

Is it worth an
hour of your
time to avoid the
mistakes that most
malpractice
victims make?

The
Seven
Deadly
Mistakes
of Malpractice
Victims

JOHN H. FISHER

**THE SEVEN DEADLY
MISTAKES
OF MALPRACTICE VICTIMS**

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John H. Fisher

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**Dedicated to the best lawyer I know,
James H. Fisher, Esq.**

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INTRODUCTION

PREVENTABLE MEDICAL MISTAKES: THE LEADING CAUSE OF ACCIDENTAL DEATH IN AMERICA

The leading cause of accidental death in America? Medical mistakes. More people die each month from preventable medical errors than died in the 9/11 terrorist attacks. The national death rate from preventable medical errors is fifteen times higher than the national murder rate.

In 1999, a report from the United States Institute of Medicine found that hospital errors caused as many as 98,000 deaths a year in the United States, costing the nation \$29 billion. This is just the tip of the iceberg: many more people are severely injured in the hospital, or die outside of the hospital, due to preventable medical errors. Even so, the deaths in hospitals from preventable medical errors are the nation's sixth leading cause of death and exceed deaths from motor vehicle wrecks, breast cancer and AIDS, according to the study entitled "*To Err Is Human.*"

"To Err Is Human" called for a mandatory nationwide reporting system for medical errors. That never happened. Only 20 states plus the District of Columbia require medical error reporting, but the evidence shows that even in those mandatory reporting states, hospitals report only a tiny percentage of their mistakes.

Nearly a decade after the Institute of Medicine report, preventable errors remain shockingly common. Hospitals account for the largest single slice of the nation's medical spending, 31 percent, or about \$650 billion in 2007, according to Medicare, and the total costs of preventable medical errors is between \$17 billion and \$29 billion per year. In its 2008 annual report to Congress, the Agency for Healthcare Research and Quality, part of the Department of Health and Human Services, reported that preventable medical injuries are growing each year by one percent.

Motor vehicle deaths are the number one cause of accidental death in the United States, with more than 43,600 deaths in 2006, according to the Center for Disease Control. The next three causes—poisoning, firearms and falls—account for 90,000 deaths, combined. However, if medical errors and infections were better tracked, they would easily top the list.

There is a huge variation of quality and safety in the system. Unfortunately, the United States has no federal agency responsible for hospital oversight. Instead, it relies on a patchwork of state health departments and a non-profit group called the Joint Commission that sets basic standards for the nation. Hospitals are rarely closed or hit with significant financial penalties for hurting patients.

Any effort to maintain national standards is left largely to Medicare and the Joint Commission, a non-profit group that, along with the state health departments, certifies that hospitals are operating safely. With fewer than 1,000 employees, the Commission accredits

and sets patient safety goals for 17,000 hospitals, nursing homes, and assisted living providers nationally.

State medical boards are supposed to discipline doctors who violate standards of care. However, less than 9% of doctors who make multiple malpractice payments are ever subject to medical board discipline. *Two-thirds of doctors who make 10 or more malpractice payments are never disciplined at all.*

The public perception is that virtually everyone is suing for even the most minor injuries or baseless complaints. While that can occur, the reality is that most victims of malpractice are not even aware that they were injured through a preventable medical mistake. A study conducted by Harvard's School of Public Health found 97% of medical malpractice claims had merit, proving only those with real injuries seek any recourse.

Studies show that only one in eight malpractice victims will bring a claim. *This means that the overwhelming majority of malpractice victims never bring a claim!*

Knowledge is power. If you know your rights, you will be a much more powerful advocate for your family's medical care when they are sick. This book will give you answers about your rights as a patient or a patient's advocate and what you can do when a doctor, nurse, hospital bureaucrat or lawyer is ignoring your rights.

I wrote this book so you will know what questions to ask the physicians, nurses and your lawyer, and how to get answers that no one else will give you.

DEADLY MISTAKE #1

HIRING THE WRONG LAWYER (DON'T HIRE AN ATTORNEY UNTIL YOU READ THIS)

Beware of the “TV Law Firms”

The law firms that advertise on TV are usually the worst law firms, with little to no trial experience. These “TV law firms” promote themselves as the “home run hitters” or the “top dogs” (or some other tacky but catchy nickname), but they rarely handle litigated cases and if the need to litigate a case arises, they refer the case to a trial law firm.

The “TV law firm” has former claims adjusters working for them, and a relatively small number of experienced lawyers; such law firms often only have one token trial lawyer on their entire staff and a dozen or more claims adjusters. The only interest of the “TV law firm” is settling your case, often at a steep discount to the true value of your case. If they can't settle your case, they will refer your case to a law firm that has experienced trial lawyers. The “TV law firm” will still get one third or more of the legal fee after they refer your case to the experienced trial lawyers.

The consumers who hire the “TV law firm” dedicate no time to researching law firms. If they did their research, they would discover that the lawyers from the “TV law firm” spend far more

time in front of TV cameras and marketing teams than they do in a courtroom. Many of the lawyers who advertise as the “home run hitters” or the “top dog” have never actually been in a courtroom and would not know what to do if they had to present a case to a jury.

The sad fact is that most people spend far more time researching used cars than they spend trying to find the right personal injury lawyer. Do you want a claims adjuster handling your case, or an experienced trial lawyer? This decision will affect your recovery more than any other information contained in this book.

“What if my lawyer asks for money up front?”

Run and hide. If a lawyer asks for money from you to pay for the costs of your case, you should find a new lawyer pronto! *Law firms experienced in malpractice litigation will never ask their clients to pay for the expenses of their case.* It is a cost of doing business for malpractice law firms to pay for the costs of hiring medical experts, obtaining medical records, paying for depositions, etc.

Lawyers who ask you to pay for the costs of your case before the case is resolved have no business in malpractice litigation and you should take such a request as an urgent warning to find a new lawyer.

Questions that your lawyer should always be able to answer

Your first question to your lawyer should be: what is the statute of limitations for my case and when do I have to file my lawsuit? If your lawyer cannot answer these questions, run for the nearest door.

If the statute of limitations on your case appears to have expired, then ask your attorney about the “continuous treatment” doctrine. The “continuous treatment” doctrine is a principle of law that gives you more time to bring a lawsuit if you have continued to treat with the potential defendant for the same injury after the malpractice occurred.

For example, if you allege that your orthopedic surgeon botched your knee surgery three years ago, the two year and six month statute of limitations has already expired. If, however, you continued to treat with the orthopedic surgeon for your knee injury for six months after the operation, then the statute of limitations does not begin until you stop treatment with the physician.

While you may assume your lawyer is carefully keeping track of these deadlines, many lawyers do not. The most common basis for a legal malpractice case is that the lawyer failed to file the lawsuit before the statute of limitations expired. If you hire an attorney who does not devote his practice to malpractice litigation, he may not even be aware of the correct statute of limitations, or when your rights will expire. This is really playing with fire.

At the first meeting with your lawyer, ask him to specify the date that the statute of limitations will expire on your case and ask him to tell you when he will give you a decision whether he will accept the case. Do not accept unclear or vague answers. If your lawyer cannot give you clear answers to these simple questions, it is time to find a new lawyer.

If your lawyer cannot make a decision whether to accept your case and begin the lawsuit within three months, then you should find out why. There may be a decent explanation, but often the truth is that the lawyer is doing nothing with your file.

How to find out if your lawyer is doing nothing with your case

If your lawyer does not answer your phone messages and will not meet with you to discuss the status of your potential case, one of two things is likely: the lawyer is too busy for your case, or he is little to no interest in your case, or possibly both. Either way, this is bad news for you.

Your basic rights in the attorney-client relationship include answers from your attorney as to what he has done with your case. For example, your attorney should have obtained your medical records within two to three weeks after you provide him with release authorizations. Within four to six weeks after you retain your lawyer, he should have sent your medical records to a medical expert and consulted with the expert about your case.

Your lawyer should be prepared to discuss the merit of your case within six weeks after you first contact with him.

You may want to ask your lawyer: Have you obtained all of my medical records? Have you sent my medical records to a medical expert? Have you spoken with a medical expert about my case? What opinions did your medical expert tell you about my case? Is your medical expert willing to testify in court regarding his opinions? If your lawyer cannot answer these questions within four to six weeks after you retain him, it is likely that your lawyer is doing very little, or nothing, with your case and you should find a new lawyer.

If your lawyer gives you vague answers about the status of your case, you need to ask why he cannot provide answers. If the lawyer cannot answer such questions, you need to find a new lawyer.

Time is not on your side

The longer you take to contact a lawyer, the less likely a lawyer will accept your case. There are many reasons, but the most important reason—that ***time is not on your side***—is called the “statute of limitations.”

The statute of limitations is a rule that requires you to bring your lawsuit within a specific deadline. In New York, a lawsuit for medical malpractice must be started within two years and six months after the date of the malpractice, and if

the patient dies as a result of the malpractice, the statute of limitations is two years. If you have a case against a federal agency, or a state, city or county hospital, your deadline is even shorter.

In claims against a county, state or city hospital, you must file a legal document known as a “notice of claim” within 90 days after the malpractice. If your lawyer does not file the notice of claim, you may lose your rights.

There is nothing a lawyer can do for you once the statute of limitations on your case expires. Your rights vanish! If you have the strongest malpractice case ever, it is meaningless if the statute of limitations has expired.

“Can I see my file?”

Yes. If you ask to review your file, and your lawyer refuses, alarms should go off in your head. If your lawyer is not willing to let you see your file, he may be hiding something.

You should request a meeting with your lawyer where you can sit down with him or her and review all of the paperwork in your file. Better yet, ask your lawyer to send you a CD containing all of the file materials in your case. This will make you a better informed client, and help your lawyer too, since he will have fewer phone calls and questions to answer after you become better acquainted with the file materials.

Questions that you should be able to answer about your case

At any moment in time, you should know the status of your case. For example: When will the depositions be held? Have the attorneys completed the exchange of paper discovery, i.e., discovery demands and responses? Will there be a defense medical examination of you and if so, when? When will the trial be scheduled by the court?

If you cannot answer these questions, then your lawyer is not keeping you informed about the status of your case. You need answers! Do not accept e-mails and phone messages—you are entitled to a meeting with your lawyer. If your lawyer is too busy to meet with you, you should find a new lawyer.

In a sense, you and your lawyer become partners. The contingent fee system serves an important function in giving lawyers who have no guarantee of collecting a fee an incentive to try hard for it, with the client the major beneficiary.

The more contact you have with your lawyer, the better, as you will be informed about the status of your case and your lawyer will have updates about your medical treatment.

“How can I get information about my case online?”

The website of the New York State Unified Court System (<http://iapps.courts.state.ny.us/Webcivil>) provides online access to information about cases in Supreme Court (New York’s trial level court) in all 62 counties of New York State. WebCivil is provided as a free public service by the New York State Unified Court System. Documents that have been electronically filed may be viewed by clicking on the “show e-Filed Documents” button in the Case Detail Screen. If the documents are not available online, you should contact the office of the County Clerk in the county where your case is being heard. You can search for case information by the name of the plaintiff or defendant or look up cases by the Attorney/Firm name and view the calendars for each court.

