the Reporter

TMLT
TEXAS MEDICAL LIABILITY TRUST
March/April 2002

CURRENT ISSUES IN PAIN MANAGEMENT

by Barbara Rose, Senior Risk Management Representative

Dark Times
I am awash with pain, my tyranny.
It covers me like seaweed,
clinging, stinking;
the salt is in my wounds.

Searing my muscles with perpetual passion,
pain invades my mind,
my privacy.
Afraid I am drowning
when I so want to live,
I cry.

Pain — all of us experience it at some time in our lives. None of us welcomes it. Pain is an uninvited intruder but functions as the body's way of telling us something is wrong. Bonica, the father of modern pain management, defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." Pain is the body's way of telling us something is lacking homeostasis, a measure of a person's well-being.

Attention to pain and its management has been a focus to a greatly varying degree of individuals who practice the art of medicine. According to the American Pain Foundation, 50 million Americans suffer from chronic pain and only 1 in 20 receive proper treatment. In addition, 40 percent of cancer patients and 50 percent of post-surgery patients receive inadequate pain relief. Elsewhere, studies establish that nearly 50 percent of the population reports having chronic pain [1] and back pain occurs in as much as 80 percent of the population. [2] In the U.S., pain is a major public health problem: more than 50 million work days are lost each year to under-treated pain including chronic pain due to arthritis, back pain, migraines, fibromyalgia, and acute pain due to injuries.

Management of pain is, without question, a popular topic in medicine today as indicated by the following:

- February 1999: Veterans Health Administration adds pain as a fifth vital sign in patient assessment.
- January 2001: JCAHO pain management standards to be implemented at accredited health care facilities.
- June 2001: Jury finds a California physician liable for elder abuse subsequent to an allegation of inadequately treating a patient's pain.

These headlines brought attention to what is widely regarded as one of the most unrecognized and untreated symptoms in health care. Pain management has congressional interest with Senator Ron Wyden (D-Ore) and Representative Darlene Hooley (D-Ore), establishing a working group to examine what role the federal government should play in alleviating pain and other end-of-life issues.

Whether your area of medicine is that of a primary care physician, a surgeon, any subspecialist or a physician specifically dedicated to pain management, the assessment and treatment of pain presents myriad challenges. The patient's age, ethnicity, spiritual/philosophical beliefs, familial and social environment will influence one's response to pain. "Pain is multi-dimensional and everyone has a different pain threshold." [3]

"Pain is one of the most common reasons that patients seek medical care, yet it is often inadequately treated. Untreated, the pain accompanying illness slows recovery, adds financial burdens to the health care system, and severely impairs quality of life." [4]

Listening to your patient lies at the heart of the physician/patient relationship. Put yourself in the patient's shoes and consider how you want to be treated in his/her situation.

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Balancing the scales in management of risk relevant to treatment of pain may feel like skating on thin ice and influence a physician's choice. Under prescribe and you may be accused of abuse, of allowing your patient to suffer needlessly. Prescribe aggressively to control pain and it may be alleged that you contributed to a drug addiction for your patient. These fears interfere with a physician's ability to focus on the medicine. "Physicians must seek a middle ground between the unfettered prescribing of opiates and the fear that prevents them from relieving pain." [5]

With so much of today's health care occurring in the ambulatory setting, evaluate your pain assessment process. Consider implementing a pain assessment chart as part of your patient history form. Add practical questions such as "How often does your pain interfere with daily activities?" and "How has your pain affected your relationships?"

Pain management is one of the most challenging areas of medicine. As a physician, assess your knowledge and competence level with pain management. Those who specialize in pain management generally believe that doctors are not learning enough about pain in medical school and residency. If an honest assessment reveals a lack of knowledge to manage this complex medical, social and even legal issue, take action. Learn pain control techniques. Assess patients for pain. Be aware of biases in treatment of pain. Learn when to refer. Be open to complimentary therapies. [6]

Acceptance
I get so frustrated when I want to work
and I can't because my body fails me.
I grieve for the energy I used to have,
for the days when I would erupt out of bed,
ready to go.

