Strategies for Managing All Types of Crises

Since you first opened the doors of your medical practice years ago, you've probably handled hundreds, maybe even thousands of different types of clinical or health-related crises. But how good are you at resolving business crises?

Many physicians have trouble applying the same problem-solving skills they use to treat patients to a business crisis. When a crisis occurs, do you diagnose the problem, gather the facts, analyze the information, evaluate your options and apply the best solution? Do you implement strategies that may prevent a crisis or keep your practice healthy, which is really no different from offering advice to patients on how they can stay healthy? Have you ever consulted with an expert on ways to resolve a business crisis just as you would consult with a specialist about a patient's illness?

When a crisis occurs, do you diagnose the problem, gather the facts, analyze the information, evaluate your options and apply the best solution? Do you implement strategies that may prevent a crisis or keep your practice healthy, which is really no different from offering advice to patients on how they can stay healthy?

Many don't, which often lands them in financial or legal trouble. Even then, some physicians are reluctant to hire a consultant or attorney, figuring they can solve the problem on their own, but end up digging themselves into a deeper hole.

Examples of physicians in trouble are everywhere. Consider this one group of radiologists who built a practice and several outpatient centers over several years. They were so successful that the group began building additional centers, which were financed through a variety of funding vehicles, ranging from bank credit lines to real estate loans, says Robert James Cimasi, president of Health Capital Consultants, a healthcare consulting firm in St. Louis.

Earlier this year, one of the group's lenders—a company that loaned the practice approximately $2 million to lease major equipment—was acquired by another company. Mr. Cimasi says that the new lender began reviewing its agreements and quickly realized that the medical practice was not honoring the terms of its contract. For example, although quarterly financial statements were required, none were filed in almost three years, and some of the operating ratios were not in accordance with the agreement. So the company sent the practice a certified letter, notifying it that it was in breach of contract.

What Not to Do When Being Sued for Malpractice

It is surprising how many physicians go to great lengths to do all the wrong things when being sued, says Brian Steller, partner at Health Care Law Practice, Connell Foley LLP, in Roseland, N.J.

Mr. Steller details nine common mistakes that physicians make:

1. Telling no one about the complaint. If in a group practice, not advising your office manager, partners or superiors of the lawsuit because you plan to manage the matter on your own.

2. Immediately pulling your patient's office chart and hospital records and making handwritten changes.

3. Immediately contacting your broker and moving all investments into other family members' names.

4. Arranging an office and hospital staff meeting/review and blatantly excusing any mistake you may have made. Instead, you blame members of your staff.

5. Calling the patient who's suing you to suggest a private meeting in hopes that he or she will drop the suit.

6. Calling every expert in the field of medicine involved within 100 miles of your office to explain why you did not breach the standard of care in this patient's case.

7. Letting your ego run amok. Calling the plaintiff's lawyer, cursing him/her out and constantly reminding the attorney that he or she obviously doesn't know who you are.

8. Deleting/destroying all video film of the surgery in question and requesting all copies of the film from the records department.

9. Denying any wrongdoing and evidence to your attorney because if he or she truly believes you're blameless, the attorney will make it all go away.

The practice's chief financial officer opened the letter and showed it to the chief executive officer. The pair began brainstorming ways to resolve the crisis. If they acknowledged the breach of contract, that meant they were in breach of other agreements. Some of their creditors could take whatever legal action they wanted, which becomes public record and is tracked by all lending agencies. Anything could happen now, from equipment being repossessed to banks withdrawing money right out of the practice's account.

> **In a crisis,** be sure to get your staff on board, says Robert James Cimasi, president of Health Capital Consultants in St. Louis. Inform them of the crisis, but don't go into great detail. Require them to sign confidentiality agreements, and provide them with telephone scripts to help them deal with any press or vendors.

That's exactly what happened. Mr. Cimasi says one bank withdrew $1.2 million out of the practice's account but re-deposited the funds the next day after legal counsel contacted the bank, asking for time to straighten out the mess.