With WebCivil, anyone can create an e-Track account, which will provide you with e-mail updates and appearance reminders for Supreme Court cases. Case updates are e-mails which are automatically generated every time the court staff updates a case in their computer system. All courts in New York are updated at least once a day, so you should get current information about your case. You can send questions to ecourts@courts.state.ny.us.

You can also use WebCivil to check the status of a defendant’s lawsuit, such as the physician involved in your case. Decisions on other lawsuits may have a bearing on your case, so it pays to keep up-to-date on cases involving your physician or hospital.

“I hate my attorney. What can I do about it?”

Fire him! You have the right to fire your lawyer at any time and for any reason. The retainer agreement that you signed does not require that you keep your lawyer. If your lawyer has been dishonest or hiding information from you and you feel that there is no trust left in your attorney-client relationship, then by all means fire the lawyer and take the time to find the right lawyer for your case.

“Can my lawyer fire me, or simply refuse to represent me, after the lawsuit is started?”

No! Your lawyer cannot simply end the lawyer-client relationship once the lawsuit in your case has been filed. Your lawyer must first request your permission to end the attorney-client relationship, and if you do not consent, the lawyer will have to get permission from the Court to terminate the relationship.

“How do I pick the right lawyer for my case?”

If you have to undergo a brain operation, would you want a heart surgeon? Of course not! The heart surgeon may be world renowned and extraordinarily skilled at operating on the heart, but what does he know about operating on the brain? This same principle applies to lawyers.

If your case involved brain damage to a baby caused by trauma at birth, then interview lawyers and ask them: How many brain-damaged baby cases have you handled? What percentage of your law practice is devoted to medical malpractice cases? What percentage of your law practice is devoted to representing children harmed at birth? Have you handled trials involving babies injured at birth? What is the total number of cases you have handled involving babies injured at birth?

The lawyer may respond that half of his time is dedicated to malpractice cases and the other half is spent on criminal defense cases. That's not bad, but he is not the best attorney for your case. The ideal answer that you want from the lawyer is: My practice is devoted exclusively to medical malpractice, I have handled dozens of brain-damaged baby cases in my career and I am currently handling several brain-damaged baby cases. This is your man!

For years, the slogan of Kentucky Fried Chicken has been that they do only one thing: chicken. The same principle applies to your selection of a lawyer. Find someone who specializes in the area you need.

Insurance carriers know that the "TV law firms" are going to settle for pennies on the dollar, and they also know that reputable litigation firms will try to maximize the value of the case by going to trial. Lesson: Hire the "TV law firms" at your own peril.

“What do I do if my lawyer promises me the moon?”

Many lawyers will promise a huge settlement to their new clients for one reason: they want the new case and their promises of high dollar figures always impress new clients. New clients are always impressed by the high figures tossed around by their lawyer and they leave the first meeting with their lawyer convinced that they will win the jackpot.

If this happens to you, run for the door! It is impossible for a lawyer to estimate the value of your case when you first meet with him. The lawyer is almost always unable to assess the permanency of your injuries, whether you will have long-term complications and difficulties, whether there will be problems proving negligence against the wrongdoer and he is usually unaware of the defendants' liability insurance coverage. All of these things will affect how much, if any, money will be recovered in your case.

Good lawyers will never tell new clients how much money they can expect to receive from their case. This is irresponsible and designed to accomplish one thing: convince you that the lawyer is the right person to handle your case. Be very wary of lawyers who promise you the moon. There are no guarantees in personal injury litigation.

“I am not the type of person to sue. Doesn’t that make me different from everyone else?”

The most common thing that I hear from clients is: “I am not the type of person to sue, but...” The fact is that very few people are the “type of person who sues,” and the persons who want to litigate over minor injuries and disputes are not the clients that I want to represent.

98% of the population is not the “type of person to sue.” However, when you or your loved one has been injured through the negligence of another person, you have basic responsibilities to ensure that medical bills are paid, lost wages are recovered, future medical expenses are paid—and if there is a physical disability, you must ensure that you or your loved one is compensated for the dramatic change in your life.

“Why do lawsuits take so long?”

For 2006 physician medical malpractice payments, the mean delay between an incident that led to a payment and the payment itself was 4.88 years, according to data from the National Practitioner Data Bank. Five years is an awfully long time to wait for your case to be resolved, either by settlement or trial.

There are a number of factors that explain the duration of a lawsuit, but the two biggest reasons are: (1) the insurer of the defendant wants to drag out litigation as long as possible and wait until the last moment before they have to decide whether to settle the case; and (2) some counties have way too many cases relative to the number of judges, resulting in long delays in getting cases scheduled for trial. You may ask the court for a trial date and receive a date for the trial that is a year or more down the road.

There is one simple answer to this problem: file the lawsuit as soon as it is determined that the case has merit and make sure that the court imposes deadlines for every step of the lawsuit, such as specific dates for depositions, defense medical examinations and the exchange of discovery responses. This will prevent the lawsuit from the inevitable delays presented by defense attorneys and their insurers and keep the case on the proverbial “fast track” to trial.

Keep this in mind: the defense will not settle your case until you get to trial. If you think the defense will want to settle as soon as your lawsuit is filed, or after the depositions have been completed, forget it! For this reason, you need to make sure that your lawyers keep your case on the fast track to trial and focus on representing you at the trial—not simply settling for whatever they can get.

“How do I know if my lawyer believes in my case?”

Many “TV law firms” accept hundreds if not thousands of cases, with the goal of settling the cases in very little time and for a minimal sum of money. This system is a money-making machine for the “TV law firms.” The “TV law firms” spend little time and money on their cases and as a result, they have little to lose if they are unable to settle a case. In many cases, the “TV law firm” will settle your case for “pennies on the dollar,” or a fraction of the true worth of your case. Ultimately, if the “TV law firm” is unable to settle a case, they refer it to a litigation law firm that is experienced bringing cases to trial and maximizing the value of their cases.

The litigation law firm is far different from the “TV law firm” in a major respect: litigation law firms generally *invest* money in their cases, finding the best expert witnesses and preparing demonstrative exhibits and computer animations for trial.

If you want to find out if your lawyer cares about your case, ask him for a list of the expenses (case expenses are called “disbursements”), that he has incurred while handling your case. At the end of the case, you are responsible to reimburse your lawyer for his expenses, and therefore, you are entitled to get an itemized list of case expenses from your lawyer whenever, and as frequently, as you want. If the lawyer refuses to give you an itemized list of the expenses, it is time to find a new lawyer.

If you get an itemized list of the lawyer's expenses on your case, check to see how many expert witnesses the lawyer has retained, and the money that he has spent on your case. If the lawyer has spent a very small sum of money on your case, or there are long periods of time where no money has been spent on your case (i.e., four months or longer), he is unwilling to invest in your case and you should find a new lawyer. You want a lawyer who is willing to invest in your case—this means that the lawyer likes your case and believes you will ultimately recover money that will pay him back in spades.

“Who makes the decision whether to settle?”

You do! Your lawyer is simply acting as your agent and he cannot force you to settle your case. If your lawyer is forcing you to settle, you should find another lawyer.

A warning sign that you may need a new lawyer occurs when the lawyer asks you to pay for the costs of your trial, such as the cost of a medical expert. This is a red flag! Good lawyers will not ask you to pay for the costs of your case in advance. If they do, you should ask the lawyer why they want you to pay for the costs of the expert now, but never told you that you would be responsible for the costs when you first met with him. It is very likely that your lawyer no longer wants to handle your case (probably because he could not settle it) and he wants you to accept a small settlement offer so he can move on to other cases.

“How is the value of my case decided?”

There are three factors: (a) severity of the injury (for example, the loss of an arm is more significant than a sprained wrist); (b) duration of the injury (a permanent, life-long injury is more significant than a temporary injury that resolves); and (c) the consequences of the injury, such as a total inability to work and play compared to a partial limit of your ability to work.

I take into consideration the economic losses, such as loss of wages and past and future medical expenses, and non-economic losses. While economic losses can be substantial, particularly when a baby suffers permanent injuries at birth, the most meaningful loss is the change in quality of life. A child suffering from spastic quadriplegia faces a life in a wheelchair and will never play ball with his friends, go to a prom during high school, or walk down the aisle at a wedding. These are the real losses.

The median and mean medical malpractice payment amounts for physicians in 2006 were \$175,000 and \$311,965, respectively. Generally for malpractice payment data the median is a better indicator of the “average” or typical payment than is the mean since the mean is skewed by a very few large payments.

“What is a lien and why should I care about it?”

Medicare and Medicaid will likely have their hands out for their money if you recover money in your case.

By federal law, Medicare and Medicaid have a lien to recover any expenses they have paid relating to the injuries that you sustain arising from malpractice. This means that Medicare and/or Medicaid will likely want a piece of the money that you recover in your lawsuit if they have expended money for your medical expenses.

Instead of waiting until the end of your case to address liens, your lawyer should work on finding out whether there will be a lien and the amount of the lien early in your case. You should ask your lawyer: Are there any liens and if so, how much are they? You want to know how much you will have to pay Medicare and Medicaid at the end of your case. If your lawyer is unable to answer these questions, you should be concerned.

The only thing that truly matters: your net recovery

Your *net recovery* is the only thing that truly matters. Your “net recovery” means the amount of money that goes in your pocket after the payment of legal fees, expenses, and liens. If the lawyers and health insurers get paid with little left for you, the litigation has failed.

When your lawyer tells you about a settlement offer, you should ask him: What will be my “net recovery” if I accept this offer? You should ask the lawyer for the amount of the (a) legal fee, (b) case expenses, and (c) any liens which must be paid from the settlement money. After deducting the legal fee, case expenses and

any liens from the settlement offer, you will be able to determine the amount of your net recovery. The net recovery is the only number that should matter to you, so make sure your lawyer provides that figure to you whenever a settlement offer is made.

“If I fire my lawyer, do I still have to pay him a percentage of the legal fee at the end of the case?”

No! If you fire your lawyer, you have the right to insist that the lawyer provide you with an itemized list showing the legal services performed by the lawyer on your case. When you fire the lawyer, you have the right to determine whether the lawyer is paid according to the total number of hours worked on your case (this is called the “per diem rate”), or a percentage of the legal fee.

In almost every case, the former attorney will insist that his work resulted in the most important contributions to your case and that he is entitled to a large percentage of the total legal fee at the end of your case. You hold all of the cards when you fire your lawyer and you should insist that he provide the itemized list of legal services that he performed and that you want to pay the “per diem rate” for those services.

“If I lose my case, do I owe you any money?”

It depends. The retainer agreement that you sign will specify whether you are responsible for reimbursing your lawyer for his expenses at the end of the case. The retainer agreement may state that you are responsible to reimburse the lawyer at the end of the case regardless of whether you win or lose your case. This could be devastating for you, as the case expenses often exceed \$50,000, and you may not be able to afford \$500, much less \$50,000.

Most clients simply sign the retainer agreement without reading it and then lose the retainer agreement. You should keep an original, fully signed retainer agreement in a safe location, e.g., safety deposit box, throughout the lawsuit. At the end of their case, clients are often unaware of the percentage of the legal fee (most assume it is one-third legal fee, which is prohibited in medical malpractice cases in New York) and they are not aware of how the legal fee is calculated. The answers to these questions can be found in the retainer agreement.

You must read the retainer agreement very carefully. When you read the retainer agreement, make sure that the retainer agreement is crystal clear as to whether you will be responsible for case expenses even if you do not win your case.

