

# THE Physicians Report

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to Present Cases



## Increasing Your Medical Liability I.Q.

# Where Medicine Meets the Law

**Once upon a time**, patients didn't claim that their physicians made their health worse. Nor did a labyrinth of regulations impact how physicians delivered care. They certainly didn't have to assign a numerical code to the care they delivered.

Ah, how things have changed. Today, health care professionals may feel like they should have earned an MBA and law license, too. Unfortunately, it's frustrating for physicians who just want to deliver quality care to their patients.

How and where physicians learn about, and integrate, a legal sensibility into their work is tricky. In medical schools, the focus is appropriately on medical training, not on legal concepts. Yet, as health care professionals begin their careers, they want to know how the legal environment can impact their practices.

It is often only after a claim that health care professionals really understand the role of the legal system in health care. And without the right perspective, with only hearsay to go on, a health care professional may start to practice defensively. But with an understanding of how the law affects their work, most health care professionals are able to develop processes and protocols that lessen the likelihood of a lawsuit and at the same time provide opportunities for delivering consistent, quality health care.

Research shows that it's not if, but when, good doctors will get sued. In this issue of the Physicians Report, we hope to arm you with a better understanding of the legal system, developments in the law in the area of professional liability, practices that can lower the likelihood of a claim, and how we can help you when they do.



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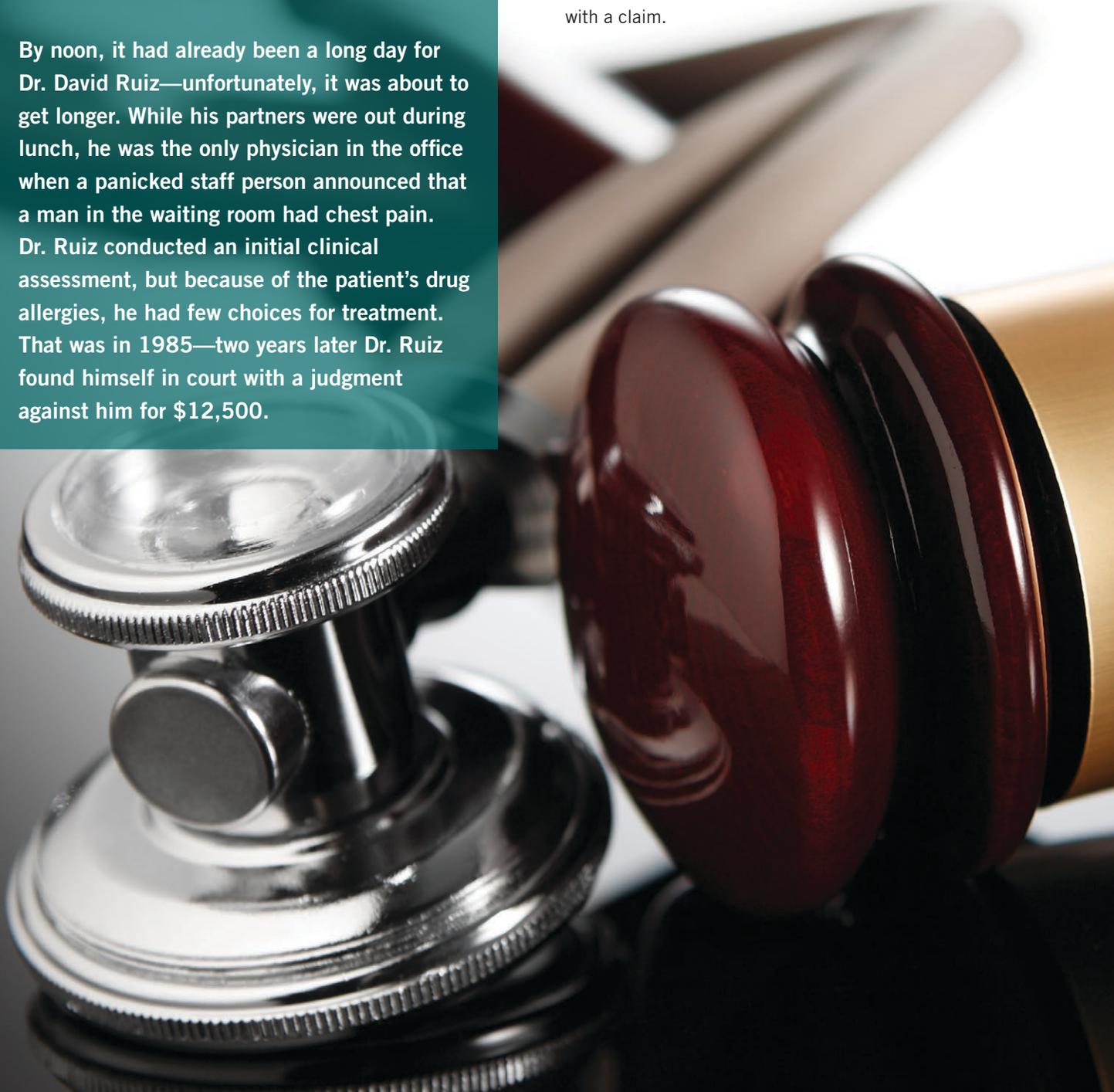
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# Where Medicine Meets the Law

By noon, it had already been a long day for Dr. David Ruiz—unfortunately, it was about to get longer. While his partners were out during lunch, he was the only physician in the office when a panicked staff person announced that a man in the waiting room had chest pain. Dr. Ruiz conducted an initial clinical assessment, but because of the patient's drug allergies, he had few choices for treatment. That was in 1985—two years later Dr. Ruiz found himself in court with a judgment against him for \$12,500.

Deeply motivated to provide good care to his patients, Dr. Ruiz took this as a personal blow. He worried that he had caused harm to his patient, wondered why the patient was so affronted by the delivery of care, and found himself unable to talk about it with peers due to the confidentiality of litigation—leading to isolation and an emotionally draining process.

Today David Ruiz, MD, a program director for family medicine residents at PeaceHealth Southwest Medical Center, draws from that personal experience to help residents develop their own sensibility around liability and learn better practices for avoiding a lawsuit. But this isn't the norm. In fact, according to some of his peers, most physicians don't learn about liability until they're faced with a claim.



“Some will be able to absorb and understand what litigation is early on,” says Amy Forbis, a defense attorney and partner at Bennett Bigelow & Leedom. “It varies depending on the practitioner and personality. Others may not have a sense of it after years of practice, and even some in the throes of litigation still won’t connect where and how medicine and the law meet.” And that’s the challenge of educating today’s medical students and new-to-practice physicians—when and how to teach them about risk and liability during an already jam-packed education schedule. Says Dr. Ruiz, “Even though there may be an underlying sense of anxiety that liability is part of our professional lives, it doesn’t become real until there is an incident. We need a better way to imprint this idea on their thinking.”

## EARLY INFLUENCERS TO LITIGATION

At a macro level, it can be argued that the top reasons for adverse outcomes or patient complaints leading to litigation

stem from poor physician-patient communication, a lack of informed consent, inadequate documentation, and a failure to diagnose—three of which have relatively little to do with the actual medicine and more to do with the physician-patient interaction. “Being more cognizant of those things that get us in trouble or those phrases and words that keep us out of trouble—all these should and can make us better clinicians,” says Dr. Ruiz. Forbis agrees: “I constantly talk about and represent in litigation the need for contemporaneous documentation during a patient visit.” Contemporaneous documentation, an important skill, occurs when physicians articulate their thoughts during the patient visit, being mindful of why they are dismissing or attributing diagnoses, and making sure that they document what they intuitively absorb.

**“IF YOU STANDARDIZE PROCESSES, MAKE FUNDAMENTAL DECISIONS ON HOW TO RUN THE BUSINESS OF MEDICINE, COMMUNICATE WITH YOUR PATIENTS IN WAYS THEY UNDERSTAND, THEN YOU IMPROVE PATIENT HEALTH AND EXPERIENCES.”**

APARNA ANANTH, MD,  
ANESTHESIOLOGIST WITH PACIFIC ANESTHESIA

Even when it is evident that the physician spent the proper amount of time with a patient—and some time was spent explaining procedures—if the documentation is skimpy and doesn’t support the physician’s story, the case becomes a “he said, she said” scenario. When this happens, suggests Forbis, it becomes difficult to convince a plaintiff’s attorney not to file a lawsuit. “When documentation is good, when a physician does it right, most good [plaintiff’s] attorneys won’t take the case. This means the physician avoids depositions, trial, and a world of grief.”

## PROCESSES, PROTOCOLS, AND THE PATIENT EXPERIENCE

But documentation is only part of the equation. It’s easy for physicians to focus on the medicine at the expense of the office practice and procedures. “Put up good protocols and practice them,” notes Forbis. “Revisiting them annually [or more frequently] is a good idea to ensure they are reflective and appropriate to the time and needs of patients, and needs

*(Continued on next page)*



of the practice.” Linking all aspects together—medicine, staff, physician extenders, and office policies and practices—helps to not only minimize the risk of an adverse patient experience, but actually improves the delivery of the care.

Some physicians argue that doing all these extra steps is impossible in today’s typical medical practice. For sure, with a 12-to-15 minute office visit, and churn of 40-plus patients a day, taking 90 minutes to review patient flow from the parking lot to waiting room to exam room, or an hour to brainstorm a more efficient way to handle urgent care patients—these can seem like unreasonable demands on an already full schedule. Forbis notes that “doing these things may seem like an

impossible task, but you have to in order to better your patient care and improve your practice, not just to avoid getting sued.”

Aparna Ananth, MD, an anesthesiologist with Pacific Anesthesia in Tacoma, Washington, supports the idea that paying attention to these details can lead to positive patient outcomes.

