendations based on objective evaluation, not on the plaintiff’s subjective claims or description of the history of the case.

**Action Step**  Physicians should not include criticisms in a patient chart or when communicating with patients.

**Mistake 7  Failing to Follow Up**
A common area for potential claims is the failure of a physician to document the follow-up with a patient on an important issue or recommendation. Copies of notes on failed appointments, reminder calls or notices, instructions, prescriptions, and attempts to ensure that the patient returns for care should all be part of the chart.

**Action Step**  Physicians should follow up with patients and document that follow-up was done.

**Mistake 8  Failing to Properly Discharge Patients From Care**
Once a patient has been discharged from care, the statute of limitations may begin to run, and obligations under the physician-patient relationship likely will end. Often, this discharge process is informal and not well documented. Creating a formal procedure and supporting
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documentation in the chart (including a communication to the patient) will help to establish a cut-off to liability.

**Action Step** Physicians should formalize the discharge process and document the steps that are taken.

**Mistake 9  Failing to Refer When Needed**
Physicians who know and understand the limitations of their practice and expertise have taken a large step in managing and minimizing their risk. Physicians who fail to do so run the risk of developing a problem from lack of expertise, often resulting in a patient seeking care from a specialist. In this scenario, the specialist, if pressed, will often criticize the general practitioner as exceeding his or her expertise. Specialists can be favorable experts for the plaintiff, since, by virtue of their specialty, their expertise is greater than that of the general practitioner. When situations occur that necessitate a referral, the process of referral should be well documented regarding the reason for the referral and, if urgent, care should be taken to ensure prompt action with the patient and specialist. Such actions work to cut off liability on that issue for the general practitioner.

**Action Step** Physicians should not hesitate to refer when appropriate and document the process.

**Mistake 10  Relying on Systems That Take Out Narrative Progress Notes and Descriptions of Communications**
In a lawsuit, the chart and documentation of communication with patients and other providers are the backbone of the defense. A well-documented chart is not only a key witness, it also preserves facts and actions that have been forgotten over time. While technology can be a great help to the busy practitioner, preprogrammed checklists or forms alone do not create the type of documentation most helpful to a defense. The narrative descriptions or issues pertinent to a particular patient’s care help to create a more comprehensive picture of the entirety of care, as well as to spark memories of those who may be called to testify years later. The clearer the picture, the better the defense.

**Action Step** Physicians should use only those charting programs that are designed to allow and encourage narrative notes.

**Conclusion**
An ounce of prevention through risk management will save time, effort, expense, and aggravation later on. Identifying problems early, educating staff, and promptly investigating issues may help prevent a claim, and if not, will assist in defending one.
RISK MANAGEMENT: CAUSES OF MALPRACTICE SUITS

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23.2 The 10 Biggest Legal Mistakes Physicians Make That Can Lead to Malpractice Suits
By Peter S. Palewski, Esq.

Executive Summary
These times are exceptionally litigious, and physicians are always a target defendant. Iatrogenic injuries are placed under a legal microscope and even unavoidable, unexpected, and inexplicable occurrences can lead to seven-digit claims. Deviation from acceptable medical procedures, even when intended to be for the patient’s benefit, and even when seemingly minuscule, can provide the basis for a lawsuit. Avoiding malpractice liability starts at the instant of the first patient contact.

Mistake 1 Planting the Seed of Revenge Through a Brusque or Dismissive Demeanor
First impressions are lasting, and every effort should be made to be courteous, polite, and professional. Each step of any medical examination must be explained to the patient and the reason given for the necessity and purpose of every part of the examination. The physician should always extend the opportunity for a concerned relative to accompany the patient during the introduction to the patient and every subsequent examination. Patience is mandatory, including repetitive statements that evince courtesy and respect. Explanations must be made in lay terms until both the patient and his or her accompanying party understand. The patient should be thanked for the opportunity for the examination.

I recall a client who had the utmost trust and respect for her regular ob-gyn from the start. She saw him because she was concerned about a small lump on her breast. He ordered a mammogram, but months went by with no word from the physician. The patient interpreted this as a negative report. Noticing that the lump had increased in size, the patient called the physician who, through some administrative failing, had never gotten the mammogram report. A repeat mammogram revealed metastasized breast cancer. The patient refused to sue.
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the physician because they had established a mutually respectful relationship. The patient died two years after the diagnosis at age 29. The point: Even in cases of glaring error, establishing a good relationship at the start is always beneficial to the physician.

**Action Step** If a physician is unable to express warmth, friendliness, and understanding to each and every patient, then he or she should consider a specialty practice, such as radiology or pathology, where socialization attributes are less essential.

**Mistake 2 Referring a Patient without Following Up**
It is rarely possible for a treating physician who is referring a specialist to directly introduce that specialist to the patient. If it can be done, it should be done. But it must be remembered that the patient still considers the referring physician to be his or her primary care provider. As soon as the specialist communicates with the referring physician, the referring physician should discuss the findings and proposed treatment with the patient. Regular communication is essential; without it, the patient feels neglected and the scenario is set for resentment and anger that could fuel a lawsuit.

**Action Step** When a referral of the patient to another physician is made, the treating physician should clearly pronounce the name of the specialist, give the patient the specialist’s card, and make it clear that the principal physician will communicate with the specialist and then with the patient. If it is possible, the referring doctor should give his or her own recommendation of the specialist and the reasons for the referral and recommendation.

**Mistake 3 Failing to Check Medications**
When a prescription is given, physicians do not always check to see whether it is contraindicated because of the use of other medications. Where several physicians are involved in a patient’s care, they may be unaware of the medication each has prescribed. In addition, elderly patients may forget to disclose some of their medications even though they ingest the drugs daily. Prescription medications often change during the course of treatment, and consumption of contraindicated medication can have grave results.

**Action Step** The physician should insist that patients undergoing a course of treatment bring in all of their medications at each visit. Patients should be instructed to patronize only one pharmacy, and the physician’s staff should regularly order medication transcripts from the patients’ pharmacy to include in the patients’ files.

**Mistake 4 Overlooking Foreign Bodies**
Operative procedures are intense, fast, and furious. The surgeon knows that the quicker the procedure is performed, the better the prognosis. However, over and over, this enables a lawyer to find a holy grail: a malpractice action because some substance or instrument was left internally at the surgical site. Physicians should always arrange instrument trays in the
same way and insist that their operating room assistants have a similar tray for used instruments to be arranged the same way as the instruments were arranged on the original sterile tray.

**Action Step** Hospitals have a double count of operative devices, but the cautious practitioner will always insist on a triple count, plus his or her own, making four counts in all.

**Mistake 5** *Failing to Take a Patient’s Complaints Seriously Enough to Hypothesize All Conditions That Could Exist*

A female patient complained of a persistent stomachache. She was examined by her regular physician, who told her to take Pepto-Bismol. In fact, she had a fallopian tube tumor. It is basic that all possible conditions must always be hypothesized, even when the patient’s complaints seem minor. Physicians should ask: “If it is not minor, what are the worst case scenarios”? They should then examine and test for conditions from “a” to “z.” If a diagnosis remains uncertain, dialogue with colleagues may be necessary.

**Action Step** Physicians should always ask what, how, when, and why. Then ask again. If a patient calls still complaining within hours or days of an examination, another immediate examination is required.

**Mistake 6** *Bragging That Can Cause Legal Fights*

Experienced physicians are entitled to apprise their patients of their expertise in their field, but not phrased in a way that is seen by the patient as a virtual guarantee. Some medical procedures are inherently dangerous. The level of the risk of harm or a poor result may vary, which should always be disclosed as diplomatically as possible. The patient should be questioned to determine whether his or her view of the procedure and the expected result is realistic and whether the patient clearly understands the risks.

**Action Step** Many physicians dispense pamphlets that thoroughly explain the procedure that a patient will undergo. Physicians should have their patients and their relative sign a release that includes a statement that they received, read, and understood the pamphlet.

**Mistake 7** *Not Telling a Patient Who Is in a Death Spiral the Grim Facts*

“You’re doing well,” says the doctor after examining an octogenarian who has a spot on his lung. The patient is frail and confused. The patient’s only relative, his daughter, is not told that the patient is likely to expire soon. Treatment goes on and, in weeks, the patient expires. The daughter has watched the treatment daily but is never told of the death spiral until the day before the patient’s expiration. The physician’s initial statement, “doing well” actually meant “under the circumstances.” The daughter is amazed that all of the treatment has not resulted in the patient’s return to health. She is grieving and angry and feels deceived. If the patient is likely to die regardless of medical efforts, he and his relatives must be told so.
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**Action Step** Physicians should tell the patient and the relatives that the best of medical care and treatment may not result in a return to health and that the inevitability of death marches on with an increasingly faster cadence when medical intervention fails. Physicians should not create false hope.

**Mistake 8** **Failing to Induce a Patient to Stop Smoking**
Physicians routinely annotate a patient’s disclosure that he or she is a smoker. But how often does a medical record note that the smoker was offered options to rid himself or herself of this habit? It is legally logical that nontreatment of a smoking habit could have malpractice implications and could perhaps succeed.

**Action Step** Physicians should use pamphlets explaining the dangers of smoking and the cessation options available and enter a statement in the records that the patient was urged to quit, given a pamphlet on this issue, and read and understood it.

**Mistake 9** **Not Dictating in the Presence of the Patient**
Patients often complain that the written physician reports in their medical records conflict with what they were told by their physician at the time of their examination. When the patient’s records are obtained for legal use, they are often juxtaposed with the client’s view and are sometimes useless to promote the client’s position. Most physicians see their daily schedule of patients then retire to their office to dictate their recollection of the examination. If the examination report is dictated in the presence of the patient, this paradox can be avoided. The physician should always think of avoiding conflict with the patient. The examination report should be, as a matter of course, sent to the patient with a courteous letter inviting suggestions or corrections. If there is a misunderstanding the physician must thoroughly (read: repetitively) explain the patient’s misconception.

**Action Step** People like to find someone else to blame because their egos see themselves as faultless individuals. Clearly and concisely telling the patient the results of the examination, while dictating, prevents assertions of conflict.

**Mistake 10** **Failing to Have a Vest Pocket Lawyer**
Most lawyers necessarily have a personality that others find difficult to relate to. Lawyer’s minds are forever bent by their law school and practice experience, which trains them to think outside the mold. It is a matter of survival. Lawyers must take punch after punch and go on to the next fight. Physicians and others find it difficult to relate to a lawyer’s psyche. But having a friend for a lawyer is priceless. When a physician is facing a possible legal headache, it can often be diffused by a *tete-à-tete* with a lawyer friend, who can give direction to confusion and create peace from chaos. How many times has a lawyer thought: “If only you came to me before you did that”?
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**Action Step** Physicians should play golf or tennis or go skiing with a lawyer.

**Conclusion**
Advising a physician to “just be yourself,” is unfortunately not enough to cover all of the pitfalls to which a physician may be exposed. Patients are often fickle and punitive. Wearing a physician’s hat during business hours is demanding but justified by rewarding experiences.

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**23.3 The 10 Biggest Legal Mistakes Physicians Make When Confronted with a Bad Outcome**
By Jack Q. Tidwell, Esq., and Scott M. Tidwell, Esq.

**Executive Summary**
Regardless of the care given and the care taken by the attending physician, a bad outcome is sometimes obtained. This always comes as a shock to the patient and the patient’s family, and quite often as a shock to the physician. The physician must absolutely confront this situation immediately. By doing so, he or she can quite often prevent a lawsuit or a complaint to the state medical board.

**Mistake 1 Failing to Maintain Contact with the Patient or the Patient’s Family**
Physicians often fail to maintain contact with the patient or the patient’s family members after a bad outcome. This is a mistake: Physicians should immediately contact either the patient or the patient’s family, as the case may be, and they should be open, honest, and explain any problems. They should discuss the prognosis, if any, and any corrective measures needed. Also, they should suggest a consultation if applicable. Taking these steps indicates that the physician cares for the patient and for the patient’s family and that the physician is there to help them through this difficult situation. It is surprising how many times a good feeling toward a physician will avert a malpractice suit, and vice versa.

**Action Step** Physicians should always maintain contact with the patient and the patient’s family members.
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**Mistake 2  Failing to Explain What Happened When Death Is the Result**
If the result is a death, physicians may be reluctant to explain the cause. However, physicians should explain what happened, express their deep sorrow, send a sympathy card, and either visit the funeral home or go to the funeral if possible. Families invariably appreciate the physician showing care and sympathy, which are part of the trust relationship that has been built between the doctor and the patient and the patient’s family. Continuing that relationship is vitally important. Again, good bedside manner and family loyalty will sometimes be helpful in being able to completely avoid a malpractice action.

**Action Step**  Physicians should never forget to show care and support for the patient and his or her family.

**Mistake 3  Criticizing Other Health Care Providers**
Criticizing other health care providers is a mistake that will come back to haunt a physician in an immediate case or future cases. If criticism is necessary, physicians should depend on their lawyer or insurance carrier to handle this matter at the appropriate time. Quite often in complicated cases, physicians are inclined to say something to the effect that they wish they could have seen the patient earlier. Statements such as this could indicate to the patient or the patient’s family that some other doctor did not do a good job in the beginning and therefore is at fault. Such circumstances can create a totally good-faith effort on the part of the patient or the patient’s family to start looking for a malpractice case, when in fact there is absolutely no basis for doing so. Physicians must be very careful in their conversations at all times.