Attorneys in New York are ethically permitted to state in the retainer agreement that the attorney will advance the expenses of the case without any expectation of reimbursement from the

client in the event the case is lost. If such a clause is contained in your retainer agreement, you cannot be held responsible for the case expenses if the case is lost. If, on the other hand, the retainer agreement provides that you are ultimately responsible for the case expenses, win or lose, then the lawyer can ask you to pay for the costs at the end of the trial, even if you lose and have no money.

“What if my lawyer asks me to pay for the case expenses just before trial?”

Before you do anything, read the retainer agreement carefully. If the retainer agreement states that your attorney may ask you to pay the expenses of the trial, then the attorney can ask you to pay the costs of medical experts and other costs of the trial.

If the retainer agreement does not state that you may be responsible to pay *in advance* the costs of the trial, the attorney cannot ask you to pay the bill.

“What if my lawyer won’t return my phone calls?”

There might be a good reason. If the lawyer is busy in trial on another case, you want the lawyer to be completely focused on that case, and he should not be returning phone messages during the trial.

Suggestion: If you are having trouble getting your lawyer to return your phone messages, ask for an appointment to meet with your lawyer face to face at his office. Good lawyers usually meet with their clients, or at least speak over the phone with their clients, at least once every two or three months to get updates about their client's medical treatment. If your lawyer is not willing to meet with you, you should find a new lawyer.

At the meeting with your lawyer, ask him to give you an update about everything that he has done with your file since you last spoke. You may want to ask: Have depositions been scheduled and if so, when will they be held? Have all discovery demands and responses been exchanged among the attorneys? When will you file a note of issue requesting a trial date? If the lawyer does not give clear answers to these questions, you need to find out why because it may be time to find a new lawyer.

You should ask your lawyer to provide you with all of the discovery responses and demands that have been exchanged among the lawyers. You are entitled to these documents, and the lawyer should be grateful that you want to know as much as possible about your case. A well-informed client has far fewer needs and places fewer demands upon the lawyer.

“What happens to the money that I recover?”

In the vast majority of cases, persons who suddenly receive a substantial sum of money, do exactly the same thing: they go on a

spending spree and have nothing within a year, give or take a few months. Of course, no one thinks this will happen to them. How many times have I heard, "I'm not that kind of person", or "That won't happen to me." Well, guess again, it will happen to you.

Many lawyers will simply hand you a check when your case is over and send you on your way. This is a gross disservice to you in most cases, because the vast majority of my clients have no financial sophistication and the only thing they think to do with their money is spend it. Of course, the money belongs to you and you are the only person who can decide how and when the money is invested or spent.

My goal for my clients is very simple once they recover money from their lawsuit and can be defined with three words: PRESERVATION OF CAPITAL. My job is to make sure that my clients hold onto their money and have the benefits of their settlement over the course of their lifetime. This is especially important for disabled clients, who will need a steady stream of income to pay for household expenses, spending money, medical bills and surgeries.

For 99% of clients, it is not enough to simply place their funds in a saving account at a bank. The temptation is just too great to take that dream vacation to Jamaica, or purchase the new Mercedes-Benz. The funds must be secured where they are safe from creditors, but more importantly, safe from the temptation of the client to raid them.

The answer for many of my clients is a structured settlement that places the funds in a long-term trust or annuity that will provide a stream of monthly income as long as the disabled client is alive. Such funds are not subject to fluctuations in the stock market and provide an assurance to the client that he will never run out of money. A structured settlement with a trust or annuity is the safest and best way to ensure that my clients go to bed at night knowing that their funds will not be gone tomorrow.

DEADLY MISTAKE #2

TRUSTING THE INSURANCE COMPANY TO “DO THE RIGHT THING”

Insurance companies operate under three basic principles: **Deny, Delay and Defend**. Once you accept this fact, you will begin to understand how the insurance company will handle your case.

Rule #1 for the Insurance Company: DENY

Doctors and hospitals almost never admit fault, even in the most obvious medical errors. It is extremely rare that a doctor or hospital will admit fault and offer to resolve your case. You will win millions in the lottery before a physician will admit to a medical error.

The doctors and hospitals in malpractice lawsuits often conspire not to blame each other. Such private agreements among the doctors will be concealed from you. However, it is a safe assumption that even before you file your lawsuit, the doctors and their lawyers are meeting in private to agree upon a strategy for defeating your case.

Warning! Some doctors will alter the medical records with notations known in the medical field as “CYA,” meaning “Cover Your Ass.” Such CYA notations in the medical records commonly blame the patient for everything that happened, i.e., “patient

refused advice to go to Emergency Room,” or “patient refuses to take medication.”

While such CYA notations may be legitimate in some cases, they are often added to the patient’s medical records immediately after the patient brings a malpractice lawsuit, or when the physician believes that a lawsuit is likely for their medical error.

Preserving the medical records and detecting the alteration of medical records by doctors and nurses is crucial. The medical records must be obtained right away from all of the physicians and hospitals where the patient received medical treatment. Once the lawsuit starts, the likelihood that the medical records will be altered to blame the patient increases.

Rule #2 for the Insurance Company: DELAY

The insurance company will try to delay your case at every opportunity. This is why it often takes more than two years from the beginning of the lawsuit until its conclusion.

Time is not on your side. With very limited exceptions such as wrongful death actions, doctors and hospitals do not pay interest on money provided to a patient in a settlement or verdict. This means that doctors and hospitals have every incentive to adjourn and delay your case until it is simply impossible to delay further.

Even days before your long-awaited trial, the insurance company often seeks to postpone the trial if it believes you are unwilling to settle on its terms. Every excuse imaginable will be offered to the judge to adjourn your trial. The only response to the delay strategy of the insurance companies is to press your case as aggressively and as quickly as possible. That is why the selection of the right lawyer is the most critical thing you do.

Rule #3 for the Insurance Company: DEFEND

The insurance company will try to blame the patient for what happened. If you did not take the prescribed medication at the right moment, you are solely to blame for everything that happens to you.

When the insurance lawyers meet to discuss your case, the first thought in their collective heads is: How can we blame the patient for what happened? It is almost always the case that the medical records will show a missed appointment or a notation that the patient should have a follow up appointment in one to two days after an Emergency Room visit.

The most common and likely defense in malpractice litigation is that the patient failed to follow the advice and/or discharge instructions given by the doctor. Emergency Room patients are routinely required to sign discharge instructions that state that they are to follow up with their primary care doctor within a one to two days. These boilerplate forms are required for every

Emergency Room patient and the nurses rarely read the discharge instructions to the patients.

Emergency medicine physicians often blame their patients for failing to seek follow-up treatment with their primary care physician after an ER visit to a hospital. The discharge instructions will contain standard language stating:

FOLLOW-UP CARE: The physician below will be providing follow-up care for you. It's important that you see him as instructed. If there is any problem, please contact us. **Your doctor feels that you should be seen for re-examination tomorrow.** Call the number below for an appointment.

At trial, the emergency medicine physician will seek to place all of the blame on the patient for failing to follow the "follow-up care" plan that he/she "explained in great detail to the patient". Of course, what the physician will not mention is that exactly the same language is contained in the discharge instructions given to every patient at the hospital. Even if you visit the Emergency Department for a routine cold, the discharge instructions will likely warn you that "your doctor feels that you should be seen for re-examination tomorrow". The discharge instructions are the #1 card played by the defense in attempting to blame the patient.

The second most common defense in medical malpractice litigation is that the patient's bad outcome was a known and

unavoidable complication or risk of the treatment. Before an operation, patients are asked to sign general consent forms that list the risks and complications of the operation with very general language. For example, a general consent form at the Albany Medical Center Hospital states, in part:

I understand that no assurance can be made concerning the results or outcome of any examination or treatment. I recognize that no explanation of examination or treatment can be exhaustive, and there may be other risks and complications. I have had had the opportunity to ask questions, and questions have been answered to my satisfaction. I may request more detailed information or explanations at any time.

The general consent forms often list “death” as one of the risks or complications of an operation, even in those operations considered routine or minor. For example, the “informed consent for anesthesia” at the Albany Medical Center Hospital states that the risks of anesthesia are the following:

RISKS: I understand that the administration of anesthesia involves drugs and procedures which are potentially harmful. **Some but not all of the possible risks and complications are:** ...permanent or temporary numbness and/or paralysis, stroke...coma or death....

The defense lawyers rely heavily on the “informed consent” documents signed by patients in arguing that the risk of a bad outcome was explained to the patient and the patient accepted the risk of untoward consequences. This is a frequent and common defense in medical malpractice litigation, particularly when there is a bad outcome following an operation.

The straight truth about settlement offers

In cases involving obvious and clear medical malpractice, clients often think the defendant physician will admit fault and the malpractice insurance carrier will want to settle the case in the early stage of the lawsuit, or even before the lawsuit is filed. WRONG!

Even in the cases of gross and obvious malpractice, the insurance carrier will almost never settle early in the lawsuit and in fact, the insurance carrier will almost always wait until the very last moment to make a settlement offer. The first settlement offer may come a day before trial, during the trial or even moments before the jury renders its verdict. Why?

The question is simple: in New York, the defendant (physician or hospital) pays no interest until the Judgment is rendered by the court with the exception of lawsuits based on wrongful death. This means that the malpractice insurance carrier has every incentive to delay settlement negotiations until it has no other way to postpone the case. The insurance carrier can delay paying

the injured victim until a Judgment is rendered by the court after the trial, which may be years after the lawsuit is filed. The insurance carrier can save potentially hundreds of thousands of dollars, or more, simply by holding out until the last possible moment.

The insurance carriers want to hold onto their money until they have no other choice and a jury forces them to part with it. For this reason, malpractice insurance carriers almost never make settlement offers early in a lawsuit and often do not make an offer until the verge of trial or later.

DEADLY MISTAKE #3

NOT HAVING ENOUGH INFORMATION ABOUT YOUR DOCTOR

Have you ever wondered: Has my doctor been disciplined by a state medical board? Where did my doctor go to medical school? What is my doctor's medical education? Is my doctor board certified? Has my doctor's license or hospital privileges ever been suspended, limited or revoked?

What you don't know can kill you. It's your job to find out who the bad doctors are, and make sure that you go to a good one.

The malpractice data from the National Practitioner Data Bank shows that 4,904 doctors each made three or more New York malpractice payments from 1992 to 2008 for a total of \$5.2 billion. That means that less than 7 percent of some 62,270 New York doctors accounted for half the total malpractice amount.

Data from the National Practitioner Data Bank indicate that just 6 percent of doctors are responsible for 58 percent of all negligence claims. ("The Great Medical Malpractice Hoax: National Practitioner Data Bank Data Continue to Show Medical Liability System Produces Rational Outcomes," *Public Citizen*, January, 2007). 82 percent of doctors have never had a medical malpractice payment.

Following are four secrets that your doctor will hide from you. It's up to you to get this information.

Secret #1: If your doctor is not board certified in his medical specialty, he will not tell you.

If a doctor is board certified, this means that he or she has graduated from medical school, completed residency (training in a hospital), trained under supervision in a specialty, and passed a national examination given by a medical specialty board. The American Board of Medical Specialists ("ABMS") assists 24 approved medical specialty boards in the development and use of standards in the evaluation and certification of physicians.