“Physicians who don’t really understand how liability works will order every test and procedure in an attempt to protect themselves. This not only adds to cost within the system, but may also increase risk. But if you standardize processes, make fundamental decisions on how to run the business of medicine, communicate with your patients in ways they understand,

*(Continued on page 30)*

## MEDICINE AND THE COURTROOM: A UNIQUE PROGRAM TRAINING NEW PHYSICIANS ABOUT LIABILITY

Sophia is a 38-year-old married, nonsmoking female establishing with a new PCP. Her medical intake form reports a history of chest pain with a negative cardiac workup, thyroid cancer and subsequent hypothyroidism, hyperlipidemia, menorrhagia, GERD, and an esophageal stricture. Her family history is significant for cardiac disease, HTN, and hyperlipidemia, and she has a surgical history of laparoscopy for an ovarian cyst. She presents with a list of current complaints, none of them urgent, such as sinus problems, headaches, cold intolerance, and she is most troubled by a facial rash.



This is one of several true cases that are posed to residents during Physicians Insurance’s Medicine and the Courtroom—a new, interactive program that brings together attending physicians and their residents, claims experts, and defense attorneys to explore how and why patient care sometimes goes from the exam room to the courtroom.

Using a physician moderator and facilitator, the two-hour program reviews the medicine of the case. Participants learn that Sophia’s life-threatening condition will not be diagnosed for nearly two years, despite care by numerous additional providers—all of whom might have made a positive difference in her outcome.

What happened to Sophia? What might have prevented her poor prognosis and the resulting lawsuit? She saw seven providers in two years. Who might have caught this? What would “medicine in a perfect world” look like in this case? What was the claim? Was there anything unique about how the claim transpired?

Residents wrestle with not just the medicine (the standard of care), but also with patient responsibility and how the system supported or inadvertently hindered patient safety. This type of case-based learning is critical in a medical student’s education career. In fact, according to a recent *Health Affairs*

*(Continued on page 9)*

# HOW OFTEN Will I Get Sued?



**Even amongst the best and brightest physicians, it is commonly accepted that adverse patient outcomes happen. Statistically it's not a matter of if, but when. An adverse event could be due to potential complications from surgery or prescription medicine interactions, human error, or negligence. And sometimes the human body responds differently than expected, even when physicians apply consistent standards of care.**

In a study reported by the RAND Institute for Civil Justice and RAND Health, on average 7.4% of all physicians (regardless of specialty) had a claim annually, of which 1.6% made an indemnity payment. In addition, the study reports that by age 45, 36% percent of physicians in low-risk specialties are likely to have at least one medical professional liability claim compared to 88% of those in high-risk categories. By age 65, however, those numbers skyrocket: 75% of physicians in low-risk, and 99% in high-risk, categories will have at least one medical professional liability claim.

Physicians Insurance A Mutual Company's recent study of claims data compared a ten-year window of claims and lawsuits

by specialty, analyzing each and finding out how many claims eventually ended up in litigation (see Table 1, page 9). In some cases, when the data pool was not large enough to create a statistically reliable percentage, the study results provide a sense of likelihood—responding to a common question physicians ask: “What’s the likelihood I am going to get sued?”

*(Continued on next page)*

**BY AGE 65, 75% OF PHYSICIANS IN LOW-RISK, AND 99% IN HIGH-RISK, CATEGORIES WILL HAVE AT LEAST ONE MEDICAL PROFESSIONAL LIABILITY CLAIM.**

\* A STUDY REPORTED BY THE RAND INSTITUTE FOR CIVIL JUSTICE AND RAND HEALTH



## DOWNLOAD YOUR PATIENT SAFE™ TOOLKIT

Physicians Insurance has developed a risk management practice-assessment program called the Patient SAFE™ Medical Practice Survey. Patient SAFE is based on three years of our insureds' claims data showing a correlation between a physician's claim losses in dollars and how closely the physician's practice followed ten standards in the delivery of patient care.

Download our easy-to-administer practice-evaluation tool that assesses the use of each of these ten safety standards. These ten standards can become part of your regular checklist systems that foster communications between providers and patients, and between providers and consultants.



[www.phyins.com/risk-management/patient-SAFE](http://www.phyins.com/risk-management/patient-SAFE)

(Continued from page 7)

### SOLUTIONS TO DECREASING RISK

In an article in *Medical Economics*, author Susan Kreimer highlights six practices for mitigating common risks in office-based practices. They include being open and honest in communications, offering explanations that make sense to patients who are facing decisions or unanticipated outcomes, ensuring informed consent, keeping up on standards and training, and following up on diagnostic tests and referrals. She also notes that variances in procedures and policies, and physicians' avoidance behaviors after an event, contribute to increased risk and should be addressed.†

Medical chart documentation standards are also key to improving patient safety and reducing risk. Providers who have scored high on compliance of these standards have had fewer medical professional liability claims.

### Ten standards have been identified as best practices in patient care chart documentation:

1. Use of problem and medication lists
2. Prominent notation of allergies/adverse reactions
3. Use/documentation of telephone triage
4. Effective on-call after-hours coverage
5. Legible medical records with correct notation of errors and additions
6. Informed consent documentation
7. Use/documentation of patient follow-up tracking system
8. Use/documentation of test tracking system
9. Use/documentation of consultant tracking system
10. Signing of incoming reports

### YOU ARE NOT ALONE

If and when a claim happens, Physicians Insurance works alongside the physicians, clinic, and hospital to navigate the process effectively and efficiently. Since every claim is unique, and each claim will develop in its own way, we use professional and experienced claims staff and attorneys who specialize in the defense of medical professional liability litigation. In other words, you're not alone. For more information about how we approach claims, please feel free to call Physicians Insurance to speak with a claims representative. <sup>PR</sup>

†Susan Kreimer, "Six Ways Physicians Can Prevent Patient Injury and Avoid Lawsuits," *Medical Economics*, December 10, 2013, accessed March 7, 2014, <http://medicaleconomics.modernmedicine.com/medical-economics/news/six-ways-physicians-can-prevent-patient-injury-and-avoid-lawsuits>.

How Often Will I Get Sued / Table 1

## PERCENT OF INCIDENTS RESULTING IN LAWSUITS

SPECIALITY	PERCENT
Plastic Surgery	41%
Neurological Surgery	39%
Urgent Care	38%
Neurology	36%
Pathology	33%
Cardiovascular Surgery	32%
Orthopedic Surgery	32%
Urological Surgery	32%
Otolaryngology	32%
General Surgery	31%
Colon and Rectal Surgery	30%
Radiology	30%
Emergency Medicine	30%
Cardiovascular Diseases	30%
Anesthesiology*	30%
Allergy	30%
Obstetrics and Gynecology	29%
Family Practice	29%
Ophthalmology	28%
Internal Medicine	27%
Hospitalist	27%
Pulmonary Diseases	26%
Obstetrics, Family & General	26%
General Practice	26%
Gynecology	24%
Pediatrics	24%
Thoracic Surgery	22%
Dermatology	22%
Gastroenterology	21%
Psychiatry	20%
Physical Medicine & Rehab.	18%
Administrative Medicine	0%

**Table 1:** Based on Physicians Insurance claims data over a ten-year period, this table indicates the percentage of all claims, by specialty, that ended up as lawsuits.

\*Does not include tooth claims.

(Physicians Insurance’s *Medicine and the Courtroom*, Continued from page 6)

article, the average physician will spend nearly 11 percent of his or her 40-year medical career with an open, unresolved malpractice claim.\*

When new physicians are on-boarded at a clinic, systems may or may not be in place to teach them about liability. Early-to-practice physicians don’t know what the process will demand of them, what the outcome will be, and how it will affect their career. They don’t know if they’ll be able to defend their case or whether it will settle, which prompts mandatory reporting. Larger clinics may have more formal processes for educating their newer staff, but not necessarily. And smaller clinics, those with fewer than 20 physicians, are likely to have little formal training around legal concerns.

Medicine and the Courtroom provides an early introduction to liability, trials, case law, common misperceptions, and the role of the physician during the claim process. 

.....

\*Seth Seabury, Amitabh Chandra, Darius Lakdawalla, and Anupam Jena, “On Average, Physicians Spend Nearly 11 Percent of Their 40-Year Careers with an Open, Unresolved Malpractice Claim,” *Health Affairs* 32 (2013): 111-119.

### Program Information

For more information about the *Medicine and the Courtroom* program taking place in Spokane on May 22, contact Physicians Insurance at:



(800) 962-1399



risk@phyins.com



# THE ART OF A GOOD DEPOSITION

BY BRUCE W. MEGARD, JR., JD

Thanks to television, many people think of a deposition as something that happens under a glaring light bulb in a dimly lit room, while attorneys grill witnesses with trick questions. Understanding what actually happens at a deposition, and how to deliver a powerful presentation, is important to a successful legal outcome.

For physicians, depositions are stressful and unnatural experiences. The process of being interrogated about allegedly negligent patient care is unnerving and atypical from the interactions and communications that physicians have with their patients and others during the course of any given day. Despite the discomfort, it is important for physicians to give good depositions. To do this, physicians should understand the deposition's purpose, know how to tell the truth when answering varying and difficult questions, and obey the rules of a deposition.

Physicians can be deposed as defendants, as treating physicians in some type of personal injury case, or as expert

witnesses who have been hired by a party either to be critical of, or to defend, another physician's care and treatment. The type of testimony the physician gives, and the extent of such testimony, varies depending on which context applies. A physician giving testimony as a defendant in a lawsuit must present well, must know the facts and the medicine, and must stay within his or her area of expertise.

## THE PHYSICIAN MUST PRESENT WELL

Physicians' depositions are one of the most important parts of the case. While many physicians see it as an opportunity to tell their side of the story, the purpose of the deposition is really for the patient's attorney to assess the physician as

a witness and to pin the physician down on critical points regarding the patient's care so that he or she can use the testimony to frame favorable questions and theories at trial. Therefore, the physician needs to look and sound professional, and while it can be difficult, the physician should maintain a calm and pleasant, yet compelling, demeanor. Physicians' depositions are often recorded by video, which can be shown during trial, so appearing unkempt, flippant, or sarcastic is not beneficial for the defense.

