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Advocate^{MD}

advisor

Issue 1 / Winter / 2006

DEDICATED TO PROTECTING TEXAS PHYSICIANS

WELCOME

FROM THE CEO

By Mark Adams

First, I would like to welcome you to Advocate, MD. This first edition of the *Advocate, MD Advisor* is being published at an exciting time both in our company and in the industry in general. The passage of HB 4 and Proposition 12 in September 2003 has had a profoundly positive impact on our company and the industry. For example, medical malpractice lawsuits filed against physicians in 2004 totaled less than half the lawsuits filed in 2003, and this trend is continuing in 2005. Clearly, this is the intended result the legislators and Texas voters were seeking when they amended the Texas State Constitution to create the

strongest tort reform of any state in the country.

As Advocate, MD was the first, fully admitted medical liability insurance underwriter licensed in Texas following the passage of Proposition 12, we have benefited by entering a market where every risk we underwrite is protected by this new legislation. This is a unique advantage as all the existing med-mal carriers in Texas prior to September 2003, have significant backlogs of non-tort protected litigation risks on their books.

Advocate, MD enjoys other unique

advantages as well. One in particular, is our capital structure. Most of the medical liability insurers in Texas are structured as trusts, reciprocal exchanges, non-profits or risk retention groups. These types of entities have restricted access to the capital markets when "surplus capital" is needed to protect their policyholders from price increases due to under capitalization. In the past few years, many of these entities turned to their policyholders to acquire the needed capital by means of "surplus contributions," increased rates, "policy service fees" or "surplus capital assessments." By

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THREE STEPS

TO A RISK MANAGEMENT PLAN

By Linda Galloway, RN

STEP 1

Create a Culture of Safety in Your Practice

First, Do No Harm. Even though this is the primary mandate for physicians, harm caused to patients by medical error is all too common. A study titled, *National Survey on Consumer's Experiences With Patient Safety and Quality Information*, found that one in three people have experienced a medical error in their own care or that of a family member. (1) Among those, 72% said the doctor involved had a lot of responsibility for the error.

It is no longer possible for physicians to believe this mandate relates only to them and their actions. Every health care provider is responsible for assisting their patients through the health care maze. Injury or oversight can occur at any turn, often when physicians are unaware of their patient's risk. A physician tends to believe their actions are the primary consideration for a patient's safety when in fact it may be: the actions of another provider, office staff, or lack of action on someone's part that cause injury or a delay in diagnosis or treatment to their patient.

What is a Culture of Safety?

A culture of safety is an environment in which every act has been analyzed, and when possible standardized to assure the ability to repeat these actions without variation. Every employee at every level must know to watch for failures in the system and make sure that any failure, whether human, mechanical or system related, is reported and analyzed to create a safer environment. There should not be an immediate focus on personal blame when an error occurs, but rather a collegial attitude that allows everyone to investigate any system or communication failure that might have resulted in a mistake.

A culture of safety encourages a willingness to thoroughly investigate any incident that could possibly cause patient harm, even if no actual harm occurred, and puts measures in place to prevent such occurrences in the future.

How Do I Create a Culture of Safety in My Office?

Begin by evaluating all office systems currently in place with a critical eye. Use every resource available to you in this review, including

staff and patients. Ask yourself these questions:

- Is my front office staff aware of the timing issues for appointments?
- If an appointment is cancelled or a patient "no shows," does someone from the office contact them? If they are contacted, what information is exchanged?
- Are patients aware of all preparation required for appointments in your office?
- Is there a foolproof system in place to track laboratory and other tests ordered from your office? Are test results provided to patients in a systemized and timely manner?
- Is there a complete patient medical history that has been reported by the patient and reviewed by a clinician?
- Are medications reviewed and updated during each appointment? Is your office staff trained to watch for medication allergies and side effects?
- Does your office have written policies and procedures? Is the staff aware of them?
- Do you follow clinical guidelines for prevention and screening of breast, colon and other cancers? Is there a system in place

to monitor this screening? Are patients educated regarding the different screening techniques?

- Do you have a documented emergency plan in place for your office that is appropriate for the level of care you offer? Is your staff trained in this plan?

The Advocate, MD website has links to several different patient safety sites as well as patient safety initiatives. Some of these sites offer free CME that focus on patient safety issues.

STEP 2

Develop a Trusted Relationship With Your Patients

To avoid medical malpractice claims, developing the skills to foster good patient relationships is every bit as important as developing technical skills. Research to determine why patients sue physicians has consistently found this to be true. Patients sue because they feel they were treated badly, rudely, their concerns were not heard, or they feel they were not told the truth. Consistently, patients who sue physicians express a feeling of “perceived indifference” on the part of their caregiver.