**Action Step**  Physicians should never criticize other providers.

**Mistake 4  Failing to Maintain All Records in Their Original Form**
For various reasons, physicians may sometimes be tempted to alter a medical record. They must, however, maintain all records in their original form without any changes whatsoever: no deletions and no additions. If something is drastically in error, physicians should make a separate memo concerning the error and then date and sign it. In a case that goes to litigation, an altered record is one of the most devastating things that can happen to a provider in the courthouse. The plaintiff’s lawyer will delight in pointing out to the jury that the physician is trying to hide something. Many cases have been lost because of this very factor, when in truth and in fact the alteration was made in total good faith.

**Action Step**  Physicians should never change original medical records. Errors can be corrected, but before doing so, physicians should always consider how the changes will be viewed in hindsight.

**Mistake 5  Failing to Immediately Advise the Insurer About a Possible Claim**
When physicians get a bad outcome, and it will happen at some time, they should
immediately advise their insurance carrier if there is a possibility of a claim being made. The insurance carrier has qualified people to investigate the matter and will be in a position early on to potentially avoid any serious consequences. The sooner the matter is investigated the better; the situation is analogous to extinguishing a small blaze as opposed to a raging conflagration. Time will very well heal old wounds, but it also wipes out memories and details, so physicians should contact their carrier promptly.

**Action Step** Physicians should always notify their insurance carrier of a potential claim so the investigation process can begin as soon as possible and before their memory fades.

**Mistake 6  Failing to Find Out From the Insurer What Lawyer Will Be Assigned to the Case**

Physicians may neglect to contact their insurance carrier about the attorney being assigned to their case. However, they should do so and then contact that lawyer immediately, followed by a face-to-face meeting. When speaking with their lawyer, physicians can rely on the attorney-client privilege to protect their conversations. The lawyer will need to know everything the physician can possibly say about the case, including any special factors and medical technology that he or she will be dealing with in defending the physician’s position. Physicians should seek to immediately establish a relationship with their attorney that will be beneficial to them until the matter is concluded.

**Action Step** Physicians should find out as soon as possible who has been assigned as counsel in their case and then meet with and assist their attorney throughout the process.

**Mistake 7  Believing the Lawyer Understands All Medical Factors Involved in the Case**

Lawyers are not doctors. Lawyers depend on doctors to explain the medical matters with which they are confronted. Physicians can do their own medical research, which they can provide and explain to their lawyer. In doing so, physicians will have a much better lawyer than if they simply assume that he or she knows everything that they know about medicine. Physicians should meet with and explain the medical issues to their lawyers.

**Action Step** Physicians should be sure to explain and discuss the medical and legal issues with their counsel.

**Mistake 8  Failing to Ask the Lawyer to Explain the Legal Issues Involved**

Physicians need to understand exactly what is going to happen in their case. They should ask their lawyer what they will be expected to do, as well as discuss time tables so that they will have a good idea as to what and when certain things will happen. Certain basic factors have to be proved and disproved in all cases, and physicians need to be aware of them. The lawyer needs to understand and explain to the physician the legal issues involved in the case so that
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ey can work together as a team. Physicians should make certain their questions are answered. Just as in high school: There are no dumb questions.

**Action Step** Physicians should be sure their lawyer explains and discusses with them the medical and legal issues involved in their case.

**Mistake 9** **Failing to Understand the Nonlegal and Nonmedical Factors Involved** Physicians need to discuss with their attorney a number of nonlegal and nonmedical matters that can affect their case, such as the court (e.g., federal or state) in which the case will be heard; who will be the judge; whether the physician or the physician’s lawyer knows the judge assigned to the case or has any personal ties to that judge; where the case will be tried (i.e., will the case be tried in the physician’s home county or in a place where he or she will be a stranger?); the type of people who may be on the jury; the possible verdict ranges and the amount of insurance the physician has to protect himself or herself; whether a settlement should be considered, and if so when; what are the possibilities of settling a case at mediation as opposed to trying the lawsuit; if the case is settled, whether the settlement will be reported to the National Practitioner Data Bank; and the effect, if any, such a report will have on the physician’s practice now and in the future. Physicians should discuss these matters with their attorney so that they know fully what their options are.

**Action Step** Physicians should always discuss with counsel any trial, settlement, and judge-related issues.

**Mistake 10** **Discussing the Case With People Other Than One’s Attorney or Insurer** Physicians should not discuss their case with anyone other than their lawyer. In fact, the only one with whom physicians have any protection is their lawyer. The conversations between the physician and his or her lawyer are protected because of the attorney-client privilege. Their other conversations are not privileged, and a physician’s best friend could be called on to testify under the penalty of perjury. Physicians should be very careful during any conversations about their case: A person might overhear, and a physician may never know who that person knows, and should always assume that person will talk.

**Action Step** Physicians should never under any circumstances discuss their case except in private with their counsel.

**Conclusion** It would be almost impossible to anticipate every situation that could lead to a malpractice case being filed against a physician. Avoiding these 10 mistakes, however, can dramatically reduce a physician’s chances of facing such a claim.
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About the Author
Jack Q. Tidwell, Esq., engaged in general practice, including the years when he was district attorney, until about 1976. Since then, he has confined his practice at Tidwell & Tidwell LLP, in Odessa, Tex. (at www.tidwellfirm.com), primarily to civil litigation. Most of this time has been on the defense side of the docket, except he has and does handle plaintiff’s cases that are not disqualified. He has experience in personal injury cases, including products liability, and oilfield and vehicular accidents; and professional liability cases (medical, attorney, insurance agent, and others). He also practices in the area of lender liability, employment law, and general commercial litigation. Tidwell has also represented many government entities in the areas of civil rights and school law. He can be contacted by telephone at 432-552-0441 or by e-mail at jtidwell@tidwellfirm.com. Scott M. Tidwell, Esq., is a partner in the firm of Tidwell & Tidwell LLP, in Odessa, Tex. (at www.tidwellfirm.com). He specializes in personal injury trial law and his areas of practice include general civil litigation and insurance defense. He is board certified by the Texas Board of Legal Specialization. He was admitted the Texas Bar in 1992 and is a member of the American Bar Association, the Texas Association of Defense Counsel, the Defense Research Institute, and the Texas Criminal Defense Lawyers Association. He can contacted by telephone at 432-552-0441 or by e-mail at stidwell@tidwellfirm.com.

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23.4 The 10 Biggest Legal Mistakes Physicians Make That Can Lead to Civil Liability Apart from Malpractice Claims
By Phil D. Mitchell, Esq.

Executive Summary
Physicians are, by their very nature, healers. As such, they often feel that they must take it upon themselves to solve their own problems through direct and personal action, such as they exhibit in their practice of medicine. In the field of litigation, however, physicians are often viewed as “deep pocket” targets, and serious mistakes are often made by physicians who believe that a simple and direct approach to a problem will resolve it. Unfortunately, this is not always the case, and many times such action will make matters worse. In this regard, it is important to consider the following mistakes in order to avoid potential litigation.

Mistake 1 Engaging in Driving Activity That Invites Litigation
Society has now become so litigious that it is impracticable to avoid all possible actions that could result in litigation. Physicians, in particular, must continually keep their guard up to avoid trouble areas that are likely to result in litigation. One area in which exposure to
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litigation arises involves the use of the automobile. When behind the wheel of a car, people tend to become one with the machine, losing their individuality and adopting a sense of invincibility. Unfortunately, they often also lose their sense of courtesy and care for others. Such conduct begs litigation. Physicians should not engage in dangerous or illegal activities while operating a motor vehicle. They should be overly cautious, and not succumb to road rage. Physicians who have consumed any amount of alcohol should not operate a motor vehicle, no matter how close they are to home or how “safe” they feel in operating the vehicle. Physicians should not use a cellular telephone while driving, but rather pull off the roadway to do so. Defending physicians who have engaged in such activities is one of the most difficult jobs for an attorney because the physicians may have lost the deep respect the public generally affords physicians.

Action Step  Physicians should avoid risky or dangerous behaviors while operating a motor vehicle that often lead to litigation.

Mistake 2  Becoming Involved in Business Activities That Seem Too Good to Be True

Physicians looking for good investments may find themselves exposed to personal litigation in the form of bad business dealings. If a business deal seems too good to be true, a physician should not get caught up in it, should get out of it, or should not invest in it. Physicians who become involved with shady, fly-by-night business partners can expect to be sued. In addition, they will not appreciate having to sit next to those partners at the counsel table when the “get rich quick” schemes and scams are exposed in court. Such physicians will be painted with the same broad brush as their business partners but since they are likely to be the only defendants who will not be “judgment proof,” they may therefore be the only ones to pay for the wrongs of all those involved.

Action Step  Physicians should closely investigate both business dealings and those involved in those business dealings before becoming involved. If physicians have suspicions going into a deal, they should not invest in it or lend their name to it.

Mistake 3  Failing to Have Sufficient Insurance Coverage to Protect Assets

Physicians often tell their attorney that they want the attorney to assist them with their actions so they “won’t be sued.” Unfortunately, there is no action that anyone can take to prevent being sued. Conversely, there are no guarantees against suit for taking what is perceived to be the right action. For a minimal filing fee to any court, anyone can be sued by anyone else. Right, wrong, indifferent, or frivolous, lawsuits are filed daily and must be defended. The key is to take actions to protect oneself if a suit is filed. Like defenses around the castles of old, barriers should be raised to protect the client and his or her assets. One of the best protections in this area is to have sufficient and adequate insurance coverage. Such coverage offers protection by providing a defense to the suit and money to satisfy any legitimate claims that
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may be brought. Physicians often overlook the value of paying for the defense of a lawsuit, when defense costs can often be more beneficial than the insurance indemnity amount.

**Action Step** Physicians should consult with their insurance provider to make sure they have sufficient insurance coverage to protect their assets. They should also discuss with their insurance provider any questions they have regarding coverage areas.

**Mistake 4 Failing to Notify Insurance Providers When There Is a Potential Claim**
Physicians who are involved in an accident (no matter how minor) or in any incident that may be covered by insurance should contact their insurer promptly upon discovering a potential claim. Some people fail to contact their carriers after an event has occurred for fear that it will increase their premiums. All insurance contracts have requirements that an insured promptly report any potential incident for which coverage may be provided. Failing to do so may result in an exclusion of coverage, effectively bypassing the very reason the insurance coverage was obtained.

**Action Step** Physicians should notify their insurance carriers promptly of any event that they feel may result in a claim. Having paid for the coverage, they should not jeopardize it by untimely reporting.

**Mistake 5 Failing to Tailor Insurance Coverage to Activities**
Failing to tailor one’s insurance indemnity to provide adequate insurance coverage to protect areas of individual concern is a mistake that can be avoided by consulting with a knowledgeable insurance agent who is skilled in all aspects of insurance. Physicians should get to know the agent in order to develop a close working relationship that can address their needs as their practice or life changes. For example, a physician who is an amateur pilot should be sure to have sufficient coverage to protect him or her from any negligence claims arising from the operation of an aircraft. A physician who is the owner of the building where his or her practice is located should have sufficient general liability insurance to defend suits or pay claims related to the operation of the building.

**Action Step** Physicians should meet at least annually with their insurance professional to discuss their liability insurance needs to ensure that they have proper insurance tailored to cover their individual activities.

**Mistake 6 Attempting to Fix the Problem Alone When Threatened With Litigation**
Physicians are skilled in the practice of medicine; they are not attorneys. The language of the law is precise, and facts can be misconstrued. Language used in everyday communication can take on a very different meaning under the law. The rights heard on television when a criminal is warned, “Anything you say can and will be used against you,” in civil litigation should be “Anything you say will be misinterpreted and used against you,” because just
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speaking to an adverse party gives that party license to embellish the facts. After speaking with the other side, that party invariably will say that the physician said something he or she did not, and the physician’s credibility will immediately be called into question from the start. Such conversations could result in admissions and additional exposure for the physician.

Action Step If threatened with litigation or if litigation seems to be inevitable, physicians should not contact the other side to attempt to resolve the matter. Instead, they should seek the advice and counsel of an attorney before any such contacts are made.

Mistake 7 Failing to Follow the Advice of One’s Attorney

Attorneys are available for advice and counsel, and they are required to take all steps under the law to protect their clients’ interests, taking into account their clients’ decisions regarding such advice. Attorneys will not make decisions for their clients, but will advise them against making unwise decisions. An attorney’s advice can be thought of as a road map. The attorney will advise a client as to what may be expected from the different paths available. Physicians should inform their attorney how such decisions will affect them personally and select the best path based on their life experiences. In litigation, however, it is imperative that physicians heed the advice of their attorney as to questions pertaining to the litigation. The attorney is the expert. In no other area can a physician’s decisions so quickly and drastically affect the outcome of their situation as by failing to follow the advice of their attorney in connection with a litigation decision.

Action Step Physicians should establish a relationship with a knowledgeable attorney in whom they have confidence. Physicians should trust the attorney to provide them with the advice they seek and follow that advice when given, especially in connection with decisions regarding litigation.

Mistake 8 Failing to Settle a Matter When Such Action Should Be Taken

Some matters should be resolved, plain and simple. Although one may not feel it is right or that he or she should be required to settle a particular matter, the fact remains that litigation is not only costly but also uncertain. The more financial risk involved in the potential outcome, the more important it is to follow this rule if a reasonable settlement can be arranged. The only way to be certain of the outcome of any lawsuit is to resolve it between the parties. If a matter can be reasonably and financially resolved and that is what the attorney advises, physicians should resolve it. It may not turn out exactly as they would have wanted, but it will turn out in a way they can accept.

Action Step When involved in litigation that can and should be reasonably settled financially upon the advice of counsel, physicians should settle the matter and not allow personal feelings to cloud good business judgment.
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Mistake 9  Failing to Consider an Umbrella Policy
As a fail-safe measure for all physicians, an umbrella liability insurance policy is recommended. An umbrella policy provides an additional layer of insurance coverage for the policyholder that does not kick in until primary coverage is exhausted. Today, such a policy is a must consideration for a potential high-asset, high-income professional.