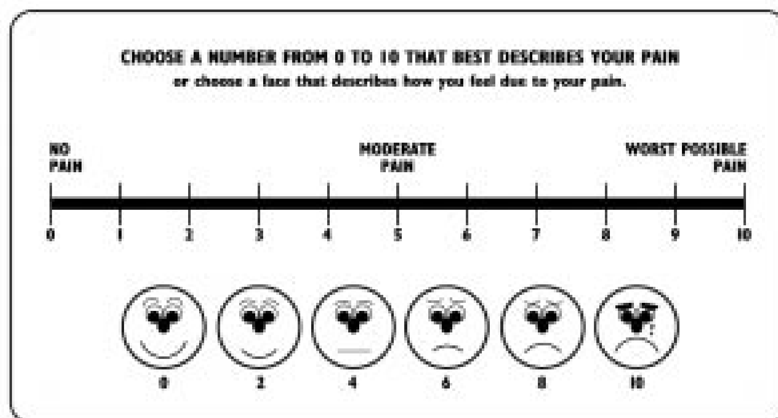
Lost times
Lost life.

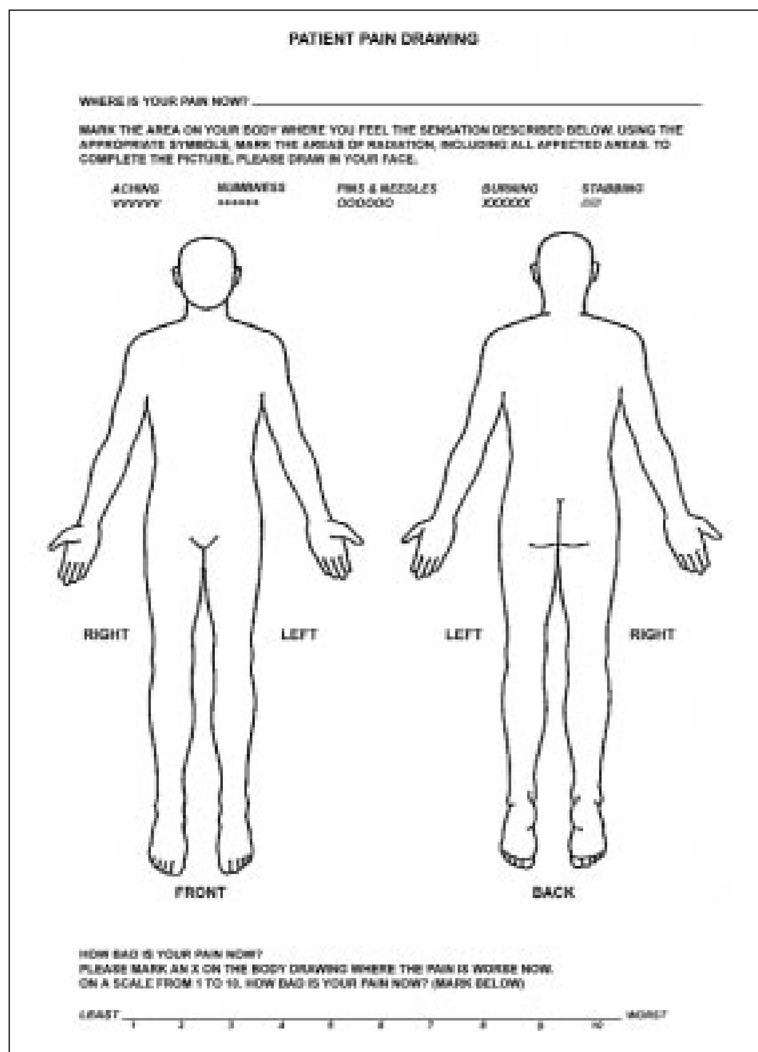
I miss the spontaneity of good health,
when I would do simple things,
like go for a drive,
or dance,
without having to consider the toll on my body.
I miss the fun.

Still . . .
I can't let the past rule my today.

So I will recognize my grief,
roll around in it,
and mourn my loss as I would
the death of a beloved child.
For only then can I get beyond it.

The music is different now.
But it's still there. [7]





Many commonly used patient pain assessment charts can range from the simple (top) to the complex (bottom).

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7. "Dark Times" and "Acceptance" are reprinted with permission from Linda Martinson, *Poetry of Pain: Poems of Truth, Acceptance and Hope for Those Who Suffer Chronic Pain,* Simply Books. For more information, email simplybookspub@yahoo.com; to order, call 800-431-1579

OXYCONTIN:
BLESSING OR BANE?

by Barbara Rose, Senior Risk Management Representative

Introduced in 1995, OxyContin is a timed-release form of oxycodone, a narcotic long available in other medications, including Percocet, Percodan, and Tylox. Unlike these products, OxyContin delivers a steady dose of the drug over a 12 hour period, which makes it a godsend for patients with disabling chronic pain.