From a communications perspective, the general rule is "less is better." This not only helps keep the deposition shorter, but it keeps the deposition focused and helps physicians avoid volunteering extraneous information. Taking care not to present as uncooperative, physicians should listen to the questions asked and provide short, well-reasoned, responsive answers. This helps prevent the plaintiff's attorney from obtaining the sound bites and points that are critical to the plaintiff's case. Working with an attorney prior to deposition helps physicians understand when less is better or when a little more is helpful.

### **THE PHYSICIAN MUST KNOW THE FACTS AND THE MEDICINE**

To present as strong witnesses, physicians should ensure that they understand the basic medicine involved and the issues in the case. The testimony by a physician who does not know the medicine can have a devastating impact on the case. Physicians should not only understand the basic medicine, but should also understand current trends, changes, or developments in the medicine involved, variations in the type of treatment that may be provided, and any relevant peer-published

guidelines or consensus statements. When and how to obtain relevant literature should be discussed with the physicians' attorneys prior to deposition.

Just as important as knowing the medicine is knowing the specifics of the care and treatment at issue. Knowing a patient's record without continuously referring to it during a deposition demonstrates both that the defendant is invested in defending the case and cares about the particular patient. In cases where there is only one visit at issue, physicians should completely and thoroughly know the relevant record. On the other hand, in cases where the care and treatment is extensive and involves a long period of time or a lengthy hospitalization, physicians should have a sufficient working

knowledge of the medical record, with specific knowledge of key points, so that they can discuss the care without constantly referring to the medical records. The medical records are available during a deposition, and physicians have a right to refer to them before answering questions if needed.

### **THE PHYSICIAN SHOULD STAY WITHIN HIS OR HER EXPERTISE**

Physicians who limit their testimony to matters that are only within their area of expertise help ensure a strong deposition. Unlike a lay person, physicians cannot only testify on factual issues, but can also give expert opinion testimony regarding the essential elements of the case. In so doing, physicians should limit their answers to matters that are only within their area of expertise. While the care and treatment at issue will be within a defendant physician's area of practice, the alleged harm or injury suffered may not. A common example of this would be alleged negligent care and treatment by a primary care provider that is then followed by an alleged cardiac injury like a myocardial infarction. The primary care physician in such an example should be careful to testify only about the

*(Continued on page 26)*

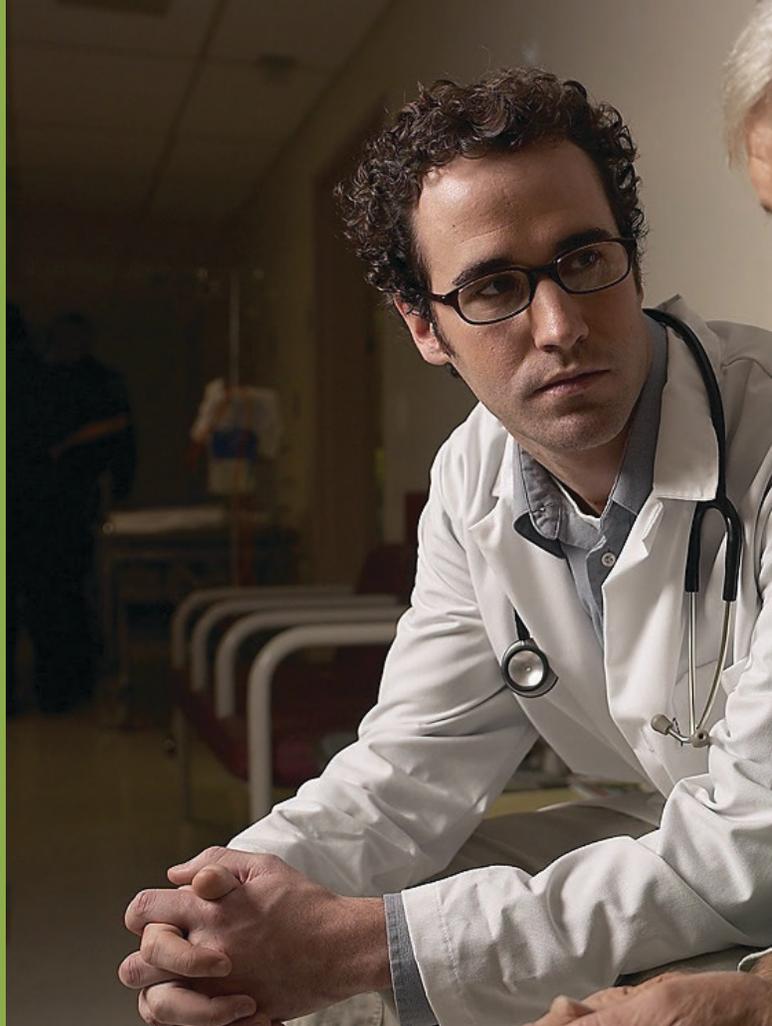


**THE KEY TO PROVIDING A QUALITY DEPOSITION IS TO PRACTICE—AND PHYSICIANS' ATTORNEYS TYPICALLY PROVIDE THE TOOLS TO HELP PREPARE FOR THE DEPOSITION.**

# NEW HORIZONS IN Responding to Patients after Adverse Events

## IMPLICATIONS FOR PHYSICIANS

BY THOMAS H. GALLAGHER, MD, PROFESSOR  
OF MEDICINE, UNIVERSITY OF WASHINGTON



**The expectation that physicians disclose adverse events and errors to patients has been present for over a decade. Yet most evidence suggests that effective disclosure remains the exception rather than the rule.**

In the past, many risk managers, malpractice insurers, and defense attorneys advised physicians to say little or nothing to patients following adverse events or errors out of concern that open disclosure would increase litigation. However, new research suggests that many patients file lawsuits simply to find out what happened and whether any lessons have been learned. About 15 years ago, organizations including the Lexington Veterans Affairs Medical Center and University of Michigan launched programs encouraging open disclosure of adverse events and errors coupled with early, proactive offers of financial compensation when care was unreasonable. Now known as communication-and-resolution programs (CRPs), these initiatives led to reductions in the number of malpractice claims, the costs associated with settling them, and the time to resolution. CRPs implemented at Stanford and the University of Illinois at Chicago also reported positive results.

COPIC Insurance Company, a physician-directed mutual company based in Colorado, adopted a somewhat different strategy for their CRP, the 3Rs Program. 3Rs (recognize, respond, and resolve) which uses a no-fault approach to provide up to \$30,000 reimbursement for patients' out-of-pocket expenses and lost time, demonstrated success in limiting the likelihood of patients filing a malpractice claim. Notably, because COPIC's 3Rs program does not provide compensation in response to a patient's written demand, and because the program does not ask the patient to waive the right to sue, reimbursement payment through the 3Rs program is not reportable to the National Practitioner Data Bank.

### GETTING MORE ANSWERS

While the success of these early communication resolution programs was encouraging, many important questions remained about their widespread applicability. Therefore, in 2010 the federal Agency for Healthcare Research and Quality (AHRQ) funded seven large, statewide demonstration projects focused on patient safety medical liability reform. Physicians Insurance, along with investigators from the University of Washington and Harvard School of Public Health, helped lead the state of Washington's CRP, the HealthPact Communication and



Nonetheless, events are being reported into the system and barriers are being identified and addressed throughout the process.

## ELIMINATING BARRIERS TO SUCCESS

One critical barrier has been physician concern about whether participating in the CRP might increase the chances of a Medical Quality Assurance Commission review. Addressing this issue, the HealthPact team worked closely with the commission and other key stakeholders, including Physicians Insurance and the Washington State Medical Association, to develop a pilot program of CRP certification. Unanimously approved by the commission's members, the CRP certification pilot program will include any cases that follow all of the CRP's recommended elements, as determined by a review committee of patient safety experts, and the commission has agreed not to independently investigate these cases, excluding certain exceptions.

CRP certification represents a major positive development for physicians in Washington State, and indicates an important commitment by all stakeholders to incorporate principles of just culture—which seeks an appropriate balance between individual and system accountability for adverse events—in their work.

Resolution Program (formerly known as the HealthPact Disclosure and Resolution Program).

The HealthPact program seeks to understand whether the CRP approach that has been successful in closed, self-insured academic health settings can also work in settings where collaboration is required between multiple insurers or stakeholders. The CRP in Washington, which has been in place for 18 months, involves Providence Regional Medical Center in Everett, Providence St. Mary Medical Center, Providence Sacred Heart Medical Center, the Everett Clinic, the Vancouver Clinic, the Polyclinic, Swedish Medical Center, and Physicians Insurance.

As with any widespread culture change, start-up of the HealthPact CRP has been time-consuming and gradual.

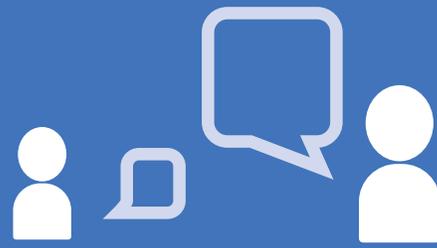
## PROVIDER SUPPORT

Important lessons are also being learned about the critical role that provider support plays after adverse events and errors. Many clinicians experience distress following adverse events and errors, and oftentimes that distress goes unsupported. The unmet emotional needs of providers in these situations can have dramatic consequences for both the health care team and for patients. Fortunately, Physicians Insurance has launched the innovative Peer Support Program for clinicians who have played a role in an adverse event. Clinicians and organization leaders should be aware of this important resource and take advantage of it should the need arise.

*(Continued on page 15)*

**PHYSICIANS INSURANCE IS A KEY PARTICIPANT IN REGIONAL AND NATIONAL INITIATIVES THAT PROMISE TO ACCELERATE PROGRESS IN DISCLOSURE OF ADVERSE EVENTS, AND PROVIDE PRACTICAL TOOLS AND RESOURCES FOR PHYSICIANS.**

# PATIENT PERSPECTIVE on Apology



We spoke with two patients actively involved in patient advocate groups at local medical institutions. Here are some of their insights on what can help make a bad outcome a little better.