Board certification is a nationwide testing process that requires physicians to pass an oral and written test; this test ensures that your doctor has the basic, minimum competence in his medical specialty. If your doctor is not board certified in his medical specialty, you should be very leery about using him as your doctor. Many hospitals will not issue admitting privileges to physicians who are not board certified in their medical specialty. If your physician is not board certified in a medical specialty, this is a bad sign and you should find a new doctor.

To find out if your doctor is board certified, contact the American Board of Medical Specialties Certification Verification Service at 1-866-275-2267. The official ABMS directory of Board Certified

Medical Specialists lists doctors' names along with their specialties and their educational backgrounds. ABMS offers this information at www.abms.org (click "Who's Certified"), or call toll-free at 866-ASK-ABMS, to see if your physician is board certified.

If you have doubts about your health care provider, you should make sure he/she has a valid New York State license, and has not had his/ her license revoked or suspended due to professional misconduct. The Office of the Professions of the New York State Education Department licenses 48 professionals in New York ranging from physicians, dentists, social workers, midwives, and pharmacists. To verify your health care provider's license go to the office of the professions website www.op.nysed.gov to confirm his/her status. New York license professionals, such as physicians, and midwives, must display a current NY registration certificate in their office that lists the professional's name, address, and dates of the registration period.

Additional information about physicians can be found on the following websites: American Board of Medical Specialties; American Medical Association—AMA Physician Select, Online Doctor Finder; Federation of State Medical Boards; New York State Department of Health Physician Profiles; and CLEAR (Council on Licensure, Enforcement and Regulation).

Secret #2: If your doctor has been suspended or reprimanded by a licensing authority, he will not tell you.

You must make sure your doctor has never been the subject of a disciplinary proceeding or has had his medical license suspended, limited or revoked. Some physicians must be monitored by another doctor based upon disciplinary actions brought against them by the state agency that regulates physicians, i.e., the New York State Department of Health. However, those physicians will not tell you about their problems with the state licensing authority. You must do your own research on the internet.

Complaints against physicians are public information if they result in a final disciplinary action. To learn if a physician has been disciplined, call OPMC at 1-800-663-6114 or access the Medical Conduct web site at www.health.state.ny.us (select "Information for Consumers").

New York's Patient Health Information and Quality Improvement Act of 2000 made it possible for all citizens of New York to get information about physicians through the State Physician Profile website, www.nydoctorprofile.com

To search for the latest discipline actions against physicians, physicians' assistants and specialist assistants, check the website of the New York State Department of Health's Office of Professional Medical Conduct at www.nydoctorprofile.com. The

OPMC website posts public documents regarding professional misconduct, and physician discipline actions taken.

The nydoctorprofile.com website provides information about the doctor's number of medical malpractice payments, the date of the payments, the court and county where the payments were made, and the "significance of the payments" relative to the average settlement amounts of other physicians.

On the OPMC website at www.health.state.ny.us, you can click the links for "Search for a Disciplined Physician", "File a Complaint" and "Contact OPMC". If your physician has been disciplined by the OPMC, the website will provide information about the "Misconduct Description" and "License Restriction" and a copy of the Hearing Committee's Determination and Order, Factual Allegations, and Findings of Fact against the physician are posted in a pdf attachment.

The section of www.health.state.ny.us that is entitled, "Disciplinary Action", provides a listing of all physicians, physicians' assistants and specialist assistants who have been disciplined since 1990. For information about physicians disciplined before 1990, call 800-663-6114, e-mail opmc@health.state.ny.us or write to the New York State Department of Health, Office of Professional Medical Conduct, 433 River Street, Suite 303, Troy, New York 12180.

Effective, November 3, 2008, both the charges filed against a physician and the Board's Determination and Order regarding all charges are made public. Pending or dismissed complaints and

the investigative file materials from all cases are not accessible to the public.

Ask your doctor for his resume, also known as curriculum vitae. The doctor should not hesitate to give you his resume if he is proud of his professional accomplishments and has nothing to hide.

Secret #3: If your doctor has lost his privileges at a hospital (and thus has no ability to admit you to the hospital), he will not tell you.

Admitting privileges give the doctor the ability to admit you to the hospital for testing and monitoring and surgery, if necessary. 49% of U.S. hospitals have never reported a single disciplinary action against one of their doctors, since the National Practitioner Data Bank was created in 1990. (Annual Report, 2006, National Practitioner Data Bank).

Hospitals are required by law to report whenever they lift a physician's privileges for at least 31 days for medical incompetence or misconduct. In two decades, surely more than half of the country's hospitals have taken such actions against doctors. Hospitals, which face no fine for failing to report, are not especially eager to turn in their doctors. Some hospitals impose only 30-day suspensions to get around the 31-day rule.

To search for the latest discipline actions against physicians, physicians' assistants and specialist assistants, check the New York State Department of Health's Office of Professional Medical Conduct homepage at www.health.state.ny.us. The OPMC website posts public documents regarding professional misconduct, and physician discipline actions taken.

The OPMC website offers valuable information in sections entitled, "Out-of-State Actions", "Current Limitations", "Hospital Privilege Restrictions" and "Criminal Convictions". The OPMC website also provides information about your doctor's medical school, graduate medical education, whether the doctor is board certified, the date of board certification and professional memberships.

The section of the OPMC website entitled, "Legal Actions", provides information about lawsuits that have resulted in a determination adverse to the doctor. The OPMC website provides information about licensing actions taken against doctors. If you would like to see if there have been any license actions taken against your doctor over the past ten years, the OPMC website provides this information.

Secret #4: If your doctor has made multiple malpractice payments, he will not tell you.

Contrary to public perception, lawsuits are not settled by physicians when the case against them has no merit. If your doctor has settled more than one or two cases in his career, he may not be a skilled physician.

You should find out whether your doctor has been sued and if so, whether your doctor had to settle the lawsuit. While some very good doctors are sued, it is only the strongest cases that are settled. It is more important to find out whether your doctor has paid money to settle a lawsuit, than to find out whether he has been sued.

A simple and easy way to determine if your doctor has been sued is to visit the OPMC website under the section entitled, “Legal Actions”, and “Out-of-State Actions”. However, lawsuits against physicians are often not reported to the Office of Professional Medical Conduct.

Another way to check for lawsuits against your doctor is to visit the County Clerk’s Office of the county where your doctor has his office and if you are ambitious, the counties surrounding the county where your doctor has his office. The computer terminals in the County Clerk’s office will have information that about lawsuits against individuals, and once you obtain the index number

for a court file, you can ask the County Clerk to review all of the court documents in the lawsuits.

“How do I learn more about my doctor?”

The Physician Profile on the website, www.nydoctorprofile.com, provides information about your physician’s educational background, including college, medical school, residency and fellowship, hospital affiliations, whether he or she is board certified, medical specialties, patient ratings and comments, awards and distinctions, and recent comments by patients. This is a great place to start your background search of a physician.

To check if a doctor has a currently valid license, you can check with the New York State Education Department, Office of the Professions, Education Building—2nd Floor, Albany, New York 12234, or call 518-474-3817, or check the Education Department’s website at www.nysed.gov/prof/profhome.htm.

“If my doctor has a clean disciplinary record, is it safe to assume he is a good doctor?”

Not necessarily. There are 85,370 licensed physicians in New York State of which 64,818 are in active medical practice in the State. A review of the activity of New York’s Office of Professional Medical Conduct (OPMC) from 1995 through 2009 reveals a total of 5,254 doctors sanctioned. In 2009, for example, there were 292 doctors sanctioned by the OPMC out of 64,818 doctors actively practicing in the State.

In 2009, the number of doctors being sanctioned by the OPMC has declined to a fifteen year low despite an increase in the number of physicians practicing in New York and a dramatic increase in complaints, according to *System Failure: A Review of New York State's Doctor Discipline System* published by the New York Public Interest Research Group in June, 2010. Furthermore, according to the Federal government's National Practitioner Data Bank, New York ranks third from the bottom in the percentage of actions taken against in-state doctors.

The bottom line is that the State of New York does not effectively monitor physicians for negligence and misconduct. The fact that your doctor has a clean disciplinary record does not mean much.

“How do you tell a good hospital from a bad one?”

Nurse-to-patient ratios at hospitals are associated with the frequency of patient injuries: the fewer nurses, the higher the rate of injuries. A series of studies from the Agency for Healthcare Research and Quality found “significant associations between lower levels of nurse staffing and higher rates of pneumonia, upper gastrointestinal bleeding, shock/cardiac arrest, urinary tract infection and failure to rescue.” Studies have shown that a low ratio of nurses to patients, such as one to five, reduces patient deaths, allows nurses to spend more time with each patient and helps keep experienced nurses on the job.

In 1999, California was the first state in the nation that enacted a law with minimum nurse-to-patient ratio of one to five. When the California law was phased in between 2004 and 2008, the results were predictable: there are fewer nurses missing changes in patient conditions, the nurses are far more likely to stay at bedside and there is less burnout resulting in higher nurse retention. Before the law, it was common to find a single nurse in charge of 8, 10 or 12 or more patients on a shift.

What is the nurse-to-patient ratio at your hospital? How many care providers are registered nurses? Now you can ask those questions and the hospital is required to tell you in New York.

On March 15, 2010, a new law, known as the Nursing Care Quality Protection Act (Public Health Law section 2805-t), went into effect in New York that requires hospitals, nursing homes, hospices, and diagnostic and treatment centers to make nurse-to-patient ratios available to the public. The law also requires health facilities to report adverse events, which may reveal facilities where staffing shortages contribute to higher rates of medical errors.

You now have the right to know how hospitals and nursing homes are staffing their units. The law also requires hospitals and nursing homes to report the number of registered nurses and licensed practical nurses (LPNs) providing direct care, the ratio of full-time nurses to patients, the number of unlicensed workers providing direct care, and information on complaints filed against the hospital and hospital staffing policies.

One catch: the information will not be collected or publicized by the state. The law requires hospitals and nursing homes to make the information available to any member of the public who requests it and to any state agency that supervises health facilities. The public can access the data by contacting the hospitals and nursing homes.

If the hospital or nursing home refuses to disclose this information, you should refer to the Nursing Care Quality Protection Act (Public Health Law section 2805-t) and inform the facility that New York law requires the disclosure of this information. If that fails, you should file a complaint with the New York State Department of Health.

The federal government also publishes information about nurse-to-patient ratios at nursing homes at www.medicare.gov/NHCompare.

The American Nurses Association website lists “magnet” hospitals—those most attractive to nurses—or a call to a hospital’s nurse supervisor should yield the nurse-to-patient ratios. Go to the American Nurses Association website at www.nursecredentialing.org/Magnet/FindaMagnetFacility for a list of the magnet hospitals that nurses find most attractive. There are 17 magnet hospitals in New York State.

The website of the New York State Department of Health (www.health.state.ny.us) has a section entitled, “Hospital Profile”, that provides information about “Quality Measures”, “Procedures”

and “Available Care” about hospitals in New York. The hospital “Quality Measures” indicate how well hospitals provide care to their patients for medical conditions such as surgical prevention, pneumonia care and heart conditions. There is a web page named, “How do these scores compare to other hospitals?”, which is useful for comparing hospitals for quality of care.