Phillipp M. Lippe, MD, executive medical director of the American Academy of Pain Medicine was quoted in the *American Medical News*: "If physicians practice good medicine and document good medicine, they have nothing to fear." A physician-patient relationship based on trust and acceptable standards of care with documentation of sound medical decision-making in support of the use of OxyContin will defend the choice of this medication.

In December 2001 during testimony before a U.S. House subcommittee, the U.S. Drug Enforcement Administration's Asa Hutchinson stated: "The DEA does not intend to restrict legitimate use of OxyContin, nor prevent practitioners acting in the usual course of medical practice from prescribing OxyContin for patients with a legitimate medical purpose."

In spite of this encouraging statement from Dr. Lippe, and assurances from Mr. Hutchinson at the DEA, scrutiny from any federal or state agency has a provocative and chilling effect. The almost daily negative reports in the media regarding OxyContin is having an impact on physicians prescribing the legitimate use of OxyContin.

On October 23, 2001, the DEA announced an unprecedented collaboration of 21 of the nation's leading pain and health care organizations to call for a balanced policy governing prescription pain medications such as OxyContin. Preventing drug abuse is an important societal goal, but there is consensus by law enforcement, health care practitioners, and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve.

On February 20, 2002, a Florida physician was found guilty of manslaughter in connection with the deaths of four patients from OxyContin overdoses. He was also found guilty of one count of racketeering and five counts of unlawful delivery of a controlled substance.

Amid the controversy about abuse of OxyContin, fueled in great part by media coverage, what can physicians do to protect themselves but continue to prescribe when medically necessary the drug of choice for a patient's pain? The following suggestions were published by Purdue Pharma to help physicians stop the diversion of OxyContin and protect their practice.

- Never sign an incomplete prescription.
- Use tamper-resistant pads that can't be photocopied.
- Write the quantity and strength of drugs in letters and numbers, as on a check. If just a number is on the prescription, it is easy to alter.
- Be wary of people who are not interested in having a physical examination, are unwilling to authorize release of prior medical records, or have no interest in a diagnosis or a referral, saying they want the prescription now.
- Be cautious if a new patient has an unusual knowledge of controlled substances or when a new patient who requests a specific controlled drug is unwilling to try another medication.
- Stick to principles and take a complete history and perform a thorough physical examination.
- Look for drug abuse signs such as inflamed nares, skin tracks and perforated nasal septum.
- Call the police if you believe someone is trying to divert prescription medication.

In addition to these suggestions, have patients sign a contract consenting to the pain management therapy as directed by the physician. The agreement is intended to protect the patient's access to appropriate controlled substances and to protect the physician's ability to prescribe for the patient in pain. (Please see sample agreement on page 4.)

For more information on OxyContin or other pain management issues, please visit the following web sites:

American Academy of Pain Management
www.aapainmanage.org

American Academy of Hospice & Palliative Medicine
www.aahpm.org

American Pain Society
www.ampainsoc.org

SAMPLE

Patient responsibility agreement for controlled substance prescriptions

Your letterhead

Controlled substance medications (i.e., narcotics, tranquilizers and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions:

1. I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early," I understand that it will not be replaced.

2. Refills of controlled substance medications:
    a. will be made only during regular office hours, Monday through Friday, in person, once a month, during a scheduled office visit. Refills will not be made at night, on weekends or during holidays. No refills by phone.
    b. will not be made if I "run out early," "lose a prescription," or "spill or misplace my medication." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
    c. will not be made as an "emergency," such as on a Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least 24 hours ahead if I need assistance with a refill, which must be refilled in person in the office.

3. It may be deemed necessary by my doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be refilled.

4. I agree to comply with random urine, blood or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications, and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.

5. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.

6. I understand that the main treatment goal is to reduce pain and improve any ability to function and/or work. In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control and avoidance of tobacco and alcohol use. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

7. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined, and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances, and that my physician will advise me of any advances in this field and will make treatment changes as needed.

I have been fully informed by Dr. ______________________________________ and staff regarding psychological dependence (addiction) of controlled substance medication, which I understand is rare. I know that some individuals may develop a tolerance to the medication, necessitating a dose increase to achieve the desired effect. I know that there is a risk of becoming physically dependent on the medication. I know that it may be necessary to stop taking the medication. If so, I know I must slowly decrease the dose while under medical supervision or I may have withdrawal symptoms.

I have read this contract and the same has been explained to me by Dr. ________________________________. In addition, I fully understand the consequences of violating this agreement.