## OLGA OWENS

*Olga Owens has been involved as a patient advocate at Seattle Children's Hospital, the Washington Patient Safety Coalition, and the HealthPact Disclosure and Resolution Work Group.*

**Q After your own devastating event involving your newborn son, you were recruited to participate in multiple patient-feedback groups. What culture shifts have you seen during those five years?**

**A** I've seen medical institutions treat patients as customers rather than just patients and start actively soliciting feedback. I think listening to the patient voice gives an institution a broader perspective of how their processes affect the people coming in through their doors.

**Q What should physicians remember so they can better relate with patients after an adverse event?**

**A** A bad outcome can be earth-shattering for a patient and their family—it is not an everyday occurrence for them. In the face of this stress, they might seem—and be—unbalanced, emotional, or angry. They need acknowledgment and honest communication. They need their physician to act not only as a medical professional, but as a human being who can help the family understand the experience and their new reality moving forward.



## JENNIFER GLICK

*Jennifer Glick has experience as a patient advocate at the University of Washington and the HealthPact Disclosure and Resolution Program Work Group.*

**Q What do patients want after an adverse event?**

**A** Many patients do not immediately go to “the blame game.” They just want to hear and understand what happened. Many lawsuits take place because people just want to know and understand what happened and no one is talking to them.

**Q What should physicians keep in mind when communicating with patients?**

**A** Using medical terminology may be very natural for physicians, but it is a foreign language for patients. As soon as physicians use “their language,” they are inadvertently putting up a barrier. They should remember they are communicating with a layperson.

**Q What have you observed in your time volunteering on advocacy groups?**

**A** Before this, I had no idea so many people besides patients were working on shifting the culture of physician communication. I wish more patients knew how much health care providers are involved. At the same time, there is still a lot of resistance to patient-centeredness, which seems rooted in misconceptions about patients demanding more control. Patients don't want to be in charge of their health care necessarily; they want to be educated and consulted. It's when physicians put up their guard that the relationship can get adversarial.



Watch the video at:  
[www.phyins.com/Jennifer](http://www.phyins.com/Jennifer)



(Responding to Adverse Events, continued from page 13)

## PATIENT SAFETY ON A NATIONAL LEVEL

Interest in the potential of Communication and Resolution Programs to improve patient safety and reduce malpractice liability continues to accelerate nationally. The success of the demonstration projects has led AHRQ to fund the development of a national CRP toolkit. The toolkit assembles important resources to assist clinicians and institutions in improving the response to medical injury, including state-of-the-art tools for adverse event reporting, analysis, communication and resolution, and care for the caregiver. After piloting, the toolkit resources will be widely available.

Lastly, the HealthPact team is leading the creation of a national collaborative for accountability following medical injury. This coalition will involve all of the leading organizations and experts around communication and resolution programs, including representation from Physicians Insurance, and will promote sharing of best practices, encourage collaborative advocacy for reform to the regulatory environment (such as the National Practitioner Data Bank), and provide a vehicle to identify and test innovations in this area.

In summary, the imperative to respond effectively to patients and the health care team following medical injury is moving rapidly from an aspiration to reality, with Physicians Insurance and other Northwest institutions continuing to play a vital role. 



*Dr. Thomas Gallagher is a general internist and professor at the University of Washington. He is an internationally known patient safety expert and the principal investigator on the AHRQ demonstration project.*

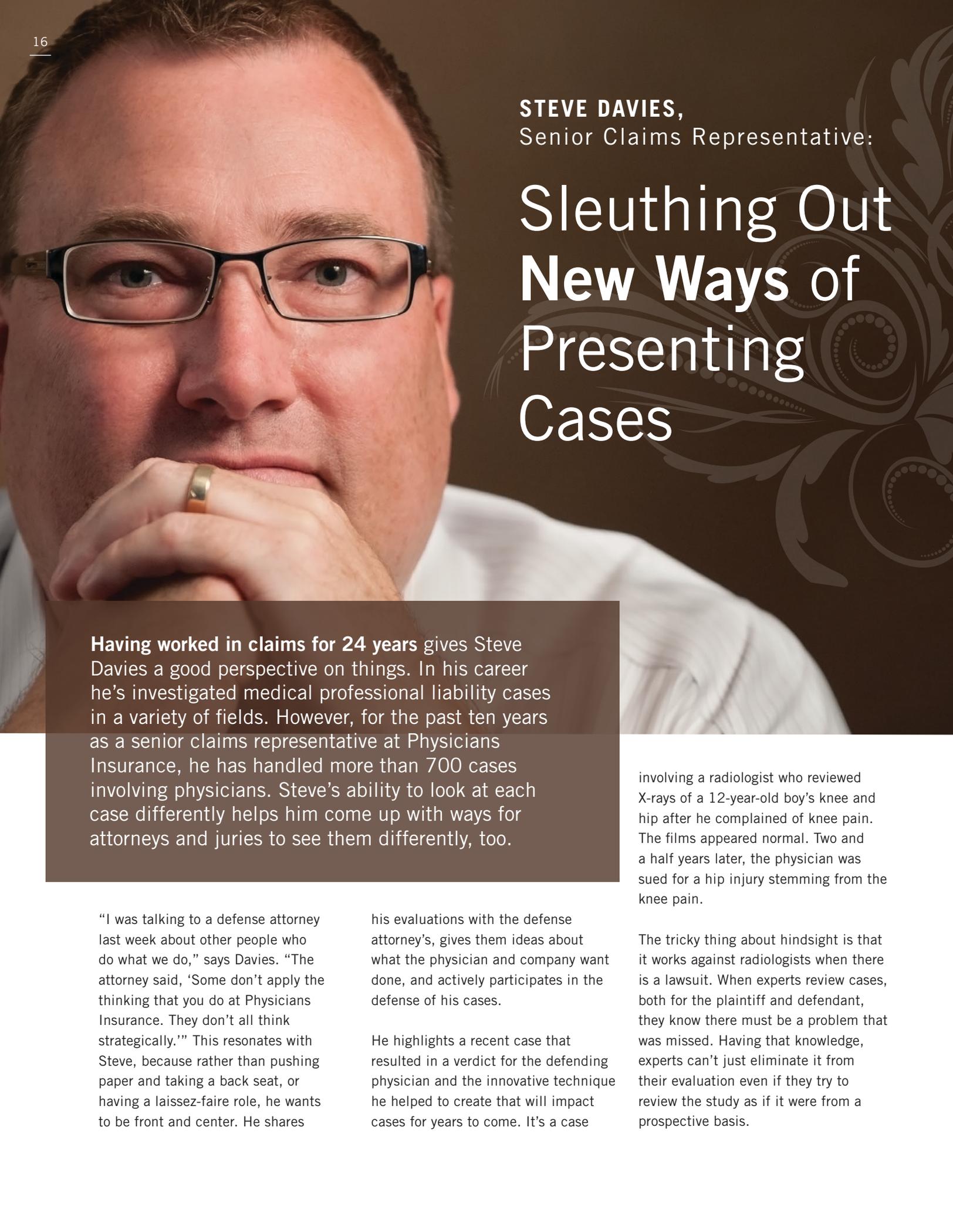


## GET PEER SUPPORT: Speak with a peer who has been there.

Clinicians often experience distress that goes unsupported following an adverse event or error, resulting in dramatic consequences for the health care team and their patients. As a part of our **Leading Well Provider Support program**, Physicians Insurance has launched the innovative Peer Support Program to provide the support of colleagues who have walked the same difficult path.



Learn more at:  
[www.phyins.com/peersupport](http://www.phyins.com/peersupport)



**STEVE DAVIES,**  
Senior Claims Representative:

# Sleuthing Out New Ways of Presenting Cases

**Having worked in claims for 24 years** gives Steve Davies a good perspective on things. In his career he's investigated medical professional liability cases in a variety of fields. However, for the past ten years as a senior claims representative at Physicians Insurance, he has handled more than 700 cases involving physicians. Steve's ability to look at each case differently helps him come up with ways for attorneys and juries to see them differently, too.

"I was talking to a defense attorney last week about other people who do what we do," says Davies. "The attorney said, 'Some don't apply the thinking that you do at Physicians Insurance. They don't all think strategically.'" This resonates with Steve, because rather than pushing paper and taking a back seat, or having a laissez-faire role, he wants to be front and center. He shares

his evaluations with the defense attorney's, gives them ideas about what the physician and company want done, and actively participates in the defense of his cases.

He highlights a recent case that resulted in a verdict for the defending physician and the innovative technique he helped to create that will impact cases for years to come. It's a case

involving a radiologist who reviewed X-rays of a 12-year-old boy's knee and hip after he complained of knee pain. The films appeared normal. Two and a half years later, the physician was sued for a hip injury stemming from the knee pain.

The tricky thing about hindsight is that it works against radiologists when there is a lawsuit. When experts review cases, both for the plaintiff and defendant, they know there must be a problem that was missed. Having that knowledge, experts can't just eliminate it from their evaluation even if they try to review the study as if it were from a prospective basis.

So, when you know that a plaintiff attorney who sent you an X-ray wants you to review it because he's thinking of filing a lawsuit, "you just can't go and look at that film like it's the day that you initially read it," says Davies. "When experts look at these cases, they've got that hindsight bias, even if they don't know the outcome."

Drawing on his investigative experience, Davies wanted to come up with a way to eliminate the hindsight bias in this case. His approach created the winning difference. "I suggested to our attorney that instead of sending one record—one or two X-rays of one patient—let's put together multiple studies that the experts could look at and they won't know which case it is." The attorney and our insured

it's different when you've attended that deposition in person and seen it firsthand. So you can really walk away, I think, with a better understanding, a better analysis of the case."

In the radiology case, when the defense attorney sat down with the medical expert to review the 19 studies, and the expert didn't see any abnormality in the real film, that's when Davies and his team confidently recommended trial. Focus groups were conducted and confirmed the evaluation that there was a strong case. And that's where even more creativity was used to battle this hindsight bias.