By now, the practice supported over 12 centers and more than 50 radiologists. There was little, if any, coordination between its doctors, administrators and external accounting and legal firms. Finger-pointing began among the physicians, administrators, consultants and even the physicians' wives. The group's greatest fear was that the local media would pick up the story. Besides receiving bad publicity, Mr. Cimasi says, the practice would have a hard time recruiting medical technologists, who have been in short supply for several years.

Meanwhile, Mr. Cimasi and his staff began search-and-rescue efforts. "It took us the better part of two months to sort out where all the lease documents were," he says. "Some were at various offices, some of the doctors had taken them home, different law firms had some, and some accounting firms had some. We found schedules that had been missing and acceptance forms that had been signed before the [equipment] had been sent."

He believes the radiologists have a one-out-of-20 chance that they're going to keep their business intact. But more than likely, several doctors will leave, and the group practice will have to divest locations and restructure the organization.

If physicians find themselves in a similar crisis, Mr. Cimasi

suggests they follow these steps:

1. Deliver bad news first. Remain calm and circle the wagons. Gather all of your practice's leaders to inform them of the crisis, and collect all of your financial documents. Now is the time for cool heads and for gaining complete command of the facts.

2. Appoint someone in charge. The person you want to handle this crisis must be objective and must have access to people directly involved in the crisis.

3. Communicate, communicate, communicate. Don't avoid lenders. Share all of your information with them. Organize the information in a comprehensible format so they can make sense out of it. For example, Mr. Cimasi developed 11-inch-by-17-inch tables that listed every lease the radiologist practice had along with loan numbers, schedules, date issued, what the loans were for, terms, back payments due, collateralizations, covenants and personal guarantees of the physicians. Also get staff on board. Inform them of the crisis, but don't go into great detail. Require them to sign confidentiality agreements—if they haven't done so already—and provide them with telephone scripts to help them deal with any press or vendors.

4. Hire a team of professionals. Put together a crisis team to develop an action plan. Never speculate or sweep anything under the carpet. Base your plan only on facts. Then implement it. The crisis won't disappear if ignored.

5. Acknowledge the problem. If contacted by the press, tell reporters that steps are being taken to address the situation. Offer a positive outlook without blowing smoke. Don't go into great detail, but commit to disclosing additional information when it becomes available.

Mr. Cimasi says that these steps cover most if not all types of crises, such as medical malpractice lawsuits, regulatory issues, fraud, abuse and even a technology failure where patient confidentiality has been compromised. In a financial crisis, he says, it is imperative that all parties stick to the plan.

"A financial crisis has a ripple effect that picks up energy and moves forward," says Mr. Cimasi, who compares it to an avalanche. "This is not the type of activity that lends itself to ad hoc decision making. This is a costly and time-consuming process."

While this story may be an extreme example of a financial cri-

sis, it is not uncommon for physicians to find themselves in hot water because of poor financial planning. When Dr. John Garofalo began practicing family medicine roughly 20 years ago, his medical records clerk was diagnosed with cervical cancer. She had worked for him for several years, did a great job and was a very loyal employee. At the time, his practice employed only two other people—a receptionist and nurse. Although the clerk received treatment and seemed to be doing okay for a month or so, her health quickly began deteriorating. Within several months, she could no longer perform the responsibilities of her job.

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That left Dr. Garofalo in a quandary. If he fired her, she would lose her insurance benefits. Worse yet, she didn't have any short-term disability insurance; at that time, such policies were not offered to small businesses. If he kept her on the payroll, he could not afford to pay someone else to replace her.

There was no good answer, but there was only one solution. He continued paying her salary. "That's when I realized I needed to make sure everybody was cross trained in everybody else's job," says Dr. Garofalo, who now practices at Newport Family Practice in Newport, Maine. "It put us in a tailspin. It was awful."

To help ease financial pressures, his wife began working at the practice. She was familiar with office procedures, such as billing, and also helped cross-train the staff, since she had managed her husband's office when he first began practicing medicine.

Several months later, the clerk died. At that point, Dr. Garofalo set up a contingency fund for emergencies. "Try to keep some money available whether it's through a line of credit or money in the bank," he says. "To be able to cover any kind of cash-flow mess was the lesson learned."