______________________________________ ______________________________________

Patient signature Witness signature

____

Date

Protecting your assets from lawsuits

By Peter J. Parenti, P.C. and Ken H. Vanway, P.C., attorneys at law

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. For more information, please visit his web site, at www.estateplanning.com/kenvanway.

About the author

Co-author and member of the TMAIT Attorney Network, Peter J. Parenti, is board certified in Tax Law, Estate Planning and Probate Law by the Texas Board of Legal Specialization. He was one of the first lawyers in Texas to create APEPs for his clients. His law office is located at 300 Convent St., Suite 2500, San Antonio, Tx, 78205-3716.

When is it too late for asset protection planning?

There is an old cliché in the insurance industry, "You can only buy insurance when you don't need it." Regarding asset protection estate planning (APEP), the best time to get it accomplished is "when you don't need it." But what if you've procrastinated and suddenly you get a letter from a lawyer asking for your medical records for that patient who had less than stellar results from your medical services, is it now too late to consider an APEP?

This article will explore the problems and possible solutions that confront the procrastinator who never got around to asset protection until the request for medical records arrived.

The Texas Uniform Fraudulent Transfer Act (TUFTA) says that if a debtor transfers assets to hinder or delay existing or known future creditors, and after the transfer the debtor has insufficient assets to pay his debts, any creditor can have the transfers set aside and recover the assets from the persons or entities to whom assets were transferred. The statute also contains an extinguishment period after which transfers which are considered old and cold cannot be set aside. The basic extinguishment period is the greater of 4 years from the date of transfer or 1 year from the date a creditor could have discovered the transfers. TUFTA, however, will not allow unknown possible future creditors to set aside transfers made prior to their becoming actual creditors. One cannot defraud a creditor or potential creditor who does not exist at the time of the transfers.

While it takes 4 years for the concrete walls of an APEP to cure as to existing and known future creditors, the curing process for unknown, non-existing future creditors is immediate. In other words, if you have no knowledge of any pending or threatened claims today and you create an APEP today, get sued tomorrow and TUFTA does not matter . . . no 4-year waiting period. Therefore, the sooner an APEP is accomplished, the better.

If you have not created an APEP and then you are sued, what can be done at this midnight hour?

1. Make an assessment of the worst-case dollar amount of liability.
2. Determine if liability insurance covers this amount.
3. If your liability insurance will not cover this amount, you will need to set aside some assets to cover the liability. You'll just have to accept the fact that since you chose to procrastinate, you won't be able to protect it all.
4. Immediately create an APEP with the balance of your assets through a competent and experienced APEP lawyer.
5. Consider paying down your mortgage on your principle residence or what the Texas constitution refers to as your homestead. Texas law exempts the homestead from most creditors (see previous article). Most creditors are prohibited from placing liens upon or attempting to foreclose on a homestead. Texas courts have held that the conversion of non-exempt assets like cash or investments to purchase a homestead or to pay off a valid lien on the homestead is not a fraudulent transfer.
6. Because you have procrastinated, the following techniques may or may not work, but bear in mind that you have limited options:

(a) Establish a family limited partnership and transfer assets to it in exchange for partnership interest. TUFTA excludes transfers for full and adequate consideration. An argument can be made that the exchange of assets for partnership interest is full and adequate consideration.

(b) Establish an offshore trust. By placing assets offshore you can put them out of the reach of the Texas courts. However, a recent debtor tried using these offshore techniques after being sued and was jailed for contempt when they refused to bring the assets back into the country. They sat in jail for several months until the court finally gave up. So if you have staying power you could outlast the court, but don't count on it.

(c) Purchase a cash value life insurance policy or an annuity. Section 21.22 of the Texas Insurance Code exempts cash value life insurance and annuities policies. But Section 22.21 contains its own fraudulent transfer provisions.

(d) Contribute to your qualified retirement plan or an IRA. As long as the contribution is within the normal contribution limits, an argument can be made that there was no intent to defraud creditors.

(e) Factor your accounts receivable and use the cash to pay down your homestead mortgage. The difficulty here is finding a factor that will buy your accounts receivable due to the uncertainty of amount of payment by third payers.

Procrastination limits your planning options, can result in losing your nest egg and affects your health during the stress of a lawsuit. By preplanning you can protect more of your wealth with much more certainty. So even though this article is about last minute planning techniques, it is much better to accomplish good planning sooner instead of later.

TMAIT will be offering asset protection seminars in 2002. Watch for information about a seminar near you in TMA publications and on the TMAIT web site, www.tmait.org.

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 Law Office of Ken H. Vanway, P.C., First Commercial Bank, 1110 RR 620 South, Suite B, Austin, Texas 78734.*

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.