Action Step  Physicians should consult an insurance professional about obtaining an umbrella liability insurance policy to provide additional insurance coverage for unforeseen events.

Mistake 10  Not Consulting Counsel in a Timely Manner
Many times a civil defendant will refuse to face the problem of a lawsuit hoping it will simply go away. If a problem has deteriorated to the point that litigation has been instituted, it will not simply go away. It is imperative that the physician seek counsel regarding any threatened or pending litigation as early as possible. It is even advisable to seek counsel’s advice if no litigation has actually begun but has been threatened. The attorney can be most helpful when he or she is involved from the earliest stages of the problem.

Action Step  Physicians should not hesitate to seek the advice of counsel if litigation has begun or is threatened. Many times an attorney’s involvement in the early stages of litigation can minimize the damage or even resolve the matter.

Conclusion
Physicians involved in litigation must be proactive in protecting themselves. They can do that by avoiding activities that are likely to lead to litigation. They must adequately insure themselves to provide for adequate defense of any claims that arise. Once litigation has been initiated or threatened, counsel should be contacted and involved from the earliest possible stages.

Additional Resources
- J. Bell, Top Courtroom Performance (Compendium Press 1994)
- Windt, Insurance Claims and Disputes (Shepard’s/McGraw-Hill 1988)

About the Author
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23.5 The 10 Biggest Legal Mistakes Physicians Make That Lead to Claims of Patient Abandonment
By Benjamin Goldstein, Esq.

Executive Summary
Abandonment is a legal claim that occurs when a physician terminates the professional relationship with a patient without reasonable notice and when continued care is medically necessary. There is no reason physicians cannot go through an entire career without ever having an abandonment claim made against them. Abandonment is not simply “walking away” from a patient. This section discusses areas in which an abandonment claim can arise and steps to avoid it.

Mistake 1 Taking a Vacation without Coverage
All physicians are entitled to take vacations or otherwise leave their office for personal and other reasons; both the public and the law recognize this right. It is, however, inappropriate for physicians to do so without arranging for another doctor, in the same specialty, to be ready to handle any emergencies or routine problems that arise. Most doctors work in groups and easily make such arrangements by ensuring that their partners and associates will be available; it is not enough, however, for physicians to leave a recorded message on the answering machine telling a patient to simply go to the hospital. A solo practitioner should arrange for another physician, in the local area and in the same specialty, to be available to handle emergencies.

Action Step Physicians should always arrange for coverage if they will be away from their office for more than one to two days.

Mistake 2 Failing to Respond to E-mail
Many physicians use e-mail and have websites that allow for automatic e-mail and give their e-mail address. Having such a website and putting the e-mail address on professional letterhead or business cards constitutes an implied invitation to patients to use e-mail to communicate with the physicians. One drawback of e-mail is that people who use it tend to believe the response time should be rapid. Physicians who intend to use e-mail to communicate with patients should have an office policy or procedure on how and when to respond. Communicating by e-mail can be convenient for physicians, since they can set aside
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a certain time each day when they can respond so they do not have to interrupt their daily practice by taking telephone calls.

**Action Step** Physicians who use e-mail should have a procedure to respond to e-mail messages within a reasonably short period of time.

**Mistake 3   Failing to Follow Up with a Patient after Prescribing Medication**
When physicians prescribe medication for a patient, especially when it is the first prescription for that medication for that patient, there should be some follow-up to determine if the patient is having problems with the medication. Physicians should always instruct the patient to contact them immediately if the patient notices any adverse or unusual side effects. In addition, if the physician knows that the medication can have serious side effects, a follow-up call from the physician’s office should be considered. Also, if follow-up blood testing is necessary to monitor the medication, the patient should be fully instructed about this step, and the physician should have a procedure to ensure that the patient is reminded of his or her obligation to have the testing done.

**Action Step** Physicians should always follow up with their patients regarding prescriptions drugs, especially drugs with known serious side effects.

**Mistake 4   Failing to Give Proper Notice to a Patient Before Withdrawing from the Case**
Physicians have the right to terminate their professional relationship with a patient, but they may only do so with proper notice. Most courts have held that proper notice means that the notice of withdrawal must be actually communicated to the patient and must give the patient sufficient time to obtain other medical treatment from another physician of the patient’s choosing. In the case of a physician who is retiring from practice or permanently relocating to another area with another physician taking over his or her cases, the notice to patients should include the qualifications or specialty of the new physician.

**Action Step** Physicians who wish to withdraw from a case must give full notice to the patient with enough time for the patient to select a new doctor.

**Mistake 5   Promising a Patient Treatment at a Specific Time or Place**
Where a physician makes a specific promise to a patient regarding the rendering of treatment by that physician, the physician may be held liable on a breach of contract theory as well as on the legal theory of abandonment. This situation may occur, for example, when a doctor tells a patient to go to the hospital and that the doctor will meet the patient there or that the doctor will visit the patient during that particular hospital stay. This situation occurs most often in ob-gyn cases in which the pregnant woman has been promised that her physician will
be present for the delivery. Even if the law in such a case would not impose a duty on the physician to attend, the physician may create that duty if he or she made such specific promises.

**Action Step** Physicians should not make promises to patients to provide treatment at a specific time or place.

**Mistake 6 Failing to Advise Patients of Who Will Perform Each Phase of a Surgical Procedure**

Much has been written about “ghost surgery,” when a surgeon other than the patient’s surgeon actually performs the operation. If the patient is not fully informed of who the surgeon will be before the operation, an abandonment claim can arise. An abandonment claim also can arise when other doctors perform various phases of surgery without the patient’s knowledge and consent. A surgeon may clearly allow other doctors to perform various procedures during the surgery (such as suturing an opening after the actual surgery has been performed) but to do so, the patient’s surgeon must always obtain the patient’s understanding and consent.

**Action Step** Surgeons should always obtain the patient’s consent when others might be assisting with the surgery.

**Mistake 7 Failing to Follow up with a Patient Advised to Go Directly to a Hospital**

Patients often call their physician’s office and describe symptoms that alarm the physician, who then instructs them to go directly to the hospital. In that situation, the physician has a duty to contact the hospital to explain why the patient was sent and to determine if there is a need for the physician to attend the patient while he or she is in the hospital. This is especially true when the patient is sent to the hospital from the doctor’s office. A physician may not simply “hand off” a patient to the hospital and then fail to follow up on the treatment within a reasonable period of time, which is generally shorter in emergencies. Where there is no follow-up by the patient’s treating doctor, an abandonment claim can arise, even when the doctor has turned the patient over to competent medical care at the hospital.

**Action Step** Physicians should always follow up on patients they send to the hospital under emergency circumstances.

**Mistake 8 Prematurely Discharging a Patient from the Hospital**

In this era of HMOs and managed care, there is great pressure on physicians to discharge a patient from the hospital as soon as possible. Later, if a determination is made that the patient needed additional hospitalization or was unstable when discharged, the patient may charge the discharging physician with abandonment. The courts have never recognized a physician’s claim that the physician was not paid as a defense to an abandonment claim when additional
medical treatment was necessary and proper notice was not given to the patient. Physicians should always exercise their own professional judgment when deciding whether or when to discharge a patient from the hospital. A patient leaving the hospital without the physician’s approval should always be required to sign a document stating that his or her discharge is against medical orders.

**Action Step**  Physicians should never discharge a patient from the hospital for purely economic reasons.

**Mistake 9  Discharging a Patient without Proper Instructions**
When it is medically appropriate to discharge a patient from the hospital or from the doctor’s continuing care, the patient must be given instructions regarding his or her present condition. (If the patient is being discharged on medication, the information in Mistake 3 should be reviewed.) A patient should always be informed under what circumstances after discharge he or she should contact the physician. Any other follow-up instructions appropriate to that patient should be considered and should be given to the patient, preferably in writing. Even after the physician appropriately determines that the patient can be discharged, an abandonment claim can arise if the patient was not instructed on what to expect and when he or she may need immediate medical care.

**Action Step**  Physicians should always fully instruct patients upon discharge from the hospital or from their continuing care.

**Mistake 10  Failing to Monitor Postoperatively a Patient Who Has Undergone Surgery**
The surgeon’s duty does not end at the end of the operation. The surgeon remains responsible for the postoperative care, including infection control and recovery. The surgeon must also determine the relative success of the operation and must exercise judgment as to whether additional operations may be needed. While the surgeon’s duty may not extend throughout the balance of the patient’s hospital course, the surgeon will be responsible for treating any surgical complications, even if they arise at some time after the surgery. Many states do allow a surgeon to limit his or her duty to the patient by contract. The better practice is for the surgeon to follow up, at least with the attending physician, to determine the patient’s condition until discharge from the hospital and perhaps for a time thereafter.

**Action Step**  Surgeons should always follow up with the patient after surgery for a reasonable period of time.

**Conclusion**
Physicians should understand the legal nature of an abandonment claim, as well as review these mistakes and the steps to avoid them.
23.6 The 10 Biggest Legal Mistakes Physicians Make That Could Lead to Liability for Failure to Provide Informed Consent
By Linda J. Hay, Esq.

Executive Summary
Failure to obtain informed consent for medical procedures is one of the leading types of claimed negligence in medical malpractice litigation. These claims are often made when common risks or complications result, and plaintiffs claim in their lawsuit that had they been aware of this risk, they would not have gone ahead with the procedure. In some limited instances, plaintiffs may not even need an expert witness to prove their case. Consistent, well-documented procedures and protocols tailored to the physician’s area of expertise can provide solid defenses to these types of claims.

Mistake 1 Failing to Develop Standardized Written Consent Forms for Risks, Benefits, and Alternatives Attendant to Common Procedures
Physicians should always obtain consent, in writing, from a patient. The best written form is tailored to the procedure, listing the common risks and complications, the more serious risks and complications, and the benefits. The form should also indicate that alternatives to the procedure were discussed, including the alternative of not having the procedure, and that the patient decided to proceed. Many medical associations provide sample forms for common
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procedures that incorporate the common risks, benefits, and alternatives, and websites for these associations can be great resources. If a full, written form is not obtained, a detailed note in the chart (signed by the patient if possible) indicating that all of the patient’s options were discussed is the next best thing.

**Action Step** Physicians should identify the common risks, the serious risks, and alternatives to common procedures in the practice. They should use this format in every informed consent discussion and document it.

**Mistake 2** Failing to Have Procedures and Protocols to Ensure That Patients Have Been Advised of Risks, Understand the Procedure, and Have No Questions

Many physicians perform certain procedures on a regular basis. For these procedures, the office should develop a specific, detailed protocol (including a specific written consent form), since these procedures will be those most likely to result in a claim. This protocol may include when the informed consent discussion is to be held and which staff will confirm that the patient has consented, that the form was signed (with a copy), and that any other written materials were given. The more standardized the procedures, the better the defense is in a lawsuit, because a written or pattern policy, known and followed by everyone in the office, provides solid, consistent testimony, in addition to written documentation, to show that the patient was informed in all relevant aspects.

**Action Step** Physicians should identify commonly performed procedures and develop a protocol on the informed consent (including documentation) process in the office.

**Mistake 3** Failing to Obtain a Written, Witnessed Consent from the Patient

One of the best defenses to an informed consent claim is to have a document signed by the patient acknowledging that a discussion was held about the procedure and that the patient understands the risks and benefits of, and the alternatives to, the procedure. This form should be witnessed by another person, dated, and if the patient does not speak English, should be in the patient’s language or be signed by the translator. The terminology should be worded so that the average patient (or juror) can understand it. A form document for common and serious risks, benefits, and alternatives (including the alternative of not having the procedure) should be included, and should also indicate all questions were answered. The form should allow space for a physician to tailor the form for any issues particular to this patient. The form should be signed at least a day in advance of the procedure and should acknowledge receipt of any brochures, videotapes, or other audio-visual materials used in connection with the consent discussion. Initialing of paragraphs and pages is ideal. Many associations or organizations provide sample forms of common procedures.

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Action Step  Physicians should develop standardized consent forms and use them for all procedures.

Mistake 4  Failing to Have an Informed Consent Discussion with the Patient in a Neutral Setting before the Procedure
The informed consent discussion should never happen immediately before the patient is to have the procedure. If it does, an argument is always made that the patient was nervous about the procedure and thus was not sure of the nature of the consent. Simply having this discussion and the documentation well before the procedure deflates such an argument by the plaintiff. Using a consistent time and place for this discussion supports written documentation. For example, every consent discussion should be in an office setting as opposed to taking place while a patient is on an examination table.

Action Step  Physicians should always have an informed consent discussion on a day (or days) prior to the procedure, and not have the discussion in an examination room, during an exam.

Mistake 5  Failing to Use Audiovisual Tools and Other Materials in the Informed Consent Process
Using audiovisual tools, videotapes, brochures, and pamphlets is an excellent way to ensure that patients understand a procedure. Documentation of the use of these materials can provide an excellent defense. A patient may testify, for example, that he or she was not aware or did not understand the risk of nerve damage, but if the patient recalls being given some brochures, and the chart indicates specific brochures were given, those brochures will be introduced into evidence and can provide an excellent defense to refute the plaintiff’s testimony. Often these materials provide simple, easy-to-understand discussions of the risks involved, which are easy for jurors to understand. A room dedicated to these tools can be used for the informed consent discussion. Documentation on the actual form, signed by the patient, of the tools used or given is even stronger evidence of plaintiff acknowledgment.

Action Step  Physicians should obtain audio-visual tools, brochures, and pamphlets; use them in the informed consent process; and document that the tools were used.