Likewise, Dr. Mark L. Friedman learned a valuable lesson. Back in the 1980s, he managed a hospital's emergency room (ER) department. One day he received a letter from an insurance company claiming it had audited the ER's invoices and discovered

that it had significantly overbilled the company by roughly $30,000. The insurer demanded a check for that amount.

"My gut reaction was, 'What did I do wrong?'" says Dr. Friedman, now an ER physician at both Silver Cross Hospital in Joliet, Ill., and the University of Illinois Clinic at Chicago O'Hare Airport. "The first thing you think of when someone accuses you of doing something like this is, 'Oh, I made a mistake, must be my fault, I did something wrong. I didn't do it intentionally, but I'm going to have to pay them all this money.'"

Since he was experienced in handling crises, he skipped the panic phase and analyzed the situation. His next thought was that he didn't make a mistake. Maybe the auditor did. He knew the coder for the ER department was well trained and usually very accurate. So he called the consultant who helped him set up his billing operations.

They contacted the insurance company and requested a meeting. After reviewing approximately 100 charts, he says, there were a few cases in which the ER received duplicate payment from the insurance company, but most of the problems boiled down to an incorrect CPT code. Apparently the insurance company didn't recognize a standard code for intermediate service. So the ER coder was forced to choose between the code below it, which paid less, or the one above it, which paid more. Guess which one she picked.

Dr. Friedman suggested that they split the difference. He said that half the codes would go up, half would go down, and in the end, payment would come out the same as if the insurer had allowed the code to be used in the first place. The carrier agreed.

However, during that same meeting, Dr. Friedman turned the tables on the insurance company. As long as the ER was being audited, why not audit the insurer, he reasoned, and pointed to payments made to the ER. Sure enough, they discovered that the insurance company had underpaid the ER for some procedures.

After all the hoopla and worry, instead of paying the insurer $30,000, he says that the ER paid only $1,200. "Had we just given in, rolled over and said, 'We made a mistake, [the insurer] is going to do all these terrible things to us, let's pay,' we would have been out $30,000, and [the insurer] would have been back next year looking for more," says Dr. Friedman, author of Everyday Crisis Management: How to Think Like an Emergency

Physician (Archer-Ellison Publishing, 2002). “I think the auditor got so beat up in the process that she was a lot less aggressive with the next doctor. She never bothered us again.”

Mother Nature Strikes

One morning in September 2004, Dr. Troy Tippett, a neurosurgeon at the Neurosurgical Group in Pensacola, Fla., was navigating his way to work, driving around tall oak trees and electric power lines that had fallen on the ground just hours before and were now blocking the roads. Earlier that morning, the city had been visited by an unwelcome guest—Ivan, a category 3 hurricane.

Dr. Tippett managed to reach the building in which his office was located, which was a tower next to a hospital. Fortunately, it was still standing. Since the city had lost all power, he climbed four flights of stairs in the dark with no air conditioning to his office. His partner had slept there during the storm to handle any

Group Fights Back Against Frivolous Lawsuits

Dr. Jeff Segal grew tired of hearing about frivolous lawsuits against physicians. Instead of griping about it, he quit his day job as a neurosurgeon and launched Medical Justice Services (MJS), a three-year-old, membership-based organization in Greensboro, N.C., that helps prevent doctors from being sued and prosecutes attorneys and even other physicians who may be the culprits behind frivolous lawsuits.

One of its cases involved a primary-care physician in Chicago who gave his patient a series of injections for ankle pain. The patient developed a superficial infection, which was successfully treated with antibiotics. Yet the patient still sued the doctor, alleging that the medicine caused male-pattern baldness. MJS’s legal staff sent a letter to the patient’s lawyer, notifying him that the organization provided members with $100,000 in legal services to counter malpractice suits. Within one week, he says, the attorney dropped the case.

The organization’s services are being sold in 40 states. Depending upon a physician’s specialty, the annual fee ranges from $625 to $1,800, and additional retroactive coverage can be purchased for a one-time fee of $1,400 to $4,000. Members also agree to review one case per year and require all patients to sign a contract that prohibits them from filing frivolous lawsuits and to settle legitimate disputes

emergencies that might develop with their hospitalized patients.