Drs. Baum and Parks elected

Alan C. Baum, MD

By Dana Leidig

In 2002, two new physicians were elected by TMLT policyholders to serve on the Trust's Board of Governors. Alan C. Baum, MD, of Houston and Robert I. Parks, MD, of Dallas, will each serve a 3-year term on the Board.

When TMA member physicians first formed TMLT in the late 70s, the founding fathers wanted to ensure that a Texas doctor's perspective was always represented when Trust decisions were made that affected all TMLT-insured physicians. A governing board was established to work along with Trust management, comprised of 9 TMLT-insured physicians elected by policyholders. Each Board member serves a 3-year term and terms of office were staggered from the very beginning so that the Board always had some members experienced with the duties of board membership. The physicians who helped establish the Trust were confident that, with this governing board in place, physician policyholders would always have their best interests represented.

TMLT Board elections are held annually with 3 positions open to policyholders who may have an interest in serving on the Board of Governors. Policyholders submit written nominations and the TMA also submits its candidates for the Board. All nominees must be current TMLT policyholders to be considered for candidacy and nominations are submitted to the TMA House of Delegates for approval before being placed on the ballot. Elections are conducted by written, mail-in ballot and the independent accounting firm of Ernst & Young tabulates the results.

Alan C. Baum, MD

Beginning his new Board term with TMLT is Houston ophthalmologist Alan C. Baum, MD. Dr. Baum has been a TMLT policyholder for 17 years. He is a partner at the Texas Eye Institute in Houston and, along with his "physician's perspective," he brings a wealth of experience working with organized medicine in Texas.

A native of Fort Scott, Kansas, Dr. Baum earned his bachelor's degree at the University of Texas at Austin and received his medical degree from the University of Texas Medical Branch at Galveston in 1968. He completed his ophthalmology residency in 1972 at the University of Texas Medical School Houston Hermann Eye Center and from 1969 to 1975, he was a captain in the 147th Fighter Squadron of the Texas Air National Guard. UTMB presented him with the Ashbel Smith Distinguished Alumnus Award in 1997.

Dr. Baum is active in a variety of professional organizations. He is a member of the American Academy of Ophthalmology, the American Medical Association, the Board of Trustees of the Texas Medical Association Foundation, American Society of Cataract and Refractive Surgery, and the UT Marine Science Institute Advisory Board. He has served as president of the Texas Ophthalmological Association and the Southwest Branch of the Harris County Medical Society and has earned the distinguished service award from TOA. He has served as chief of staff at Memorial Southeast Hospital in Houston and chair of the ophthalmology sections of both the Memorial Southwest and Memorial Southeast Hospitals.

In 1991, as chair of the TMA Board of Trustees, Dr. Baum promoted the TMA's 1992 endorsement of TMLT. He appointed a TMA/TMLT Liaison Committee to focus on tort reform and medical liability; he continues to serve on the committee. Dr. Baum served as 1999-2000 president of the TMA and is a past chair for both the TMA Board of Trustees and TEXPAC.

It was Dr. Baum's close involvement with the TMA that lead him to the TMLT Board of Governors. "While serving as a member of the TMA Board of Trustees, we would have ongoing meetings with the TMLT Board, and through those meetings I gained some insight into the work being done by the Trust. I saw that the work was meritorious and believed that I could make some contribution."

As a board member, one of Dr. Baum's goals is to help physicians during the medical liability crisis.

to TMLT Board of Governors

"We are experiencing a terrible crisis in the tort arena as pertains to medical malpractice issues. The Board needs to do all it can to ensure that our policyholders are well represented. We need to be doing all we can to provide the best coverage at the best rate. Many physicians are going to be put out of business by high premiums or the fact that they just can't get coverage."

He would also like to help educate the Texas Medical Association about medical liability issues. "We would make the membership of the TMA, which brought TMLT into existence, understand the complexity of the problems the Trust has to deal with and represent."

Robert I. Parks, MD

The TMLT Board of Governors welcomes the experience of another newly elected member, Robert I. Parks, Jr, MD, an anesthesiologist from Dallas. Dr. Parks graduated from the University of Texas Southwestern Medical School at Dallas in 1972. He completed his internship at Baylor University Medical Center and Parkland Memorial Hospital in Dallas and his residency in anesthesiology, 1973-75, at Parkland Memorial Hospital. Dr. Parks served in the United States Air Force, 1975-77 in Biloxi, Mississippi at the USAF Medical Center Keesler. In 1977, he returned to Dallas to start private practice at Baylor University Medical Center where he continues practice today.