Mistake 6  Failing to Advise Staff of the Importance of Recognizing a Patient’s Lack of Informed Consent
Often in a lawsuit, staff from the physician’s office will be identified and called to testify. The better educated the staff on the issues, protocol, and documentation, the more helpful to the defense they can be. Having staff assist with protocols, ensuring that standard documentation is complete, and being alert to patient questions help to quell problems before the procedure and, if a claim arises, help to ensure solid testimony by a witness for the
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defense. Staff can be invaluable in spotting issues or problem patients and alerting the physicians to them before a serious problem or claim arises.

**Action Step** Physicians should educate and train their staff to assist in the process and to recognize problems with patients early enough to resolve them.

**Mistake 7  Failing to Use Laymen’s Terms**
Physicians should ensure that all discussions with a patient and the forms a patient signs explain matters in simple terms. Doing so ensures that the patient truly understands the issues and gives consent, as well as assists in explaining to the jurors that the patient was able to understand the risks, benefits, and alternatives. For example, the risk of nerve injury to the mouth should describe the potential injury as not only motor and sensory nerve damage, but also should identify symptoms, such as numbness, tingling, drooling, and difficulty chewing and speaking, temporary or permanent, which are terms that are easily understandable.

**Action Step** Physicians should use terminology that is easily understandable to the average patient (or juror).

**Mistake 8  Failing to Document Informed Refusal of Treatment**
Just as important as documenting the informed consent process is documenting the refusal of treatment. Although not as usual a situation, all of the same principles apply, and often the risk of refusal carries a much more serious risk of injury or harm. Exceptional care should be taken with the process of discussing the risks, benefits, and alternatives; the reasons for the refusal; and the relevant documentation. A patient’s signature and acknowledgment are often critical. Follow-up documentation of further discussion with the patient may often be necessitated by the standard of care. Patient refusal of treatment may also include requests to call in family members or others to ensure that the patient is making an informed refusal, all of which should be documented.

**Action Step** Physicians should be aware that informed refusal requires even more action and documentation than informed consent.

**Mistake 9  Delegating Informed Consent Duties to Other Providers and Relying on Institutional Forms**
Physicians cannot rely on institutional or hospital forms. In litigation, the issue is whether the physician complied with the standard of care, and plaintiff’s experts will testify that the standard requires the treating physician to obtain the informed consent. Hospital forms are typically general, and not specific to that patient. There is no in-depth discussion of the procedure, and often the hospital consent is obtained by a practitioner, such as a resident or a house physician, who has no information on the patient’s history.
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**Action Step**  Physicians should use hospital consent forms only as an extra step in or a double-check on the physician consent process.

**Mistake 10  Failing to Document the Informed Consent Process**
Documentation is key in defending a lawsuit. A well-documented chart on informed consent, with identification of many of the items listed in this section, and acknowledgment by the patient of the risks and alternatives may persuade a potential plaintiff’s attorney not to file a suit. If a suit is filed, documentation made contemporaneously will be evidence admitted for the jury to review. This documentation will solidly refute the plaintiff’s claim of a lack of informed consent and present powerful evidence. The more documentation on this process, the better.

**Action Step**  Physicians should fully document the informed consent process.

**Conclusion**
Physicians must take the time to assess their practice and their common procedures and develop standardized consistent protocols to achieve good informed consent. Documentation of all of these steps provides a solid defense to a claim.

**About the Author**
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23.7 The 10 Biggest Legal Mistakes Physicians Make in the Peer Review Process
By George E. Leonard, Esq.

**Executive Summary**
Every year, thousands of physicians engage in peer review of other physicians. This is done by the physicians as part of their responsibility to the hospital at which they have been granted medical staff privileges. If a physician has exhibited problems (e.g., in quality of care, substance abuse, or disruptive behavior), it is likely that many physicians on the medical staff with that physician will be involved in the peer review process of that physician. This
section focuses on protecting those “peer reviewers” (and the hospital for which they are acting as quality control agents). This is necessary because often physicians whose privileges are reduced or revoked file a lawsuit alleging, among other things, antitrust violations, libel or slander, tortious (“wrongful”) interference with business, or breach of contract. Physicians who engaged in the peer review are often named as defendants in those lawsuits.

Mistake 1  Failing to Follow Medical Staff Bylaws
All too often, peer review committees act without having first reread the medical staff bylaws. By acting first, significant damage to the process can occur, which becomes evident only too late (e.g., in a lawsuit). These missteps can be as basic as: (1) failing to give a potentially affected practitioner required notice in advance of a meeting or hearing or (as has actually happened) failing to give the affected practitioner notice in the method prescribed by the medical staff bylaws (e.g., “registered mail, return receipt requested”) and (2) failing to notify an affected practitioner of his or her rights after an adverse action or process.

Action Step  Physicians who are members of a peer review committee should always reread the medical staff bylaws before taking any action to ensure that the required steps are followed. Failure to do so could be held to be a breach of contract, at a minimum, and possibly worse.

Mistake 2  Voting on Adverse Actions That Affect a Competitor
Any peer review committee member who is a direct competitor of the physician whose privileges are being reviewed runs a huge risk in participating as a voting member of the committee. Because of committee assignments, a direct competitor may well be on a committee that is preparing to vote on an action that could adversely affect the privileges of a practitioner. For the sake of that committee member competitor, the process, and the hospital, the competitor physician should not only abstain, but also absent himself or herself, from the meeting prior to voting.

It is even more problematic if the competitor physician appears to be the “leader” of the investigation or process. Serving as a witness (such as reviewing a chart or charts and then giving opinions on the quality of care to a committee) should be done only at the direct request of the executive committee of the medical staff or the chair of the department in which both physicians practice.

A recent decision, Patel v. Soriano, et al. (Appellate Division, Superior Court of New Jersey, No. A-4239-01T3), is a good example of what not to do. In that case, the physician, who was a direct economic competitor of the applicant for privileges, solicited comments from copractitioners and apparently misreported the results of interviews.
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**Action Step**  Unless they want to end up as a defendant in a lawsuit, physicians should not vote on any action that could adversely affect a direct competitor.

**Mistake 3  Failing to Adequately Document the Process**
It is not at all uncommon for litigation to occur several years after committee meetings in the peer review process were held. Memories fade, particularly when the review is simply of a chart for a patient whom the reviewer has never seen or met. Concerns raised, or criticisms that were warranted, may be forgotten. Indeed, even which peer reviewer reviewed which patient charts may well be forgotten. Good, specific minutes of the peer review committee meetings will help greatly to alleviate the problems caused by the passage of time. Memories can be refreshed far more easily from well-written committee minutes, which document who did what, and who said what.

**Action Step**  Physicians should make certain that someone, possibly the medical records librarian or the medical staff secretary, takes good notes and transcribes them into accurate minutes, which are then read and approved by the peer review committee. Which physician reviewed what chart (or charts), as well as comments, concerns, or criticisms by identified physicians, should be included in the minutes.

**Mistake 4  Failing to Preserve the Files Reviewed**
This mistake is related to Mistake 3. If a peer review committee is prepared to take an action that will adversely affect a practitioner’s privileges, the charts that form the basis of the action should be photocopied as of the date of the review and kept segregated. Attempting later to segregate the irrelevant (or later added materials) from a file is difficult and time-consuming, and mistakes may be made. It is better to keep the files, as reviewed, “sacrosanct” from the beginning.

**Action Step**  Immediately after any meeting in which an adverse action is taken, or recommended, an identified person should be charged with: (1) photocopying the entirety of every chart that was reviewed; and (2) segregating them in a secure, identified place.

**Mistake 5  Appearing to Have Prejudged the Result**
As a member of a peer review committee, it is anticipated that physicians will keep an open mind, weigh the “evidence,” and arrive at a fair result (not unlike what is expected of, and hoped for, from jurors). It may be that a physician who is being reviewed has performed so poorly that a physician on the committee “knows” that an adverse action must be taken. That physician should keep that opinion/conclusion to himself or herself until the entire committee is prepared to discuss and deliberate the issues. Prematurely announcing a “result” makes the process appear to be a rubberstamp.
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**Action Step** Physicians should keep their conclusions to themselves until the entire peer review committee is prepared to, and does, discuss the issues.

**Mistake 6 Using Personal Stationery for Peer Review Business**
When physicians serve on peer review committees, they are acting as agents for the hospital in monitoring the quality of care. As hospital agents, any written communication (whether to the affected practitioner, to an attorney for the practitioner, or to an outside reviewer) should be on either hospital or medical staff stationery. Nothing should go out in writing in the peer review process on the personal or office stationery of a physician who is a peer reviewer.

**Action Step** Physicians in the peer review process are acting as agents of the hospital. The correspondence of those agents should reflect that fact by being written on hospital or medical staff stationery only.

**Mistake 7 Failing to Recognize and Observe the Limits or Constraints on the Committee**
Each member of a peer review committee needs to know what the powers and duties of the committee are. One example of the failure to know the limits of power of the committee was when a medical staff voted to “revoke” the privileges of a practitioner but the medical staff had authority only to recommend revocation to the hospital board. A trial judge ordered the hospital to reinstate a substandard physician because of this “minor” technical error (later reversed). A second example was when the hearing committee in proceeding to revoke a practitioner’s privileges decided to offer “reinstatement, based on practitioner agreeing to psychological testing/counseling” when the practitioner’s mental state was never an issue. The medical executive committee (MEC) chose not to accept the recommendation for reinstatement because the committee had no basis to require psychological testing or counseling. This refusal became the linchpin of antitrust claims that the MEC violated antitrust laws.

**Action Step** Physicians should be sure that they understand the scope of the committee’s purpose and powers.

**Mistake 8 Failing to Grant a Fair Hearing**
The federal Health Care Quality Improvement Act of 1986 (HCQIA) provides absolute immunity from damages for any kind of claim if certain criteria are met. One criterion is that, at some point, the affected practitioner must have been given a “fair process.” The act provides a “safe harbor” in which a process is conclusively presumed to be fair if five elements are given to the affected practitioner: (1) a hearing with a record or transcript; (2) the right to an attorney; (3) the right to call witnesses and cross-examine them; (4) notice; and (5) the right to submit written argument after the hearing.
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**Action Step**  
There are few “sure things” in the law. One is that the peer review process will be held to have been fair if the five elements listed in this mistake are extended to the affected practitioner. Just do it!

**Mistake 9  Talking in the Doctors’ Lounge and Losing Immunity**

As noted in Mistake 6, physicians act as agents for the hospital when they engage in peer review proceedings. This has two beneficial results. First, the physicians are entitled to immunities granted by laws, such as federal (HCQIA, discussed in Mistake 8) or state immunity statutes as peer reviewers engaged in that process. Second, agents (physicians) cannot conspire with their principal (hospital). But both of these advantages are lost if there is evidence of conduct outside the peer review process. Talking with other medical staff members in the doctors’ lounge or in the 19th hole at the country club can cause the immunities to be lost and can strip the physician of the position as an agent of the hospital. Without that agency, the physician is legally capable of “conspiring” with the hospital and with other physicians. Evidence of a discussion with another physician about a practitioner, outside of the peer review process, and of actions by the physicians to the discussion thereafter, could lead to a submissible case of a “conspiracy” to “get” the affected practitioner.

**Action Step**  
Peer review matters are confidential. They should be kept that way. Outside discussions can lead to an inference of an “agreement” or conspiracy.

**Mistake 10  Failing to Timely Obtain a Knowledgeable Attorney**

The peer review process can be very tricky. Having an experienced lawyer who has handled similar proceedings and has defended lawsuits arising from proceedings is the best insurance. This does not mean hiring the brother-in-law of the medical staff president or the administrator’s next-door neighbor who prepares the board minutes. The problems identified in Mistakes 1 through 9 should persuade any physician not to make Mistake 10 as well.

**Action Step**  
Physicians should find a lawyer who has peer review process experience, either from having handled the process or from having successfully defended cases in which the process was challenged or both. Physicians should retain that lawyer before any adverse action is taken or the first time a physician subjected to a peer review process threatens a lawsuit (whichever comes first).

**Conclusion**

Physicians involved in peer reviewing their colleagues should avoid these 10 mistakes.

**About the Author**

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23.8 The 10 Biggest Legal Mistakes Physicians Make When Dealing with Suspected Child Abuse and Suspected Sexual Abuse
By Richard T. Meehan, Jr., Esq.

Executive Summary
Reported instances of sexual abuse and other physical abuse in children have increased dramatically in recent years. According to the U.S. Department of Health and Human Services, there were 1,070,000 referrals to child protection agencies in 2000, while there were 1.8 million two years later. As primary caregivers, physicians, especially pediatricians, are often the first to suspect or learn of instances of such abuse. Child welfare laws throughout the country obligate physicians who suspect or learn of child abuse to report such abuse to the appropriate child welfare agency. In some states, failure to properly report suspected abuse exposes physicians to criminal prosecution. In a case that gained national prominence, a well-respected pediatrician in Bridgeport, Conn., and his associate were arrested and prosecuted for failing to report the pregnancy of an 11-year-old girl. In addition to criminal prosecution, these physicians faced disciplinary action jeopardizing their continued licensure by the state’s Department of Public Health. The state and local medical societies joined the legal battle on behalf of the physicians. Claims were raised in the criminal and administrative forums that the reporting laws were imprecise and that the state’s Department of Children and Families had failed to adequately inform and educate physicians of the obligation and method of reporting suspected abuse. In addition, once pregnancy was suspected, the pediatrician referred the child to an ob/gyn to confirm or rule out the suspected pregnancy. Neither issue was found by the court to insulate the physicians from prosecution or administrative disciplinary action. The case serves as a harsh lesson to primary caregivers who deal with children.