A research study surveying both

physicians who have been sued, as well as plaintiff patients found a significant difference in their perception of the patient-physician relationship. (2) Two-thirds of sued physicians thought they had been open and honest with their patients, but only one-third of the patients thought communications were open and honest. Nearly two-thirds of all subjects in this study agreed that the most effective method for preventing malpractice claims would be improved physician-patient communication.

Another study published in *The Lancet* surveyed 227 patients and relatives who took legal action. “I wanted an explanation” was given as a reason to sue by 90% of the respondents. Where explanations were given, less than 15% were considered satisfactory. When asked, “Once the original incident had occurred, could anything have been done which would have meant you did not feel the need to take legal action?” 37% of the respondents who answered “yes” said an explanation and apology could have prevented legal action. (3)

Just as poor communication is likely to cause trouble in the physician-patient relationship, good communication is the touchstone of creating a sound and rewarding relationship with your patients. These suggestions for improving communication in your office may seem remedial, but they have proven to be effective:

- Facilitate the visit. Review the chart to learn why the patient is visiting and check notes from the previous visit to see if something needs to be followed up on. Tell each patient what to expect and explain why any lab or diagnostic tests are being ordered. Summarize what the treatment plan is and what steps will be taken next.
- Always establish eye contact at the beginning of each patient encounter.
- Sit down while talking to your patients. A conversation in which you are seated and give a patient your full attention is perceived differently than one where you stand near the door.
- Define any medical terms used.
- Address patients by name.
- Do not review records or sit with your back to the patient during the visit.
- Ask your patients to repeat what you have said after explaining complex issues to ensure understanding.
- Patients, like most people, appreciate humor.
- Listening is the most important skill needed for clear communication.

When there has been a complication, a medical error or an unanticipated event, it is even more important to be available to your patient and their family. At these times, it

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IS HONESTY THE BEST POLICY?

DISCLOSURE OF MEDICAL ERRORS

By Terrence G. Hurst, CPHRM, MHA

A majority of states have adopted or are considering apology laws that exempt expressions of regret, sympathy or compassion from being considered as admissions of liability and medical malpractice lawsuits. The intent is to encourage physicians and other health care providers to apologize to patients when a medical error, accident or unanticipated outcome occurs without the apology being taken as an admission of guilt. The consensus is that health care providers have become reluctant to explain to patients and their families what happened when procedures go wrong because they fear the information will be used against them in court. Health care providers have struggled with their desire to apologize to their patient, but have been strongly advised against such open discussions by their defense attorney. Is the reluctance justified or is honesty really the best policy?

As a Health Care Risk Manager, I have found that failing to disclose medical errors or failing to explain unanticipated outcomes to patients often creates frustration and anger and may lead patients or their families to file lawsuits to “get to the bottom of the matter”. A perceived “cover-up” is a certain invitation to being sued. I have seen many instances of a patient suing over their anger of feeling like

they weren't being given the facts by their doctor, and then not being angry over the mistake when it was finally explained to them. As a result, I agree that honesty and an open dialogue with a patient is the best policy; however, it is imperative that health care providers be fully informed and knowledgeable regarding how to appropriately provide “apologies” to patients and their families.

While most states have joined in the trend to protect medical

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apologies, several state laws continue to allow statements concerning culpable conduct or admissions of fault to be admitted as evidence of liability. Health care providers should work with their employer or professional liability insurer's risk management or legal staff to fully understand the applicable state law regarding “I am sorry” guidelines, just as they are educated on state laws regarding patient consent is-

sues. Most insurers are receptive to their providers participating in these discussions and apologies when properly conducted. An excellent source of information for health care providers, attorneys, risk managers, and insurance carriers is **The Sorry Works! Coalition**, which is a national group advocating a formal apology program for medical errors as a proactive solution to the medical malpractice crisis and proposals for tort reform. The group has received allies in Senators Clinton and Obama who have introduced federal legislation regarding the communication and apology of medical errors. Several large health care centers and professional negligence carriers are advocates of these principles, and have incorporated the “Sorry Works” approach into their risk management educational programs.

