

the Reporter

How physicians sabotage their defense



By Laura Hale Brockway

Any physician who has ever been sued can tell you the experience is arduous and demanding. It begins with a notice of claim letter, generally accompanied by a request for medical records, followed by interrogatories, investigation, retention of experts, depositions, mediation, and perhaps a trial. There are many potential stumbling blocks along the way. After resolving more than 23,000 medical liability claims, TMLT claims management staff offer experienced insight into the most common mistakes physicians make when facing a lawsuit, and how to avoid them.

The pre-suit phase

According to TMLT claim and risk management professionals, physicians can often weaken their own defense before a lawsuit is even filed.

Inadequate documentation, inadequate or ineffective communication with the patient, poor bedside manner, lack of empathy with the patient, failure to follow up

when appropriate, lack of continuity in the health care rendered, and failure to review prior records and recommendations can make litigation more likely and cases more difficult to defend. "Often patients are more willing to file litigation when they feel that their physician did not care about them and did not tell them what they needed to know," says Jill McLain, vice president of claim operations at TMLT.

Physicians can also jeopardize their defense if they react poorly or defensively when a bad outcome occurs. "Clearly there are no guarantees of a favorable outcome any time medical care is rendered, but all physicians want their patients to have good results. When an untoward result occurs, it is appropriate to be open with the patient and to show concern and empathy. Sometimes physicians do this in such a way as to give the patient the impression that they feel responsible for the outcome, translated by the patient into negligence," McLain says. "Patients and their family members are generally in an emotional state at that time, and often react with anger or by blaming the doctor. Most of the time the outcome is a result of multifactorial issues that must be examined objectively before causation can be determined. It is rarely appropriate to assess these issues while dealing with the emotions resulting from unanticipated or undesirable complications. There is a big difference between actual negligence and an unfortunate, but unavoidable, complication of treatment."

One of the most pervasive problems in defending physicians involves inadequate or poorly worded documentation. "In many of the cases we see, documentation is incomplete. Consider a situation in which the doctor recommends a procedure, the patient refuses and wants to try conservative care. The doctor may have fully

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explained the risks and benefits of both options to the patient, but failed to document this in the record. After the fact, the patient rarely recalls or admits to remembering that conversation. Contemporaneous documentation of the risks and benefits that were explained to the patient will generally convince a jury that the doctor did provide adequate information to help the patient decide on an appropriate course of action," says Sue Mills, assistant vice president of claim operations for TMLT.

Complete documentation should include taking a full patient history. "Asking patients to complete comprehensive patient history forms that are updated annually helps jog their memories about pertinent details and gives you with the information you need to provide the best medical care. Patients appreciate it when you take the time to go over the relevant information during their visit," Mills says.

Other documentation suggestions include:

- Document in a timely manner. Waiting too long to dictate a report or an operative note can affect the accuracy and completeness of the information or can cause others to question the physician's ability to recall details long after the events took place. The timeliness and accuracy of documentation affects credibility during testimony.

- Note the time of any hospital visit in the hospital progress notes, when possible. It is especially important to do so when emergency or critical care is rendered. Notes should be kept in chronological order. When possible, avoid writing in the margins or on sticky notes.

- Do not alter medical records. To add to the record, note it as an addendum, sign and date it.

- Document objectively and factually. Avoid judgmental, non-objective statements about the patient, but include information that may be relevant to the patient's care and/or outcome, such as known substance abuse, documented history of emotional problems, etc.

- Document any advice given on smoking cessation, exercise, limiting alcohol intake, diet, controlling blood sugar, losing weight, etc. and document it each time it is given.

- Document any recommended follow up appointments and any patient non-compliance.

- If patient information handouts are given, document this in the record.

- At each visit with the patient, look back in the record at the previous encounters.

- Have a tickler system to keep track of lab work and referrals and document this. Keep phone slips in patient's chart. "No shows" should be documented. Documenting "no shows" not only memorializes the patient's non-compliance, but helps the physicians advise the patient of the need for compliance at the next opportunity.

Notice of claim phase

Once a notice of claim letter has been received, report it to TMLT immediately as required by the TMLT policy. The patient's attorney will likely request medical records, unless the patient has previously obtained them. Physicians are urged to read the authorization carefully, make sure it is properly worded, and is signed by the patient, or in the event of death, minority, or incompetence, the patient's authorized representative. If those conditions are met, send copies of all of the requested records.

"Send only those records the patient authorizes and

the attorney requests. Holding records back may appear to be intentionally hiding something, even though that is not necessarily the case. Send complete records if you are asked for complete records," Mills says.

"Policyholders should also keep any paperwork regarding the claim, lawsuit and any and all correspondence from TMLT and the defense attorney in a separate file. Do not keep it with the patient's chart because everything in the patient's chart can be subpoenaed by the plaintiff attorney," Mills says.

During suit

Once a claim or lawsuit is filed, a physician's initial response can inadvertently damage the defense of the case. "Sometimes physicians believe that because they have reported the claim to TMLT, we will somehow be aware of the lawsuit when it is filed. That is not the case. If a notice of claim letter or a lawsuit is received, the physician should call TMLT immediately and forward suit papers as required," McLain says. "Timely response is the only way to assure that a default judgment will not be entered against the defendant doctor. Do not call the plaintiff's attorney no matter how tempted you are. Anything you say at this point can be used against you. Also, resist the urge to call the patient."

Physicians can also find themselves in a precarious situation when a patient who is suing them shows up for a routine appointment or for treatment. If this occurs, in order to avoid misunderstandings that could ultimately be heard by a jury, it is generally advisable to avoid discussing the details of the claim or suit with the patient.

"When in doubt, call TMLT. You may terminate your physician-patient relationship with a patient who is suing you, as long as you remain willing to take care of acute illnesses or injuries for a reasonable period of time until the patient can transfer care to another physician. TMLT can provide information on how to do this in an appropriate manner," Mills says.

If the physician continues to treat the patient on an ongoing basis after litigation is filed, it is suggested that the physician have a nurse in the examining room during these visits. These encounters may be the subject of discussions between the patient, the patient's family, and the patient's attorney. Keep this in mind when treating the patient's family members as well.

"You should assume that anything you say might be mentioned in court. Maintain the high level of concern you have always had for the well being of the patient, document the details of these visits and your recommendations thoroughly. Continue to communicate openly with the patient about health issues. And again, call TMLT or your defense attorney if you have any questions or concerns," McLain says.

Another critical way physicians may sabotage their defense is by not taking an active role in their case. "Physicians must be very familiar with all aspects of their case as it develops," McLain says. "We know it's difficult, but they must make the time to meet with their defense attorney, to review the medical records and expert witness reports, and to be familiar with the literature and other testimony before giving their deposition. Attending the patient's deposition and the plaintiff's experts' depositions will put the physician in the best

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tmlt perspective



Tort reform legislation: evaluation and analysis

by Bob Fields, executive vice president, claim operations

In the Fall of 2001, TMLT joined the Texas Medical Association, the Texas Hospital Association, and other interested parties including county medical societies, specialty societies, tort reform groups, large physician groups, hospital systems, charitable patient clinics in the fight to achieve meaningful medical liability reform during the 2003 legislative session. This coalition became the Texas Alliance for Patient Access (TAPA), a group committed to solving the problem of deteriorating access to health care by reforming the medical liability system. TAPA membership grew to more than 200 entities united to begin the battle for common sense in our legal system. TAPA created a legal team that analyzed weaknesses and injustices in the current medical liability laws and we prepared proposals to correct them.