The website of the U.S. Department of Health and Human Services (www.hospitalcompare.hhs.gov) has a web page entitled, “Hospital Compare”, that is based on data involving Medicare patients treated between July 2006 and July 2009. The study includes average death rates for various illnesses, such as heart failure and pneumonia, and includes readmission rates to hospitals. On average in the United States, one in five Medicare beneficiaries discharged from hospitals ends up returning within a month.

You should find the hospital with the longest track record, best survival rate and the highest volume on the procedure. You don’t want to be the hospital’s third lung transplant. Do your research before selecting the hospital.

“How do you tell a good nursing home from a bad one?”

In 2001, the Centers for Medicare and Medicaid Services (CMS) reported to Congress that *91% of nursing homes in the United States did not have sufficient staff to prevent harm to residents*. The Centers for Medicare and Medicaid Services released the “National List: Nursing Homes Targeted for High-Risk Pressure Ulcer (bedsores)

and/or Physical Restrain Improvement”, and 4,000 nursing homes were found deficient in these two important categories of care. The prevalence of pressure sores and the use of restraints are indicators of neglect and insufficient staff.

The smaller the underpaid and non-skilled staff is, the more money that can be made by nursing homes. There are strong financial incentives for nursing homes to cut corners not only in the number of staff, but also in the training and qualifications of the skilled staff. Most of the revenue of nursing homes comes from Medicare and Medicaid, but the owners of nursing homes need not account to Medicare or Medicaid for how they spend the money they are paid. As a result, the number of lower paid, less trained nursing assistants have increased.

The number of ratio of aides/nurses to residents may be one aid for 15 residents during the night and it is not unusual to find a lone nurse or aid caring for as many as 30 residents. The low staffing will result in poor quality of care, such as malnutrition of residents, bedsores, urinary tract infections, residents confined to their chairs or bed, and neglect.

The New York State Department of Health measures performance rankings of all nursing homes in New York at the Department of Health’s Nursing Home Profile at www.nursinghomes.nyhealth.gov/nh-quality For each quality measure, the nursing homes in New York are divided into five groups according to their scores, with roughly 20% of the nursing homes in each group.

The quality measure performance rankings show how the nursing homes rank in relation to other nursing homes in New York. There are performance rankings for the percentage of residents with urinary tract infections, the percentage of residents who were physically restrained, the percentage of residents who have pressure sores, the percentage of residents who lose too much weight, and the percentage of residents who have had a catheter inserted and left in their bladder.

The performance ranking for the percentage of residents with urinary tract infection is a good indicator of the sanitary practices of the nursing home. Most urinary tract infections can be prevented by keeping the area clean, emptying the bladder regularly, and drinking enough fluid. The nursing home staff should make sure the resident has good hygiene.

Medicare also provides performance ranking measures of nursing homes at its webpage, www.Medicare.gov/NHCompare. At this useful website, Medicare lists specific information for nursing homes throughout the United States concerning nursing home staffing, quality measures, and health inspections, and you can compare up to three nursing homes in each category.

“When is the best time to visit an Emergency Department?”

A 2007 study by the Institute of Medicine found that hospital emergency departments are overburdened, under-funded and

ill-prepared to hand disasters as the number of people turning to emergency departments for primary care keep rising. An ambulance is turned away from an ER once every minute, according to the study.

If possible, avoid the ER between 3 p.m. and 1 a.m.—the busiest shift. For the shortest wait, early morning between 4 a.m. and 9 a.m. is the best time for a visit to the ER.

If you can, stay away from hospitals during the summer, especially July. That's the month when medical students become interns, interns become residents and residents become fellows and doctors. The adjusted mortality rate rises 4% in July and August for the average teaching hospital, according to the National Bureau of Economic Research.

“I really like my doctor. Does that mean anything?”

Not necessarily. Studies from both the *Annals of Internal Medicine* and the *British Medical Journal* did not find a strong correlation between patient satisfaction and the quality of care. In other words, just because you like your doctor doesn't necessarily mean he's a competent physician.

Satisfaction scores can help physicians improve their patient relations, but it's a mistake to use patient satisfaction as a doctor's report card on the quality of their care.

“What are the most important questions to ask my primary care doctor?”

Are you board certified? This is an absolute must.

Where do you admit patients? This will let you know what hospital to use if necessary.

Do you take care of patients in the hospital? This is good to know. If your doctor says yes, you should ask how many hospitalized patients does he/she see every year and who covers the hospital when he/she is not available.

Who answers your calls and how do I get in touch with you? Some practices use answering services, which are okay, but sometimes you need to speak with the doctor.

What are your after hours and weekend availability? You don't control when you get sick, so you need to know who will see you at night or on the weekend and where.

“How do I find out if my doctor has practiced in another state?” You can find out this information through the website, www.docinfo.org, of the Office of Professional Medical Conduct of the Federation of State Medical Board's (FSMB), which provides you with information on physicians and physicians' assistants licensed in the United States, including information on disciplinary sanctions, education, medical specialty, licensure history and locations. You can also reach the FSMB by calling 817-868-4000.

The website, docinfo.org, will provide you with information about your physicians' medical license and disciplinary history in states throughout the United States, whereas the website of New York's Office of Professional Medical Conduct, www.nydoctorprofile.com, limits the physicians' background history to disciplinary action just within New York.

“Is a nurse practitioner just as good as physician?”

With a shortage of primary care physicians, many states are expanding the authority of nurse practitioners. Nurse practitioners are registered nurses with an advanced degree in nursing, who have the power to practice without a physician's supervision, prescribe controlled substances and perform most of the same tasks of a physician.

The American Medical Association believes that a doctor shortage is not a reason to put nurses in charge and endanger patients. Nurse practitioners, on the other hand, say there is no danger and that they are as highly trained and as skilled as doctors.

Will the expanding role of nurse practitioners be good for patients? Generally, nurse practitioners are capable of treating routine and common illnesses. However, if you have a complex medical condition or a potentially life-threatening medical issue, you should insist on a doctor. Doctors possess much more training, education and knowledge than a nurse practitioner.

DEADLY MISTAKE #4

MISUNDERSTANDING THE IMPORTANCE OF MEDICAL RECORDS TO YOUR CASE

A common scenario is that a new client will call me with a potential case and tell me that he already has *all* of the medical records. When the medical records are given to me by my new client, it is almost never the case that the hospital or doctor's office gave all of the records to the client. How do I know? Most of the time there are critical records that are missing from a standard medical chart, such as lab reports or reports of imaging studies, and in many cases, the client possesses only a fraction of the entire medical chart.

Clients often explain that they requested "everything" from the hospital and assumed that the hospital complied with his request. Bad assumption! Unfortunately, "everything" is almost never provided to the client.

This can be avoided by specifically requesting an appointment at the hospital or doctor's office to copy and inspect the medical records in their entirety.

"How long should it take to get my medical record?"

Section 18(2) of the Public Health Law requires that *within 10 days of the written request* for access to the medical records, the health

care provider must give the qualified person the opportunity to inspect the medical records. Hence, your health care provider must let you inspect or see your medical records within ten (10) days of your request.

Public Health Law sections 17 and 18(2)(a), and (d) gives a patient the right to inspect his or her medical information contained in the custody of a healthcare provider and to obtain a copy thereof upon payment of reasonable fees. A physician cannot refuse to let a patient see medical records because of an unpaid bill. For more information, contact the Access to Patient Information Program at 518-402-0814.

“Can I be charged for looking at my medical records?”

No. While New York law permits a provider to charge an “inspection fee” if you simply want to look at your records, the HIPAA Privacy Rule does not. Since the HIPAA Privacy Rule provides more protection of your rights, your health care provider must follow the HIPAA Privacy Rule. Your health care provider cannot charge you an inspection fee.

You cannot be charged a fee for the custodian of the medical records searching for your records. This fee is sometimes called a “retrieval” or “clerical” fee and they are not permitted.

“How do I request my medical records?”

You should call your health care provider about his specific procedures for getting your medical records. Your physician may have a form for requesting medical records. You should be able to find information about getting your medical record in your physician’s notice of privacy practices.

“What information should be included in the request for medical records?”

Other than your name, date of birth and address, your request might include: Dates of treatment, whether you want the entire record or just part of the record, specific test results, whether you want copies of imaging films, such as X-rays or CT scans, and whether you want to see your medical record, want a copy of your record, or want both.

“Am I forced to choose between seeing my medical record and getting a copy of it?”

No. You have the right to do both.

“Can I ask my doctor to mail the medical records to me?”

Under the federal privacy rule established by HIPAA, a “covered entity”, such as a physician or hospital, must

accommodate “reasonable” requests by patients to receive the medical records. This means that a practitioner cannot require the patient to come to their office to pick up the record. If you ask that your medical record be mailed or faxed, your physician or hospital cannot refuse to do so as it is a “reasonable” request.

“What do I do if the doctor refuses to let me see my medical records?”

If the medical provider refuses to allow you to see your medical records within 10 days of your request, you should send a letter by certified mail to the physician notifying him that you intend to notify the New York State Department of Health about his non-compliance with sections 17 and 18(2)(a) and (3) of the Public Health Law. This almost always ensures a rapid response from the physician.

Never assume the doctor has provided you with all of your medical records

Keep in mind that the doctor’s office typically will produce only the paper copy of your medical records, and unless you ask, you will not be shown the electronic records kept by the doctor. You should specifically ask to see the electronic records maintained by the physician.

When you go to copy and inspect your medical records, it would be ideal to bring a color scanner to scan the records in color.

“Who owns the medical records?”

Under 10 New York Code, Rules and Regulations section 405.10(a)(3), the medical care providers have a legal duty to keep and maintain the medical records. The medical records are the property of the hospital and/or medical group, but the information in the record belongs to the patient, who retains the right to direct the transfer of such information.

Under New York law, the health care provider owns the actual medical records. If your health care provider maintains paper medical records, your provider has the right to keep the original record. You have the right to see and get a copy of it.

“How long are health care providers required to keep my medical records?”

Under New York law, health care providers must keep medical records for a minimum period of time. Physicians and hospitals are required to keep medical records in their “original or legally reproduced form” for a period of at least six years from the date of discharge or three years after the patient’s age of majority (18 years of age in New York), whichever is longer or at least six years after death. 10 N.Y.C.R.R. section 405.10(a)(4). Many health care

providers keep their records longer than the minimum period of time permitted under New York law.

“Can I make changes to the medical records?”

Under Public Health Law section 18(8), entitled “Challenges to accuracy”, you have a right to see, get a copy of, and amend your medical record as long as the health care provider has it. When you read your medical records and you find something that is not accurate, you have the right to amend your medical record by adding information to your record to make it more complete or accurate. This right is called the “right to amend” your medical records.

There are two ways to amend your medical record: (1) You can write a statement and give it to your health care provider to add to your medical record under New York law, or (2) You can ask that your health care provider amend your record under the HIPAA Privacy Rule.

If you give your physician a written statement challenging your medical records, your health care provider must make this statement a permanent part of your medical record (Public Health Law section 18(8):“This statement shall become a permanent part of the patient information and shall be released whenever the information at issue is released.”) You do not have the right under New York law or the HIPAA Privacy Rule to have information removed from your medical records.

If there is someone who acts as your personal representative, they usually have the right to get and amend your record on your behalf. A personal representative is a person who has the right to make health care decisions on your behalf.

