Reporter
TMLT
TEXAS MEDICAL LIABILITY TRUST
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This is the first in a series of articles about future challenges in medicine

Looking ahead — what will the future bring?

by Scott Berglund, Vice President, Risk Management

Survival of the dreaded Y2K meltdown is assured, so it is time to look toward the future of health care in the new millennium, although by now there may not be anyone who is not truly sick of hearing the phrases "Y2K" or "new millennium."

Now that our attention can be focused elsewhere, it is important to renew our awareness of and responsiveness to the continuing rapid pace of changes in health care delivery that began in the 1980s and has since only increased in momentum.

Changes

It's not news that physicians have historically been extremely independent in their manner of practicing medicine. In most cases such independence has provided leadership and courage in healing illness, performing surgery and pioneering new technologies. The advent of managed care, brought into being because of speedily rising health costs, has irreversibly changed the environment in which health care is provided, and the independent and self reliant nature of many physicians is not presently serving them well.

So many areas of health care delivery have changed that they cannot be numbered. Suffice it to say that virtually every aspect of providing health care either has been, is being, or will be examined under the proverbial microscope in the near future.

Physicians, who are clearly the lynchpins of modern medicine, are keenly feeling the focused glare of dissatisfied patients, unwieldy managed care organizations, government agencies and politicians, all of whom have one interest or another in how health care is delivered. In such a pressured environment, it is no wonder that the critical, cooperative relationships necessary to effectively deliver health care services have been seriously damaged. But much of the medical community is not reacting as quickly or effectively as it should in dealing with so much upheaval.

Aided by an overzealous media in our age of instant information, one could conclude that in health care delivery "no good deed goes unpunished." A recent "study" released to the press in all of its glory indicated that between 45,000 and 90,000 Americans die each year as a result of otherwise avoidable medical mistakes. Although the accuracy of these numbers is currently being called into question by several groups, additional damage has been done to the ideals of trust and competency in the medical profession. Whether the numbers prove to be accurate or not, all of us as patients are being bombarded by such revelations on almost a daily basis.

Change is never easy, as many resist the call to examine health care processes and make appropriate modifications in their practice habits. Risk management experts frequently express frustration in their efforts to actually produce and implement behavioral change among health care professionals in some fairly basic principles of health care delivery and practice habits.

Challenges to face

Looking to the future means being willing to realistically examine the present and to uncover the challenges which stand in the way of progress. Of the myriad of challenges to be met and conquered, several issues emerge as pivotal. In part one of this series on challenges, one issue will be discussed that could potentially change every physician/patient interaction in the future — electronic medical records.

Electronic medical records

The explosion of medical knowledge and the proliferation of medications have gone beyond the ability of even the most agile medical mind to grasp and utilize. Yet, medical knowledge is still not being shared and utilized as rapidly as it could be. A study by Medical Records International, an organization developing an electronic medical record system, discovered that an average person has accumulated approximately a dozen separate medical records by age 30. These records exist separately, for the most part, in countless doctors' offices, clinics and hospitals where the patient gets treatment over years. Each physician is unaware of additional medical information, which in many instances could make a significant difference in the quality of care delivered.

There has emerged a large number of pretenders to the EMR throne, which has caused confusion and reticence among physicians in committing to any one of them. Many of the software developers have targeted large institutions and closed medical systems as their potential clients for marketing and profit reasons, leaving small groups and solo practitioners without many feasible options, cost being only one of the hurdles to implementation.

Also still lacking is an effective and accepted standard by which to judge the good from the not so good EMR, as well as a universal interface to allow one brand to talk to another. It appears inevitable, like it or not, that the utilization of electronic medical records will become widespread and even mandatory in the not too distant future. Time should be spent now by virtually all members of the health care team, from physicians to receptionists, in becoming adequately computer literate and knowledgeable about electronic medical record systems.

This article originally appeared in the risk management publication, Loss Minimizer. *Reprinted with permission.*

Medical peer review explained

by Lynne Dakers, RN, JD, Risk Management Representative

Editor's note: As alluded to in Scott Berglund's article regarding future challenges in medicine, a recent study indicating thousands of patient deaths as a result of avoidable medical errors has captured media and political attention. As the government pledges to get to the root of this problem, peer review has never been more important. In this and the next two issues of the Reporter, *peer review will be featured. Along with these articles, TMLT is conducting a survey to assess physician participation in peer review. Please take a few minutes to complete the enclosed survey and fax it to TMLT. — Barbara Rose, Managing Editor*

Peer review is critical to the teaching and advancement of medicine. As explained by the Supreme Court of Pennsylvania, peer review statutes have been " . . . promulgated to serve the legitimate purpose of maintaining high professional standards in the medical practice for the protection of patients and the general public. (The statutes) represent a determination by the legislature that, because of the expertise and level of skill required in the practice of medicine, the medical profession itself is in the best position to police its own activities." Cooper v. Delaware Valley Med. Ctr., 630 A.2d 1, 7 (Pa.Super. 1993), affirmed 539 Pa. 620, 654 A.2d 547 (1995).