During the 2003 legislative session, TAPA led the way in providing witnesses who testified before the House Civil Practices Committee and the Senate State Affairs Committee. We provided information and testimony that clearly showed the results of skyrocketing insurance premiums driven by ever increasing claims payout caused by more and more litigation filed against doctors, hospitals, and nursing homes.

When the dust settled at the state capitol, House Bill 4 had been passed and TAPA and its allies had achieved the best quality medical liability reform seen in the past 25 years in Texas. The following will be an analysis of some of the most important parts of this bill which we feel will level the playing field with plaintiff's attorneys, stopping the exodus of doctors from the state, and bringing affordable medical care to all patients and citizens in the state of Texas.

\$250,000 non-economic cap

The new cap will limit pain and suffering and other non-economic damages to \$250,000. Note that this does not affect economic damages such as past and future medical bills or past and future lost wages. The cap applies per claimant which includes all persons (i.e., family members, estate, etc.)

and cannot be multiplied regardless of the number of doctors sued. It is not indexed or increased for inflation as past caps have been. (The previous medical malpractice death cap which was originally set at \$500,000 in 1977 is now at more than \$1.45 million due to indexing).

Death cap changes

The above mentioned death cap has been changed to apply per claimant versus defendant. This will reduce or eliminate the "stacking" of multiple death caps with the practice of suing multiple defendants. Punitive damages and pre-judgment interest will now be included within the cap. New language has been added indicating the health care defendant's insurance carrier cannot be responsible for any amount higher than the defendant's own liability exposure.

Pre- and post-judgment interest

Currently, Texas law allows plaintiffs to receive 10 percent interest compounded annually on any judgment rendered after the date of injury until the award is paid. We felt this was entirely too high considering the current state of the economy. We were successful in reducing this rate to the prime rate with a minimum of 5 percent and a maximum of 15 percent. (The current prime rate is slightly below 5 percent). The accrual of pre-judgment interest has been moved back from the date of injury to the earlier of the date of suit filing or six months after filing of notice of claim.

Periodic payment of future damages

On all future payments of medical, custodial, or health care expenses, periodic payments must be ordered by the judge. In the past, if a plaintiff died shortly after a trial, the defendant would be ordered to pay all future medical expenses awarded in the judgment, even if those expenses were never incurred by the patient. With the new law, the future death of the plaintiff will end any further payment of future medical expenses. All other future damages may be ordered to be paid periodically by the judge.

Settlement credits

In Texas, defendants have a legal right to have their judgments reduced for payments made by settling co-defendants. However, in the past, those payments (credits) could be reduced by a "sliding scale" percentage credit. The new law allows for a full percentage or dollar for dollar credit.

Appeal bonds

In the past, appeal bonds had to be purchased for the full amount of the judgment against defendants plus two years post-judgment interest at 10 percent per year. That made the option of appealing wrongful jury awards prohibitive. The new law excludes the requirement to bond any punitive damage portion of the judgment and caps the amount required for bonding to \$25 million or 50 percent of the defendant's net worth. In most cases we see, physician's net worth is low enough that it will make it more affordable to appeal unwarranted verdicts.

HIPAA medical authorizations

Since the passage of HIPAA privacy rules, plaintiffs' lawyers have been threatening criminal action against doctors and hospitals who released medical records as allowed under Texas state law on medical malpractice cases. This new provision of the law requires patients and their plaintiffs' attorneys to submit a HIPAA-designed medical authorization which will allow for the release of records under HIPAA. If the plaintiffs' attorneys refuse to provide these required medical authorizations, the tolling of the statute of limitations and 60 day discovery abatement period is not triggered and the suit may not proceed.

Expert reports

Under old law, plaintiffs were required to file an expert report against the defendant doctor within 180 days or the case could be dismissed with prejudice at the judge's discretion. Many judges refused to enforce

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this provision since they were given “judicial discretion” in the wording of the statute. Under the new law, qualified expert reports must be filed within 120 days. The judge can grant one 30-day extension for a deficient report at his discretion, and then if the report is not filed timely, the judge must grant a non-suit with prejudice dismissing the suit. If the judge refuses to do so, as some have refused in the past, the suit can be appealed to the courts of appeal without the suit proceeding to trial.

Vendors endorsement

In the past, on pharmaceutical related suits against doctors, insurers for drug manufacturers refused to indemnify doctors when they prescribed their products. With this new law, those insurers “may not exclude coverage (under a vendors endorsement) for physicians or otherwise limit coverage . . . issued to a manufacturer.”

Proof of damages

The new law requires that recovery of health care expenses are limited to the amount actually paid or incurred by the

patient (not what was initially billed by the health care provider). In past cases, defendant doctors could be forced by judges to pay more than what the patient actually incurred on past medical expenses. In addition, past and future loss of earnings may be reduced by whatever state and federal income taxes would have been assessed against those earnings. Currently, jury awards for those damages are not taxable and are not reduced for future income taxes.

Effective dates

The effective dates for the \$250,000 non-economic cap, death cap changes, periodic payment of future damages, HIPAA medical authorization, expert reports, and proof of damages is September 1, 2003. In other words, the new law will take effect for all new suits filed on or after that date. The effective date for settlement credits was July 1, 2003. Provisions for appeal bonds and interest will apply to judgments signed on or after September 1, 2003.

Amendment election on September 13, 2003

A bill was passed during this legislative session that allows the citizens of Texas to

vote on whether the legislature should be given the right to set caps on non-economic damages such as those discussed in this article. The election will take place on September 13, 2003, and, if passed, will allow the caps passed during the session to stand. We, at TMLT and TAPA, will be joining with other groups concerned about the health care crisis in an effort to win this election for our doctors and their patients. The TMA will be contacting you in the near future regarding the role physicians and their staffs can play in this monumental battle with plaintiff’s attorneys and their supporters. With your help, we are confident we can achieve victory . . . again.

If we are successful in the above effort, and with these new changes to our medical liability laws, TMLT is hopeful and confident that lawsuit abuse will be moderated, and that claims payout will moderate accordingly, allowing for more reasonable insurance premiums in the future. This will allow doctors to continue practicing in Texas, reducing the access to care crisis we are now experiencing. In the long run, the citizens of Texas are the winners in this historic legislative session.

position to assist in the defense of the case.” Working as a team with your defense attorney and claims supervisor will provide the best opportunity for a successful outcome.

Being prepared for deposition and involved in the case can help prevent some of the common missteps that can occur during the pendency of the case. “The limit of what can be asked at deposition or at trial is bounded only by the imagination of the attorney. The physician needs to be fully prepared to educate the jury on the medicine, and to do so in a way that demonstrates competence and concern for the patient. The defense attorney can assist the physician in anticipating questions that might not be expected from a medical standpoint, but which may have emotional appeal to a jury,” Mills says.

“Another problem often seen at trial is the tendency for physicians to focus on the plaintiff’s attorney instead of the jury when testifying. The plaintiff’s attorney wants the physician’s focus at trial, so that the attorney will be able to speak to the jury through the words of the doctor,” McLain says. “We want that jury to look to the physician for the truth. Keep in mind that the physician will always

know more about medicine than the plaintiff’s attorney. The attorney may try to trick or confuse the doctor with information from obscure sources or with quotes taken out of context. The better prepared a physician is ahead of time, the less likely he or she will be adversely affected by the understandable stress of testifying.”