Dr. Tippett surveyed the damage as best he could. Water had leaked through the windows and down through the ceiling, ruining all of the office's carpeting. Luckily, patient records were stored at another location. Most of the office was intact.

His staff had been sent home almost two days earlier to prepare for the storm. The practice had established a phone tree: each employee called another to check on each other's safety. However, the city didn't have any phone service; not even cell phones worked, because towers were either damaged or destroyed.

"There was absolutely no way to communicate with staff short of smoke signals," Dr. Tippett says. "Our people already knew that the central place to come was the hospital. I didn't want them to come, to put themselves at risk by coming in. And if they didn't have things shored up at home, then they weren't going to be much help to anybody here. They would be more worried about what's happening at home."

through board-certified experts.

But if a suit does wind up in a courtroom and the doctor wins, the case is reviewed by members. If it is considered frivolous, he says, MJS files a claim with professional societies, medical licensing boards or credentialing committees against attorneys and physicians who serve as expert witnesses. In some cases, doctors have been disciplined or suspended.

Dr. Segal believes his organization has made a dent in reducing the number of frivolous suits. In Florida, where MJS was first launched, some 10 to 15 percent of physicians are sued each year, he says. But MJS members are sued at an annual rate of less than 2 percent.

There is also some evidence that MJS can help decrease rates for malpractice insurance. Dr. Segal tells the story of a three-physician urology practice in Ohio that was sued twice. MJS intervened, both suits were dropped, and the practice's insurance rates fell from $102,000 in 2004 to $78,000 this year.

"The attorneys who take these cases are not seasoned veterans," says Dr. Segal, chief executive officer at MJS, which supports 1,200 physicians and is managing 200 open cases. "They're general plaintiff attorneys who don't know the medical arena that well. Their goal is not a home run. Their goal is to get some money out of it."

Both power and phone services were restored roughly one week later. Until then, he says, the hospital distributed walkie-talkies to Dr. Tippett and other physicians so its staff could communicate with them and each other. Meanwhile, Dr. Tippett says he learned about the safety of his staff by word-of-mouth from people who stopped by the hospital. Fortunately, no one was seriously injured. His staff began trickling in to work later that week—all except one nurse, who didn't return to work for three weeks because her home had been washed away.

As soon as you find out about an impending disaster like a hurricane, count on things to be worse than predicted. Above all, says Dr. Troy Tippett, a Pensacola, Fla. neurosurgeon who weathered Hurricane Ivan last year, "Release your employees ASAP," so that they can prepare their family or homes for disaster.

Dr. Tippett says that as soon as you find out about an impending disaster like a hurricane, count on things to be worse than predicted. Keeping a generator on hand couldn't hurt, either, which can help your practice get back on its feet. But above all, it's "terrible to make your employees stay at their job until the very last minute [because] they don't have time to adequately prepare their family or homes for disaster," he says. "Release your employees ASAP. Let them leave at their discretion."

In January 1998, Dr. Garofalo, who was working for a medical practice that was owned by a hospital, was forced to close his office for two days because of a horrific ice storm. Even if his patients could make it in for their scheduled appointment, he says, it wasn't safe for anybody to be on the road.

That experience offered valuable lessons and demonstrated the importance for all physicians in private practice to develop a crisis plan. Since then, he says he has created his own version for natural disasters, which includes a phone tree that is initiated by his office manager or lead physician, and arrangements with the local hospital and a nearby supermarket to store perishables, such as vaccines that must be refrigerated or frozen.

When developing the plan, Dr. Garafalo triaged all staff positions based on their importance. For example, during an ice storm or other extreme emergencies, only level-one staff—basically physicians and other healthcare providers—are required to come

to work whenever possible. When his practice starts seeing patients again, level-two people, who are medical assistants and other support staff, are called in. Level-three people—billing clerks—are the last ones who will be needed during a crisis.

Still, even the best crisis plan isn't foolproof. "Trying to plan for emergencies is kind of like trying to childproof a home," says Dr. Garofalo. "No matter how well you thought it through, the kid will find something he can get into. Disaster planning is the same way."