"We knew that the plaintiffs had experts who would come in and offer criticisms during the trial. But we felt the real

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**"BEING INVOLVED in all aspects of a case, and sleuthing out new ways of presenting information, are critical to a good defense."**

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took that idea to the next level. The result was a total of 19 studies from 19 different patients. Recalls Davies, "And then our attorney met with our experts and, by golly, that worked—you're really then putting yourself in the day in the life of a radiologist. You don't know which one it is. There're going to be abnormal studies. There're going to be normal studies. There're going to be close calls. There're going to be obvious calls. And there's going to be this one."

Davies feels he can bring ideas like this to the table because the full weight of the company and its expertise are behind him. This also means everyone involved from company management, to the defense attorney, to Steve are familiar with the details of each case. "You get to know your policyholders better because you're meeting them individually and you're communicating with them throughout the case," he says. "You meet them at the initial meeting of the claim stage. You meet them again if it turns into a lawsuit. Then you meet them at their deposition. And all this personal involvement builds confidence and rapport when they can sit across and know that they've got somebody that knows what they're doing. It instills the confidence in them."

Davies adds that the plaintiff's deposition provides him with firsthand perspective as well. "You're seeing how well they do. You're seeing them tell their story. You're seeing if it's believable and credible." Comparatively, some companies just wait for the deposition reports from the attorneys. "But

focus was this hindsight bias. So, in the opening statements the attorney explained this concept and put an image up on the screen of hundreds of coffee beans. And then in one of the beans in one little spot there's a face." When jurors first looked at the image they didn't see it. "Then our attorney pointed it out and said, 'See that right there?' And then throughout the trial he put it back up there. And it's the hindsight bias. Once you know that there's something that's there, your eye goes right to it and that's all you see." 

**"WHEN EXPERTS look at these cases, they've got that hindsight bias, even if they don't know the outcome."**

STEVE DAVIES

**TAKING CARE:**

# Blogging Our Way to Patient Safety

Featuring our physician members as guest authors



Wondering how your peers maximize their EMR to improve patient relations? Want to hear what other physicians are doing in terms of opioid agreements? Thinking about incorporating an interpreter into your practice? Up to 77% of Internet users read blogs, and they do so because they find the content interesting and trustworthy. Knowing that blogs are a powerful way to share very specific knowledge to a key group of people, we launched our blog in 2013 with a focus on patient safety. Now you can check in regularly to learn from case studies and local physicians' groundbreaking successes in patient care.

Titled **Taking Care: Safer Practices, Happier Patients**, our blog articles are developed by our own risk management experts and external guest authors. If you've visited our blog lately, you might have recognized a few colleagues' names:

## IMPROVING OBSTETRICAL CARE, ONE HOSPITAL AT A TIME

*By Kristin Sitcov, Ellen Kauffman, MD, & Terry Rogers, MD*

## HOW I USE MYCHART TO BENEFIT MY PATIENTS AND MY PRACTICE

*By Susan Baumgaertel, MD*

## SIMULATION TRAINING: MY JOURNEY TO IMPROVE TEAMWORK AND SAVE PATIENTS' LIVES

*By Angela Chien, MD*

## SIX ELEMENTS OF A PREAMBLE TO AN OPIOID AGREEMENT

*By Michael Schiesser, MD*

Have some patient safety topics you'd like to see explored on the blog? Or a topic you've mastered and would like to author?

Feedback and suggestions are welcome at [takingcare@phyins.com](mailto:takingcare@phyins.com). 



Visit our blog,  
[www.phyins.com/taking-care](http://www.phyins.com/taking-care)

## CLARITY ON WASHINGTON STATE AMENDMENT

# Electronic Prescription of Schedule II Controlled Substances – Allowed, Not Mandated

Washington members recently received notification from Physicians Insurance about the state amendment allowing for electronic prescription of Schedule II controlled substances. The amendment provides that it is allowable—but not mandated—that Schedule II controlled substances may be both prescribed and dispensed pursuant to an electronically communicated prescription.

This amendment aligns Washington policy with the federal Uniform Controlled Substances Act, which was amended to allow the electronic prescription of Schedule II controlled substances in 2010.

### What this means to you:

Importantly, like the federal law, this amendment does not mandate that Schedule II prescriptions must be prescribed electronically, nor does it mandate that pharmacists must fill prescriptions they receive electronically. It simply allows for it. This legislation does not necessarily change your prescription process for these medications, unless you have verified the recipient pharmacist is now accepting electronic prescriptions for Schedule II controlled substances.

## MORE TO KNOW

> This amendment also says that prescriptions for Schedules III through V cannot be filled or refilled beyond six months from the issue date or refilled more than five times, unless renewed by the practitioner, regardless of the form of the prescription. Previously, schedule prescriptions often defaulted to the one-year expiration for a noncontrolled substance prescription.

> To prescribe electronically, you must be using an electronic prescription system approved by the Washington State Pharmacy Quality Assurance Commission. A list of approved systems is available on the commission's Web site. Providers may also apply for system approval by submitting a request for review through a form available from the commission's "Electronic Rx Transmission Systems" page. <sup>PR</sup>

 For more resources, visit [www.phyins.com/meds](http://www.phyins.com/meds)

**RISK MANAGEMENT TIP CARD**

**AMENDED WASHINGTON STATE LAW** Changes to Dispensement of Schedule II Controlled Substances

**Effective July 28, 2013**, Washington law was amended to provide that Schedule II controlled substances may now be dispensed pursuant to an electronically communicated prescription. A Schedule II prescription may not be filled more than six months after the date of issuance.

In addition, the law clarifies that a prescription for Schedules III through V cannot be filled or refilled beyond six months from the issue date or refilled more than five times, unless renewed by the practitioner, regardless of the form of the prescription. In the past, schedule prescriptions often defaulted to the one-year expiration for a noncontrolled substance prescription.

**Please post and share this information with all medical staff who have responsibilities around prescribing Schedule II substances.**

 **Physicians Insurance**  
A MUTUAL COMPANY



## CME COURSES

### **New!** How Risky Is Your EHR? Improving Patient Safety

#### **COURSE DESCRIPTION:**

Strong patient records strike a balance between structured data (data readable by a computer) and narrative information; maintaining this balance can be challenging. While electronic health records (EHRs) show promise for long-term quality improvement in health care, it's clear they are not a panacea for patient safety problems in the short run, and may initially contribute to patient safety events. There is growing evidence that a variety of EHR-related patient safety events occur frequently, including errors such as wrong patient, wrong field, wrong time, failure to finalize transaction, misreading or misinterpreting displayed information, and providers incorrectly accepting default values when entering orders.

#### **At the conclusion of this one-hour e-learning course, participants should be able to:**

- Describe the most common types of EHR patient safety events.
- List the most frequently occurring EHR patient safety events.
- Identify EHR patient safety events in your practice.
- Implement risk strategies to minimize risk of EHR patient safety events.

#### **WHO SHOULD TAKE THIS COURSE:**

Physicians of all specialties and other allied health care staff



### **New!** Informed Consent: More than Just a Form

#### **COURSE DESCRIPTION:**

National data indicates that more than one-third of all malpractice claims and lawsuits allege a failure to obtain informed consent. The truth is patients are not as informed as physicians think. A recent study showed that actually only 40 percent of patients think the informed consent they signed reflects their actual understanding of the procedure and its risks and benefits. Informed consent is a process, not just a piece of paper, and good informed consent practices have measurable benefits. Patients have a better understanding of the procedures and/or treatments proposed, improved patient satisfaction, improved patient compliance, and better clinical outcomes. This one-hour webinar will help physicians better understand informed consent as a process and its importance to both themselves and their patients.

#### **At the conclusion of this educational activity, participants will be able to:**

- Describe the elements of informed consent and why informed consent is required.
- Discuss the importance of informed consent to both patient and provider.
- Create a "procedure specific" consent form for common procedures within the practice.
- Describe informed consent requirements when dealing with the "incompetent" patient and with minors.

#### **WHO SHOULD TAKE THIS COURSE:**

Physicians involved in patient care and the informed consent process

## New! Dangers of the EMR for Urologists: Increasing Patient Safety and Lowering Liability

### COURSE DESCRIPTION:

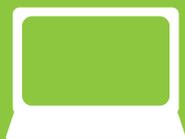
The electronic medical record can be a great ally in patient safety and care coordination—or it can expose lapses in critical communication and overwhelm you with conflicting data. This webinar gives you practical guidelines for using the EMR to your best advantage. It includes urology-specific case examples of how to manage alerts and macros, how to steer around pitfalls, and how to ensure agreement between different parts of the record. Part I is presented by a national authority in urology, Carl Olsson, MD. Part II includes an interview between board-certified urologist Kathleen Latino, MD, and top trial lawyer Elizabeth Leedom. Both components show you how to improve patient care and bolster your defense in the event of a malpractice claim.

### At the conclusion of this one-hour webinar, participants will be able to:

- Summarize the extent of malpractice claims and payments in urologic practice.
- Cite the most common liability pitfalls related to use of the EMR.
- Describe examples of disconnects between parts of the EMR.
- Implement recommendations of the proper use of EMR to decrease practice liability.

### WHO SHOULD TAKE THIS COURSE:

Urologists and ancillary personnel who use electronic medical records



Sign up for a course today:  
[www.PHYINS.COM/CME](http://www.PHYINS.COM/CME)



## Risk Management Tips for EMR

### COURSE DESCRIPTION:

Practitioners will learn from real case examples how EMR can both improve documentation and create potential litigation traps for the unwary. We will also explore how electronic discovery in a malpractice lawsuit interacts with the EMR and how awareness of these interactions can help the provider reduce liability exposure.

### Following this one-hour webinar, practitioners will be able to:

- Describe how EMR is utilized in a malpractice lawsuit, both by plaintiff and by the defense.
- Demonstrate strategies for using EMR to reduce liability risk.
- List common EMR pitfalls in the litigation context.
- Discuss the way electronic discovery impacts the development of the facts in a malpractice case.