Equally important is for the physician to understand how vital credibility is in a jury trial. “Some physicians may feel that their credibility is solely the result of what they have accomplished in their careers, such as their education and training, board status, and what they have published,” Mills says. “Credibility is something more personal. It involves being consistently honest, being competent and knowledgeable, and being a caring, sincere person. This characterizes a credible physician, and a credible physician has a greater chance of winning the confidence and respect of the jury. A physician who earns the trust of the jury is more likely to prevail in the case.”

Other areas to consider when testifying:

- Be honest and factual during deposition. Do not ramble. Answer concisely and objectively. Do not conjecture, repeat or rephrase. Think carefully about your answers.
- Listen carefully to the questions asked,

and do not hesitate to have questions repeated or rephrased if necessary. If asked to agree with information that is not before you, ask to see and read the information before commenting.

- When testifying at trial, speak at a level the jury can understand. Be a good teacher. Juries love physicians who teach them about medicine.
- Keep in mind that in Texas, the standard of care is that which an ordinary and prudent physician in the same field would do under the same or similar circumstances. Standard of care does not require perfection.
- Physicians should also be aware of their appearance. Be well groomed and dressed professionally.
- Be polite and respectful when answering the attorney’s questions. Keep tempers in check and do not become impatient, or appear defensive.

Enduring the claim and litigation process can be difficult, time consuming, and emotionally taxing. However, physicians should remember that they are not alone in this process. They have an extensive support team behind them. Ask questions and share any concerns or ideas with the TMLT claim representative or defense attorney.



TEXAS MEDICAL LIABILITY TRUST

TMLT PHYSICIANS ARE NOW BEING SUED FOR PRESCRIBING HRT

August 2003

Recently, new information concerning the potential health risks associated with hormone replacement therapy has been in the news. Now is a good time to review your informed consent process, in order to make sure this new information is provided to patients when hormone replacement therapy is prescribed, and that the delivery of this information to the patient is recorded in the medical record. Much of this information has resulted from the ongoing Women's Health Initiative (WHI) study. A portion of that study was published in the July 2002 *Journal of the American Medical Association* in an article entitled "Risks and Benefits of Estrogen Plus Progestin in Healthy Postmenopausal Women: Principal Results from the Women's Health Initiative Randomized Controlled Trial." (*JAMA*. 2002 Jul 17; 288(3): 321-33.) This study initially reported an increased risk of heart attack, stroke, breast cancer, pulmonary emboli and deep vein thrombosis associated with hormone replacement therapy. In addition, a recent report from the same study indicated that women on such therapy might be at an increased risk of developing dementia.

Importantly, even more new information regarding hormone replacement therapy (HRT) was published at the time this article was being prepared. Two new articles entitled "Influence of Estrogen Plus Progestin on Breast Cancer and Mammography in Healthy Postmenopausal Women: The Women's Health Initiative Randomized Trial" and "Relationship Between Long Durations and Different Regimens of Hormone Therapy and Risk of Breast Cancer," were first released in the June 25, 2003 *Journal of the American Medical Association*. (*JAMA*. 2003; 289: 3243-3253 and 289:3254-3263.) The first referenced article is new information from the WHI. The WHI trial of combined estrogen plus progestin was discontinued when the investigators determined that overall health risks, including invasive breast cancer, exceeded the benefits. This new report of the WHI data sought "to determine the relationship among estrogen plus progestin use, breast cancer characteristics and mammography recommendations." The summary paragraph in this most recent report on the WHI concludes:

"In summary, results from this prospective randomized trial indicate that combined estrogen plus progestin use increases the risk of incident breast cancers, which are diagnosed at a more advanced state compared with placebo use, and substantially increases the frequency of abnormal mammograms. In light of these findings, abnormal mammograms in women receiving menopausal hormone therapy deserve heightened scrutiny. The increased frequency of abnormal mammograms requiring medical evaluation and increased breast cancer risk should be added to the already known risks of short-duration menopausal hormone use. Consideration for use of estrogen plus progestin for any duration by postmenopausal women should incorporate the current findings into established and emerging risks and benefits of these agents."

The second *JAMA* article of June 25, 2003, reports on a case-control study conducted on 975 women between the ages of 65 and 79 diagnosed with invasive breast cancer in three counties in western Washington state. The authors report in the Results section of the abstract that "women using unopposed estrogen replacement therapy (ERT) (exclusive ERT use), even for 25 years or longer, had no appreciable increase in risk of breast cancer, although the associated odds ratio were not inconsistent with a possible small effect." However, the authors' conclusion states:

"These data suggest that use of CHRT [combined estrogen and progestin] is associated with an

increased risk of breast cancer, particularly invasive lobular tumors, whether the progestin component was taken in a sequential or in a continuous manner.”

You should be aware that Wyeth, the manufacturer of Premarin, Prempro and Premphase, has made changes and additions to the package insert and has also added information to the black box warning in the package insert on these products. It is important to note that the changes in the package insert information reflected in this article were made before the two most recent articles of June 25, 2003, were published. Accordingly, future package inserts for HRTs may contain additional changes. With that in mind, this article will discuss the most recent changes of which we are aware and suggestions for a patient informed consent process.

The black box warning for Prempro and Premphase currently states:

WARNING

Estrogens and progestins should not be used for the prevention of cardiovascular disease.

The Women’s Health Initiative (WHI) reported increased risks of myocardial infarction, stroke, invasive breast cancer, pulmonary emboli, and deep vein thrombosis in postmenopausal women during 5 years of treatment with conjugated equine estrogens (0.625 mg) combined with medroxyprogesterone acetate (2.5 mg) relative to placebo (see **CLINICAL PHARMACOLOGY, Clinical Studies**). Other doses of conjugated estrogens and medroxyprogesterone acetate, and other combinations of estrogens and progestins were not studied in the WHI and, in the absence of comparable data, these risks should be assumed to be similar. Because of these risks, estrogens with or without progestins should be prescribed at the lowest effective doses for the shortest duration consistent with treatment goals and risks for the individual woman.

The black box warning for Premarin states:

ESTROGENS INCREASE THE RISK OF ENDOMETRIAL CANCER

Close clinical surveillance of all women taking estrogens is important. Adequate diagnostic measures, including endometrial sampling when indicated, should be undertaken to rule out malignancy in all cases of undiagnosed persistent or recurring abnormal vaginal bleeding. There is no evidence that the use of “natural” estrogens results in a different endometrial risk profile than synthetic estrogens of equivalent estrogen dose.

CARDIOVASCULAR AND OTHER RISKS

Estrogens with or without progestins should not be used for the prevention of cardiovascular disease.

The Women’s Health Initiative (WHI) study reported increased risks of myocardial infarction, stroke, invasive breast cancer, pulmonary emboli, and deep vein thrombosis in postmenopausal women during 5 years of treatment with conjugated equine estrogens (0.625 mg) combined with medroxyprogesterone acetate (2.5 mg) relative to placebo (see **CLINICAL PHARMACOLOGY, Clinical Studies**). Other doses of conjugated estrogens and medroxyprogesterone acetate, and other combinations of estrogens and progestins were not studied in the WHI and, in the absence of comparable data, these risks should be assumed to be similar. Because of these risks, estrogens with or without progestins should be prescribed at the lowest effective doses and for the shortest duration consistent with treatment goals and risks for the individual woman.

(Note: A lower dose version of Prempro which has 0.45 milligrams of estrogen and 1.5 milligrams of progestin has been approved and will reach the market later this year.)