Dr. Maurice A. Ramirez, who practices emergency medicine at South Bay Hospital in Sun City Center, Fla., is also a national disaster life support instructor and teaches disaster medicine workshops around the country. He says physicians need to test the vulnerabilities of their practices.

For example, is your practice located in an area that is prone to hurricanes or floods? If so, do your computers, medical records and other essential equipment sit off the floor? Even if you're hundreds of miles away from the nearest river or ocean, man-made disasters, such as plumbing leaks or electrical malfunctions, can still temporarily put you out of business.

Dr. Ramirez suggests conducting office drills for all types of emergencies so that staff can be better prepared whenever an actual crisis occurs. It also gives employees the chance to evaluate the plan's strengths and weaknesses and identify areas they may need to improve upon. But everybody—including physicians—must participate.

Dr. Ramirez tells the story of a pediatrician who was in the habit of opening his office on weekends for sick patients. Once, a mother called him, saying her child was experiencing trouble breathing. The doctor met them at his office. But when he saw the child, the situation was far from minor. The child was a having a severe asthma attack and suddenly stopped breathing. The doctor panicked and didn't call 911 immediately. Worse yet, he didn't know where any of his emergency equipment was stored. Although his staff participated in emergency drills twice a year—his insurance company required they drill once a year—he never did. So instead of using appropriate equipment to resuscitate the child, he administered CPR. By the time paramedics arrived, the child had died. Not surprisingly, the child's family sued the physician. The case was settled out of court in 1997.

Handle With Care

Doctors end up in court for all kinds of reasons. But not all physicians know how to handle lawsuits. Many often say wrong things to the press, which can make them appear guilty. Some keep staff in the dark, don't reveal important details or even fail to prepare telephone scripts for them, which can negatively impact morale and productivity. Other times, doctors can unintentionally make insensitive comments to the family members of patients, which can exacerbate the situation and possibly provoke legal action.

That's exactly what happened to one primary-care physician in a small town. About two years ago during the Christmas holiday, the doctor ordered a chest X-ray of an elderly patient who complained of a bad cold. He wanted to rule out pneumonia since the patient had a predisposition toward upper-respiratory problems, says Karen Berg, chief executive officer at CommCore Strategies, a communications coaching firm in White Plains, N.Y.

But the physician was in a hurry to vacation with his grandchildren in Florida. Somehow he neglected to ask the radiologist to read the X-ray and placed it in the patient's file. Then he left town for two weeks.

The patient's health rapidly declined. He actually did have pneumonia, developed congestive heart failure and died within the same two weeks.

When the physician returned and learned of the man's death, she says he scolded this patient's family for not contacting him or going to the emergency room, despite the fact that the X-ray clearly showed he had pneumonia.

"Physicians can be their own worst enemy," Ms. Berg says, explaining that the physician's verbal reprimand probably contributed to the family's reasons for filing a lawsuit against him. "The patient didn't even know he had pneumonia because he was never told."

She says that about half of the lawsuits against physicians are circumvented by proper communication. When physicians even get a whiff of a potential lawsuit, she says, they must be aggressive in immediately contacting the patient and his or her family. If handled correctly, she says that physicians can extend their sympathy without placing blame on themselves.

She offers comments such as, "This is a tragic thing that hap-

pened. I just wanted to let you know that my thoughts are with you." They can also meet with the patient and his or her family to discuss the situation and once again extend their sympathy. While speaking, she says, you must look people directly in the eye instead of looking at the patient's chart as physicians often do. By making eye contact, you'll appear confident and sincere.

"Show your humanness," she says, adding that a quick phone call to your attorney or communications coach about appropriate comments to make would be wise. "Reach out as you would to a friend. You want to pull that patient or family in so you work out the situation before a lawsuit is slapped on you."

But the doctor didn't do any of these things and ended up being sued by the patient's family. He lost, she says, adding that the settlement was in at least the six-figure range.

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Years ago, Dr. Friedman, an ER physician, got a good scare when a patient's family threatened to sue him. It all started when he tried to dictate a patient's chart, but couldn't remember anything about the man, whom he had treated about five days earlier in the ER around 3:00 in the morning.