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Mistake 1  

**Failing to Know the Law**

Reporting requirements in each state differ slightly, namely concerning when a doctor is required to report suspected abuse. Generally, however, state child welfare laws impose an

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14 The following statutes require health care providers to report suspected abuse. Physicians should review the applicable statute in their state for greater detail. Alabama §26-14-3(a), §26-14-10 (1992): “Known or suspected”; Alaska §47.17.020(a), §47.17.023, §47.17.060 (1996): “Have reasonable cause to suspect”; Arizona §13-3620(A), §8-805(B) – (C): “Have reasonable grounds to believe”; Arkansas §12-12-507(b), §12-12-518(b)(1): “Have reasonable cause to suspect. . . Have observed conditions which would reasonably result”; California Penal Code §11166(a), (c), §11165.7(a): “Have knowledge of or observe, know or reasonably suspect”; Colorado §19-3-304(1), (2), (2.5); §19-3-311: “Have reasonable cause to know or suspect. . . Have observed conditions which would reasonably result”; Connecticut §17a-101a: “Have reasonable cause to suspect or believe”; Delaware Tit. 16, §903, §909: “Know or in good faith suspect”; District of Columbia §4-1321.02(a), (b), (d); §4-1321.05: “Know or have reasonable cause to suspect”; Florida §39.201(1), §39.204: “Know or have reasonable cause to suspect;” Georgia §19-7-5(c)(1), (g); §16-12-100(c): “Have reasonable cause to believe”; Hawaii §350-1.1(a), §350-5: “Have reason to believe”; Idaho §16-1619(a), (c); §16-1620: “Have reason to know or observe . . . Have observed conditions which would reasonably result”; Illinois 325 ILCS 5/4, 720 ILCS 5/11-20.2: “Have reasonable cause to believe”; Indiana §31-33-5-1, §31-33-5-2, §31-32-11-1: “Have reason to believe”; Iowa §§232.69(1)(a) – (b), §278.14(1), §232.74: “Reasonably believe”; Kansas §38.1522(a), (b): “Have reason to suspect”; Kentucky §620.030(1), (2), §620.050(3): “Have reason to suspect”; Louisiana Ch. Code. §603(13), §609(A)(1), §610(F): “Have cause to believe”; Maine Tit. §411-A(1), §4015: “Know or have reasonable cause to suspect”; Maryland Family Law §5-704(a), §5-705(a)(1): “Have reason to believe”; Massachusetts Ch. 119, §51A, §51B: “Have reasonable cause to believe”; Michigan §722.623(1), (8), §722.631: “Have reasonable cause to suspect”; Minnesota §626.556 Subd.3(a), 8: “Know or have reason to believe”; Mississippi §43-21-353(1): “Have reasonable cause to suspect”; Missouri §210.115(1), §568.110, §210.140: “Have reasonable cause to suspect. . . Have observed conditions which would reasonably result”; Montana §41-3-201(1) – (2), (4): “Know or have reasonable cause to suspect”; Nebraska §28-711(1), §28-714: “Have reasonable cause to believe. . . Have observed conditions which would reasonably result”; Nevada §432B.220(3), (5), §432B.250: “Know or have reason to believe”; New Hampshire §169-C:29, §169-C:32: “Have reasoning to suspect”; New Jersey §6-8:10: “Have reasonable cause to believe”; New Mexico §32A-4-3(A), §32A-4-5(A): “Know or have reasonable suspicion”; New York Soc. Serv. Law §413(1): “Have reasonable cause to suspect”; North Carolina §7B-301, §7B-310: “Have cause to suspect”; North Dakota §50-25.1-03, §50-25.1-10: “Have knowledge of or reasonable cause to suspect”; Ohio §2151.421(A)(1), (A)(2), (G)(1)(b): “Know or suspect”; Oklahoma Tit. 10, §7103(A)(1), §7104, §7113; Tit. 21, §1021.4: “Have reason to believe”; Oregon §419B.005(3), §419B.010(b): “Have reasonable cause to believe”; Pennsylvania 23 Pa. §6311(a), (b): “Have reasonable cause to suspect”; Puerto Rico Tit. 8, §441a, §441b: “Should know or have knowledge of. . . Suspects. . . Observers”; Rhode Island §40-11-3(a), §40-11-6(a), §40-11-11: “Have reasonable cause to know or suspect”; South Carolina §20-7-510(A), §20-7-550: “Have reason to believe”; South Dakota §26-8A-3, §26-8A-15: “Have reasonable cause to suspect”; Tennessee §37-1-403(a), §37-1-605(a), §37-1-411: “Knowledge of/reasonably know. . . Have reasonable cause to suspect”;

Texas §261.101(a) – (c), §261.102: “Have cause to believe”; Utah §62A-4a-403(1)-(3), §62A-4a-412(5):
obligation on those who deal frequently with children to recognize and report instances of suspected abuse. In many states, these persons are referred to as “mandated reporters.” Other examples of mandated reporters include counselors, therapists, social workers, teachers, and school administrators. Many states, similar to Connecticut, have done an inadequate job of educating mandated reporters about the requirements of law and the mechanism by which reports are to be made. A time-worn cliché in the law nevertheless rings true in this instance: “Ignorance of the law is no excuse.”

**Action Step** Physicians who treat children should investigate whether their state has mandatory reporting laws. In a hospital or clinical setting, physicians should seek out training from the administration. Those in private practice should turn to their local or state medical societies to request training. In most states, prosecutors have separate units specifically to train lawyers to investigate and prosecute child physical and sexual abuse. These individuals, if requested, often participate in in-service training or seminars to educate medical professionals on requirements of the law.

**Mistake 2 Failing to Report Abuse**
Child welfare laws obligate physicians, as mandated reporters, to report suspected physical or sexual abuse of a child. Failure to report that abuse, as in the instance of the Connecticut physicians, can lead to criminal prosecution and serious disciplinary action. More important, a child who is suspected to be the victim of abuse is at risk of further serious harm, physical and emotional, without appropriate intervention by a child welfare agency. Physicians, who suspect abuse and fail to follow state guidelines, also expose themselves to the risk of a future lawsuit. Take for example, the emergency room physician who treats a very young child for a fracture of an extremity and finds x-ray evidence of prior healed fractures and a history of recent admissions for serious or suspicious traumatic injuries. The physician suspects abuse, but makes no report and releases the child to the caretaker. Shortly thereafter, the child dies as a result of a battering by the caretaker. Attorneys for that child’s estate can and will sue that doctor for failing to take appropriate steps to protect that child by reporting the suspected abuse.

“Have reason to believe … Have observed conditions which would reasonably result”; *Vermont* Tit. 33, §4913(a), (f) – (h): “Have reasonable cause to believe”; *Virginia* §63.2-1509(A), §63.2-1512: “Have reason to suspect”; *Washington* §26.44.030(1), (2); §26.44.060(3): “Have reasonable cause to believe”; *West Virginia* §49-6A-2, §49-6A-7: “Reasonable cause to suspect. . . When believed. . . Have observed”; *Wisconsin* §48.981(2), (2m)(c)-(e): “Have reasonable cause to suspect. . . Have reason to believe”; *Wyoming* §14-3-205(a), §14-3-210: “Know or have reasonable cause to believe or suspect. . . Have observed conditions which would reasonably result.”
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Action Step  A physician who has a reasonable suspicion that a child has been subjected to physical or sexual abuse should immediately report to the appropriate child welfare agency.

Mistake 3  Failing to Recognize Abuse
The signs and residual effects of physical abuse are often more apparent than those associated with sexual abuse. Most mandatory reporting laws do not require physicians to prove abuse with certainty before the obligation to report is imposed. Rather, a good-faith basis to suspect abuse generally triggers the reporting obligation. When the protection of children is at stake, the child welfare agency would rather that the physician err on the side of reporting. Typically, physicians who have a good-faith basis to suspect abuse are insulated from repercussions by the patient or the caretaker. Child welfare agencies in each state exist solely for the benefit of children. Most have protocols that allow confidential investigations to be conducted and proactive intervention to avoid harm to a child at risk.

Action Step  Physicians should know how their state’s child welfare laws define abuse. Also, they should know the difference between “suspected abuse” and abuse that can be categorically proven, as well as whether their state requires them to report suspected abuse.

Mistake 4  Engaging in Overzealous Reporting
Physicians are subject to possible prosecution, suit, and disciplinary action for failure to report. But what of the physician who wrongly reports the claim of suspected abuse? Many states provide administrative and sometimes criminal penalties for those who falsely report claims of abuse, which sometime creates a delicate, fine line for doctors who are uncertain whether abuse has occurred. Again, a reasonable, good-faith basis for suspecting abuse will generally insulate the physician. Those subject to prosecution or administrative sanction for falsely reporting are generally doctors who have either intentionally or recklessly overreacted to a situation.

Action Step  Physicians should act diligently and have a good-faith, reasonable basis to suspect abuse. They should never falsely report an incident, but in a situation in which there is some basis to suspect abuse, the physician is better off reporting and allowing the child welfare agency to make the appropriate determination.

Mistake 5  Failing to Timely Report Abuse
In most states with mandatory reporting laws, there is generally a time requirement dictating when a report must be made and the manner of reporting. A physician should strive to know the time limits and the mechanism for making such reports. Most child welfare agencies have a 24-hour hotline or care line for a mandated reporter to make a verbal report of suspected abuse. Many states require a written follow-up within a further limited time. The physician who suspects abuse and makes either a verbal or a written report outside of the prescribed time periods runs the same risks as the physician who fails to report at all.

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Action Step  Physicians should know the time limits within which reports must be made and the manner in which reports must be made.

Mistake 6  Referring to a Specialist
“I suspected some form of abuse, but I referred the child to an appropriate specialist for further determination.” The Connecticut physicians suspected pregnancy but were concerned, based on the child’s age and an equivocal history given by the caretaker, that the pregnancy test may have provided a false positive. In that instance, rather than file the mandated report, those physicians referred the child to an ob/gyn. Although this action is generally accepted as good medical practice, in the instance of suspected physical or sexual abuse of a child, once the primary care physician has a reasonable suspicion, the law imposes on that physician the duty to report. Referral to a specialist, who may report the abuse later, does not insulate the primary care provider.

Action Step  Even if the physician is referring a child to a specialist to confirm a diagnosis, if there is a reasonable basis to suspect abuse, that primary care physician has an obligation to make the necessary report to the child welfare agency.

Mistake 7  Failing to Create an Office Protocol and to Adequately Document Patient History and Findings
Every physician who may treat a child has an obligation to educate his or her staff and create an office protocol to ensure the fact that suspected abuse is immediately made known to the physician so an appropriate report can be made. Physician assistants and nurse practitioners are generally considered mandated reporters in their own right, independent of the obligations the law places on their employer physician. But what happens when a triage nurse obtains a history that strongly suggests abuse and fails to either note that in the chart or provide that information to the physician? The nurse’s failure to act does not insulate that physician from the responsibility for failure to make the appropriate report. What happens in the instance of a physician who sees a young child and obtains a history that suggests sexual abuse? Further, the physician conducts a physical examination and observes some physical manifestation of the claimed abuse. The physician properly discharges his or her duty by filing the appropriately mandated report to the child welfare agency. However, the physician remains open to criticism if he or she fails to accurately and fully record the patient’s history and resulting medical findings. Sloppy charting exposes the physician to aggressive cross-examination in the criminal prosecution of the abuser. Criminal defense lawyers will seek out the treatment chart. Despite claims of a vivid memory of certain patient information, failure to record fully and accurately in the patient’s chart results in fertile avenues for an experienced cross-examiner to impugn a doctor’s findings and opinions.

Action Step  Physicians should educate their staff as to reporting requirements and create a written office protocol requiring all staff to undergo training. When child abuse is
suspected, physicians should be certain the chart fully and clearly reflects the complete history they have obtained as well as the full extent of any physical findings.

**Mistake 8  Failing to Report Suspected Abuse During an Ongoing Child Custody Case**

Probably the most difficult situation for a physician is a report by one parent that a child has been sexually abused by the other parent and the physician knows or learns that a bitter custody battle is taking place. All too often, one parent will raise false claims of sexual abuse against the other to gain leverage in a custody or visitation fight. Sorting out the truth in these situations is a difficult and complex task best left to those who have a particular expertise in investigating sexual abuse allegations. A physician who has been informed of a claim of sexual abuse, but who suspects or believes that the informing parent may be using this allegation as a wedge, nonetheless has a duty to report and leave it to the appropriate child welfare agency to determine the validity of the claim.

**Action Step**  Physicians should report any claim of child sexual abuse even if they suspect that one parent is attempting to use this report improperly as a tool in a custody or visitation fight. In these instances, it certainly is appropriate for the physician to include in the report his or her concern that the allegation may be the result of a custody battle.

**Mistake 9  Interviewing a Child**

Although the incidents of reported child sexual abuse have increased significantly in recent years, the number of such *false* claims also has risen dramatically. Studies show that children can be the victims of suggestive questioning even by the most well-meaning interviewer. A parent who has chosen to make a false allegation of sexual abuse will often go to great lengths to shape and create a recollection, particularly in a younger child. Often, physicians, social workers, and police officers, with little or no knowledge of appropriate forensic interview techniques, have unwittingly reinforced false memories by the manner in which the interview is conducted. If a physician obtains a history from a parent or sees signs that a child has been sexually abused, unless the physician has been trained in the appropriate forensic interview process, he or she should not interrogate the child. The physician should document the chart accordingly, thoroughly noting the history that was obtained and any physical findings that were made, and then report the matter immediately. Because of the rash of false allegations that have arisen in recent years, most law enforcement professionals have access to a trained team that often includes a prosecutor, a social worker, or a psychologist specially trained in the forensic interview process, and appropriately trained police officers. Physicians should let them do their work.