In addition to the black box warning, the package inserts for Prempro, Premphase and Premarin all contain a statement under the "Precautions" section which states as follows:

PRECAUTIONS

B. Patient Information

Physicians are advised to discuss the contents of the PATIENT INFORMATION leaflet with patients for whom they prescribe [Prempro/Premphase/Premarin].

Besides the changes in the package insert, Wyeth recently made a major press announcement entitled "A Message from Wyeth — Recent Reports on Hormone Therapy and Where We Stand Today" (Message). This Message was placed in major newspapers across the United States. A copy of the Message is available at www.tmlt.org. Click on Risk Alert and the Message link will be listed in the content. In the Message, Wyeth reports that the WHI found an increased risk of heart attack, stroke, breast cancer, blood clots, and dementia in women on hormone replacement therapy. This is essentially the same information contained in the black box warnings. Further, in the Message Wyeth notes that their package inserts have changed and advises women to discuss the changes with their doctors. Also of import, Wyeth publicly states, as does the revised package insert, that hormone replacement therapy should be prescribed at the lowest effective dose and for the shortest duration possible.

Based upon the recent WHI report, Wyeth's revised package insert (which includes a black box warning), and the Message from Wyeth, it is our opinion that doctors should take steps to assure that their medical charts reflect that this new information has been provided to their patients when hormone replacement therapy is prescribed. Having written documentation and acknowledgment of consent will place doctors in a better position to defend themselves if and when they are sued as a result of prescribing hormone replacement therapy. Accordingly, we suggest that doctors have their patients sign a written "Acknowledgment of Informed Consent and Receipt of Patient Information" each time they prescribe hormone replacement therapy. A copy of a suggested consent form is available at the TMLT web site, www.tmlt.org. As part of that process, we further suggest that patients be provided the "Patient Information" leaflet that Wyeth has prepared for their hormone replacement products. The "Acknowledgment of Informed Consent and Receipt of Patient Information" has the patient acknowledge that you, the physician, have provided them with Wyeth's "Patient Information" and that the risks and side effects of hormone replacement therapy have been discussed prior to the prescription. If you have not received the "Patient Information" from Wyeth, visit Wyeth's web site and obtain the "Patient Information" for Prempro and Premphase as well as for Premarin at www.wyeth.com/index.asp

If you have any additional questions, please feel free to contact Ginny Markham at TMLT, 800-580-8658, extension 5917.

The Reporter will feature a bimonthly column to answer your most frequently asked questions about asset protection. We invite you to email or write Ken Vanway with your questions, ken@vanway.org or Vanway, Thrash & Associates, PLLC, 1110 R.R. 620 South, Suite B, Austin, Texas 78734, 512-263-2886.

The information provided in this article is not to be construed as legal advice and should not be relied upon without specific consultation with a professional.

The perfect corporate structure — Part 2 **Should the medical practice be a C or S corporation?**

Last issue, we addressed the asset protection reasons for incorporating your medical practice. When you incorporate your medical practice, you create a contract with the state of Texas to take advantage of favorable state laws. Your new entity will need a separate tax ID, and you will have a planning choice to make with the IRS.

- equity disability trusts
- malpractice equity trusts
- captive insurance companies
- long term care
- traditional retirement plan
- 412i plans
- 419 plans
- 125 plans

2. Discriminatory benefit planning — only a C-corp allows you to take a 100 percent tax deduction to fund a discriminatory Equity Disability Trust where 94 percent of the money is invested in a growth account available for future refund similar to an IRA.

3. Free long term care insurance — also, you can deduct 100 percent for long term care insurance on a discriminatory basis with a return of premium option.

Disadvantages of S corporations

1. No tax-deductible fringe benefits — if an S corporation shareholder is a “2-percent or greater

Protecting your assets from lawsuits

By Ken H. Vanway, P.C., attorney at law, senior partner, Vanway, Thrash & Associates



About the author

Ken H. Vanway is board certified in Estate Planning and Probate Law — Texas Board of Legal Specialization. Ken has more than 20 years experience. His firm practices in many areas of estate planning and lawsuit protection including wills, living trusts, insurance trusts, family partnerships, charitable trusts, private foundations and asset protection. For more information, please visit his web site, at www.estateplanning.com/kenvanway.

This issue, we will address the pros and cons of C versus S corporations. If you do nothing, then by default you become a regular corporation known as a “C corporation” from subchapter C of the tax code. As an alternative, you can file Form 2553 with the IRS and elect to have your new entity be taxed as an “S corporation.” Note that if you are married, your spouse should also sign Form 2553 agreeing to this election.

There are pros and cons for both C and S corporations. The following is a brief comparison of some of the factors which go into your decision.

Disadvantages of C corporations

1. Separate tax entity — a C-corp is not a “pass-through” entity meaning that any income left in the corporation at the end of the year is taxed at the corporate tax rate (35 percent for physicians).

2. Potential double-tax — if a corporate tax is paid and then the money is later distributed to the physician-owners, the owners also pay ordinary income tax on the monies coming out of the C-corp no matter if the income is dividend income or W-2 income. The author believes that this is a non-issue if the corporation distributes these monies to the physician-owner by year-end in the form of W-2 income which is deductible and avoids the corporate tax.

Advantages of C corporations

1. More tax deductible fringe benefits — under a C-corp, the physician-owner can deduct 100 percent of certain fringe benefit contributions:

- medical insurance
- medical savings accounts
- disability insurance
- medical expense reimbursement plan
- group term life insurance

shareholder,” then he or she is treated as a partner. For the purpose of dealing with fringe benefit taxation, the corporation is treated as a partnership. Thus, amounts paid for fringe benefits for a shareholder-employee who is a 2 percent shareholder are not deductible by the corporation. The shareholder must include the amounts received in gross income, and is permitted deductions only to the extent allowed a partner (i.e. medical expenses in excess of 5 percent of gross income).

Advantages of S corporations

1. Medicare tax savings — a physician-owner has the ability as an S-corp to take upwards of 40 percent of his/her income as a partner distribution which avoids the 1.45 percent in Medicare tax and the corporation will avoid its matching 1.45 percent in Medicare tax for a total savings of 2.9 percent.

2. Pass-through taxation — S corporations are true conduits or pass-through of income, losses, deductions, or credits flowing to the physician-owners in their pro rata share regardless of whether the money is left in the bank account or not. This could be especially important if you have depreciable equipment or real estate owned by the corporation. However, we are advocates of **not owning assets** in the corporation since they can be seized by a malpractice judgment.

Author’s opinion — you should periodically compare the Medicare tax savings of an S-corp to the list of deductible fringe benefit tax savings in a C-corp. The IRS will permit you to periodically change from C to S and vice-versa.

Please contact my office if you would like information on a feasibility study on this topic. Check our web site for copies of my articles from prior issues.

Barriers to communication

Low health literacy and limited English proficiency



Objectives

At the conclusion of this activity, the physician will be able to:

1. Identify barriers to effective physician-patient communication.
2. Implement techniques to address the needs of patients with low health literacy.
3. Understand the requirements of Title VI regarding those with limited English proficiency.

Course author

Michele Luckie is a risk management representative at TMLT.

Disclosure

Michele Luckie has no commercial affiliations/interests to disclose related to this activity.

Target audience

This one hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

CME credit statement

TMLT is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. TMLT takes responsibility for the content, quality and scientific integrity of this CME activity.

TMLT designates this continuing medical education activity as meeting the criteria for 1 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association. Physicians should claim only those hours actually spent in the activity.