"I hadn't even written notes on [the chart]," he says. "I looked at the chart, tried to remember the patient and for the life of me, could not remember what had gone on with this patient."

To help jog his memory, he decided to call the patient at home, see how he was doing and determine whether he had made a follow-up appointment with his family doctor. After he introduced himself, there was silence on the other end of the line. Then the person said, "He's dead, and we're going to sue you, the hospital," recalls Dr. Friedman, adding that the person went into a long diatribe, then hung up the phone.

Dr. Friedman was in shock. Besides a blank chart in front of him, he now had a dead patient and still couldn't remember a single detail about what had happened. Panic and fear took over.

He managed to calm himself down and decided to call the patient's attending physician, hoping, maybe even praying, that he could fill in the blanks. As it turned out, the physician remembered every detail. Dr. Friedman had called him that morning, very concerned about the patient who had been quickly admitted to the hospital. He had died two days later.

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In essence, Dr. Friedman had done everything right and believes that this scenario was nothing more than a grief-stricken relative who needed to vent his anger or frustration over the man's death. The moral of this story is "don't panic," he says, adding that since then, he always writes notes on charts after seeing patients so that when he dictates them, he can recall clinical details. "Chances are it's not nearly as bad as you think it is initially."

Not all lawsuits, however, are unavoidable. Some even place physicians on the offensive. One of Ms. Berg's physician clients along with his partner headed a thriving family practice that supported six staff members. About four years ago, the partner developed a gambling problem and ran off with the practice's profits. The physician began laying off staff. Little problems began erupting: patient co-payments were not being recorded, and patients complained about being billed for co-pays that had been paid at time of service.

Instead of coming clean, the doctor was trying to hide his problem from everyone—including his partner's patients. He told them that his partner wasn't available and that he was temporarily taking over his workload. In essence, he did everything wrong for the right reasons—trying to control the damage to his once-successful practice.

Soon the doctor became overburdened and ineffective. Patients started leaving his practice. He even started hearing complaints from his peers.

Staff obviously knew what had happened, and the truth began to leak out. Ms. Berg helped him manage the press and develop

a "stand-by statement," which is a template that the physician used when talking with the press. Here's a brief example: "This was an unfortunate situation. I was so sorry to hear that (fill in the blank). This is the action we're taking (fill in the blank)…"

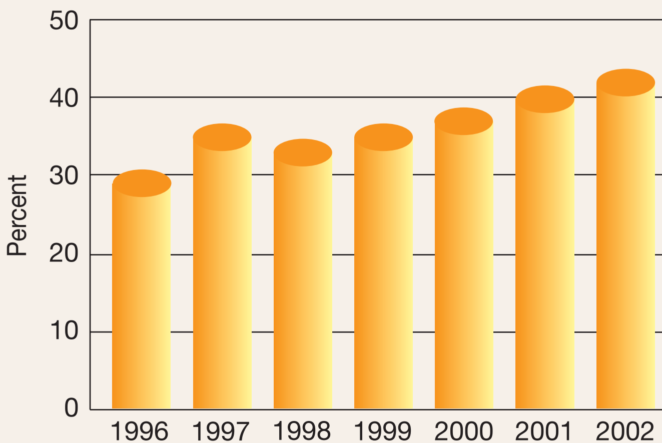
"The last thing you want to be saying is 'No comment,'" she says, adding that the physician ended up migrating to a very small practice. "The less you say, the more guilty you're going to be perceived. With lack of information, people start making up their own information."

Often legal firms will hire public relations agencies to help physicians and their employees manage media and patient inquiries.

Susan M. Tellem created a procedural form for staff that contains specific tips on how to handle aggressive reporters. For example, if a reporter calls, direct them to the practice's attor-

Medical Malpractice Plaintiff Recovery Rate

The plaintiff recovery rate (ratio of plaintiff verdicts to total verdicts) in malpractice lawsuits has risen significantly since 1996, but defendants still win the majority of such cases.



Source: Jury Verdict Research.

ney, who is fielding all media questions. Ms. Tellem, a former practicing registered nurse, heads up Tellem Worldwide, a public relations, marketing and communications agency in Los Angeles that specializes in crisis management.