Dr. Parks has been active in his specialty society, both at the state and national levels. He has served the Texas Society of Anesthesiologists as president, 1992-93. He has been an alternate delegate, 1984-91, delegate, 1991-present, and a member of the Board of Directors, 1999 to present, to the American Society of Anesthesiologists.

Working with TMLT management on Trust issues is not a new experience for Dr. Parks, who has been a TMLT policyholder for 8 years. He has been a member of the TMLT claims review committee since 1998. He has also served as president of the medical staff at Baylor University Medical Center in 1999, and chairman of the medical board at Baylor University Medical Center, in 2000. He is currently serving as the physician representative to the Baylor Health Care System Board of Trustees, a seven-hospital system. Dr. Parks sits on the Board of Directors of the Baylor Heart and Vascular Hospital in Dallas.

Robert I. Parks, MD

Dr. Parks' experience on the claims review committee prompted his interest in serving on the TMLT Board of Governors. "Interaction with board members at case review conference convinced me of the sincerity, character, integrity and resolve of these members to fairly represent the physicians of Texas in their quest to lower TMLT premiums through risk management and tort reform."

During his board term, Dr. Parks would like to focus on achieving medical liability reform and bringing risk management education to more physicians.

"I would like to strengthen TMLT's relationship with the TMA to lead to tort reform that will pass the constitutionality test. I also hope to expand the successful risk management program by continuing the regional seminars, but also find new marketing methods to reach those physicians who thus far have not participated."

Dr. Parks would also like to see a greater understanding develop between policyholders and board members. "I would like to accomplish more face-to-face explanations to policyholders why rates are exploding and why the Board must act in its fiduciary function of keeping TMLT a viable company."

The TMLT Board of Governors will face difficult decisions for the Trust in 2002. The Board and TMLT management are working together closely and intelligently to steer the Trust through the stormy waters of a medical liability crisis that is driving up premiums to an unprecedented level, and that is forcing physicians to consider whether they can continue to practice medicine in Texas. If you are seeking ways to help solve the medical liability crisis, please contact your county medical society, the Texas Medical Association, or TMLT for information on how you can have an impact.

Fact vs Fiction

in the medical liability reform debate

Much of the discussion about the health care system in the U.S. has been centered on managed care and the logistics of health care delivery. Medical liability, as a salient health care issue, has been off the radar screen for the last several years. But now that we find ourselves neck-deep in a medical liability crisis severe enough to affect patient access, the press and public are starting to take notice. In newspapers and on network news broadcasts, physicians are talking about how our unfettered legal system is affecting their practices and the delivery of health care.

But this increased scrutiny comes at a price. In their attempts to present balanced information, reporters will often seek out the opinions of trial lawyers and consumer advocates who espouse their own views on the subject. Among other things, these pundits claim that the perceived medical liability crisis is actually the result of stock market losses and mismanagement by insurance companies, not the filing of nonmeritorious lawsuits. Even more alarming are their claims that medical malpractice litigation is necessary to improve the quality of health care and reduce medical errors, and that high premiums and lawsuits act to protect patients.

While everyone is entitled to an opinion, it is a little mystifying how these purportedly rational, educated people can simply disregard the facts when professing their viewpoint. It can be compared to someone relentlessly insisting that the sun revolves around the earth, the facts be damned!

The fight for medical liability reform in Texas is growing ugly, as it has been in Pennsylvania and West Virginia. The plaintiff's bar is waging a bloody public relations war, vilifying physicians and insurance companies alike. The best chance for success against this powerful and united opponent is to be united ourselves. Physicians and their medical liability insurance carriers need to work together to achieve common goals, but this is a complex issue. Misinformation abounds and it is easy to become sidetracked by supposition and half-truths. We cannnot afford to disregard the facts.

Patient safety and malpractice litigation

"The real bottom line is medical care needs to be improved," said a personal injury attorney in the *Corpus Christi Caller-Times.* And while the medical community and their insurance carriers can agree with this statement, they would not agree with the assertion that malpractice litigation is necessary to ensure patient safety.