Generally, a parent has the right to get and amend a minor's medical record related to treatment. In New York, you have these rights until your child turns 18.

“How can I ask my physician to change my medical record?”

Before making this request, you should identify the part of the medical record that you believe is inaccurate or incomplete, and identify the health care provider that made the entry in your medical records.

Your physician is allowed to require that you give him a reason that you want to change your medical record. Your request should include the type of information you want to change, a description of the information you believe is inaccurate or incomplete, the information that you want them to add to your record, and the reason why the information should be added.

You do not have the right to have information that is in your record removed or changed. You only have the right to add information.

Within 60 days after your physician receives your request, he must either: add the information to your medical record as requested, or deny your request in writing.

“Who can get the medical records when a family member dies?”

If a family member dies, a distributee of the decedent, or the holder of a power of attorney, has the right to obtain the decedent’s medical records as long as he/she provides a copy of a certified copy of the death certificate. Public Health Law section 18(3)(g). It is not necessary to have a personal representative of the decedent’s Estate appointed in order to get the medical records.

If the holder of a power of attorney requests the medical records, a copy of the power of attorney must be provided with the request for the medical records. Section 18(3)(g) provides that: “Where the written request for patient information... is signed by a distributee of a deceased subject for whom a patient representative has not been appointed, or from the holder of a power of attorney from such a distributee, a copy of the certificate of death of the subject shall be attached to the written request.”

A “distributee” is most often the spouse of the decedent, and if the decedent has surviving children, the decedent’s children. If the decedent is not survived by a spouse or children, the distributee will be his/her parents, under section 1-2.5 of the Estates, Powers

and Trusts Law. A request for medical records must be made in writing either to the individual physician or the health care facility.

“What happens if I cannot afford to pay the copying fee?”

Under New York law, you cannot be denied access to your medical records because you are unable to pay the copying fee. Public Health Law section 17 (“A release of records under this section shall not be denied solely because of inability to pay.”) Your health care provider also cannot deny your request for medical records because you have an unpaid medical bill.

“Does my physician have rules about access to medical records?”

The Health Insurance Portability and Accountability Act (HIPAA) requires that physicians inform patients of their right to get a copy of their medical records and describes when access to these records may be granted to others.

The *Notice of Privacy Practices* is a notice required under the HIPAA Privacy Rule that lists a person’s right to obtain and correct their medical records. The notice also describes when a health care provider can use and disclose health information. The Notice of Privacy Rights must give the name and telephone number of a contact person who is able to answer questions about getting and amending medical records. A physician must give a Notice

of Privacy Rights to a patient on their first visit and upon the patient's request.

“What are my rights under the HIPAA Privacy Rule?”

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and New York laws give you rights to your medical records. The HIPAA Privacy Rule establishes standards that apply to records held by health care providers across the nation, and New York law sets standards for records maintained by health care providers within the state. Health care providers in New York must follow both the HIPAA Privacy Rule and New York law.

HIPAA is intended not only to protect your medical information from unwarranted disclosure, but also to protect your rights as a patient. Here's how you can exercise those rights:

Conditions: If you are a patient in a hospital, people who call to obtain a condition report will be given a one or two word summary, such as “serious” or “critical.” If you don't want that summary given, you have the right to request non-disclosure.

Observers: If you are being examined by a physician and your treatment is being observed by others who aren't participating in your care, such as sales representatives, consultants or office administrators, you can ask them to leave the room.

Forms: Read carefully any privacy forms you are asked to sign. Some forms that at first appear only to be an acknowledgment of your rights also provide authorization for sharing of information for marketing purposes, which is allowed under HIPAA. You should not be required to sign any disclosure-consent forms as a condition of treatment.

Surveys: Customer-satisfaction surveys are given to patients by many clinics and hospitals. You are not required to complete them, but they can help providers improve patient care. Be wary of questions about your age, income level, buying habits and ZIP code. They're more likely to be used for marketing purposes.

Policies: You should obtain copies of your care provider's "notice of privacy practices" and the name and phone number of the provider's privacy officer.

Database: You can access some of your medical information at no charge each year from the Medical Information Bureau.

Your medical records may be disclosed without asking or even notifying you. Hospitals will hand over information regarding your treatment to other doctors, and they will readily share those details with insurance companies for payment purposes. Roughly millions of entities that are loosely involved in the health care system have access to your health care information.

The Medical Information Bureau (MIB) is a central database of medical information shared by insurance companies.

Approximately 15 million Americans and Canadians are on file in the MIB's computers. Insurance companies report information to the MIB, such as codes for specific medical conditions and lifestyle choices, i.e., hypertension, asthma, diabetes or depression.

The MIB does not have a file on everyone. But if you have a MIB file, you will want to be sure it's correct. You can obtain a copy for free once a year by calling (866)692-6901 or by visiting the MIB's website, www.mib.com, or you can contact the MIB at the Medical Information Bureau, P.O. Box 105, Essex Station, Boston, Massachusetts 02112, or by sending an e-mail to infoline@mib.com.

Disclosures: If you suspect your medical records have been improperly shared, you can ask providers for an accounting of all disclosures. Under HIPAA, you have the right to receive an accounting of disclosures that a "covered entity", i.e., physician or hospital, make of your medical records in the six-year period preceding the date on which the accounting is requested.

Enforcing HIPAA: Civil enforcement of HIPAA, which can lead to fines, is left to the Office of Civil Rights within the U.S. Department of Health and Human Services. Criminal enforcement, which can include fines and prison terms, is handled by the U.S. Department of Justice.

Case: Of 38,000 HIPAA complaints made across the nation in the past five years, the Office for Civil Rights has referred 437 cases to the Department of Justice for criminal prosecution.

Outcome: Nationally, fewer than a half-dozen cases have been prosecuted. No civil fines have been imposed, but one case recently led to a \$100,000 settlement. So far, prosecutors have focused almost exclusively on the few people who have gained access to patient information with the intent of selling it or using it as part of some other crime, such as identity theft. Health care workers who have obtained medical information improperly and then shared it, free of charge, with friends and neighbors, have not been prosecuted.

“What law determines my rights to my medical records, HIPAA or New York law?”

Both. The HIPAA Privacy Rule, effective beginning April 14, 2003, is the first ever federal privacy standards to protect patient’s medical records and other medical information. The federal privacy standards established by HIPAA do not affect state laws that provide additional privacy protections for patients.

The HIPAA Privacy Rule sets a national “floor” of privacy standards that protect all Americans, and any state law providing additional protections, such as New York’s Public Health Law sections 17 and 18, continues to apply. You can rely upon both the HIPAA Privacy Rule and New York’s Public Health Law in asserting access to your health care records.

“How do I file a complaint about a HIPAA violation?”

Here’s how to file a complaint about a HIPAA violation: Complaints go to the U.S. Department of Health and Human Services’ Office for Civil Rights. The Office for Civil Rights investigates complaints against many different types of entities, including national pharmacy chains, major medical centers, group health plans, hospital chains, and small provider offices. However, the office tells consumers that it “cannot look into all civil rights or privacy complaints.”

Complaints must be made in writing. You can download a complaint form from www.hhs.gov/ocr and follow the link marked “How to file a health-information privacy complaint.” Complaints typically must be filed within 180 days of a violation.

“What if my doctor refuses to provide the medical records to me?”

Don’t be surprised. Doctors in small medical practices often refuse to allow their patients to have access to medical records. This is when you assert your rights!

This book gives you citations to the law that require the health care provider to allow you to inspect and copy of the medical records. The first step is to advise the health care provider of your rights under the law and ask the doctor to explain in writing why he is not complying with your statutory rights. If this fails, you should notify the physician that you intend to make a complaint

wit the NYS Department of Health about his refusal to permit access to your records. At that point, you will almost always receive cooperation from the physician.

“What the hospital does not want you to know about paying your bill”

Everything is negotiable, even your hospital bill. If you are among the uninsured—who can pay up to three times more for procedures—it does not hurt to ask for a reduction in your hospital bill. Some hospitals provide a 40% discount for uninsured patients and hospitals frequently work with patients offering payment plans or discounts. In some cases, the hospital will waive its bill completely.

You should look for the office of patient accounts or the financial assistance office at the hospital. The staff in this office will explain the procedures for seeking a reduction or waiver of your hospital bill.

“What are the three most important records in a nursing home?”

There are three specific documents that are required on all nursing home charts under federal law known as the Omnibus Budget Reconciliation Act (OBRA). If you are concerned about care provided to you or a loved one at a nursing home, you should ask to review the Minimum Data Set (MDS), the Resident

Assessment Protocol (RAP) and the individual Care Plan with the medical director of the nursing home.

#1: Minimum Data Set (MDS): The Minimum Data Set is a comprehensive assessment of the resident's functional capabilities and helps the nursing staff identify health problems. Certain items on the MDS will indicate that a resident is at risk, i.e., falling, pressure sores, urinary tract infections, etc. When a MDS shows a health problem, it triggers the Resident Assessment Protocol.

#2: Resident Assessment Protocol (RAP): After the Minimum Data Set is completed, a resident who has one or more risks (also known as "triggers") will trigger a Resident Assessment Protocol. This form is to provide clues as to risks presented by residents in nursing homes. The Resident Assessment Protocol is the foundation upon which a resident's individual Care Plan is formed.

#3: Care Plans: The Care Plan should contain interventions to minimize injuries. Examples of such interventions include the use of a sitter and the use of bed and chair alarms for residents at risk of falling.

How you can waive your legal rights by signing the informed consent document before your operation

An informed consent document is a form that your doctor will ask you to sign before you have an operation. The content of

the informed consent document varies for every physician and hospital and in some cases, particularly in ophthalmology and plastic surgery, you may be waiving your legal rights when you sign the document. For example, a plastic surgeon may require that you sign an informed consent document before your operation that reads as follows:

Should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as Dr. Jones [fictitious name]...Finally, you (the patient) agree that counsel for me (physician) shall have the right and be free to depose such expert witnesses at least 120 days before any scheduled trial date... Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses and attorney fees associated with the litigation.

What's wrong with this? Under New York law, the defendants have no right to take a deposition of the plaintiff's expert witnesses and further, the defendants are not entitled to disclosure of the identity of your medical expert witness. Furthermore, it is a basic principle of law that the successful party in personal injury and medical malpractice lawsuits is not entitled to recover attorney fees against the losing party. Hence, in this case, the physician is

attempting to deprive you of basic rights by asking you to sign the informed consent document.

By signing this informed consent document, you are signing away basic rights that you have under New York law. In 95% of situations, the patient is anxious about his/her operation and signs the informed consent document without reading it. In the remaining 5% of the cases where the patient actually reads the informed consent document, he/she has no idea about their legal rights under New York law and will likely assume that the conditions set forth in the informed consent document are reasonable, fair and comply with the law.

You should ask your physician to review the informed consent document with you in the office setting days before the operation (rather than on the morning of the operation), so you are not under pressure to sign it and can ask the physician questions about the risks and complications of the operation. You may ask the doctor to remove portions of the informed consent document that you find objectionable. It can't hurt to ask and you will be surprised that most physicians are not familiar with the form and have never explained it to any of their patients.