"Sometimes the staff gets caught up in the moment and will talk to a reporter, thinking they're doing a favor for everybody, and of course, it isn't always a good thing," she says. You have to be aggressive about saying that any deviation from this [form] can result in dismissal."

Be specific. Leave no room for doubt. Describe the procedures in an employee letter as well as the consequences for staff members who don't follow them. Written documentation tells employees you mean business and also holds them accountable for their actions.

Once in a while, Ms. Tellem will test employees by calling the office, pretending to be a reporter. Other times, she'll spend several hours rehearsing different scenarios with physicians. For example, if a reporter ambushes you by jumping out from behind the bushes, holding a microphone up to your face, would you know what to do?

Putting Out Fires

She tells physicians to resist the urge to run into their office or jump into their car. Instead, stop and face the reporter, then say, "This is a legal matter. For that reason, I cannot speak about the issue. I suggest you contact my attorney. Here's his name and phone number. Sorry I can't be more useful."

Several years ago, a couple of anesthesiologists in private practice refused to give any anesthetic to women during childbirth because they could not afford to pay the doctors upfront for their services. The story became front-page news, and the doctors retained attorneys to protect their reputation and positions.

Ms. Tellem crafted generic statements for the doctors that didn't explain their potentially unethical behavior but put a different spin on it. In this case, it stated that there was a mix-up at the hospital about billing and that procedures were created to prevent this scenario from happening in the future. Letters containing similar statements can even be sent to patients.

Before writing statements, identify several key points or messages you want everyone to know. Then keep in mind two pieces

of advice: If you communicate only facts, you could be perceived as being cold or insensitive to the situation, and the longer you talk, the greater the likelihood that these points won't get across, says Jonathan Bernstein, president at Bernstein Crisis Management in Monrovia, Calif.

Overall, the goal of crisis management is to put out fires when they're barely started so that minimal damage occurs, Mr. Bernstein says. Unfortunately, some physicians look the other way or wait too long to act.

Mr. Bernstein relates the story of a very prominent clinic that serviced mostly wealthy patients. He says that the practice's physicians had warning signs that the clinic's chief of psychiatry was experiencing coping difficulties, yet did nothing. Then one morning, the doctor went into his office with a gun and threatened his secretary, who happened to be his lover and had recently ended their affair.

Often legal firms will hire public relations agencies to help physicians and their employees manage media and patient inquiries. Susan M. Tellem, a Los Angeles PR consultant, created a procedural form for staff that contains specific tips on how to handle aggressive reporters. For example, if a reporter calls, direct them to the practice's attorney, who is fielding all media questions.

Somebody passing by his office saw the scary scene. Immediately the building was evacuated and the police were called. Mr. Bernstein says that the physician held his former lover as a hostage for roughly 12 hours. No one was hurt, and the psychiatrist ended up in jail.

If this happened in your building, what would you tell your patients, your vendors? What would you say to staff? When a crisis like this occurs, Mr. Bernstein says, there's no substitute for in-person communication.

In this situation, he says, a toll-free number was established that provided a recorded message, which was updated every hour. The following day, the clinic held senior staff meetings, which in turn led to department meetings. Intervention counselors were also brought in for staff. Also, an improved system was developed and quickly implemented by which staff could anonymously report employees who were acting inappropriately or

believed that their behavior could affect someone's life or property or even damage an individual's reputation.

"Be compassionate when it's a threatening crisis," Mr. Bernstein says, adding that the longer you wait to communicate information to staff and others, the more damage can occur.

Another group of physicians waited a bit too long to handle a different type of crisis that could have impacted their reputation.

Before writing statements, identify key points you want everyone to know. Then keep in mind two pieces of advice: If you communicate only facts, you could be perceived as being cold or insensitive to the situation, and the longer you talk, the greater the likelihood that these points won't get across, says Jonathan Bernstein, a crisis-management consultant in Monrovia, Calif.

Last year, a medical group was providing a very profitable specialty service to a hospital that was partially controlled by the county, says Mr. Bernstein. It was so successful that several hospital leaders decided to form their own group that offered the same services. But instead of competing with the organization, they wanted to destroy it by undermining its credibility and preventing it from delivering services anywhere else in the state.