Ethics statement

This course has been designated by TMLT for one hour of education in medical ethics and/or professional responsibility.

Directions

Please read the entire article and answer the CME test questions. In order to receive credit, submit the completed test and evaluation form to TMLT. All test questions must be completed. Please print your name and address clearly. Allow four to six weeks from receipt of test and evaluation forms for delivery of certificate.

Estimated time to complete activity

It should take approximately one hour to read this article and complete the questions.

Release/review date

This activity is released on August 10, 2003, and expires on August 10, 2005. Please note that this CME activity does **not** meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

Introduction

Communication, the giving or exchanging of information, is paramount in a health care setting. Physicians must be able to gather necessary information from their patients in order to develop effective treatment plans. Subsequently, patients need to be able to understand the directions they are being given in order to be compliant with those treatment plans. Unfortunately, there is often a mismatch between a clinician's level of communication and a patient's level of comprehension. This lack of understanding can lead to medication errors, missed appointments, adverse medical outcomes and even malpractice lawsuits.

There are two main barriers to effective communication in health care today. One is easily recognizable in that it deals with the ever-growing population of people with limited English proficiency (LEP).

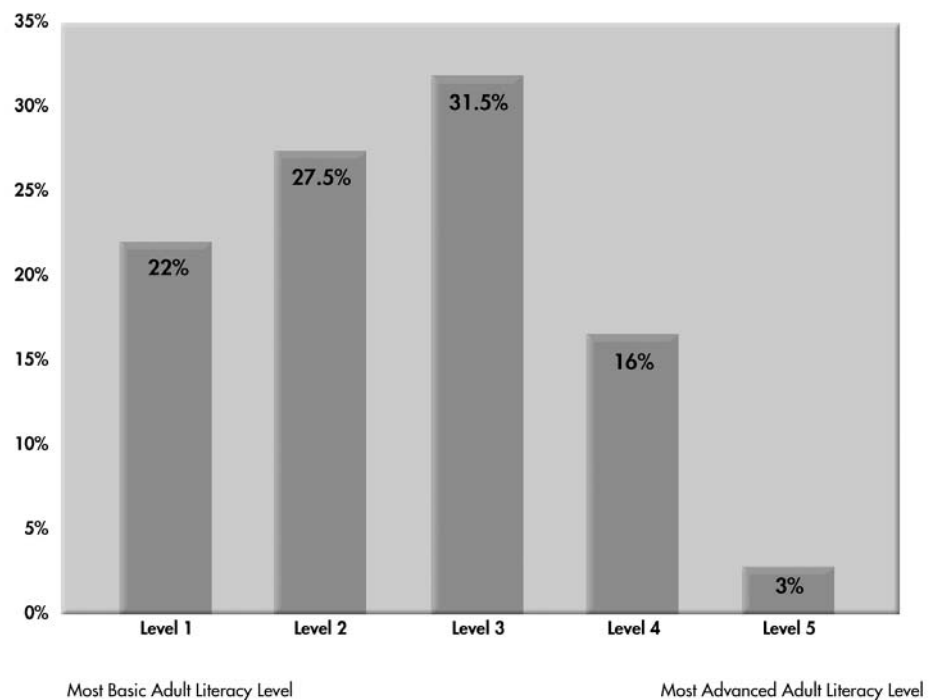
The other is a silent epidemic known as low health literacy. Each of these issues presents unique challenges for physicians and health care providers in all settings. This article will address low health literacy and review methods to enhance effective communication thus increasing patient compliance with better outcomes and decreasing opportunities for complaints against physicians. The second part of the article will include a review of federal guidelines for health care providers who see patients with limited English proficiency and describe resources available to assist in meeting those requirements.

Part one — Low health literacy

Health literacy is defined as the ability to read, understand, and use health information to make appropriate health care decisions and follow instructions for treatment. No national studies have been done that directly measure the health literacy skills of U.S. citizens. However, a good indicator of low health literacy is an individual's general literacy, or the ability to read, write and understand written material. The U.S. Department of Education conducted a survey in 1992 known as The National Adult Literacy Survey (NALS) that provides the most comprehensive view of the general literacy skills of American adults. The NALS tested a random sample of 26,000 adults who were asked to provide personal background information and to complete a booklet of literacy tasks. The results were reported by dividing the literacy skills into five levels of difficulty according to their ability to use and understand text and numbers. (Please see graph to the right.)

Nearly all doctoral-level physicians fall within the NALS level 5, but fewer than 5 percent of all adult Americans have that level of literacy skills. Americans are reportedly more educated today than at any other time in history with the average educational attainment higher than the 12th grade level. However, educational level does not necessarily translate into a corresponding level of reading or comprehension. One out of every five American adults reads at the 5th or 6th grade level or below. The average American reads at the 8th or 9th grade level.

Results of the National Adult Literacy Survey (NALS)



Almost half of the U.S. population is either functionally illiterate or marginally literate (levels 1 or 2). Poor health literacy is a problem that affects people of all social classes. However, the elderly, non-whites, immigrants, and those with low incomes are disproportionately more likely to have poor literacy skills. More than 66 percent of adults aged 60 or over have either inadequate or marginal literacy skills. The survey also shows that 50 percent of Hispanics, 40 percent of African Americans and 33 percent of Asians have reading problems.

The scope of the problem

Low health literacy is a crisis of understanding medical information rather than one of access to information.

Medical information is becoming increasingly complex and, all too often, physicians do not explain the information in a way that patients can understand. Physicians are under increasing time constraints in today's clinical setting and, even more important, they may not know when patients do not understand medical information or instructions. Many patients, because they are embarrassed or intimidated by the dynamic of the

patient-physician encounter, do not ask health care providers to explain difficult or complicated information. If patients do not understand medication and self-care instructions, a critical part of their medical care is missing, which may ultimately have an adverse effect on their outcome.

Take the following scenarios for example:

- This is a common instruction in medicine: "Take 1 teaspoon orally 3 times a day until all is taken." When low-income mothers were asked to bring in the spoons they used when the medication was given, a great variation was seen in the size of spoons — and doses — that were used. Some of the mothers did not know what "orally" meant. One mother thought that the direction, "until all is taken," meant that the entire bottle should be used in 1 day.

- Physicians routinely advise patients with high cholesterol levels to avoid eating "red meat." But according to health literacy expert Janet Ohene-Fremong, MS, "To some people, red meat means uncooked or raw meat, compared with cooked meat. If you want them to eat chicken and fish instead of beef or pork, you have to say that."

In addition, consider the changes in the

complexity of treatment regimens over the last 20 years. In 1980, the usual care for an asthma patient involved taking one pill twice daily. If an exacerbation occurred, treatment would consist of an emergency room visit for shots of epinephrine and nebulizer treatments administered by a therapist to stop the attack. Now patients are expected to administer one or two chronic “stabilizer” medications via a metered dose inhaler, measure and plot their peak flow, decide when they should add a “rescue” inhaler (determination is based on a graph) and administer it with a “spacer,” decide if this treatment is sufficient and if not, either self administer steroids or call their physician for an office visit for additional treatment.

While these changes in treatment plan are very positive for patients and health care costs, they are complex and no one should be surprised that patients with low literacy find them impossible to implement. When physicians are confronted with treatment plan failures they tend to assume that this is a result of poor compliance and label that patient as “non-compliant.” In many cases inadequate health literacy should be considered as a likely explanation. If someone cannot understand health information, they may not know how to follow a doctor’s instructions. This can put the person’s health at risk. Research suggests that people with low literacy make more medication or treatment errors, are less able to follow treatment plans, and are at a higher risk for hospitalization than people with adequate literacy skills.