Also recognizing a need to address the issues, Congress passed the Health Care Quality Improvement Act (HCQIA) of 1986, finding:

• The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state.

• There is a national need to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance.

• This nationwide problem can be remedied through effective professional peer review.

• The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

• There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review. 42 U.S.C.A. s.11101.

There is a strong public policy to provide incentive and protection for physicians engaged in effective professional peer review by maintaining the confidentiality of this sensitive information. In order to promote candor in the peer review process, the Texas legislature and courts have created protections against discovery and use of peer review materials in professional liability actions. Practitioners are encouraged to develop peer review policies and procedures which both advance the practice of peer review as well as protect this sensitive information from discovery.

The following is an overview of the Texas Medical Practice Act, other Texas statutes relevant to peer review activities, and the HCQIA. Certain court decisions will be addressed as well. Finally, guidelines on how to protect the deliberations of peer review committees from disclosure in medical malpractice cases will be provided.

The Medical Practice Act

Definitions

"Medical peer review committee" or "professional review body" means "a committee of a health care entity, the governing board of a health care entity, or the medical staff of a health care entity, provided the committee or medical staff operates pursuant to written bylaws that have been approved by the policy-making body or the governing board of the health care entity and authorized to evaluate the quality of medical and health care services or the competence of physicians." (s. 1.03(6)). Included are the employees or agents of the committee.

"Medical peer review" or "professional review action" means the evaluation of medical and health care services, including evaluation of the qualifications of professional health care practitioners and of patient care rendered by those practitioners. The term includes the evaluation of the merits of complaints relating to health care practitioners and determinations or recommendations regarding these complaints. (s. 1.03(9)). The term specifically includes evaluation of:

- accuracy of diagnosis
- quality of care rendered
- reports made to committee concerning matters under its authority
- reports made by the committee to another committee or the board
- implementation of the duties of the committee members, agents, or employees

"Health care entity" includes: a duly licensed hospital; a health care facility, including a group medical practice, that provides medical or health care services and that follows a formal peer review process for the purposes of furthering quality medical care or health care; a professional society or association, or a committee thereof, of physicians that follows a formal peer review process for the purpose of furthering quality medical or health care; and an organization established by a professional society or association of physicians or of hospitals, or both, that collects and verifies the authenticity of documents and other data concerning the qualifications, competence, or performance of licensed health care professionals and that acts as a health care facility's agent pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C.A. s. 11101-11152). (s. 1.03(5).

Confidentiality and disclosure of peer review

Except as otherwise provided, all proceedings and records of a medical peer review committee are confidential, and all communications made to

a medical peer review committee are privileged unless disclosure is required or authorized by law (s. 506). In Texas, this privilege of confidentiality can only be waived by some officers of the committee and only if the waiver is in writing. In general, reports and records of peer review committees are immune from discovery in medical professional liability suits, but not in Texas State Board of Medical Examiners' (TSBME) proceedings.

Immunity for participation in peer review

The statute protects individuals who act as members of, or who furnish information or assistance to, a peer review committee from liability so long as he or she acts without malice.

Reporting requirements

Each medical peer review committee or health care entity shall report to the TSBME any action that adversely affects the clinical privileges of a physician for longer than 30 days. The HCQIA defines "adversely affecting" as including reducing, restricting, suspending, revoking, denying, or failing to renew. Surrender of privileges while under investigation or in return for not conducting an investigation must also be reported. Under the HCQIA, the TSBME must, in turn, report to the National Practitioner Data Bank (NPDB). Reports made to the TSBME are confidential and not subject to disclosure under the open records law.

Licensed physicians and medical peer review committees, among others, shall report relevant information relating to another physician if, in his/her/its opinion, that practitioner, through the practice of medicine, poses a continuing threat to the public welfare.

Business record exception

Although records and proceedings of a medical peer review committee are confidential, "(r)ecords made or maintained in the regular course of business" are not protected (Texas Health and Safety Code, Title 4, Subtitle H, Chapter A, sec. 161.032(c)).

Court interpretation

In 1996, the Texas Supreme Court had the opportunity to interpret this legislation in a trilogy of cases. (Memorial Hospital-The Woodlands v. McCown, 927 S.W.2d 1 (Tex. 1996); Brownwood Regional Hosp. v. Eleventh Court of Appeals, 927 S.W.2d 24 (Tex. 1996); Irving Healthcare Sys. v. Brooks, 927 S.W.2d 12 (Tex. 1996)). These cases concerned the discoverability of the proceedings of a credentialing committee considering an application for initial staff privileges. The Court concluded that the broad protection afforded peer review in the MPA should apply to a committee's determination of initial staff privileges. The Court went even further in 1997. It held that the peer review immunity provisions in the MPA, that provide immunity for credentialing decisions absent a showing of malice, bar a cause of action against a hospital or health care entity for negligent credentialing. St. Luke's Episcopal Hosp. v. Agbor, 952 S.W.2d 503 (Tex. 1997).

To be continued . . . next issue: protection against antitrust litigation; medical staff privileges and due process requirements; federal rules; and a call for physician group peer review.