How does making physicians afraid to take emergency room call protect patient safety? How does running neurosurgeons out of the Rio Grande Valley protect patient safety? How does compelling ob/gyns to abandon obstetrics protect patient safety? Does any sane, rational person out there really believe that enacting medical liability reform will make health care less safe, that higher malpractice premiums actually improve the quality of health care? Following this logic, patients in Pennsylvania, West Virginia and Texas are safer than patients in California, which has had strong medical liability reform in place since 1975. This simply does not pass the common sense test. Researchers at the Stanford University Graduate School of Business found that medical liability reform lowered health care costs with no significant impact on health outcomes in states that have limited noneconomic and punitive damage awards.[1]

Our out-of-control legal system does very little to actually improve the health care system. The plaintiff's attorneys who flourish under it leach billions of dollars away from the health care system at a time when resources are scarce. It's bad enough that the money is taken out of health care, but under our current system, it does not even make it to injured patients. According to the Health Care Liability Alliance, 43 cents of every malpractice premium dollar goes to patients as compensation. The remaining 57 cents goes primarily toward legal fees. The current system mainly serves to enrich those who abuse it and who would make money off the suffering of others.

The IOM report

An Institute of Medicine Report released in 1999 claimed medical errors and accidents in hospitals caused between 44,000 and 98,000 deaths each year. [2] And while no one can disagree with the main point of the report, that hospitals should be made safer, several subsequent studies have revealed flaws in the IOM report. [3-4] These studies maintain the 98,000 deaths was probably an overestimation, but this higher figure is thrown around by plaintiff's attorneys and patient safety advocates to illustrate the need for malpractice litigation.

What the plaintiff's attorneys and con-

sumer advocates don't include when they quote the IOM report is that the report itself stipulates that measures be taken to make health care providers more forthcoming in discussing errors so that others can learn from them. "The focus must shift away from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. This does not mean that individuals can be careless. People must be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error." [5]

Lawsuits do not create a safer health care environment. Instead they complicate efforts to prevent medical errors by imposing secrecy and silence, breeding fear and insecurity. Fear of litigation stifles any attempt to discuss medical errors and prevent them. If we want to seriously address patient safety, the first step should be reforming the medical liability system. According to the American Association of Health Plans, "the current malpractice system . . . is now considered to be the single most important barrier to improving the safety of the health care system." [6]

Non-meritorious litigation

Again, it is completely baffling to witness the tenacious insistence of the plaintiff's bar that most medical liability claims are meritorious. A trial lawyer was quoted in a news story on KGBT in Harlingen, "medical malpractice cases they say generally are frivolous. That's just not true." However, the statistics speak for themselves. TMLT routinely closes more than 85 percent of claims with no indemnity payment. In 1999, the figure was 88.9 percent; in 2000 it was 86.6 percent; in 2001 it was 89.8 percent. No indemnity means no payment was made on behalf of the physician to the patient for personal injury, loss or damage.

Increase the sample size, and the results are the same. The TMA reviewed claim data from three of the state's largest carriers, including TMLT. For all three companies, the closed without indemnity rate was 82 percent in 1999 and 86 percent in 2000.

This data indicates that more than 80 percent of medical liability cases can be considered non-meritorious. Defending these types of claims costs insurance companies millions of dollars in legal expenses, court costs and staff time. In 2000, TMLT spent $26 million just in the defense of non-meritorious claims. In 2001, that number increased to $28 million.

Settlement of malpractice suits

Another prominent argument for the cause of the "manufactured" crisis is that insurance companies fight claims instead of settling them. Plaintiff's attorneys are actually blaming this crisis on the insurance companies because they fight claims. They're filing non-meritorious suits in record numbers and insurance companies are at fault?

The "if you pay us, we'll go away," argument is the most self-serving of all. In TMLT's experience, settling claims only invites the filing of more claims. Attorneys track and pursue insurance companies that settle easily, following the path of least resistance.

In 2001, TMLT defended and closed 89.8 percent of claims with no indemnity payment and won 51 of 63 cases taken to trial. So, following the plaintiff bar's argument, settling all these claims would have saved the company money.

Admittedly, it is expensive to fight medical liability claims, but these costs pale in comparison to the money required to settle claims outright. In addition, the argument for settling claims rather than fighting them disregards the insurance company's commitment to look out for the best interests of its policyholders and to help them avoid the very serious consequences that occur when a claim is settled.

TMLT's claim philosophy has always been to defend doctors, not pay claims. Only by aggressively defending non-meritorious claims can we protect physicians' reputations and keep the number of malpractice suits filed against all physicians in check. A soft settlement policy will only make things worse.

Investment income

Another misconception being propagated is that stock market losses are responsible for the increase in premiums, not lawsuit abuse. This argument is the easiest of all to believe — it's plausible. For most physicians, the increase in malpractice insurance rates hit at the same time the stock market began its decline. All the opposition had to do was put two and two together. But, as the familiar saying goes, correlation does not equal causation.