Studies in health settings have shown that persons with limited literacy skills often have a poor understanding of basic medical terminology and concepts. One study found that many patients did not really understand the meanings of words that physicians regularly use in their discussions — words like “bowel,” “colon,” “screening test,” and “tumor.” In another study it was discovered that one out of four women who thought they knew what a mammogram was, did not.

Adverse health outcomes due to low health literacy translate into increased costs for the health care system. The combination of medication errors, excess hospitalizations, longer hospital stays, greater use of the emergency room, and a generally higher level of illness results in an estimated excess cost for the health care system of \$50 to \$73 billion per year attributable to low health literacy. According to the Center for Health Care Strategies, this amount is equal to what

Medicare pays for physician services, dental services, home health care, drugs and nursing home care combined.

Myths, misperceptions and reality

Making the issue of low health literacy even more difficult to address are the many myths surrounding the problem. Take, for instance, the myth that “illiterates are dumb and learn slowly.” In reality, when a person has trouble reading, it tends to be related more to economic factors than to low intelligence. Most people with low literacy skill have average IQs, and they function well in daily life by compensating for their lack of reading skills in other ways. Another misconception is that the number of completed years of schooling is a good measure of literacy level. Surveys have shown that, on average, adults read three to five grade levels lower than the years of schooling they have completed. And through disuse, the reading skills of many older adults may decrease over time. Finally, there is the myth that people will tell you if they cannot read. There is a strong stigma attached to people with reading problems, and nearly all non-readers or poor readers try to conceal the fact that they have trouble reading. In a study of 58 patients who admitted having difficulty reading, 75 percent had never told their health care provider, 67 percent had never told their spouse, and 19 percent had never told anyone.

Patients with limited health literacy skills can be difficult to identify. Many have developed a number of clever and successful coping strategies that allow them to conceal their problems. Some patients may bring along a friend or family member who can assist with reading. Patients may also watch the behavior of others in the same situation and copy their actions. Some might ask for help from the medical staff, while others may ask for assistance from other patients. Although these patients may appear on the surface to be in control of their health care and treatment plans, they are often lacking the critical information they need to effectively manage their condition.

Even though it might be difficult to identify a patient with low health literacy, there are some “red flags” that a patient may need additional help. Incomplete registration forms or health questionnaires could indicate a limited literacy level. Written materials being handed to a relative or someone accompanying the patient might be a clue. Other clues to limited literacy are:

Behaviors:

- patient frequently misses appointments;
- noncompliance with medication regimens;
- lack of follow-through with lab tests, imaging tests, or referrals to consultants;
- patients say they are taking their medication, but lab tests or physiological parameters do not change as expected.

Responses to receiving written information:

- “I forgot my glasses. I’ll read this at home.”
- “I forgot my glasses. Can you read this to me?”
- “Let me take this home so I can discuss it with my children.”

Responses to questions about medication:

- unable to name medications;
- unable to explain a medication’s purpose;
- unable to explain timing of medication administration.

The absence of these clues does not always indicate that a person has adequate health literacy. Patients may be verbally articulate and appear well educated and knowledgeable yet fail to grasp disease concepts or understand how to carry out medication orders properly. In other words, you cannot tell by looking at them and you cannot expect your patients to tell you.

Physician awareness

A recent AMA Foundation survey found that awareness of health literacy needs to be raised among physicians. According to the survey, approximately two-thirds had not previously heard the term “health literacy.” “I think many physicians are surprised to hear that their patients still have some confusion after leaving a consultation,” comments Joseph Riggs, MD, president of the AMA Foundation and an AMA Trustee. More and more health care professionals are agreeing that health literacy is an issue that must be addressed.

In the March 5, 2003, issue of the *Journal of the American Medical Association*, a team of Boston researchers revealed that many individuals over the age of 65 take their medications improperly, which could lead to adverse, and possibly deadly, reactions. In addition, of all seniors, 90 percent take at least one medication per week and 40 percent take five or more medications per week, creating a high probability for error. “What we’ve

found is that there are about 50 adverse drug events for every 1,000 people every year,” said David Bates, MD, the study’s lead investigator. “Statistically, that’s a significant number of people who are clearly struggling to understand and maintain their prescription regimens.”

The Institute of Medicine of the National Academies has also issued a report identifying health literacy as one of the country’s top priorities for improving the quality and delivery of health care. The report, “Priority Areas for National Action: Transforming Health Care Quality,” lists health literacy as one of only two priority areas considered “cross-cutting” because it affects patients suffering from all types of medical conditions. The report describes efforts to improve health literacy as “essential for effective self-management and collaborative care.”

Even U.S. Surgeon General Richard Carmona, MD, is getting on the bandwagon. In his address to the AMA House of Delegates on June 14, 2003, he focused on health literacy. According to Dr. Carmona, public health preparedness, prevention and resolving health care disparities are three top public health priorities in the United States today. “There is a widespread problem that is seriously affecting these three priority areas, and that is low health literacy — the ability of an individual to understand, access and use health-related information and services,” he said. Low health literacy is a threat to the health and well-being of Americans.

Strategies to enhance patients’ health literacy

It is important for providers to create a “blame-free” environment in which patients with low literacy skill levels can seek help without feeling ashamed or stigmatized. A general attitude of helpfulness from all members of the physician’s staff can go a long way in helping patients feel comfortable in your practice. When patients call the office to make an appointment, collect only the information that is needed to expedite the process. Assist patients in preparing for their visit by asking them to bring all their current medications and to make a list of the questions they want to ask. Assure them that they are welcome to have someone accompany them and be part of the discussion.

First-time patients are faced with having to complete registration forms and personal health questionnaires at most health care facilities. These often present an obstacle for people with limited general or health literacy

skills. Solutions to this problem are simple and beneficial to all patients. First, and perhaps most importantly, office staff should routinely offer all patients the opportunity to have someone assist them in completing registration forms. This can be done by stating, “Some of these forms can be difficult to fill out. If you need help with them, please don’t hesitate to ask me.” Any assistance given should be provided in a confidential manner. Second, registration forms should be simple and request only necessary information. Asking patients for unnecessary information serves no real purpose and intimidates patients who find it difficult to provide the information. Third, information should be collected in the patient’s preferred language whenever possible.

In many cases, going to see your family practitioner results in a referral to a specialist for a consultation and/or a procedure. At the very least, most patients are directed to have laboratory or imaging studies done in order to determine the best course of treatment. Imagine you are a patient with limited literacy skills. You would need to read the referral instructions, then call and make an appointment in another practice that has its own registration system. You might also need to follow pre-appointment instructions, which could include specific preparation or medication adjustment prior to a test or procedure. For a patient who is a NALS level 1 reader, these tasks may be overwhelming. To assist these patients, any written instructions should be clear, simple and written in easy-to-understand language and format. A staff member should verbally review instructions with patients and check that they understand them. It’s a good idea to read written information aloud rather than assume the patient can read and understand the information.

Interpersonal communication between physicians and patients is an important dynamic in health literacy. Poor communication is a major factor in malpractice lawsuits. Attorneys estimate that a clinician’s communication style and attitude are factors in nearly 75 percent of malpractice suits. The most frequently identified communication errors are inadequate explanations of diagnosis or treatment, communication in such a way that the patient feels ignored and that patients feel rushed during their time with physicians.