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For Immediate Release: February 8, 2000

Contact: Don Chow, Vice President Marketing
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TMLT, TMIC and The Hartford Form New Alliance

Austin, Texas . . . Texas Medical Liability Trust (TMLT) and Texas Medical Insurance Company (TMIC) have entered into a strategic alliance with the Commercial Affinity segment of The Hartford in order to provide Texas physicians with access to a wide variety of quality insurance coverage, including workers' compensation, general liability, commercial automobile and other vital insurance protection.

"The strategic partnership between TMLT/TMIC and The Hartford will provide Texas physicians with one of the most comprehensive insurance programs available to medical professionals. Both TMLT/TMIC and The Hartford are recognized leaders in their respective areas of the insurance industry. Together, we are uniquely positioned to provide unparalleled insurance protection and potential savings to Texas physicians and medical professionals," said Michael A. Garguilo, Regional Vice President for The Hartford's Texas Regional Office.

Tom Cotten, President and CEO of Texas Medical Liability Trust, stated, "Both Texas Medical Liability Trust and Texas Medical Insurance Company were formed to serve as convenient sources of needed insurance protection for Texas physicians. We believe that administrators of large practices with many physician members as well as those running smaller group or individual practices appreciate the efficiencies that are possible when a collection of insurance coverages can be administered smoothly. This new partnership with The Hartford will offer TMLT and TMIC policyholders access to excellent additional coverages at competitive premiums."

Austin-based Texas Medical Liability Trust was created in 1979 by Texas Medical Association to provide a stable source of medical liability coverage for Texas physicians. TMLT's wholly owned subsidiary, Texas Medical Insurance Company (TMIC) was formed in 1995 to provide an expanded menu of insurance products and services for Texas physicians.

The Hartford Financial Services Group, Inc. (NYSE:HIG) is one of the nation's largest international insurance and financial services companies, with 1998 revenues of $15.0 billion. As of Sept. 30, 1999, The Hartford had assets of $153.6 billion and shareholders' equity of $5.8 billion. The company is a leading provider of commercial property and casualty insurance; reinsurance; automobile and homeowners coverages; and a variety of life insurance, investment products, employee benefits, group retirement plans and institutional liability funding products.

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Inside INSURANCE

The Tail of Doctor Curie

by Marshall Wyatt, Senior Underwriter

Dr. Curie had been working for XYZ Pediatrics for what seemed like forever. She started with the group eight years earlier right out of residency and had become one of six partners in the group. Desiring a different environment, she and her husband decided to leave Dallas and relocate their family to her small hometown.

As she reflected upon this decision and her plans to start a solo practice, she mulled over the many decisions that needed to be made. She made a "to do" list and went over each item.

Dr. Curie needed to talk to TMLT about her medical malpractice coverage. She explained her plans to move and start a new practice. Could TMLT help her deal with all issues that would affect her professional liability insurance? "No problem" said Rick Danger, her TMLT Underwriter. "Before we make any changes, have you discussed purchasing an extended reporting period endorsement (tail coverage) with XYZ Pediatrics?"

Rick then explained what tail coverage is and how important it becomes when doctors join or leave practices. Dr. Curie had not anticipated this question. The $15,899 cost Rick quoted for the coverage was a surprise since her annual premium was $7,949. Rick also explained that tail coverage was important to doctors and their groups/employers in slightly different ways.

When a doctor who is insured under a claims-made policy leaves a group, the coverage provided by the policy moves with her. After she leaves, the group is unable to determine the status of the doctor's coverage. If coverage subsequently lapses, the group has a legitimate concern that it may become the target of lawsuits that otherwise would have been made against the doctor, had her insurance policy still been effective. Accordingly, groups usually want to ensure that coverage is permanently in place for the time that the doctor worked in, or on behalf of the group.

The doctor, however, often has a somewhat different viewpoint. She usually intends to continue working and has no plans to let coverage lapse. She sees no reason to spend the dollars required to buy tail coverage when she can take advantage of TMLT's free tail coverage offer at retirement.

The doctor has other options as well. If she chooses to go to a new insurance carrier when she leaves the group, she may have an option of buying coverage from her old insurer, or her new one. If she buys coverage from the old insurer it is called tail coverage. If purchased from the new insurer, it is called prior acts. If she wants to buy tail coverage, she simply pays the tail premium, and this coverage is added to her old policy. All claims arising from this period of time then become the responsibility of that company. She is then free to purchase a new policy at the new company's "first year" rates. Should she prefer to purchase prior acts, her new policy is rated to include premium charges for the period of time covered under her prior policy. Claims filed after the new policy takes effect are then the responsibility of the new carrier.

Armed with new information, Dr. Curie approached her partners. After considering the long statute of limitations to which pediatricians are subject, they ultimately decided that purchasing tail coverage was the best option for all concerned. As a condition for Dr. Curie's authorization for the purchase, the group agreed to assist her with the cost of the tail premium. TMLT issued the permanent tail coverage for the time Dr. Curie had practiced following her residency and then rewrote her claims-made coverage for her new practice. At retirement, if still insured with TMLT, Dr. Curie will be eligible for free tail coverage with TMLT.