### WHO SHOULD TAKE THIS COURSE:

Physicians and affiliated providers who use an electronic medical record



# From Banking to Family Medicine—

## It's *Always* about Relationships

**I**t was in an exam room with his wife that Jeffrey Geier's life would change. It wasn't the fact that he and his wife were expecting babies four and five (twins)—rather, it was during a conversation with the physician that the community bank president and CEO would learn of the opportunity to run a medical practice.

The practice needed a medical manager, not necessarily someone from the medical world, but someone who understood management and finance. Armed with an economics degree, banking background, and his own experience as a consumer of medicine, he took the challenge to manage his first medical group. Fourteen years later, Geier is administrator of Moscow Family Medicine, which serves a variety of patient needs at four facilities.

Upon entering medicine, Geier was most surprised by the complexity of managing a medical group. Accomplishing organizational goals in the medical world requires more teamwork than in the banking world. He says, "In medicine, every customer walking in the door is a unique individual with unique needs, wanting different things. It takes a lot more people moving in the same direction to meet those needs." And getting those people—a diverse range of employees from the highly trained and scientifically educated to the first-job workers—moving in the same direction is a challenge Geier relishes.

What makes it more challenging is the wide mix of patients they serve at their four locations. Although Moscow is a modest-sized town, its catchment area includes a varied population of 250,000. Farming, logging, and ranching are common vocations for many of their clients—and they have a desire for traditional family medicine. At the Main Street and West Side Clinics, their longtime patients expect to see the same physician they've come to trust and think of as their own, and they want this physician to care for their whole family. Moscow is the kind of setting where "we run into our patients all the time outside the clinic—at the

store, out on Main Street. Our kids go to school with their kids. Many of our patients appreciate and have come to expect a friendlier relationship with their doctor.”

In contrast, their QuickCARE Walk-In Clinic serves more emergent patient needs, promising through extended hours “the kind of care you need, when you need it.” Those patients want to see anyone who can help them and are not attached to seeing a specific doctor. “We never know who—or what ailments—will walk in. The challenge there is that you staff for what you think you’ll need, but it can be hard to get the staffing levels just right in that setting.”

And still in yet another health care setting Moscow Family Medicine operates, the University of Idaho Student Health Clinic cares for students and their dependents. In this situation “most of the patients are managing their own health for the first time, so the physicians get to spend a lot of time educating patients,” says Geier. However, in the university setting patients are accustomed to a more institutional approach to their care and don’t assume they’ll see the same physician from visit to visit.

Across the spectrum of locations and ways patients can get care, one of the most unusual things at Moscow Family Medicine is their longtime use of EMR. Having used EMR for more than 13 years, Geier feels that each system upgrade gives them new efficiencies—which is critical to helping them deliver high-quality care, as well as continuity of care, across their locations. “One of our longtime patients might need to be seen at the QuickCARE clinic over the weekend, and the staff there will have access to the patient’s medical record.” Plus, the EMR helps lift administrative burden by providing information physicians need before they examine a patient—triage detail, test results, previous office visits—and allows them to anticipate the care that might be needed, while making their time with the patient more connected and focused.

Regardless of the setting, one of the biggest challenges

## FAST FACTS

**ESTABLISHED:** 1983  
**TOTAL STAFF:** 85  
**LOCATIONS:** 4

- > MAIN STREET CLINIC
- > WEST SIDE CLINIC
- > QUICKCARE WALK-IN CLINIC
- > UNIVERSITY OF IDAHO STUDENT HEALTH CLINIC

**PHYSICIANS INSURANCE MEMBER:**  
 SINCE 2007

facing Moscow Family Medicine is finding family medicine physicians. Notes Geier, “More are retiring than are being trained. The current system doesn’t financially entice them.” Plus, given the downward trend on reimbursement levels, it is becoming harder to meet the special expectations patients have of family practitioners. Geier says, “It is time-consuming to have a strong one-to-one relationship with patients and to care for the whole family; each appointment might need to be longer to address multiple issues.” And that’s where Moscow Family Medicine distinguishes itself. “They use different words to say it, but all of our physicians just want to care for people,” says Geier. “For them, it is not ‘let’s get paid’ first, but ‘let’s take care of people.’”

That’s why Geier believes there is an art to practicing medicine. “It requires strong relationships—between the patient and the physician, as well as the nurses, the schedulers, the receptionists, and everyone involved in caring for our patients.” Moscow Family Medicine has been caring for patients for 30 years. In fact, two of their founding physicians are still on staff, Dr. Ruby and Dr. Spain. “We joke that they delivered the babies of the babies they’ve delivered,” says Geier—which means they must be doing something right. PR

## Welcome to all our New Physicians Insurance Members

**Cascade Kidney Specialists, Bellevue, WA**

**Keystone Medical Services, Auburn, WA**

**Ideal Option, Kennewick, WA / Yakima, WA**

**Physicians Immediate Care,  
 Richland, WA / Meadow Springs, WA**

**Spine Institute of Idaho, Meridian, ID**

**Washington Sports Medicine, Kirkland, WA**

# OUR COMMITMENT TO YOU:

BY CATHERINE WALBERG, JD

Tracking Legal Developments Important to Oregon, Washington, Idaho, and Wyoming members

This fast-changing health care environment makes it challenging to keep track of all the legislative and policy issues that impact physicians, clinics, and hospitals. That's why Physicians Insurance regularly monitors the status of numerous legal and regulatory issues on behalf of the medical and health care community. As we move into 2014, following are a few items with which we're engaging policymakers on your behalf.

## OREGON

In late 2013 the Oregon legislature passed Senate Bill 483, a voluntary early-discussion and resolution law titled Resolution of Adverse Health Care Incidents.

Under the new law, physicians, hospitals, other health care providers, and patients can initiate an early discussion among relevant providers and the patient about an *adverse health care incident*. (In SB 483, Section 1, adverse health care incident is defined as "an objective, definable, and unanticipated consequence of patient care that is usually preventable and results in the death of or serious physical injury to the patient.") When agreed to by participants, the discussion can include resolution of any issues surrounding the event and can include the payment of compensation.

- Discussions, subject to the law, are confidential and protected from discovery unless a communication during

the discussion contradicts a statement made during a subsequent adjudicatory proceeding and is material to the claims presented in such proceedings (SB 484, Section 4).

- Additionally, in any subsequent adjudicatory proceeding, any offer of compensation and the amount, payment, or acceptance of any compensation made during the early discussion and resolution process are inadmissible. Any compensation paid as part of the early discussion and resolution, however, reduces the amount owed under any subsequent judgment in favor of the patient (SB 483, Section 7).
- Additionally, insurers may not provide, and cannot be required to provide, information related to an adverse health care incident for credentialing purposes (SB 483, Section 15).

A Professional's Guide to SB 483  
Resolution of Adverse  
Health Care Incidents

### OREGON MEMBERS: Download the brochure on SB 483



[www.phyins.com/EDR](http://www.phyins.com/EDR)



Call (800) 962-1399

If you are notified that an early discussion has been initiated by a patient or another provider regarding an adverse health care incident, contact the Physicians Insurance Claims Department as soon as possible.

One open issue is whether payments made pursuant to the new Oregon law are reportable to the National Practitioner Data Bank.

- The law states that a payment made as part of the early discussion and resolution process is not a “payment resulting from a written claim or demand for payment” (SB 483, Section 6).
- This provision and other sections of SB 483 raise the question as to whether payments made as part of the discussion and resolution process are reportable to the Data Bank.
- Because the Data Bank obligation is governed by federal law, it is not clear whether the federal government will recognize Oregon’s attempt to shield resolutions under SB 483 from the reporting obligation.

The Oregon Patient Safety Commission and its statutorily created task force are charged with developing rules and regulations to implement the early discussion and resolution law. The commission anticipates proposing a draft of such rules in April 2014.

- Physicians Insurance will make suggestions and voice concerns as the new rules and regulations are developed and will serve as a trusted and valuable resource to the Oregon Patient Safety Commission as it implements the new law.
- Physicians Insurance will also participate in the open meetings of the commission’s Task Force and Rules Committee and the ad hoc Patient Advisory Committee, and Physicians Insurance defense attorneys will serve along with others on the ad hoc Implementation Stakeholder Committee
- We will continue to inform our members of developments relevant to this new law.

## IDAHO, WYOMING, OREGON, AND WASHINGTON

Of interest to all our members, Physicians Insurance continues its efforts on a national level to prevent patient safety and quality standards from being used as standards of care in litigation against health care professionals. Through the Physician Insurers Association of America (PIAA), a national trade association representing medical professional liability insurers, Physicians Insurance supports such legislation.



- Physicians Insurance recently joined a phone campaign to congressional members in support of the Standard of Care Protection Act (Toomey-Carper Amendment #1) as part of an amendment to the SGR fix clarifying that standards for best practices regarding patient safety and quality are not standards of care that can be used in litigation.

The Department of Health and Human Services (HHS) has issued a draft revision of the National Practitioner Data Bank Guidebook, which details the reporting obligations relating to credentialing decisions and professional liability payments made on behalf of health care providers.

- Members can request a PDF of the draft guidebook by e-mailing the Division of Practitioner Data Banks at [NPDBPolicy@hrsa.gov](mailto:NPDBPolicy@hrsa.gov).
- Physicians Insurance and the PIAA are drafting comments to HHS focused on clarifying the reporting obligations—since these can often impact resolution of a claim. Additionally, Physicians Insurance will continue to monitor the effect of any expansion of the availability of health insurance on liability exposure.

In these and many more ways, Physicians Insurance daily lives its commitment to monitor the legal liability issues that affect its members.

## WASHINGTON

- As more health care professionals and facilities gravitate to electronic health records (EHR), health care professionals and facilities struggle with limiting risks associated with EHR while at the same time maximizing EHR opportunities. A number of resources are available to support our members (see page 20 for courses).