There is little research done on how best to communicate with patients who have low literacy skills. However, there is general consensus among health literacy and communi-

cation experts that six basic steps can help you improve communication with patients.

1. Slow down. Take time to listen to a patient’s concerns. Data from multiple states in the U.S. indicate that primary care physicians who have been involved in a malpractice claim spend an average of 15 minutes per patient on routine visits. The same data shows physicians that have never been sued spend an average of 18 minutes. Speaking slowly and spending just a small amount of additional time with each patient can improve communication. Foster a patient-centered interaction by sitting rather than standing, listening rather than speaking and encouraging patients to ask questions.

2. Use plain, nonmedical language. Words that clinicians use in their day-to-day conversations with colleagues may be unfamiliar to the majority of people. A good approach is to explain things to patients in a language that you might use when talking to your own family. This is sometimes referred to as “living room language” or conversational language. Conversational language creates opportunities for dialogue between the physician and the patient rather than limiting communication to a monologue by the clinician. Examples include:

<i>Medical term</i>	<i>Plain language term</i>
Analgesic	Pain killer
Carcinoma	Cancer
Hypertension	High blood pressure
Monitor	Keep track of, keep an eye on
Toxic	Poisonous

3. Show or draw pictures. The expression “a picture is worth a thousand words” is particularly true when communicating with patients who may have trouble understanding medical concepts. It is well known that visual images are remembered better than letters and words. In one study, mean correct recall of information was 85 percent with pictographs and 14 percent without.

4. Limit the amount of information provided and repeat it. This does not mean you should withhold information. Instead, focus on the one or two most important things a patient needs to know at the time. Most patients recall only about half of what is said during an office visit, and those with low health literacy even less. If a patient is only going to remember one or two things make them count. For example, at a patient’s first

visit following a diagnosis of type 2 diabetes, the most important message is that “the sugar level in your blood is too high, and you must start taking medication to lower it.” Information about the potential complications of diabetes might be mentioned, but they are not the focus of the visit.

After discussing the key information with the patient, it should be reviewed and repeated. Repetition is the key to learning and memory. Ideally, other members of the staff will be enlisted to go over the information again before the patient leaves in an effort to increase patient understanding. Some experts suggest calling patients several days after delivering important information to further reinforce education.

5. Use the teach-back or show-me technique. These techniques involve asking patients to explain or demonstrate what they have been told. Do not simply ask a patient, “Do you understand?” Experience shows that patients often answer “yes” to such questions, even when they understand nothing. Instead ask patients to explain in their own words or demonstrate how they will undertake a recommended treatment. If a patient does not explain correctly, assume that you have not provided adequate teaching or understandable instructions. Use an alternate approach to ensure patients learn what they need to know. It is important not to appear rushed, annoyed or bored during these efforts.

6. Create a shame-free environment. This can be accomplished by letting patients know that “many people have difficulty reading and understanding the medical information I give them, so please feel comfortable asking questions if there’s something you don’t understand.” As discussed earlier, patients with limited literacy skills are often ashamed and rarely speak of it. Even patients with well-developed skills may pretend to understand materials to avoid seeming “stupid” or annoying to a physician. Another strategy is to ask patients during the visit if they would like a family member or friend to be with them during discussions about diagnoses and options for treatment. By asking in a routine, nonjudgmental way, you can help them feel comfortable about bringing others into the examination room to help at the time of the visit.

Medical advances are outpacing improvements in patient-physician communication. Effective communication may be even more

important than blockbuster medical breakthroughs. If patients cannot understand a physician’s instructions, all the medical advances will be useless, noted Darren DeWalt, MD. To improve health care, especially for those patients with low levels of health literacy, we must affect change in the provider’s and staff perspectives and demonstrate the courage to change our processes.

Part two — Limited English proficiency

The Census Bureau estimated that the nation’s foreign-born population last year numbered 32.5 million, accounting for 11.5 percent of the total U.S. population. Language barriers, coupled with limited access to interpreters, could be impacting the health care delivered to millions of Americans who speak English poorly or not at all. All patients, including those with limited English proficiency (LEP), deserve the highest quality medical care possible and need to be fully informed. Much like those with low health literacy, LEP patients struggle to communicate in the health care system.

In halting English, Elvia Marin’s husband struggled to tell the nurses and doctor that the pain in his wife’s stomach and back was so intense, it was worse for her than giving birth. But the words that would have helped pinpoint her ailment — urinary tract stone — eluded him, and the doctors in the emergency room could not identify the problem by her discomfort alone. A few hours later, the pain subsided and she left without treatment. Others who do not speak English relate similarly disheartening tales of failing to receive medical help. Without adequate translation, health care for patients who speak limited English is at best inconvenient, and at worst, life-threatening.

The current situation of linguistic access to health care is disturbing. It has led to improper diagnosis, poor patient compliance and frustrated patients and providers. In August 2000, the Office of Civil Rights (OCR) for the Department of Health and Human Services issued policy guidance on Title VI of the Civil rights Act of 1964. Title VI was created to eliminate barriers on the basis of race, color or national origin in federally assisted programs or activities. In addition, physicians who fail to ensure adequate communication with LEP patients are at risk for malpractice claims arising from injuries suffered as a result of poor communication.

Case Study

The plaintiff was a native of Mexico whose native tongue was Spanish but spoke a limited amount of English. He was on a construction site using a nail gun when he was struck in the eye by a 6mm piece of metal. At the time of the accident, the man advised his employer of his injury. However, he was not taken to a freestanding urgent care center and examined until the following day. The clinic did not provide an interpreter on site and neither the physician nor her assistant spoke Spanish. An interpreter was made available through a phone service, but it was the physician who remained on the line and the three parties were not joined via speakerphone. The patient never spoke directly to the interpreter.

The plaintiff claimed that he tried to communicate that he had been using a nail gun at the time of the accident and that a piece of metal struck his eye. However, it was noted in the clinic’s medical record that the patient had previously been hit in the eye by a wood chip. Ultimately the patient was diagnosed with an abrasion to the eye and treated accordingly. By the next morning, the plaintiff’s condition worsened and he returned to the clinic. After he was triaged, he was sent immediately to the neighboring hospital. Once seen in the ED, surgery was performed to remove a piece of metal lodged in his eye. Subsequent surgeries were performed but to no avail. The man’s sight remains impaired.

The plaintiff brought suit against the clinic and the treating physician claiming that the lack of an interactive interpreter resulted in the impaired vision. The plaintiff alleged that the standard of care required immediate referral to an ED if there was a history of using any sort of power tool at the time of injury, as was the case in this instance. The plaintiff maintained that had he been able to communicate directly with the interpreter, the details of the mode and extent of the injuries would have been conveyed to the practitioner. The plaintiff’s expert testified that had the surgery been performed earlier, the man’s sight could have been saved. The jury returned the verdict in favor of the plaintiff.

Title VI Compliance

In order to comply with the guidelines issued by the OCR, recipients of federal funds must take steps to ensure that LEP persons have “meaningful access” to their services. The steps taken must guarantee that the LEP person is given adequate information, is able

to understand the services and benefits available, and is able to receive those to which he or she is eligible. The covered entity must also ensure that the LEP person can effectively communicate the relevant circumstances of his or her situation to the service provider. Exactly what type of language assistance is needed will be determined by many factors, including the size of the recipient, number of eligible LEP persons, frequency of contacts with this population, resources available to the covered entity and frequency in which particular languages are encountered, to name a few.