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15 In one case the author defended, the mother and father of a four-year-old girl were involved in a contentious custody battle. The mother reported to the local police department that the father had been sexually abusing the child. A child welfare caseworker and a police officer ordered the father to bring
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Action Step  Physicians should refer the child to the appropriate agency so that the proper forensic interview of the child can occur.

Mistake 10  Violating Confidentiality Laws
Many states, recognizing the high incidence of underage pregnancy, have created confidentiality laws to encourage youngsters to seek advice and care. The duty to report suspected sexual abuse is not limited to small children. Often, laws require that any suspected abuse of a youngster under age 16 must be reported to the appropriate child welfare agency. Under many of these laws, physicians are prohibited from informing a child’s parent or caretaker that the child has sought reproductive or abortion counseling or services. Violating these confidentiality laws can expose a physician to civil, criminal, or administrative sanctions.

What should the physician do when a 14-year-old comes to the school health clinic, reports a history of active sexual behavior, and seeks counseling or birth control? This situation is probably the single greatest dilemma for the physician because there is a clear conflict between the obligation to report sexual abuse and the confidentiality laws that protect the minor. Physicians who practice in settings where these issues can occur should not wait until the question arises in the clinical setting. Rather, the provident thing to do is to seek out from the appropriate child welfare agency and the state licensing board a clear definition of the physician’s obligations. Commonly accepted definitions of child sexual abuse generally envision a younger child. The manner in which the term “sexual abuse” is defined in state law, however, may make that term broad enough to include the 14- or 15-year-old with a history of sexual activity. Even if this youngster is voluntarily engaging in this conduct, most
states prohibit youngsters under a certain age from consenting to sexual activity. These laws are commonly referred to as statutory rape laws. In this context, a youngster who is under the age of lawful consent cannot willingly engage in sexual activity. The person with whom that person engages in such sexual activity is violating the criminal laws. In most instances, this activity is viewed as “sexual abuse.” It is not the traditional definition of sexual abuse.

Doctors who practice in school clinics should insulate themselves by making certain that they have a specific directive as to when such sexual activity must be reported to child welfare agencies. The physician’s personal beliefs as to birth control and abortion should not govern that physician’s conduct in this setting. If the law mandates reporting sexual activity by a young teen then, regardless of the confidentiality laws that prohibit the physician from informing the parent, the physician is obligated to follow the mandated reporting laws set down by that child welfare agency.

**Action Step** Physicians who provide reproductive and sexual counseling services to teenagers should seek out and obtain clear direction as to when sexual activity must be reported and to whom.

**Conclusion** Physicians must develop prudent procedures to deal with cases of suspected child abuse and suspected sexual abuse.

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23.9 The 10 Biggest Legal Mistakes Physicians Make That Prevent Them from Transferring Risk
By Anne M. Oldenburg, Esq.

Executive Summary
Under certain theories of liability, physicians may be held personally liable for the conduct of others or for forces beyond their immediate control. It is important for physicians to identify these potential risks and perform a comprehensive evaluation of them. Once the risk is identified, the practitioner can take affirmative steps to ensure that appropriate risk-management protocols are in place. Physicians can further protect themselves through education and supervision of those who pose potential risk.

Mistake 1 Failing to Perform an Appropriate Investigation Before Hiring Employees
Under the law, physicians can be held responsible for the negligent hiring of an employee. If they fail to conduct an adequate investigation, check references, and confirm credentials, physicians could be held liable for any negligence that may result from this lack of training and credentials. When hiring certified or licensed paraprofessionals, it is important for physicians to confirm the existence of the credentials. In addition, they should have protocols in place to monitor any recredentialing or continuing education requirements for their paraprofessionals.

Action Step Physicians should develop an office protocol for investigating all candidates for employment positions. They should keep detailed personnel files, including continuing education requirements and compliance with those requirements.

Mistake 2 Failing to Adequately Supervise and Educate Employees
Under the theory of vicarious liability, physicians may be held responsible for the conduct of their employees in the performance of the employees’ job responsibilities. Consequently, it becomes important for physicians to be aware of each employee’s level of skill, training, and work experience. Physicians should ensure that training programs are in place if necessary. Additionally, steps should be taken to ensure that all employees are educated about any specific clinical aspects of the practice. Detailed personnel files should be kept in the event there is any question regarding an employee’s training or experience.

Action Step Physicians should provide education for their employees when necessary and be aware of the skill level and conduct of their employees.
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Mistake 3  **Failing to Have Good Physician-Patient Relations**
Many studies have shown that the breakdown in communication between the clinician and the patient increases the likelihood of a lawsuit. It is important not only for the physician, but also for all of the staff, to have a good bedside manner. Patients who respect the physician and staff are less likely to institute litigation. Physicians should ensure that their staff conducts itself in a fashion that is professional and compassionate. It is important to evaluate personalities of potential employees to determine if they fit into a physician’s clinical practice.

**Action Step**  Physicians should ensure that their staff has a good bedside manner.

Mistake 4  **Failing to Maintain and Complete Records of Patient Contacts**
From a legal perspective, the documentation of the health care being provided is as important as the rendition of the care itself. In a malpractice suit, the medical record is evidence and is often introduced to the jury and evaluated by members of the jury during deliberations. A comprehensive and chronological documentation of all care, contact, test results, and follow-up recommendations will act as the best defense in a medical malpractice case. It is important that staff members are instructed with regard to the significance of documentation. All patient contact should be documented in the medical record. Physicians should ensure that patients are thoroughly advised and that the medical record is an accurate description of every clinical interaction that occurred between the practitioner and the patient.

**Action Step**  Physicians should ensure that all staff adequately and accurately document all clinical contact with the patient.

Mistake 5  **Failing to Adequately Inform Patients of Test and Procedure Results**
Often, physicians do not provide sufficient information with respect to tests and procedures and the results that are reported to them. It is important for physicians to adequately explain the significance of any and all test results that are performed. They should thoroughly explain what course of action, if any, should be taken in light of the specific result. They should also provide thorough explanations of any medications and side effects as well as what the anticipated outcome of the clinical course of treatment should be. Physicians should make clear that care and treatment are an attempt to treat conditions and symptoms, but that there is no guarantee. Patients who have an informed understanding of their diagnosis, symptoms, and course of treatment will work together with the physician and not against the interests of the physician and his or her practice.

**Action Step**  Physicians should have protocols in place so that patients are advised of all test and procedure results and have specific instructions regarding follow-up.
Mistake 6  Failing to Conduct and Document Continuous Educational, Quality Assurance, and Risk Management Training of Staff
It is the duty of physicians to ensure that everyone working with them in their practice has appropriate training and experience. Policies and procedures to maintain an appropriate quality of care should be instituted. Physicians should appoint a person to be in charge of education and quality assurance. That person should maintain files and information regarding education and credentialing. This information should be maintained in the facility where the physicians practice.

Action Step  Physicians should ensure that all staff is being educated and that measures are being taken to ensure the quality of care.

Mistake 7  Failing to Refer to Specialists or Consultants
In many instances, general practitioners must decide whether to continue to treat a patient or refer the patient to a specialist. These practitioners should be mindful of the extent of their training, experience, board certification, and other credentials. Often, the failure to timely refer a patient to a specialist for an evaluation will result in a malpractice suit. In addition, the failure to refer to an appropriate specialist may be called into question. It is important that general practitioners be aware of their limitations and refer to or consult with a specialist when necessary.

Action Step  Physicians should recognize patients who may be in need of a referral and refer in a timely and appropriate fashion.

Mistake 8  Failing to Understand and Comply With State and Federal Laws
During recent years, scrutiny of the confidentiality of medical information has increased. There are both state and federal statutes governing this issue. It is important that practitioners be aware of these statutes and have protocols and procedures in place to ensure that their patients’ medical information is not being wrongfully disclosed. Many forms and educational opportunities are available to address the specific issues involved. Practitioners should take it upon themselves to ensure that they have all pertinent information with regard to the confidentiality of medical records and that all staff involved in dealing with the medical record are educated on this issue.

Action Step  Physicians should educate and supervise the staff on current laws and regulations regarding medical records. They should update their protocols and procedures accordingly.

Mistake 9  Failing to Exercise Professional Skill and Judgment
Practicing sound medicine with good clinical skill and judgment will prevent malpractice. Physicians must take the time to ensure that their clinical skills are up to the applicable
standard of care, and they should continuously educate and update themselves on these skills. Attending seminars, participating in professional organizations, and keeping abreast of the pertinent literature are vital to staying ahead of the game in this litigious environment.

**Action Step**  Physicians should engage in continuous education and self-evaluation of their clinical skills.

**Mistake 10  Continuing to Practice When Aware of a Disability That Impairs the Ability to Perform**

Physicians who find themselves in a situation in which they are no longer able to practice due to an illness or disability must take themselves out of practice to avoid negligence. The standard of care requires that physicians be able to perform as would a reasonably prudent practitioner in the same or similar specialty. If any illness or disability affects that level of performance, then it is the physician’s responsibility to recognize that and remove himself or herself from the practice of medicine. In circumstances in which a disability arises, the risk of negligence is substantially increased. To avoid liability, the physician should take steps to remove himself or herself from the practice of medicine and arrange for a transfer of care of his or her patients to ensure that they are being provided continuous medical treatment.

**Action Step**  Physicians should recognize when they have an illness or disability that affects their ability to practice medicine and promptly provide alternative treatments for patients.

**Conclusion**

In certain instances, physicians can protect themselves from liability by ensuring that their entire office staff and referral network are competent, well trained, and educated. The careful selection and education of staff are as critical as the care being provided by the physicians. The ability to intelligently transfer risk can prevent claims.

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RISK MANAGEMENT: OBTAINING INSURANCE COVERAGE

23.10 The 10 Biggest Legal Mistakes Physicians Make When Obtaining Insurance Coverage
By Anne M. Oldenburg, Esq.

Executive Summary
In the current environment of increased malpractice litigation, large jury awards and settlements are proliferating, insurance premiums are soaring, and purchasing professional liability insurance coverage can be daunting. Nonetheless, malpractice insurance is an indispensable component of a physician’s practice. Practitioners must fully investigate all of their options and be fully informed about the nature and extent of the coverage they are purchasing. In these matters, an experienced insurance broker can be helpful. Many physicians make mistakes when purchasing malpractice coverage. Such mistakes can be financially devastating.

Mistake 1 Selecting Insurance Based on Short-Term Cost
Physicians often purchase professional liability insurance based on the cost of the premium. But premiums vary from specialty to specialty and from insurer to insurer. In the current market of ever-changing companies, it is important to evaluate all aspects of coverage in light of the cost of the policy. The chosen insurance company should be well established and financially sound. Often, the assumption that policies or insurance companies are interchangeable is incorrect, and physicians should refrain from having the premium cost be the sole consideration in making a choice. More important is that physicians purchase coverage from a company that stands behind its policy and provides the protection necessary if a claim is filed.

Action Step Physicians should fully investigate the company from which they are purchasing coverage, its track record in the industry, and all aspects of coverage before basing a decision on short-term cost.

Mistake 2 Selecting the Wrong Malpractice Insurance
Understanding the extent of coverage being provided is important. The most common type of professional liability insurance coverage available is a “claims-made policy,” which provides for protection of claims that occur and are reported while the policy is in effect. Within the conditions of a claims-made policy, a claim must be reported to the carrier in writing by the insured. An “occurrence policy” covers acts that occur while the policy is in effect. It does not matter if coverage is in effect when the claim is made. Under an occurrence policy, coverage will be provided for all events that occur while the policy is in effect even if the physician later cancels the policy. Occurrence policies tend to have higher premiums than those of claims-made policies, and they may be more difficult to obtain.
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Action Step  Physicians should be aware of the extent of the coverage being provided. They should be mindful that an occurrence policy provides the best coverage.

Mistake 3  Failing to Obtain Supplemental Coverage When Changing Insurance
Changing insurance coverage (whether related to a change in employment, a change in carrier, or a change in coverage) can leave a gap in available coverage. “Tail coverage” is a policy that can be purchased when a physician terminates a claims-made policy for any reason. The tail allows the physician to continue reporting claims for the years that he or she was insured under the original policy. “Prior acts coverage” (also referred to as “nose coverage”) provides coverage for claims that arise from the “prior acts” of the policyholder while insured with the previous claims-made carrier. Prior acts coverage eliminates the need to purchase a reporting endorsement. It covers claims first made against a physician after the effective date of coverage on the policy. To be covered, such claims must arise out of the physician’s acts performed before the policy’s effective date and after its retroactive date.

Action Step  When purchasing a policy, physicians should evaluate whether coverage will be provided for prior and subsequent acts that occur in relation to the policy period being purchased.

Mistake 4  Failing to Understand the Limits of Liability Coverage and to Obtain Excess or Umbrella Coverage
The limits of liability coverage are the maximum amount that will be paid under the terms of the policy. A professional liability insurance policy usually has two limits: a per-claim limit and an annual aggregate limit. For example, a $1 million to $5 million limit means that the most that would be paid on any claim is $1 million and the number of yearly $1 million claims that could be paid on behalf of a physician is five, for a total annual aggregate of $5 million. Excess, or umbrella, insurance is a separate insurance policy that provides limits above the primary or “first dollar” policy. It is important for physicians to understand the amount of coverage that will be available for the policy period if there is a possibility that the entire aggregate could be used based on claim history; if such a possibility exists, an investigation into the purchase of excess or umbrella coverage should be undertaken.

Action Step  Physicians should be aware of their potential liabilities and investigate what their potential liabilities might be. They should be sure to purchase realistic coverages in light of their potential exposure.