The bottom line is that open communications with patients throughout their care has a dramatic effect on making a patient “feel” like they are in control and are a part of the health care team. When a mistake is made, an open discussion of the error, within the guidelines of state and federal law, has been shown to decrease the likelihood of the patient filing a lawsuit, and can decrease the costs of defending a meritorious claim by taking anger out of the equation. ■

CDC RECOMMENDS VACCINATIONS

FOR ADOLESCENTS AND YOUNG ADULTS

By Linda Galloway, RN

The Centers for Disease Control and Prevention (CDC) now recommends routine vaccination of children 11-12 years old, previously unvaccinated adolescents at high school entry, and college freshmen living in dormitories, with the newly licensed meningococcal conjugate vaccine (MCV4). The new recommendation is designed to help achieve vaccination among those at highest risk for meningococcal disease. College freshmen living in the close quarters of dormitories are at a higher risk for meningococcal disease compared with peers the same age who are not attending college.

Meningococcal disease strikes up to 3,000 Americans, killing 300 people every year. Up to 12 percent of

people with meningococcal disease die, and up to 15 percent of survivors may suffer long-term permanent disabilities including hearing loss, limb amputation or brain damage. The disease often begins with symptoms that can be mistaken as a common illness, such as the flu. However, meningococcal disease is particularly dangerous because it progresses rapidly and can kill within hours.

This new vaccine should offer longer protection than previous vaccines, is a single shot, and the most common reaction is a sore arm. However, it does not protect people against meningococcal disease caused by serogroup B bacteria. This serogroup of bacteria causes

one-third of meningococcal cases in the United States. More than half of the cases among infants under the age of 1 year are caused by type B, for which no vaccine is licensed or available in the United States. This vaccine was licensed by the U.S. Food and Drug Administration (FDA) in January of 2005 for use in people 11-55 years of age. It is manufactured by Sanofi Pasteur and is marketed as Menactra.

For additional information on meningococcal disease visit: http://www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm

Source: URL: <http://www.cdc.gov/od/oc/media/pressrel/r050526b.htm> Retrieved on May 28, 2005 from the internet. ■

MEDICAL RECORDS

STAYING IN COMPLIANCE WITH TMB

By Linda Galloway, RN

In June of 2005 the Texas Medical Board (TMB) cited 10 Texas physicians for allegations regarding medical records. You have 15 business days to produce the medical records after receiving a valid authorization. Six of these complaints alleged the physician failed to provide medical records in a timely fashion. Other allegations were failure to use diligence in management of medical records, and failure to maintain adequate medical records as well as closing a

practice without informing the patient of where medical records can be obtained.

This would seem to be a good time to brush up on the requirements for maintaining and providing medical records. There is a direct link under Risk Management on the Advocate, MD website to the TMB rules on maintaining and providing medical records.

Your Advocate, MD policy does in-

clude coverage for defense of a TMB investigation. Most physicians feel it is not necessary to have legal help to answer a complaint or deal with a TMB investigation. However, it has been our experience that the earlier legal counsel is involved, the easier and more quickly the matter is settled. Do not hesitate to contact the Advocate, MD Claims Department at 512-427-2384 if you receive notice of a complaint against you or a TMB investigation. ■

(Welcome Letter continued from page 1)

contrast, Advocate, MD is a stock company. As such, we can routinely access these capital markets by exchanging equity in our company for additional capital surplus. This allows us to protect our physicians while maintaining a healthy surplus capital ratio and providing long term rate stability, without requiring our insureds to pay additional surplus assessments or surplus contributions.

We carefully chose our name "Advocate, MD" because that is how we view our company charter...to be the physician's advocate. Physicians spend their careers helping and protecting their patients, and they need a medical liability insurer in Texas, such as Advocate, MD,

that has a stable capital structure designed to do the same for them!

Our company is unique in our timing, structure and culture. Currently, we have over 120 years of Texas based medical liability insurance experience on our team. From the President of our Insurance Company Jack Murphy, the founder and former CEO of one of our competitors, to our outstanding team of Underwriters, Finance and Accounting, Risk Management and Sales and Marketing personnel, our team well understands the Texas medical liability insurance business and we are here to stay!

Thank you for choosing Advocate, MD to be your medical liability in-

surer. We appreciate the trust and confidence you have placed in our organization! You can be confident that we will continue to work hard every day to provide you outstanding medical liability protection, stable pricing and unmatched service. We are proud to be your medical liability advocate in Texas.

Sincerely,



Mark E. Adams
Chairman, President &
Chief Executive Officer
Advocate, MD Financial Group Inc.

(Three Steps... continued from page 3)

may be impossible to answer all of their questions at first. Explain to the patient that you will share with them only what you know for certain. Assure the patient and their family that you or a specifically identified person will be responsible for sharing information with them as it becomes available. Check in frequently, even if you do not have new information, since your attentiveness indicates your concern and commitment. Be prepared to repeat your explanations. It is not uncommon for the most sophisticated person to be unable to take in all the information that is given during such a conversation. As long as the patient is dis-

cussing these issues with you, they are probably not seeking assistance from a plaintiff's attorney.