While the OCR indicates that recipients will have “considerable flexibility” in determining how to achieve meaningful access, to ensure compliance with guidelines, they have identified four elements that are usually part of an effective language assistance program. Failure to implement one of the elements does not necessarily mean that the program is not in compliance with Title VI, if, in the view of the OCR, the objectives are otherwise met.

1. *Assessment* — A thorough assessment of the language needs of the population to be served should be done. This would include identifying the LEP persons who need assistance and the languages spoken; instances in which language assistance is likely to be needed; necessary resources as well as their location and availability; and arrangements that must be made to access these resources.

2. *Development of comprehensive written policy on language access* — In addition to provisions regarding assessment, the training of staff and monitoring of the program, the policy should include:

- Oral language interpretation procedures for providing trained and competent interpreters and other language assistance services. For example:

- hiring bilingual staff;
- hiring staff interpreters;
- contracting with an outside interpreter service;
- arranging for services of voluntary community interpreters;
- arranging for the use of telephone interpreter services.

- Translation of written material that is routinely provided to English speaking patients should be available in regularly encountered languages other than English. This would include:

- consent forms;
- letters regarding services and benefits or conditions of participation;

- notice of the availability of free language assistance.

- The OCR will determine a given recipient’s obligation to provide translated documents on a case-by-case basis.

- Methods for providing notice to LEP persons — individuals must be notified of their right to language assistance free of charge. Methods may include:

- use of language identification cards stating what language the patient speaks;
- signs in regularly encountered languages;
- translation of forms and other written material;
- booklets or brochures outlining available services.

3. *Training of staff* — recipients must develop ways to train staff to ensure effective communication with LEP persons. Methods may include:

- training as a part of staff orientation;
- maintaining a training registry;
- making staff aware of LEP policies and procedures;
- training staff to work with telephone and in-person interpreters;
- understanding dynamics of interpretation between physicians, patients and interpreters.

When training staff, begin with ensuring the person making appointments is asking enough questions. If someone calls stating, “I’m calling to make an appointment for my mother,” the first thing you need to find out is why the patient is not calling. In asking “why” you might discover that the patient only speaks a certain language, which can give you an opportunity to determine what services will be needed.

4. *Monitoring* — the program must be monitored for efficacy. Recipients should consider:

- reviewing their program annually
- current LEP population;
- current language assistance programs;
- whether the program is meeting needs;
- whether staff is knowledgeable about policies and procedures and knows how to implement them;
- whether resources are still current and viable.

Claudia Schlosberg, JD, who is the acting director of the Program, Policy and Training Division of the Department of Human Services, recently reported that the OCR is in the process of revisiting its LEP guidance to con-

form to the U.S. Department of Justice LEP guidance published at 67 FR 41455 on June 18, 2002. “In the near future, we expect to republish our revised guidance in the *Federal Register* for public comment, and will welcome your comments during the comment period. For more information please visit the OCR web site at www.hhs.gov/ocr/lep/guide.html

Communication, essential for the effective delivery of health care, is perhaps one of the most powerful tools in a clinician’s arsenal. Physicians can readily improve their patients’ understanding of health care information by adopting a more patient-friendly style of interaction regardless of the barriers. A patient who truly understands his or her health problems can be more actively involved in the entire health care process, which hopefully will result in better treatment compliance and outcomes. A proactive, rather than reactive, approach to these communication issues should be part of the commitment to patients for all health care professionals.

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CME test questions

Instructions: Using black ink, read each question, select the best answer, and then clearly mark your selection. When you have completed the test, please fax it to the TMLT risk management department, attention Natalie Gilmore (512) 425-5996. A certificate of completion will be mailed to the address you provide below.

1. According to the National Adult Literacy Survey (NALS) what percentage of the U.S. population is either functionally illiterate or marginally literate:
 - a. 30 percent
 - b. 70 percent
 - c. 49.5 percent
 - d. 25 percent
2. Adverse health outcomes due to low health literacy result in an estimated excess cost for the health care system of:
 - a. \$90 million a year
 - b. \$50-\$73 billion a year
 - c. \$5 billion a year
 - d. \$45 million a year
3. Some strategies that may be used to enhance interpersonal communications between physicians and patients are:
 - a. Slow down and listen to concerns
 - b. Use plain, nonmedical language
 - c. Use the teach-back or show-me technique
 - d. All of the above
4. According to the Census Bureau estimates in 2002, the U.S. foreign-born population was:
 - a. 10 million
 - b. 22.5 million
 - c. 43 million
 - d. 32.5 million
5. Health care providers who participate in Federal programs must assume the cost of interpretive services for those with limited English proficiency.
 - a. True
 - b. False

CME evaluation form

Please complete the following questions regarding the article, "Barriers to communication."

1. The objectives for this CME were met. Yes No
2. The material will be useful in my practice. Yes No
3. Did you perceive any evidence of bias for or against any commercial products? If yes, please explain. Yes No
4. How long did it take you to complete this learning activity? 0.5 hrs 0.75 hrs 1 hr 1.25 hrs
5. On a scale of 1 to 5, with 5 being the highest, how do you rank the effectiveness of this activity as it pertains to your practice? 1 2 3 4 5
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7. Suggestions for future topics include:

8. What will you do differently in your medical practice after reading this article?

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In case you missed it . . .

• In order to assist you in complying with HIPAA, TMLT has developed a Business Associate Agreement. This agreement complies with privacy regulations and establishes a standardized internal process demonstrating TMLT's commitment to comply with federal privacy regulations.

Copies of the TMLT Business Associate Agreement were mailed to all policyholders in April. The agreement is also available on the TMLT web site, www.tmlt.org/overview/news.

If you have any questions regarding this agreement or about HIPAA compliance in general, please contact Michele Luckie at 800-580-8658, ext. 5903 or the TMLT Risk Management Department at ext. 5912.

• In July, the Texas State Board of Medical Examiners began distributing new information for Texas physicians about the disciplinary process and the expanded role of TSBME. The video, *The TSBME: A*

Glimpse of Licensure and Discipline is now available at no charge to Texas physicians, medical organizations, hospitals, medical schools and residency programs, and is designated to meet the one-hour continuing medical education (CME) requirements in the area of medical ethics and professional responsibility.

The video was produced and funded by the Texas Medical Foundation, and is now available on the TMF web site, www.tmf.org, for online viewing. An application for CME credit is also posted online at the TMF web site. To obtain a free copy of the DVD or VHS video, along with the CME application packet, call TMF at 800-725-9216.

The video reviews the composition, purpose and scope of the TSBME; the relationship between the TSBME and professional associations; the licensing process; the responsibilities of the licensee; common violations of the Medical Practice Act; and the investigative process of the Board. It also

reviews the Informal Settlement Conference, a tool used to resolve complaints against physicians.

• With this issue, Laura Hale Brockway assumed the duties of editor for *the Reporter*. If you are a regular reader of the newsletter, you are familiar with her thorough research and clear writing style on such featured topics as breast cancer, hyponatremia, and chest pain. An honors graduate in journalism from the University of Texas at Austin, Ms. Brockway has been employed in the TMLT communications department for four years. In 2002, she received her core curriculum certificate in editing/writing from the American Medical Writers Association, and is currently working on her advanced certification.

Please contact her at laura-brockway@tmlt.org or (512) 425-5936 if you have any questions or suggestions concerning *the Reporter*.