*(Continued on page 29)*

*(The Art of a Good Deposition, Continued from page 11)*

medicine with which he or she is familiar and leave the more detailed testimony about the myocardial infarction and its sequelae to a cardiologist, cardiac surgeon, or other qualified specialist. The same is true if there are other physicians who are defendants (or nondefendant treating physicians) in the case who practice in different specialties. Because their expertise is different, leave the testimony about the others' care and treatment to them and their expert witnesses. Being a physician does not mean one should know the ins and outs of care provided by others or have an opinion about that care and treatment.

When answering a plaintiff's attorney's questions, physicians should never speculate. Instead, physicians should limit their answers only to matters about which they have personal knowledge. In many cases, physicians may not recall the patient or may not recall the specifics of the care and treatment that are at issue. Just because a specific recollection may be absent, however, does not mean that physicians do not have personal knowledge. In addition to having an independent recollection, physicians can rely on the medical records, as well as policies and procedures, routines, habits, and customs and practices. For a question about a matter for which a physician has no personal, firsthand knowledge, the answer should be "I don't know." Physicians are not required to know something even if the attorney asks the question more than one time.

### **CONTROLLING ACCURACY**

Furthermore, deposition testimony is taken under oath, and an attorney presumes that when physicians answer a question that has been asked, the question is understood. Oftentimes, though, that is not the case. Attorneys are not physicians, may not have a good understanding of the medicine, or may not be well-prepared, which can lead to awkward questions. That is why it is very important that physicians make the attorney ask good, articulate, coherent questions. Physicians can do this by asking to have the question rephrased or by asking for clarification. Doing this helps ensure accuracy in the record (remember, it can be

used at trial), gives physicians additional time to formulate cohesive responses, and simply forces the plaintiff's attorney to ask a well-developed question. It also allows physicians to be involved in controlling the pace of the deposition and the types of questions asked. And if the attorney misstates something as part of the question, physicians should point out the error in the answer.

Finally, physicians should exercise caution in responding to hypothetical questions. Because physicians are somewhat unique in that they can respond to questions calling for factual responses and opinions, plaintiffs' attorneys will frequently attempt to establish basic elements of their case by using hypothetical questions involving circumstances similar to those at issue, such as "Let's say you have a patient who . . ." Physicians should keep in mind that, depending on the hypothetical question, they do not need to respond with a "yes" or "no" answer. They do not need to agree with a hypothetical. The hypothetical question will inevitably be missing critical clinical information and involve a patient that the deponent has not examined or evaluated. If the question simply calls for general medical knowledge, physicians should first clarify on the record that the attorney is not talking about the patient at issue. Second, if appropriate, physician should inform the attorney that they cannot answer the question as posed because more information would be needed to assess the patient and provide a response.

### **YOUR TIME TO SHINE**

The key to providing a quality deposition is to practice—and physicians' attorneys typically provide the tools to help prepare for the deposition. It is up to the physicians, however, to use those tools both in continuing to prepare for the deposition on their own and at the deposition itself. The attorney cannot answer the questions for physicians at their depositions. The physicians' attorneys can object to a question for various reasons at the deposition, but in most instances, the physician will still need to answer the question. The objection should alert physicians to problems with the question and cause them to draw on the strategies developed during preparation to address the problems with the question.

Ultimately, physicians should practice and use the skills necessary to impress on the plaintiff's attorney that they make good witnesses. Whether being deposed or giving testimony at a trial, it is important to remember that the physicians' experience will not be like what is seen on television or in the movies. For sure, the stakes are usually high and the process can be intimidating. But with practice, preparation, and by following the advice of the attorneys, neither the deposition nor trial testimony need to be feared. 

**WITH PRACTICE, PREPARATION,  
AND BY FOLLOWING THE ADVICE  
OF THE ATTORNEYS, NEITHER  
THE DEPOSITION NOR TRIAL  
TESTIMONY NEED TO BE FEARED**

# HOW TO REPORT AN INCIDENT OR CLAIM



While we hope you will not need to file a claim, we offer the following information to help you quickly and easily report any incident.



## MEDICAL PROFESSIONAL LIABILITY CLAIMS

Whether you prefer to discuss an incident over the phone or submit information to us online, we have secure and protected channels to support you. In the interest of confidentiality, do not report claims, or refer to any specific claims, by e-mail or fax. Please use the following methods to report claims or to discuss incidents or related issues.

- PHONE:** (800) 962-1399  
Mon-Fri, 8 a.m. – 5 p.m. PT
- MAIL:** PO Box 91220, Seattle, WA 98111
- ONLINE:** [www.phyins.com/claims/incident-form](http://www.phyins.com/claims/incident-form)



## BUSINESS OFFICE CLAIMS

If you have protection with business insurance policies you've purchased, note that each insurance policy has its own requirements for claims reporting.

*Here are some tips and tricks to make sure you get the most from your insurance protections.*

**WHEN TO CONTACT:** Check your policy's definition of a claim, which identifies when to report an incident or claim.

**REPORTING TIME FRAMES:** Pay special attention to your policy's notification requirements. If you fail to report an incident or claim within a required time frame, you could lose out on coverage.

**WHAT INFO TO INCLUDE:** Follow the instructions for what should be included when filing a claim. Some companies prefer details; others do not, depending on discovery and confidentiality issues. The claims representative assigned to you may ask for additional backup documentation. It's important to provide everything in a timely manner in order to meet possible legal deadlines.

**WHOM TO CONTACT:** A declarations page attached to the front of your policy usually provides an address or phone number to report your claim. When in doubt, you can ask your insurer or broker to assist you in locating reporting information in your policy. However, reporting a claim to your broker may not fulfill your reporting obligations under a policy, so be sure to always confirm your report directly with your carrier. **PR**

# Trial Results

Physicians Insurance is committed to informing its members about issues that impact health care professionals. The majority of cases resolved by settlement are confidential, so it is impossible to disclose all the issues and results of those cases. However, trials are a matter of public record and we are not constrained by confidentiality. While we share information we think may be informative, we choose not to disclose the names of participants when reporting trial outcomes. The following case summaries are selected from those that went to trial in 2013 and may represent some of the more prevalent issues facing providers today.



## Improper Performance

**SPECIALTY:** Anesthesiology

**ALLEGATION:** A 66-year-old male underwent a lithotripsy procedure requiring general anesthesia, and the procedure was uneventful. The patient met extubation criteria, and extubation began. After the patient developed an obstruction and two laryngospasms, the anesthesiologist immediately initiated all appropriate measures. The second laryngospasm proved refractory, the patient went into cardiac arrest, and the surgical team initiated CPR and called a code. After 73 minutes of resuscitation, the patient was revived but sustained an anoxic brain injury and died four days later. The plaintiff alleged wrongful death and high economic damages as the patient was a successful and prominent businessman. The plaintiff attorney also attempted to cast suspicion on the medical records, citing the nine-page addendum that had been prepared by the physician shortly after the patient's death, and alleged that the facility's electronic data had not been preserved.

**PLAINTIFF ATTORNEY:** Stephen Haskell, Stephen Haskell Law Offices, Spokane, WA

**PLAINTIFF EXPERTS:** John Olsen, MD, Cardiology, Seattle, WA; Richard Cooper, MD, Anesthesiology/Acute Resuscitation,

Toronto, Ontario, Canada; Carin Hagberg, MD, Anesthesiology/Difficult Airways, Houston, TX

**DEFENSE ATTORNEYS:** Dan Keefe, Keefe Bowman & Bruya, Spokane, WA; Mike McMahon, Etter, McMahon, Lamberson, Clary & Oreskovich, Spokane, WA

**DEFENSE EXPERTS:** Gust Bardy, MD, Cardiology/Electrophysiology, Seattle, WA; Jonathan Benumof, MD, Anesthesiology, San Diego, CA; Robert Caplan, MD, Anesthesiology, Seattle, WA; Tim Chestnut, MD, Pulmonology, Critical Care, Spokane, WA

**RESULT:** The jury agreed that the patient's underlying heart disease led to this result. Defense verdict (on appeal), Spokane County Superior Court, Judge O'Connor.

**COST TO DEFEND:**  
\$675,345.00 to date

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## Unnecessary Surgery

**SPECIALTY:** Cardiac surgery, pediatrics, and hospital negligence

**ALLEGATION:** A three-year-old female died eighteen days following a ventricular septal defect repair surgery.

The patient had been diagnosed with a perimembranous ventricular septal defect in the first year of her life. Her care had been discussed with the cardiologist and cardiac surgeon and presented at a care conference in which the consensus was to wait to perform surgery. Two years later, when the patient's case was again discussed, it was determined the chance of spontaneous closure had passed and surgery was recommended. The parents met with the cardiac surgeon in July 2009 and proceeded with surgery in October of 2009. The surgery was uneventful, and the patient was discharged with instructions on what to watch for. Twelve days post-procedure, the patient developed a cough and was seen by her pediatrician, with a normal exam. The patient also underwent an echocardiogram and chest X-ray, and it was determined the repair was successful. The patient's cough waxed and waned over the next few days, and other family members had similar symptoms. This occurred during the H1N1 flu outbreak and the patient received Tamiflu, prophylactically. Twenty-four days post-procedure, the patient developed chest pain and vomiting. One of the parents called a consulting telephone line and was advised to take the patient to the ER. The parent decided to wait for the other parent to return home. Several hours later, the patient's respirations became labored and the parents called 911. The patient

was airlifted to the hospital but died en route. The plaintiffs claimed that the surgery was not indicated or, alternatively, should have been performed at another institution and that the physicians failed to recognize and treat postpericardiotomy syndrome, resulting in wrongful death.