This medical group was the only one that provided such services in a multistate region in the Midwest, he says. It demonstrated that there was an untapped, lucrative business opportunity in the state's healthcare market. And these hospital leaders knew it.

Over a several-month period, he says, the leaders intentionally made false allegations against the group, claiming that it improperly used physician assistants in the operating room and violated terms of its contract. "They tried to stir up a lot of phony trouble, but they did it in a very credible-sounding way," says Mr. Bernstein. "They did a lot of things behind the backs of physicians. They would tell the physicians, 'Yes, we're going to address your concerns,' but in fact, never did."

The organization was ready to go public, but Mr. Bernstein suggested that it try a different approach: quietly brief one county commissioner who was influential with the other board members and would be sympathetic to their situation. He suspected that the commissioner would address this issue with the hospital's board chairman, asking him if he really wanted the organization

to publicly air their grievances.

Mr. Bernstein's hunch paid off. The commissioner met with the chairman, who was shocked by the whole affair. Apparently, he was being briefed by these hospital leaders, who told a completely different version of the story in an attempt to cover their tracks. After learning the truth, the chairman approached them, and the problem was immediately corrected.

"In hindsight, [the organization] should have moved on this more quickly," Mr. Bernstein says. "A lot of times, medical practices are so focused on doing their day-to-day business that they forget about the fact that they can be put out of business very quickly by the acts of other human beings, threats to their reputation, by sudden business interruptions. They didn't take this seriously enough early-on."

Bruce Rubin of RBB Public Relations in Coral Gables, Fla., offers another technique. In 2003, one of his male physician clients was being sued for sexual harassment by a female employee who worked in the practice's front office. The family practitioner worked with two other physicians in the group practice.

The doctor admitted having a sexual relationship with her, but said he broke it off. However, the woman claimed she was being sexually harassed and pressured into the relationship.

"It was made worse because it wasn't settled in time to prevent any publicity and simply because the person in this case was a physician," explains Mr. Rubin, adding that the public tends not to forgive physicians for their misdeeds as easily as corporate executives because they hold doctors to a higher standard. "It impacts the physician's future referrals. Other doctors get a little nervous making referrals. It raises questions where they may have hospital privileges—everyone's lawyer wants to look at it and try to bulletproof themselves."

The other two partners disclosed that other physicians indeed were reluctant to make referrals to the group. There was also other residual damage to the practice's revenues. While long-time patients remained, the number of new patients dropped. The two partners thought about leaving the practice but elected to stay.

To avoid further damage, Mr. Rubin arranged for the physician to interview with the journalist who first reported the story. His mission was to demonstrate that the doctor wasn't an evil mon-

ster, that he was a good physician, a human being who made a mistake, he says, adding that this tactic did soften the physician's reputation.

"My advice to doctors is if you have to deal with the news media, get help," he says, adding that the case was settled out of court and the woman received a payout in the mid-six-figure range. "Don't try to be your own doctor. There's a tendency for physicians to think they can fix and solve everything themselves. It's not as easy as people think."

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Richard Southard, an attorney who practices civil and criminal litigation in New York, has a variety of physician clients, including some who have been sued for sexual harassment or even arrested for criminal misconduct. No matter what they're charged with, he says, documentation is one of the best ways to scare off the plaintiff's attorney from filing a lawsuit.

Mr. Southard tells his physician clients to involve themselves in their defense. In other words, if you believe you did everything right, then prove it. If you're being sued for medical malpractice, for instance, then present medical literature that backs up your treatment decisions. Staying current with medical research is what will protect you, he says.

Good doctor-patient relations seem to be the answer for resolving many practice issues, ranging from lawsuits to poor communication and compliance problems.

"Patients are much less likely to have an adverse position or smell a lawsuit against a doctor that they have a very good working relationship with," Mr. Southard says. "Ask the patient whether or not all of their questions or concerns were answered, return phone calls promptly, show a concern or interest in the patient's well-being. Little things like that put the patient in less of a litigious mindset."