DEADLY MISTAKE #5

FAILING TO FILE A COMPLAINT WITH THE DEPARTMENT OF HEALTH

Many malpractice trials boil down to the so-called “battle of the experts,” with medical experts on each side taking conflicting positions. Even though the facts of your case may have overwhelming evidence of medical neglect, the jury is left to decide which expert is telling the truth—often an impossible task for a jury with no medical training or expertise.

How do you prove that the defense expert is a liar? The first step is filing a complaint against the physician or hospital with the New York State Department of Health. The Office of Professional Medical Conduct (“OPMC”) is responsible for investigating complaints about physicians, physicians’ assistants and specialist assistants. The OPMC also monitors practitioners who have been placed on probation.

The Department of Health, Office of Professional Medical Conduct, investigates all reports of possible professional misconduct by physicians and physicians’ assistants. An investigation may result in a formal hearing before a committee of the Board for Professional Medical Conduct. Information regarding final disciplinary actions taken against the New York medical licenses of physicians and physicians’ assistants is a matter of public record.

You can file a complaint against a physician with the New York State Department of Health, Office of Professional Medical Conduct at the New York State Department of Health, Office of Professional Medical Conduct, 433 River Street, Suite 303, Troy, New York 12180-2299. Complaints must be in writing. You can get information about filing a complaint and download a complaint form at: www.health.state.ny.us/nysdoh/opmc/main.htm You can also call 1-800-663-6117 to get a complaint form or if you have questions.

Findings of medical neglect issued by the Department of Health are sometimes admissible in evidence at a trial, and when admitted into evidence, such findings can be very powerful in convincing a jury that your medical expert is telling the truth. The “battle of the experts” is no longer a battle with this powerful evidence in hand.

“What is the procedure at the Office of Professional Medical Conduct for determining whether my complaint has merit?”

Written complaints are reviewed by the OPMC investigative and medical staff. Complaints that raise possible misconduct issues are assigned to investigators and OPMC medical coordinators provide clinical advice to the investigators.

Typically, complainants, doctors and others involved are interviewed. Interviews may be conducted over the telephone or may be in person. Complainants’ identities are kept confidential.

If an investigation uncovers sufficient evidence to suggest misconduct, the case is presented to an investigation committee consisting of two physicians and one lay person drawn from the Board of Professional Medical Conduct (the “Board”). The committee can recommend to the Director any of the following: a hearing, additional investigation, a dismissal of the matter, or non-disciplinary warnings or consultations.

If the investigation committee finds evidence suggesting misconduct, or if the commissioner orders a summary suspension, charges are filed against the physician and a hearing is held. If sufficient evidence suggesting misconduct is not found, the investigation is terminated and the case is closed. A record of the investigation remains in OPMC files for future reference.

Cases ordered to hearing go before another committee of the Board, also consisting of two physicians and a lay member, which hears and reviews evidence from both sides. The physician and the state are usually represented by counsel who introduce evidence and call and question witnesses. The committee rules on the case and determines if a penalty is warranted.

The hearing committee decision may be appealed by either side to an Administrative Review Board composed of three physicians and two lay members of the Board of Professional Medical Conduct.

The Board of Professional Medical Conduct has the authority to take action against a physician’s license. A physician’s license can

be revoked or suspended. The Board can also limit a physician's license; issue a censure and reprimand; or education or retraining; levy a fine; or require community service.

Investigative files are confidential and are not disclosed to complainants or physicians.

In the case of a hospital, if the investigation by the Department of Health substantiates the allegations in your case, it will issue a formal document that lists the deficiencies and preventable medical errors; in the case of hospitals, it will require that the hospital submit a plan of correction to ensure that future medical errors are prevented.

“What information should I include in my complaint to the OPMC?”

On the complaint form, you should describe your complaint as thoroughly as possible and include the names, addresses and telephone numbers of witnesses. When preparing a complaint for a client, I often prepare a memo summarizing the facts and annex a copy of the medical records to the complaint form in order to confirm the content of the complaint.

“How do I file a complaint against a hospital?”

If you have a complaint about a hospital, you can call the toll-free telephone number, 1-800-804-5447, or you may file a complaint and send it to the New York State Department of Health,

Centralized Hospital Intake Program, 433 River Street, 6th Floor,
Troy, New York 12180.

“How do I file a complaint against non-physicians, such as nurses, dentists and physical therapists?”

If you feel you received negligent care from healthcare professional, such as nurses, dentists, social workers, optometrists, psychologists, physical or occupational therapists, or podiatrists, you can file a complaint by contacting the New York State Education Department, Office of Professional Discipline, 475 Park Avenue, Second Floor, New York, New York 10016. The complaint hotline is 1- 800-442-8106. You can get information about filing complaints, getting a list of regional offices and downloading a complaint form at www.op.nysed.gov/opd.htm or www.op.nysed.gov/faq.htm#complain.

If the investigation by the Education Department, Office of Professional Discipline substantiates the allegations in your case, it will issue a formal document that lists the deficiencies and preventable errors.

You can also find out if a dentist has any kind of legal action taken against him or her by contacting the Department of Education. To get a full copy of the actions taken against a dentist, you must send a written request that includes the name, profession and license number of the dentist to the New York State Education

Department, Division of Professional Licensing Services, Room 3045, Cultural Education Center, Albany, New York 12234.

“How do I file a complaint against a nursing home?”

The New York State Division of Quality and Surveillance for Nursing Homes and Intermediate Care Facilities (DQS) is responsible for investigating complaints and incidents against nursing homes in New York State. Complaints and incidents may be submitted by fax (518-408-1157) or by mail to: Centralized Complaint Intake Unit, 161 Delaware Avenue, Delmar, New York 12054. You can also call the NYS Department of Health’s Nursing Home complaint hotline at 1-888-201-4563, available 24 hours a day, 7 days a week.

The most serious complaints and incidents require Department investigators to conduct interviews, review medical records, and other facility documentation, and perform other activities onsite at the nursing home. If an investigation determines that any of the allegations did occur, then the allegation is sustained.

The investigation will also determine whether a nursing home has failed to meet federal and/or state regulations. In cases where the Department of Health determines that the nursing home violated a regulation, the Department will issue a citation to the nursing home. The nursing home must then submit a plan of correction

that is acceptable to the Department of Health and correct the deficient practice.

Additionally, the State Office for the Aging (SOFA) employs an ombudsman in each County of New York. An ombudsman is an advocate for residents of nursing homes and assisted living facilities. Ombudsmen provide information about how to find a nursing home that is right for you or your family member and what to do to get quality care. The ombudsman can also assist you with a complaint against a nursing home. The State Office for the Aging can be reached at 1-800-342-9871.

DEADLY MISTAKE #6

NOT GETTING CLEAR ANSWERS FROM YOUR DOCTOR

A vast majority of patients leave their doctors' offices or the emergency room without understanding the treatment they received, or how to care for themselves once they get home. This can lead to medication errors and serious complications that can send them right back to the hospital.

In a recent study, patients discharged from emergency departments were asked for their understanding in four areas—their diagnosis, their ER treatment, instructions for their in-home care, and warning signs of when to return to the hospital.

The study, published online by the *Annals of Emergency Medicine*, found that 78 percent of patients did not understand at least one area and about half did not understand two or more areas. "Patient Comprehension of Emergency Department Care and Instructions: Are Patients Aware of When They Do Not Understand?" *Annals of Emergency Medicine*. The greatest confusion surrounded home care—instructions about things like medications, rest, wound care, and when to have a follow-up visit with a doctor.

The researchers described a woman in her twenties who went to the emergency room with abdominal pain. After extensive testing, doctors there diagnosed pelvic inflammatory disease, a sexually

transmitted infection. But when interviewed by a researcher, the woman said that she was not aware of any diagnosis, that she did not realize she had been sent home with an antibiotic (she only took the pain medication she was given), and that she did not know she should abstain from sex, tell her partner or have follow-up care.

Similar results have been found for patients leaving hospitals, not just emergency rooms. Everything is exaggerated in the emergency department. Doctors are busy, they have little time to go over complicated information and they do not know the patients. Most patients are anxious, upset and not likely to be thinking clearly. This is not the best environment for someone to remember information.

The problem is particularly acute when it comes to drugs. A patient-education program used in 130 health delivery systems across the country found that about 40 percent of patients 65 or older have a medication error after they leave the hospital. A 2006 report by the Institute of Medicine found that doctors and nurses were contributing to these errors by not providing information in an effective way.

Patients who did not follow discharge instructions are often labeled as “non-compliant.” However, doctors are notoriously inept at communicating to patients.

The new study found that people were not aware of what they did not understand, suggesting that simply asking a patient if

he understands is not enough. Older patients are particularly vulnerable with communication barriers, such as vision and hearing problems.

Experts in doctor-patient communication recommend a “teach back” approach, in which the patient, preferably accompanied by a relative, friend or caregiver, has to repeat the instructions back to the doctor.

When talking with your doctor, always ask if you do not understand specific words the doctor is using or what your doctor is recommending is not clear. Make sure you leave your doctor’s office with a clear understanding of: (a) your diagnosis, (b) your treatment, (c) at-home care and (d) warning signs of when to return to the hospital or doctor’s office.

For example, you should ask your doctor and insist on answers to the following questions:

What is my diagnosis?

If your diagnosis is unknown, ask: What is the differential diagnosis? Among the possible diagnoses, which is most likely and why?

Have you dealt with patients with problems like mine before?

What is the usual course of treatment for my condition?

What can I do to get better?

How soon can I expect to feel well again?

All patients in New York State hospitals must receive a written discharge plan and a written discharge notice before they leave the hospital. This plan should describe the arrangements for any health care services you may need after you leave the hospital. Patients must be provided with the opportunity to sign the discharge documents and receive a copy of the signed documents. 10 N.Y.C.R.R. section 405.9(g)(1), 405.9(g)(3)(i).

It's up to the patients to get the information they need. Do not be afraid to ask questions, call, or return to the hospital or doctor's office if you do not understand something.

DEADLY MISTAKE #7

NOT ASSERTING YOUR RIGHTS AS A PATIENT

I saved my most important tip for last: BE YOUR OWN HEALTH CARE ADVOCATE! Most medical mistakes are easily preventable.

“How do I assert my rights in a hospital?”

New York’s Patient Bill of Rights is contained in the Public Health Law section 2803(1)(g), and 10 N.Y.C.R.R. sections 405.7, 405.7(a) (1) and 405.7(c). Every hospital in New York is required to give a written copy of the Patients’ Bill of Rights to each patient at or prior to the time of the admission to the hospital. Unfortunately, this is almost never done.

New York’s Patient Bill of Rights states that: “As a patient in a hospital in New York State, you have the right, consistent with law, to”, among other things:

Be informed of the name and position of the doctor who will be in charge of your care in the hospital. (#5 of the Patients’ Bill of Rights)

Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation. (#6 of the Patients’ Bill of Rights)

Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge. (#14 of the Patients' Bill of Rights)

Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay. (#15 of the Patients' Bill of Rights)

Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number. (#17 of the Patients' Bill of Rights)

You have the right to know about your medical condition. You must talk to your doctor about your health care questions.

You have the right to be fully informed about decisions affecting your care. SPEAK UP, PLEASE.

You have the right to designate a representative to act on your behalf.

You have the right to receive all of the hospital care you need for the treatment of your illness or injury.

“Who’s in charge at the hospital?”

Who’s in charge? Getting the attention of the right person can be difficult in a hospital.