**PLAINTIFF ATTORNEYS:** Michael Wampold and Felix Luna, Peterson Wampold Rosato Luna & Knopp, Seattle, WA

**PLAINTIFF EXPERTS:** Anthony Azakie, MD, Pediatric Cardiothoracic Surgery, San Francisco, CA; Hugh Allen, MD, Pediatric Cardiology, Columbus, OH; Michael Brook, MD, Pediatric Cardiology, San Francisco, CA; Christopher Panchelli, RN, Exton, PA

**DEFENSE ATTORNEYS:** John Rosendahl, Williams Kastner, Tacoma, WA; Rando Wick, Johnson, Graffe, Keay, Moniz & Wick, Seattle, WA

**DEFENSE EXPERTS:** Victor Morell, MD, Pediatric Cardiovascular Surgery, Pittsburgh, PA; Carl Backer, Pediatric Cardiovascular Surgery, Chicago, IL

**RESULT:** Defense verdict, King County Superior Court, Judge Trickey

**COST TO DEFEND:** \$343,916

## Improper Performance

**SPECIALTY:** Vascular Surgery

**ALLEGATION:** A 50-year-old female alleged medical battery consisting of severe pain and emotional distress during a laser saphenous vein procedure for varicose veins. Although she said she had requested the procedure's termination while undergoing the procedure, the defense disputed this, saying the consent had been obtained and the procedure

had been performed with no request to terminate the procedure. The patient had returned to the office two days after the procedure and reported doing well with no discussion of the later allegations. Due to the nominal damages, the case was placed in arbitration with a \$25,000 damage cap.

**PLAINTIFF ATTORNEY:** Reed Schifferman, Law Offices of Reed Schifferman, Seattle, WA

**PLAINTIFF EXPERT:** None

**DEFENSE ATTORNEY:** Lory Lybeck, Lybeck Murphy, Mercer Island, WA

**DEFENSE EXPERT:** None

**RESULT:** Defense verdict, Arbitrator Steven Pruzan, Miracle Pruzan & Pruzan, Seattle, WA

**COST TO DEFEND:** \$5,242

*(Government Affairs, Continued from page 25)*

In addition, Physicians Insurance is monitoring the efforts by the Washington Medical Quality Assurance Commission (MQAC) to create EHR guidance. Recently, MQAC's Policy Committee approved the creation of an EHR sub-committee to evaluate the patient safety issues surrounding the use of EHR and to consider opportunities for publishing guidance.

- As health care professionals look for appropriate ways to use social media outlets yet stay within appropriate professional boundaries, Physicians Insurance and WSMA are working to develop practical advice on the use of social media/electronic communication in the clinical setting. A number of resources are available to support our members (see page 20 for courses). Additionally, Physicians Insurance and WSMA are sharing the health care professional's perspective with MQAC as it develops support material regarding social media and electronic communication.

- In Washington, Physicians Insurance and the Washington State Medical Association are closely monitoring any effort to expand the Wrongful Death Act. We are also working to curtail attempts to broaden Washington consumer protection laws to the learned practice of medicine. **PR**

### WASHINGTON MEMBERS:

Physicians Insurance continues to support the legislative efforts of the WSMA. For information on the legislative agenda:



Visit [wsma.org/legislative-agenda](http://wsma.org/legislative-agenda)

*(Where Medicine and the Law Meet, continued from page 6)*

then you improve patient health and experiences.” In other words, a healthy sensibility for liability allows practitioners to improve care overall, rather than resort to aggressively defensive medicine focused not on patient care but avoidance of litigation.

### INCREASING LIABILITY I.Q.

But all this is simply just good advice if physicians are not taught how to document in this manner—which begs the question of when to teach about risk and liability. Notes Dr. Ananth, “The day you hear about a lawsuit is not the best time to learn about it. In business school there are entire courses taught on business and the law; in medicine there may be only

Unfortunately, the training and education needed may not be what is being taught in medical school. In a 2009 survey conducted by Jackson Healthcare, those who were surveyed estimated that 34 percent of health care costs stem from defensive medicine. And 90 percent of the participants reported practicing defensive medicine in large part because that’s what they’re being taught. For relatively new-to-practice physicians (aged 25-34), 83 percent reported being taught to practice defensive medicine in medical school or residency by an attending physician or mentor. That number falls precipitously for physicians older than 65, with only 19 percent reporting being taught to practice defensive medicine. This means that, according to Gallup and Jackson surveys, “between \$650 billion and \$850 billion are being spent each year due to defensive, or lawsuit-driven, medicine,”\* which means that physicians are trying to do anything possible to avoid a lawsuit

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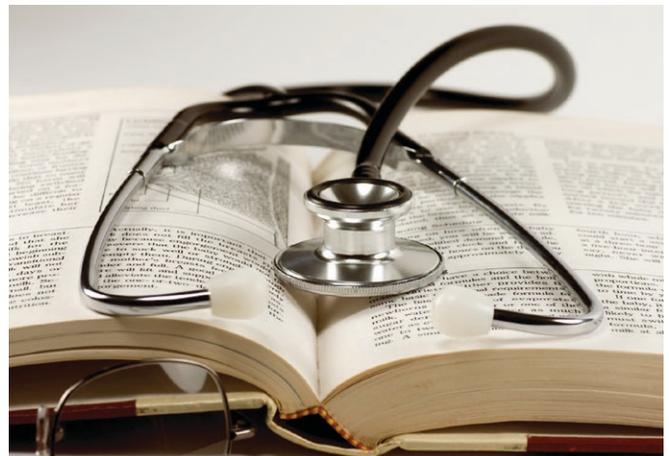
“Physicians who don’t really understand how liability works will order every test and procedure in an attempt to protect themselves. This not only adds to cost within the system, but may also increase risk.”

APARNA ANANTH, MD

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a few hours.” This simply is not enough, according to residency program director Dr. Ruiz. “I’d like to have this be a big part of the latter half of the third year into the fourth year of medical school, not during residency,” he says. During this time in a typical medical student’s career, there is a little less structure and more time for electives. “And,” notes Dr. Ruiz, “we have to move away from the traditional didactic to a case-based or simulation teaching method. This provides the medical student with a chance to think analytically about risks (medical and business) and discuss possible solutions.”

Leslie Struxness, MD, an obstetrical gynecologist with Aethna Gynecology Associates in Vancouver, Washington, agrees. “We need to give more than just lip service in residency. It might not even stick at that point and most new physicians don’t think about private practice anymore, so they aren’t thinking about their own professional liability—they believe someone else will take care of it.” Instead, Dr. Struxness suggests sprinkling liability throughout the curriculum for a more integrated medical school experience. “When you talk about EMR, documentation, patient communications, informed consent—those are teachable moments to also talk about potential liability. Liability doesn’t have to be a separate class or event; it can be woven into short, daily, in-the-moment conversations.”



“LIABILITY DOESN’T HAVE TO BE A SEPARATE CLASS OR EVENT; IT CAN BE WOVEN INTO SHORT, DAILY, IN-THE-MOMENT CONVERSATIONS.”

LESLIE STRUXNESS, MD

even when they know they should be trying to reduce the overall costs of medicine.

But even if physicians receive more liability education and training, how well do they understand the integration between defensive medicine and their effectiveness in patient care? “It’s not just about the medicine,” suggests Dr. Ananth. “Learning about where potential liability exists in your practice can make you a better physician. Having a comprehensive view of risk management, how to minimize or mitigate risks throughout your practice, how to see things from the patient as well as the physician perspective—all of this makes the system work better, improves patient care, and lowers costs.”

And that ideal presents an opportunity for the next generation of physicians coming into practice—and those who are teaching them. How can the medical education system teach up-and-coming physicians about liability and this new perspective while the same physicians are moving further away from choosing and interacting with their own professional liability insurers? “As the practice grows, or if physicians are employed in larger systems or hospitals, they are less involved in vetting and choosing a professional liability insurer. Some don’t even know who their insurer is,” notes Dr. Struxness, who was two years into her own career before she learned who her liability carrier was—and that was because she was being sued. PR

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\*Jackson Healthcare, “Physician Study: Quantifying the Cost of Defensive Medicine,” accessed January 24, 2014, <http://www.jacksonhealthcare.com/media-room/surveys/defensive-medicine-study-2010.aspx>.



**G**eneral liability insurance is often called “slip and fall” coverage because it can cover claims involving just that. It can alleviate worries about accidents that may happen during the course of your job that are not related to the delivery of medicine. This coverage, included on most home and business owners policies, provides defense when you’re named in a suit, regardless of how baseless the accusations. Below is one such scenario.

**EVENT:** A geriatric physician making rounds at a nursing home noticed that an expensive medication he prescribed a patient was lying on the bedside table when it should have been stored in the refrigerator. Alarmed, he spoke with the in-facility nurse in charge of delivering medications. The nurse quickly apologized and promised it would not happen again. A week later, he found medication in a patient’s room that was not prescribed for that patient. This time the physician went straight to the director of the facility and voiced his concerns for patient safety due to this sloppy drug handling. The director opened an investigation that ended in the nurse’s termination. Several months later, the physician was served with a summons. The nurse was suing him and his small practice for slander.

**IMPACT:** The physician felt scared and affronted. He had never been sued and felt he was acting in a manner advocating for good patient care. Besides, he didn’t have time to deal with the legal headache this was sure to cause. He was annoyed he might need to invest time and money in defending himself for doing what he knew was right.

**BENEFITS PROVIDED:** Defense costs  
**PRACTICE TYPE:** Solo geriatric consultant  
**COVERAGE IN PLACE:** General liability coverage included in a business owners policy

**RESULT:** The case was dismissed; \$36,543 in defense paid



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For more information on general liability insurance, contact Janet Jay at (800) 962-1399.



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The screenshot shows the Physicians Insurance website interface. At the top right, there are 'LOG IN' and 'CREATE ACCOUNT' buttons. A search bar is located below the navigation menu. The navigation menu includes 'PRODUCTS', 'RISK MANAGEMENT', 'CLAIMS', 'CME', and 'YOUR ACCOUNT'. The 'YOUR ACCOUNT' menu is expanded, showing options for 'Billing and Payments', 'Manage Account', and 'Create an Account'. A callout box highlights the 'YOUR ACCOUNT' menu item with a left-pointing arrow. Another callout box highlights the 'CREATE AN ACCOUNT / LOG IN' button with a right-pointing arrow. The main content area features a 'New ACA Market' section with a 'Read more' button, and three article teasers: 'Successful Examples of Voluntary Arbitration and Mandatory Arbitration', 'Helping an Impaired Health Care Professional Return to Practice', and 'Responding to a Patient's Complaint'.



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