Mistake 5  Failing to Understand and Evaluate the Contract When Insurance Is Purchased for a Physician
In certain instances, a hospital or a group may purchase insurance that provides coverage for the individual practitioner. It is important that physicians be aware of the specifics regarding this coverage. They need to know whether they are protected individually and the context in
which that protection is provided. Also, they need to investigate whether coverage is available for any conduct outside the hospital or group setting. In addition, they need to be aware of the nose and tail coverages in these instances.

**Action Step** Physicians should evaluate any policy provided for them by a hospital or group practice to ensure that they are covered for all professional conduct.

**Mistake 6** **Failing to Understand a Policy’s Exclusions, Conditions, and Noncompliance Provisions**

All professional liability insurance policies contain limits on liability per occurrence and, in the aggregate, deductibles and coverage contingencies. Such contingencies can include timely payment of premiums, timely reporting of occurrences, and timely reporting of any changes in the professional practice. Each professional liability insurance policy includes specific conditions. The policies provide that the practitioner must cooperate with claims investigations and that the practitioner notify the insurer in writing of any illness or disability that might potentially impair the physician’s ability to practice medicine after the physician is aware of any such illness or disability. The policy sets forth guidelines for the reporting of claims and the handling of claims once the carrier is on notice. The policies and procedures for reporting claims differ from carrier to carrier. It is important that coverage contingencies and conditions be complied with; failing to do so can impair the available coverage. If coverage contingencies and conditions are not complied with, an insurance carrier may refuse coverage or dispute coverage in a litigated matter.

**Action Step** Physicians should be fully aware of any and all exclusions, contingencies, and conditions in their policy. They should comply with them to ensure that coverage will be continuous and available.

**Mistake 7** **Failing to Pay Attention to Endorsements That Add, Exclude, or Modify Coverage**

An endorsement is an amendment (sometimes referred to as a rider) that is added in writing to an insurance contract or policy. Endorsements might add coverage for additional groups or employees. They may also exclude or modify coverage for specific acts or specific individuals. A physician in a group practice, with licensed or certified practitioners or assistants, should consider coverage for the acts of those individuals during the course of their employment. Under the theory of *respondeat superior* (or vicarious liability), the practitioner can be held liable for the acts of these individuals and thus coverage for that conduct should be considered.

**Action Step** Physicians should evaluate all professional services being rendered and ensure that any and all services that they may be ultimately responsible for will be covered under their policy.
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Mistake 8  **Failing to Pay Attention to the Duration of the Insurance Coverage**
A policy of insurance has a specific policy term. That term is the length of time for which a policy is written. The policy will define the specific dates and describe the obligations and responsibilities of the insureds during this period of time. It is important for the practitioner to continue to maintain consistent coverage, to be aware of the policy period dates, and to have protocols in place to ensure that coverage is continuous.

**Action Step**  Physicians need to be acutely aware of the policy period and ensure that coverage is continuous from term to term.

Mistake 9  **Failing to Retain Records of Coverage Dates and Providers**
In some instances, a claim for malpractice may be filed years after the actual treatment occurred. In those instances, the physician may need to consult with prior carriers to determine which carrier provided coverage for the act in question. It is therefore important that physicians maintain an insurance file that includes all information relating to professional liability insurance coverages, with policy terms and information on the type of policy that was purchased.

**Action Step**  Physicians should keep an insurance file with all information on coverages or maintain that information through their broker.

Mistake 10  **Failing to Obtain Adequate Coverage for Specific Practice Factors**
Premiums will vary from specialty to specialty. Certain areas of practice have been designated as high-risk specialties, including neurology, ob-gyn, surgery, and emergency medicine. Physicians should be mindful of the area of their practice and the risks that have been affiliated with that type of medicine. They should consult with their broker to determine that they have adequate coverages in the event that a claim is made. These types of factors will be calculated when determining their premium.

**Action Step**  Physicians need to be mindful of the specific liability issues related to certain types of clinical practice groups and maintain sufficient coverage in light of that information.

**Conclusion**
In the current environment, a physician must be an educated consumer when it comes to purchasing professional liability insurance. The thorough investigation of companies, claims-handling measures, and cost will provide beneficial information when purchasing coverage. An experienced broker can be of great assistance in these matters.

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23.11 The 10 Biggest Risk Management Mistakes Physicians Make While Performing Nonclinical Medical-Legal Work (Expert Testimony)
By Daniel H. Willick, Esq.

Executive Summary
Physicians are often called on to provide expert consultation and expert testimony in legal proceedings. Indeed, some physicians specialize in providing such forensic services. What many physicians do not realize is that there are unique risks associated with forensic work. This section discusses 10 of the biggest mistakes that create risk for forensic physicians.

Mistake 1  Failing to Have the Necessary Qualifications and Expertise
Physicians should not accept forensic employment as an expert consultant or an expert witness unless they have the education and other qualifications in the subject matter on which they wish to be retained to perform expert services. (Council on Ethical and Judicial Affairs, American Medical Association, Current Opinions, Policy E-9.07.) A physician who overstates his or her expertise is at risk of providing negligent or incompetent advice and having his or her testimony excluded under the stringent requirements for expert testimony found in cases such as Daubert v. Merrill Dow Pharmaceuticals, Inc., 509 U.S. 579, 125 L.Ed. 2d 469, 113 S.Ct. 2786 (1993); and Kumho Tire Co. v. Carmichael, 526 U.S. 137, 143 L.Ed. 2d 119, S.Ct. 1167 (1999).

Action Step  Physicians should offer expert consultation or testimony only in the areas in which they are board certified or have extensive and recognized expertise.

Mistake 2  Failing to Define the Scope of Work
Physician experts should be retained by the attorney to whom they will report and for whom they will potentially testify. The work to be performed should be defined in consultation with and at the direction of the attorney. This creates a means whereby the physician’s opinions
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communicated to the attorney may be protected by the attorney work product doctrine in the event the attorney chooses not to use the physician as an expert witness.

**Action Step**  Physicians should be retained by an attorney when performing forensic work and should perform the work pursuant to instructions from the attorney.

**Mistake 3  Failing to Discern Whether They Are Retained as a Witness or as a Consultant**

A common mistake attorneys make when retaining expert consultants is to retain the consultant as an expert witness before they know what opinion the forensic consultant will render. This means that the forensic consultant’s opinion, if it is not favorable, may be disclosed to the opposing party. The proper way to handle this issue is for the forensic consultant to be retained as a consultant with the attorney having the option of using the consultant as an expert witness if the consultant’s opinion supports the attorney’s case. If that does not occur, the consultant should not be designated as a witness and should be admonished to maintain the confidentiality of the information reviewed and the opinion rendered to the attorney. Such confidential information would be protected by the attorney work product doctrine.

**Action Step**  When retained, the physician should be retained as an expert consultant with the attorney having the option of converting the physician to an expert witness.

**Mistake 4  Failing to Prepare for Attack Based on a Treating Relationship**

If the treating physician is the primary expert witness, there will be a tendency by the opposing party to blame the patient’s damaged condition on incompetent treatment by the treating physician expert witness. This tendency will subject the physician to attack and serve to undermine the credibility of the physician as a witness.

**Action Step**  Physicians should be prepared for attacks when they testify for any patient who is in treatment with them. It is not advisable for a treating physician to be the primary expert witness for a patient who is being treated.

**Mistake 5  Making Payment for Services Contingent on the Outcome of the Case**

Services rendered for forensic work by a physician should be paid for based on an hourly rate or a flat fee and should not be contingent on the outcome of the case. (Council on Ethical and Judicial Affairs, American Medical Association, *Current Opinions*, Policy E-9.07.) Any contingent fee for forensic work subjects the forensic witness to a claim that his or her testimony is shaped by a direct financial interest in the recovery. Cross-examination on this point will undercut the credibility of the expert witness.

**Action Step**  Physicians should not perform forensic work on a contingent fee basis.
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Mistake 6  Failing to Have Counsel Sign a Written Fee Agreement
A physician performing forensic work should enter into a written contract for services with the attorney who is retaining the physician and may wish to have the contract reviewed by the physician’s own attorney. The contract should contain a specification of the fees to be charged and the terms of payment. The contract also should state that the attorney retaining the physician is responsible for evaluating the relevance and admissibility of the work performed by the physician and should disclose that there is no certainty that the physician’s opinions would be allowed into evidence in a lawsuit due to the discretion allowed to the trial court judge to exclude such evidence. Other terms of the contract should include that the physician is being retained initially as a consultant with the attorney having the option to convert the physician into an expert witness.

Action Step  Physicians performing forensic work should enter into a written contract with the attorney who is retaining them and may wish to have the contract reviewed by their own attorney.

Mistake 7  Failing to Make Disclosures to the Person Being Examined
When a physician conducts a forensic examination of a party to a lawsuit, there should be disclosure to the person being examined that the physician is not diagnosing or treating that person as a patient and will be disclosing statements made during the examination as well as the results of the examination to third parties.

Action Step  Physicians performing forensic examinations should disclose in writing to the person being examined that there is no physician-patient relationship and that statements made during the examination as well as the results of the examination will be disclosed to third parties. If possible, the person being examined should countersign the written disclosure to indicate the person is aware that he or she is not a patient.

Mistake 8  Failing to Inform Adverse Party About Lack of Confidentiality
A physician conducting a forensic examination must make clear to any adverse party being examined that statements made during the examination and the results of the examination will not be kept confidential and will be subject to disclosure to the persons retaining the physician and to disclosure in open court.

Action Step  When a physician conducts a forensic examination of an adverse party, the adverse party should be informed in writing of the lack of confidentiality of statements made during the examination and of the results of the examination.

Mistake 9  Failing to Maintain Liability Insurance
A physician performing forensic work should purchase a liability insurance policy providing coverage for forensic work, including expert testimony, and for possible personal injury
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claims resulting from any forensic medical examination performed by the physician. Some malpractice insurance policies do not provide such coverage and care should be taken when performing forensic work to obtain liability insurance coverage for the forensic work.

**Action Step** Physicians who perform forensic work should purchase liability insurance that provides coverage for such work.

**Mistake 10  Failing to Obtain a License to Perform Medical Work When a License Is Required to Perform Forensic Work**

Some jurisdictions prohibit a physician from performing forensic work unless the physician is also licensed to practice medicine in that jurisdiction. Before entering into an agreement to perform forensic work in a jurisdiction other than where the physician is already licensed to practice medicine, the physician should determine whether he or she needs to obtain a license to practice medicine in order to be permitted to perform forensic work in the jurisdiction.

**Action Step** A physician performing forensic work should do so only in a jurisdiction where he or she is already licensed to practice medicine or which permits forensic work to be performed by a physician who is not licensed in that jurisdiction.

**Conclusion**

Physicians performing forensic work who follow the action steps listed in this section should be able to reduce the risks involved in such work and be better able to provide competent and professional forensic services.

**Additional Resources**


**About the Author**

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Chapter 24 Taxation

24.1 The 10 Biggest Legal Mistakes Physicians Make That Lead to Excessive Federal Income Tax Liability

By James L. Whitlatch, Esq.

Executive Summary
Each year, many physicians pay unduly excessive federal income tax because the tax laws are highly complex and can be difficult to apply in specific situations. By having a general understanding of some basic tax rules and various traps for the unwary, physicians can avoid paying excessive federal income tax.

Mistake 1 Not Taking Advantage of the Higher Expensing Limit
The 2003 tax act increased the amount that business taxpayers may elect to take as an expense deduction for the purchase of tangible personal property used in the business. An expense deduction lowers taxable income by an immediate tax write-off, instead of depreciating the amount of the expenditure over the life of the property. The amount of the deduction has been increased to $100,000, but the deduction is totally phased out if investment in property for the tax year exceeds $490,000.

Action Step Physicians should manage their investments in office equipment to take full advantage of the increased expense deduction. They should consider advancing or delaying purchases of office equipment around year-end to obtain the maximum deductible amount.

Mistake 2 Assigning a High Value to a Covenant Not to Compete
Physicians who sell the assets of their medical practices are often asked to sign a covenant not to compete with the buyer of the practice. These covenants can last for a number of years and cover a designated geographic area. The amount of the purchase price that is allocated by the physician to the value of the covenant not to compete will be taxed to the physician at ordinary income tax rates (35%). However, the amount of the purchase price that is allocated to the goodwill of the practice will be taxed at capital gains tax rates (15%). This means that for every thousand dollars of purchase price that is allocated to goodwill instead of to a covenant not to compete, the physician will net additional cash of $200 through tax savings.

Action Step Physicians should negotiate with the buyer of their practice for a written allocation of the purchase price that minimizes the value of the covenant not to compete.

Mistake 3 Not Understanding Qualified Dividends
The 2003 tax act reduced the tax rate for “qualified dividends” to the applicable long-term capital gains rate. As such, dividends that were previously taxed at a rate as high as 35% may now be taxed at a rate as low as 15%. A “qualified dividend” is a dividend from most
domestic and foreign stocks, but does not include amounts paid by real estate investment trusts (REITs) or amounts paid on preferred stocks. Also, to be entitled to treat the dividends as qualified, a taxpayer must hold the stock for more than 60 days within a 120-day window that surrounds the stock’s ex-dividend date.

**Action Step**    Physicians who buy and hold investments will not have much difficulty following the qualified dividend holding period rules, while physicians who are active stock traders should invest in personal finance software program that can track the details of their investments.

**Mistake 4     Not Bunching Up Deductions**
Physicians typically expend considerable amounts for professional association fees. While these amounts are generally deductible for tax purposes, the deduction is limited to the amount of the fees paid during the year that exceeds 2% of the physician’s adjusted gross income. That threshold can be difficult to reach. For example, if a physician has an adjusted gross income of $200,000, only the amount of professional fees paid in excess of $4,000 will be deductible. Physicians should bunch deductions into a single tax year to exceed the minimum requirement.