Train office staff in customer service principles. At times, a physician's staff members may not feel the need to be accommodating to patients. In a court of law, the physician is held responsible if a member of their staff causes harm to a patient. In the eyes of a patient, the physician may be held responsible for disrespectful, impolite or uncaring behavior by the office staff. Make sure your office staff understands the importance of strong patient relationships. Appoint the best equipped person on the staff

to deal with unhappy or dissatisfied patients. Have policies and procedures in place that reinforce these behaviors. Train office staff to resolve conflicts and refer patients to someone else in the office if they are unable to provide a suitable resolution to a problem.

STEP 3

Prepare a Defense Before a Lawsuit Occurs

The most important and meaningful parts of a defense for a malpractice claim are created before a lawsuit is ever filed against a phy-

sician. Medical records are the primary source of factual information in medical malpractice litigation. Consistent, thorough documentation habits are a must for preparing a strong defense.

- **Make sure your dictation is timely.** Dictation should be completed within 24 to 48 hours of a procedure. Juries have a hard time believing physicians can remember accurate details when dictating weeks or months after an episode or procedure.

- **Document all telephone conversations with patients.** The best practice is to keep a triplicate phone message book with you when you are on call. One copy is for the patient chart, one copy is given to the patient's physician the next day for review and one is retained for your records. An alternate method of documentation is to keep a log of phone calls only. Treat telephone calls from patients as opportunities for potential miscommunication. The exact exchange of information in these calls is frequently disputed during litigation. Documentation of the exact time of the call and the instructions given could have quickly ended some malpractice claims that went on for years.

- **Document review of the patient intake form.** Most physicians have complete health history and intake forms. As you review them and clarify information with your patients, initial or add

to the information in your own handwriting to document your thorough review of the information.

- **Date and time all entries in the hospital record.** Piecing together the puzzle of events in litigation is much easier with exact information. Timing your notes also lets the other physicians on your team know what time your assessment of the patient occurred.

- **Legibility is important.** A Texas jury ruled in favor of the plaintiff at trial when a pharmacist misread a prescription written by the physician. After the trial the jury stated they felt the physician was an excellent doctor, but he needed to be responsible for his handwriting.

- **Never obliterate, erase, or write over an entry.** Correct any errors in the medical record by drawing one line through the entry and initialing.

- **Document your absences from practice.** Include the name and number of the physician who is covering for you as well as the time and date you will leave and return to service.

- **Document patient instructions precisely.** When instructions or explanations are frequently repeated in a practice, it is wise to create a printed, patient instruction sheet. Rather than documenting the conversation repeatedly, you may document that the patient education sheet

was provided.

- **Use only standard and accepted abbreviations.**

In May 2005, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) affirmed its "do not use" list of abbreviations. For accreditation purposes, this list of prohibited abbreviations will apply, at a minimum, to all orders and all medication-related documentation that is handwritten or on pre-printed forms. Your organization may have a more extensive list of abbreviations that are not to be used; make sure you are familiar with them and comply.

By taking these three steps; creating a safe environment for your patients, developing a strong, mutually respectful relationship and thoroughly documenting your care, you will have put in place an excellent, effective risk management program.

(1) Kaiser Family Foundation, Agency for Health Care Research and Quality, and Harvard School of Public Health. "National Survey on Consumer's Experiences with Patient Safety and Quality Information." November 2004. 15 Jul 2005 <<http://www.kff.org/kaiserfpolls>>.

(2) Lawrence SL, Shapiro RS, Schiedermayer DA, Sobocinski KA, Talsky AM, "A Survey of Sued and Nonsued Physicians and Suing Patients." Archives Internal Medicine 149 (1989): 2190-2196.

(3) Vincent C, Young M, Phillips A. "Why do people sue doctors? A Study of Patients and Relatives Taking Legal Action." The Lancet 343 (1994): 1609-1613. ■

NEED ANSWERS?

Contact Advocate, MD to have your questions addressed in our next issue of the *Advocate, MD Advisor*. We have an experienced and knowledgeable staff ready to answer any question you may have. Also, please contact us if you would like to submit an article, testimonial, story, or suggestions that may benefit other policyholders.

We value our policyholders and would like to extend an opportunity to help you further.

If you would like to receive updates and our quarterly newsletter via email, please send a request to marketing@advocatemd.com

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