Nurses do not report to doctors, but rather to nurse supervisors. Some hospitals employ “hospitalists”—doctors who act as a point person to conduct the flow of information. In the hospital, you will be faced with doctors and nurses who you don’t know and have never treated you. The new doctor and nurses are unfamiliar with your medical background, and you do not know who to turn to for answers.

Because of the confusion as to who is in charge, you should ask, “Who is the *attending physician* for me?” The term, “attending physician”, has special meaning in a hospital. The attending physician’s name is listed in bold print at the top of your medical chart and the attending physician is ultimately responsible for the care provided to you. In most cases, you can learn the name of your attending physician simply by looking at the top of the first page of your medical chart and if not, you should ask your nurse or the nurse supervisor, “Who is my attending physician?”

Once you have identified the name of your “attending physician”, you then know who you can turn to for answers. You should insist upon a face-to-face meeting with your attending physician and during the meeting, you should ask for the attending physician’s cell phone number in case you want to speak with him/her again. The attending physician will coordinate all of your treatment at the hospital and he/she is the person who you turn to for answers.

When you need answers from the person “in charge” of your care at the hospital, make sure you speak with your attending physician.

“When I am getting no answers from the doctors and nurses at the hospital, who can I turn to for answers in the hospital?”

Ask to speak with the Patient Representative. The Patient Representative is a member of the hospital staff who serves as a link between the patient, family, physicians and other hospital staff. The Patient Representative should be available to answer questions about hospital procedures, help with special needs or concerns and solve problems. The Patient Representative should be familiar with hospital services and assist you. There is no charge for services provided by the Patient Representative.

“Can I designate a family member to make decisions and get answers for me?”

New York State has a law that permits you to appoint someone you trust, such as a family member or close friend, to act as your Health Care Agent, to ask questions of the care providers and decide about your treatment. If you ask a nurse at the hospital for a Health Care Proxy Form, you can authorize a family member or friend to act on your behalf regarding your medical treatment.

“What do I do if I am denied access to my medical records?”

New York State Law requires all health care practitioners and facilities to grant patients access to their medical records. If the hospital or physician fails to acknowledge and act on your request, you should complain to the New York State Department of Health by calling 1-800-804-5447.

If you have been denied access to all or part of your hospital records, you may also appeal to the New York State Department of Health Medical Records Access Review Committee. The hospital/doctor is required to provide a form (DOH-1989) that gives the reason(s) for denial and information on the appeals process.

“What are my rights in a nursing home?”

Under federal regulations, all nursing homes must have written policies that describe the rights of the residents. The nursing home

is required by law to make this policy statement—the “Nursing Home Resident’s Bill of Rights”—available to any resident who requests it.

The rights include the right to be informed about your medical condition, the right to participate in the plan of care, the right to choose your own physician, and the right to be free from physical restraints. Upon your admission to the nursing home, you should make sure that you get a copy of the “Nursing Home Resident’s Bill of Rights”, so you have a clear understanding of your rights in a nursing home.

“How do I prevent the most common medical mistake?”

A study recently released by Resources for the Future, a nonprofit group that conducts independent research on public health issues, found that infections of sepsis and pneumonia acquired in the hospital kill 48,000 people each year. According to the study, these infections cost \$8.1 billion to treat and lead to 2.3 million total days of hospitalization. Further, the Centers for Disease Control and Prevention estimate that *between 10% and 20% of hospital patients acquire infections in the hospital.*

Even today, doctors tell their patients that hospital-acquired infections are not preventable even with the best care. An 18-month study by Johns Hopkins University has proven this theory wrong.

For 18 months between 2005 and 2006, more than 100 Michigan hospitals enrolled their intensive care units in the initiative known as the Michigan Keystone ICU Project. The project targeted a specific type of infection that ICU patients can get while in the hospital: catheter-related bloodstream infections, and involved having ICU personnel use a five-step safety checklist when inserting catheters into patients.

The simple five-step checklist required ICU personnel to take the following steps when placing a central line catheter: (1) wash their hands, (2) wear a mask, hat, gown and gloves, (3) put sterile drapes over the patient, (4) clean a patient's skin, and (5) remove the catheter as soon as it is no longer needed. The results were amazing.

The five-step checklist virtually eliminated bloodstream infections in hospitals' intensive care units to zero. Of the 127 intensive care units participating in the project, 103 Michigan intensive care units reduced catheter-related bloodstream infections to zero during the first three months of the study and up to 66% sustained the zero rates during the 18-month study period. This led to the near elimination of catheter-related bloodstream infections.

The best way to minimize infections in the hospital is low tech: make sure anyone who touches you washes his or her hands and follows the five-step checklist used in the Michigan Keystone ICU Project.

CONCLUSION

This book arms you with the information you need to make sure you are not another victim of medical malpractice that kills 98,000 Americans every year in hospitals across the United States. **ASSERT YOUR RIGHTS.**

You have the right and the responsibility to fully participate in all decisions related to your health care. If you are unable to fully participate in treatment decisions, you should be represented by parents, guardians or family members. **INSIST ON ANSWERS TO YOUR QUESTIONS!**

If you leave the hospital without a clear understanding about the diagnosis, prognosis and plan of treatment, you are not doing your job. Insist on seeing the medical records and have the records explained by the attending physician. If the attending physician is unavailable, tell the hospital staff that you want an appointment to meet with him/her. Do not accept the vanilla answers given by the nursing staff.

If the attending physicians cannot answer your questions, you should ask why and insist that a medical specialist treat you. While the hospital staff may be annoyed that you are asserting your rights, **WHO CARES!** You should be polite and respectful in asserting your rights, but always be firm.

The patient and the patient's family usually have a better idea that something is seriously wrong with the patient than the physicians or the nursing staff. **TRUST YOUR INSTINCTS!** Do not leave the hospital if your gut instincts are telling you that you are not ready to be discharged. Hospitals have policies that permit you to get the second opinion of a hospital representative if you feel that discharge from the hospital is not appropriate.

The number one mistake made by malpractice victims is the blind acceptance of the "wisdom" and advice of the health care provider. While it is natural to want to like your physician and trust that you are getting sound advice from him/her, the fact is that physicians are human just like you and I and mistakes not only occur, they are common.

Do not blindly accept the "wisdom" of the physicians and nurses. Learn everything you can about your medical condition through the internet and be prepared with a list of questions to ask your physician. If the physician cannot give you answers, you should insist on getting a second opinion from another physician.

DO NOT BE ANOTHER VICTIM! Assert the rights that you have and be a proactive advocate for your health and the health of your family.

CLIENTS SPEAK

“The court has seldom seen as thorough a job as was done here by plaintiff’s counsel.”

Honorable Beatrice Shainswit in *Ross v. Reliance*

“I want to thank you for all that you have done. You helped make an unbearable situation, easier by being sensitive, understanding, and so very helpful. I felt a little sad to get this letter as our final business together. Your hard work and determination has made a huge difference in my life. Thank you again and I wish you all the best. Hopefully I will see you around. With love.”

“Thank you for all your effort and work over the past few years. Your dedication and determination led to our favorable outcome.”

“I especially appreciate you being open and honest through this process. Your assistance, and knowledge has been invaluable to my brothers and I during this process.”

“I want to formally thank you and extend my gratitude from my family and me. You’re a great lawyer and seem like a great guy.”

“Thank you for your sincere effort in helping me to find someone to handle my case. I can’t tell you in words how wonderful it is to know someone cares enough to take the time and effort in helping a fellow human being. Thanks again for your kindness.”

“I have received your letter and paperwork. I wanted to write and convey my gratitude for looking into the situation. During our first meeting you were clear that there was a possibility that a case may or may not be made pending the outcome of your investigation. I have been quite satisfied with the work that you and your firm have done.”

“The mere fact that you looked into the situation has been a blessing. As mentioned before, regardless of the outcome, your assistance will reinforce the healing process.”

“Please reiterate my words of thanks to those in your firm who have taken the time to investigate and sequester medical records. You took the time and worked with me despite limited financial resources.”

“On behalf of my family, and myself thank you for all of your help and assistance these last couple years. You and your firm are a testament to your profession.”

“I just wanted to thank you again for helping me learn + grow at this firm. You are truly one of the most hardworking, ethical and

determined lawyers I've known. It was truly a pleasure to work on cases with you. God bless you + Lisa + the kids.”

“We volunteered to write this heartfelt endorsement of John Fisher. His professional, caring, protective and aggressive representation of our medical malpractice case enabled us to reach an out-of-court settlement. We were more than pleased with the outcome. We recommend him without reservation. He obtained a just result under trying circumstances.”

“John—words fall short—you are such a hard-working, intelligent, lawyer. The clients are fortunate to have you + I am very proud to work along side you.”

ABOUT JOHN

John's practice of law is unique in two respects: (1) John only practices in the area of personal injury and medical malpractice and he only represents the victims of such negligence. John does not represent insurance companies or defendants; and (2) John limits his practice to substantial and catastrophic injury cases.

John is highly selective in the type of cases that he accepts and the vast majority of cases are either rejected or referred to other counsel. By accepting a very small number of cases, John is able to make sure that each case gets the time and attention it deserves.

Since 1996, John has dedicated all of his time to the representation of seriously injured persons. John handles all types of medical malpractice claims, including many different types of birth injury cases involving cerebral palsy, brain injuries, microcephaly, pregnancy induced hypertension, brachial plexus injuries and premature delivery.

While the cases have ranged from brain damaged infants to paralyzed senior citizens, the one thing that does not change is the gratification that John gets from making a difference in the lives of his clients. To John, the practice of law is more than simply a way to earn a living, but the chance to make a lasting difference for his clients.

John has been recognized by his peers to be very highly rated in both legal ability and ethical practice by Martindale-Hubbell's

Peer Review Rating. John is a member of various professional organizations, including the American Association for Justice and the New York State Academy of Trial Lawyers and has lectured to paralegals, law students and civic organizations on numerous occasions. John particularly enjoys sharing his experiences as a personal injury lawyer with college and law students. Away from work, John enjoys spending time with his wife, Lisa, their three children, Alek, Tim and Liliya, and his bichon frise, Oscar.

John graduated from the University of Notre Dame with a Bachelor of Arts degree in Government in 1988 and graduated from University of Notre Dame Law School in 1991. John is admitted to practice law in New York, Connecticut and Illinois.

You can learn more about your rights as a patient by visiting John's website at www.protectingpatientrights.com, and subscribing to John's blog about patient rights on the website. The "frequently asked questions" section of John's website provides valuable information about the process of evaluating medical malpractice claims and the procedures that can be expected after the filing of a malpractice lawsuit.

WA

The Seven Deadly Mistakes of Malpractice Victims



JOHN H. FISHER

Many people don't realize that medical mistakes are the leading cause of accidental death in America. More people die each month from preventable medical errors than died in the 9/11 terrorist attacks, and the national death rate from preventable medical errors is fifteen times higher than the national murder rate!

Many people are shocked by these statistics. If you or someone you know is a victim of medical malpractice, this book will help you understand that you are not alone. This useful book helps prevent you from making the most common mistakes that can ruin your claim, from not getting clear answers from your doctor, to hiring the wrong lawyer for your case.

This important book will help you understand your rights as a patient or a patient's advocate so that you will be a much more powerful advocate for your family's medical care.

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