**Action Step**    Physicians should consider prepaying deductible expenses by December 31 of the year in order to exceed the floor on deductible amounts.

**Mistake 5     Not Keeping Adequate Records**
A general rule of the tax code is that deductions are allowed a matter of grace and that the burden is on the taxpayer to prove that they are entitled to the deduction. As such, physicians should always keep receipts, records, statements, and checks that support their deductions. The documentation should be kept for three years from the due date of the return or the date on which the return was filed, whichever is later. After three years, the Internal Revenue Service can assess a taxpayer only if it can be proven that the taxpayer committed fraud with respect to filing his or her tax return.

**Action Step**    Physicians should separate out and save receipts, records, and checks by deductible category.

**Mistake 6     Not Owning a Home**
The tax laws are undeniably skewed in favor of home ownership. Interest paid on mortgage loans and home equity loans are deductible on tax returns. Also deductible are property taxes paid during the year. Additionally, upon purchasing a home, taxpayers are allowed to fully deduct any points charged by the lender, whether it is the buyer or the seller who actually pays the points.
Physicians who use a portion of their house as a home office can depreciate that portion of the house and deduct the amount of utility costs and homeowners insurance that relate to the use of the home office. The biggest tax benefit to home ownership by far is that if the home has been lived in for at least two of the last five years as a primary residence, then the gain recognized on the sale of the house will be totally excluded from income and never taxed.

**Action Step** Physicians should buy a home.

**Mistake 7 Failing to Deduct Moving Expenses**
Physicians often relocate for employment opportunities. If the costs of moving to a new locale are not reimbursed by an employer, the physician may be able to deduct the moving expenses on a federal tax return. To take the deduction, two tests must be met: first, the new office must be 50 miles farther from the old home than was the physician’s old office; and second, the physician must work at least 39 weeks during the immediate 12 months after the move. Moving expenses include the cost of moving of household goods, mileage, and lodging.

**Action Step** Physicians should keep track of all unreimbursed moving expenses incurred in relocating for employment.

**Mistake 8 Failing to Pay Attention to the Alternative Minimum Tax**
The tax cuts of 2001 and 2003 magnified the risk that physicians will be hit by the alternative minimum tax. The AMT is a parallel tax system to the regular federal income tax designed to make sure that taxpayers do not pay too little tax. The AMT has its own rates and rules on deductions and add-backs. Physicians will pay to the government the greater of either their regular federal tax liability or their AMT tax liability. The likelihood of being subject to the AMT increases as a physician’s income increases. If an AMT liability is due and the physician has not paid enough in taxes throughout the year (either through withholding or by making estimated tax payments), the physician may be subject to penalties and interest.

**Action Step** Physicians should consult with their tax professional and inquire about their susceptibility to the AMT.

**Mistake 9 Not Tracking Tax Basis in Investments**
A physician’s original tax basis in investment assets is generally the amount paid for the investment. The basis is increased by the amount of any commissions or fees incurred in consummating the purchase. If investment property is inherited, however, the physician’s tax basis is the fair market value on the date of the decedent’s death. If dividends and capital gains paid on the investment have been reinvested, then the tax basis of the investment is increased for these amounts because they were taxable to the physician in the year reported.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

**Action Step**  More investment companies are tracking taxpayers’ basis in their investments. However, good practice is to maintain all account statements that detail any activity with respect to the investment.

**Mistake 10  Failing to Hire a Tax Professional**
Physicians should hire a qualified professional to advise them on tax matters. The tax laws are vastly complex, and there is generally no benefit to physicians in spending their time attempting to learn tax law. Also, because the incomes of physicians are typically well above the median income level, applying the tax laws to physicians becomes even more complex, since many tax deductions and credits may either be unavailable or substantially limited.

**Action Step**  Physicians should seek recommendations from colleagues for a qualified tax professional.

**Conclusion**
Physicians who understand some basic tax rules and principles will generally pay less in federal income taxes.

**Additional Resources**

**About the Author**
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TAXATION: ESTATE TAX

24.2 The 10 Biggest Legal Mistakes Physicians Make That Could Lead to Excess Tax Liability Upon Death
By Philip A. Goldblum, Esq., and Theresa A. Malmstrom, Esq.

Executive Summary
Improper planning can result in needlessly paying death taxes. The top federal death tax bracket is 48%, and some retirement plans can be taxed at a cumulative rate of 80% to 90%. Tax laws are in a constant state of flux, and physicians need to consult periodically with qualified tax and legal advisers to avoid excess tax liability upon death.

Mistake 1 Failing to Plan
By far the biggest and most widespread mistake physicians make is simply failing to plan their estates properly. Some may not be aware of the existence or the magnitude of death taxes. Others may assume that their estates are not large enough to be taxed or that the taxes won’t exist when they die. Others are too busy to focus on the process and get it done. As the saying goes: “You can be certain of only two things: death and taxes.” Failing to plan properly for the occurrence of the two can be financially catastrophic for a physician’s family. Under the current tax law, the federal estate tax kicks in for estates of more than $1.5 million at a 45% bracket and reach a top tax bracket of 48%. The total of $1.5 million may seem like a lot of money, but many people are surprised at how quickly their estates reach this level when they start totaling all their assets and life insurance.

Action Step Physicians should consult an attorney experienced in estate planning and start looking into the available planning opportunities. The earlier they start planning, the better off they will be.

Mistake 2 Not Taking Advantage of State Death Tax Opportunities
So much attention is focused on planning for the federal estate tax that it is possible to overlook opportunities at the state level. In addition to the federal estate tax, many states impose their own form of death tax. Fortunately, the state rates usually pale in comparison to those of the federal estate tax, but they are still worth addressing, especially when moving from one state to another. For example, a physician who had some planning done while in residency in one state but then took a position with a hospital in another state may mistakenly assume that the current estate planning documents are adequate.

Action Step Physicians should talk with their estate planning professionals to ensure that they are taking advantage of all state death tax savings opportunities. When physicians relocate to another state, they should have a local attorney review their existing documents to ensure that they pick up any savings under the new state’s laws.
THE BIGGEST LEGAL MISTAKES PHYSICIANS MAKE

Mistake 3  **Failing to Coordinate Assets With the Estate Plan**
The most comprehensive set of wills and trusts can be rendered useless from a tax planning perspective if the assets are not properly coordinated with the estate plan. To understand why, it helps to have an idea of how property passes at death. A will generally controls only those assets that are owned in an individual’s name with no beneficiary designation. If most of the physician’s assets are titled jointly with someone else (such as a spouse) so that they pass outside of the will, or if everything is subject to a beneficiary or “transfer on death” designation so that they also bypass the will, there may be few if any assets passing through the will to take advantage of the tax planning strategies it provides. In general, it is important that both spouses have assets in their individual names, which is not often the case when the working physician spouse accumulates all of the retirement plans and is the insured under all of the life insurance.

**Action Step**  Physicians should make certain that their adviser works with them on the coordination of their assets when their estate plan is done, and they should initiate an annual review of that plan. Proper implementation of the plan is critical.

Mistake 4  **Not Taking Advantage of Lifetime Gifting Strategies**
The federal estate and gift taxes are a combined system of taxation. Under the current law, everyone is allowed to gift as much as $11,000 annually per person free of the federal gift tax. The flip side of that is that any dollar gifted in excess of the $11,000 annual gift tax exclusion starts to “use up” the $1.5 million that can be left free of the federal estate tax at death. While this strategy may not be for everyone, it sometimes makes sense to make gifts of as much as $11,000 per year to individuals in younger generations. Not only does this strategy remove the gifted asset from taxation in the estate, it also removes all future appreciation of the asset starting from the date of the gift.

**Action Step**  Physicians should consult their adviser and consider whether it makes sense to start gifting to younger generations now, especially since Uncle Sam may end up with 48 cents of every dollar that they fail to gift, thanks to the federal estate tax. There are a variety of sophisticated gift-giving options that may have drastic effects on the physician’s tax planning and asset-protection strategies.

Mistake 5  **Failing to Update Beneficiary Designations on Life Insurance**
Although this mistake is related to Mistake 3, it is worthy of its own mention given how often problems occur in this area. Life insurance comprises a substantial portion of the estates of many physicians and is purchased for a variety of intended uses. All too often, though, the ownership and the beneficiaries of the policies are not what they should be, either because of new circumstances involving the insured’s family, business, or previous estate planning, or as a result of tax law changes. The potential inconsistencies are too numerous to list.
TAXATION: ESTATE TAX

Action Step  Physicians should make certain that their advisers are aware of all insurance coverage in place, even a group policy that they took out years ago during residency and which may still list their parents as beneficiaries. They should also make sure that the primary and contingent beneficiaries are named as they should be on each policy. Additionally, it is critical to determine the correct ownership of these policies, since one should never assume that the insured should always be the owner.

Mistake 6  Having Incorrect or No Beneficiary Designations on Retirement Plans
Also related to Mistake 3, this mistake merits its own mention. A few years ago, in a stroke of uncharacteristic compassion toward taxpayers, the Internal Revenue Service simplified the rules regarding minimum required distributions from retirement funds and actually made it easier to plan with them. That is the good news. The bad news is that retirement plans can be subject to a multitude of taxes, including income tax, state death tax, and federal estate tax. If not properly planned for, the cumulative tax rate can reach 80% to 90%. Retirement funds are another asset that often comprises a large portion of physicians’ estates.

Action Step  Despite the simplification of the tax laws, there are still no easy answers. Physicians need to consult an adviser who knows the rules and can work through the possibilities in light of what the physicians are trying to accomplish from both a retirement and an estate-planning perspective. Potentially, the worst-case scenario for tax purposes is to have named no one as a beneficiary on the retirement plans. So, if physicians do nothing else, they should make sure that they have both a primary and a contingent beneficiary named, as well as make certain that those beneficiaries are actually the persons whom the physicians want to receive the retirement funds upon their death. Remember that a beneficiary designation trumps the provisions of the will.

Mistake 7  Failing to Address Business Succession Planning Issues
Many physicians have an ownership interest in their practice, whether it is through a corporation, a limited liability company, or some other entity. Potentially, a properly drafted buy-sell agreement can save an estate thousands of dollars in taxes by valuing the business assets appropriately. Having such an agreement is also critical in order to handle issues smoothly that otherwise would be disruptive to many businesses.

Action Step  Physicians should consult with their adviser to document and implement an appropriate buy-sell agreement among themselves and their partners.

Mistake 8  Failing to Coordinate Professionals
Most physicians have numerous professionals with whom they work, such as a stockbroker, an accountant, and an attorney. Too often, these professionals never talk to each other to coordinate what they are individually doing for their physician client. The stockbroker should have an understanding of what the physician has structured from an estate planning point of
view, so that as questions arise regarding the titling of account, for example, the stockbroker can properly inform the physician. Likewise, the accountant should be aware of any potential transactions that might affect the physician’s income tax liability for the year.

**Action Step** Physicians should make sure that each of their professional advisers knows of all their other professional advisers. Physicians should ask that they consult each other (which might require making telephone calls or provide them with some form of written consent to do so) prior to making decisions that could affect the work that the others are doing on the physicians’ behalf. For example, a physician’s estate planning attorney and accountant may have agreed on a specific way for the physician’s assets to be titled for purposes of the estate plan. That plan could be completely undone by the physician’s stockbroker if he or she is not aware of the details of the plan and automatically titles a new account or purchases a new holding differently.

**Mistake 9 Failing to Update**
Unfortunately, life and tax laws are not static, which is very much the case with the federal estate tax. As mentioned earlier, the current exemption from the tax is $1.5 million. The exemption amount will continue to increase as shown in the following table:

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<tr>
<th>Year</th>
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<tr>
<td>2004 and 2005</td>
<td>$1.5 million</td>
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<tr>
<td>2006, 2007, and 2008</td>
<td>$2 million</td>
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<tr>
<td>2009</td>
<td>$3.5 million</td>
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Beginning in 2010, the federal estate tax will be eliminated, but a substantial alteration of the rules regarding the “step-up” in basis that is generally granted to inherited assets (for income and capital gains tax purposes) will be added in. In 2011, however, the estate tax comes back into effect and the excludable amount will drop once again to $1 million. Although this change is confusing, it is crucial that physicians keep informed of these changes, especially if their total estate (including life insurance) exceeds the exclusion amount. Documents may need to be revised and assets may once again need to be retitled, all in order to make certain that the physician’s estate can take advantage of changing tax laws.

**Action Step** Physicians should consult with their advisers and ask that their estate plan be reviewed annually if necessary in light of the tax law changes and changes to their family and financial situations. Creating flexibility in the plan documents is also important.

**Mistake 10 Failing to Carry Proper Levels of Life Insurance**
Despite the increasing exemption amounts, many physicians still find themselves with a taxable estate as value builds in retirement plans and practices. Sometimes the issue is not so much how to avoid taxes, but how to pay the taxes that might be due upon death. For
example, despite the illiquidity of the assets in an estate with a highly valued practice, large retirement fund, or piece of real estate, the taxes are still due on the value of those assets nine months from the date of death. Rather than being forced to sell assets at a fire sale to raise cash, it may make sense to purchase properly structured life insurance (in terms of amount, ownership, etc.) to provide liquidity to cover the tax liability.

**Action Step** Physicians should consult their estate planning attorney to prepare a liquidity analysis of their estate given their assets and potential tax liability. If necessary, they should then work with an insurance agent who can assist them with purchasing and properly structuring life insurance coverage.

**Conclusion**
All physicians, regardless of whether they have already done some estate planning, should be cognizant of these mistakes and take steps to protect their estates from the payment of unnecessary death taxes. Consultation with counsel at an early stage is critical.

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