It is important to realize that losses experienced by TMLT cannot be attributed to the recent downturn in the stock market. Like many other physician-owned insurance companies, TMLT invests in bonds and fixed-income vehicles. Less than 10 percent of our investable assets are in the stock market. Due to TMLT's not-for-profit status, the Trust has never had a substantial investable asset base — like for-profit insurance companies — on which to earn investment income. Investment income received is used primarily to cover operating expenses, excluding claim costs. TMLT's operating costs are reviewed annually and are well below the operating expenses of our competitors. TMLT also reviews rates regularly and changes in premium rates are determined after considering current actuarial data.

Information about any carrier's income, assets, surplus and investments is available from the company's annual report. Independent insurance rating agencies and state departments of insurance can also provide this data. Check the facts before assuming investment income is the reason for increasing premiums. St. Paul, the nation's second largest physician insurer, announced in December it would exit medical liability altogether. St Paul's medical liability division lost $940 million in 2001, and the company disputes the argument that the stock market was to blame for their losses. "We made the decision to exit medical malpractice because of the huge losses we have incurred in this line over the past number of years on a national basis," said a company spokesperson in the *Las Vegas Sun.* [7]

Regardless of the investment income issue, one cannot argue with the numbers from the TMA data studies and the Texas Department of Insurance. Claim frequency is increasing. Jury awards, settlements and legal expenses are increasing. In 2001, regulated carriers paid out more money in claims than they received in premiums.

As has been stated, medical liability is a complex issue. This article has covered only some of the misinformation currently being spread by the opponents of medical liability reform. But make no mistake about it, their campaign of misrepresentation will continue.

As an active participant in the fight for medical liability reform, TMLT has an obligation to respond to these claims and see that the medical community's perspective prevails.

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closed claim study

Failure to monitor and properly treat

by Barbara Rose, Senior Risk Management Representative

The following closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.

Clinical presentation

A patient had a longstanding history of coronary artery disease, suffering his first MI at age 47. He had recurrent chest pain a year later and underwent a work up to rule out MI. He was treated medically without invasive procedures. Four years after the first MI, he presented to a new cardiologist, the defendant in this case.

A cardiac catheterization showed 99 percent proximal right coronary artery disease with a 90 percent circumflex lesion, a 70 percent diagonal branch and total occlusion of the left anterior descending coronary artery. His ejection fraction was less than 20 percent, and he had unstable angina. The patient underwent right and left heart catheterization, coronary arteriography and percutaneous translumenal coronary angioplasty.

Nine months later, the patient returned to the cardiologist for repeat cardiac catheterization. This catheterization showed a totally occluded left anterior descending coronary artery, no advancement in the 40 to 50 percent narrowing of the circumflex, some evidence of re-stenosis in the proximal one-third of the very large coronary artery which was diffusely diseased, and a 50 to 70 percent lesion at the site of the previous angioplasty. He was discharged without further procedures under medical therapy.

The patient returned to the cardiologist two years later for a repeat cardiac catheterization. The LAD remained totally occluded, the circumflex was a small vessel and it was not possible to do an angioplasty on that vessel.

The patient was again seen by the cardiologist seven years later and the cardiologist reported the patient was doing quite well with occasional shortness of breath upon exertion. He was on medical therapy and was without any significant changes in his clinical status except a reported presence of a Grade I mitral regurgitation murmur.

Physician action

Approximately two months after his last appointment with the cardiologist, the 61-year-old patient presented to a local emergency room complaining of chest pain, burning in his left chest and epigastric area and shortness of breath. He was transferred via air ambulance to an urban hospital and to the care of his cardiologist. The EKG showed premature ventricular complexes, left atrial enlargement, septal infarction of indeterminate age, marked ST abnormality, and possible inferior subendocardial injury. The patient was seen in consultation by a gastroenterologist who performed a esophagogastroduodenoscopy that revealed focal erythema, edema and small raised dots of reddened mucosa involving the antrum. He diagnosed mild gastritis.

The cardiologist performed an echocardiogram that was described as showing severe mitral insufficiency, biatrial enlargement, calculated right ventricular systolic pressure of 43 mm Hg and left ventricular dysfunction with an ejection fraction of 26 percent. An EKG performed the following day was interpreted as showing left atrial enlargement, septal infarction and marked ST abnormality, and possible inferior subendocardial injury. The patient had a fever of just over 100 every day during his 3-day admission, including the day of discharge.

According to the cardiologist, but not documented in the patient's medical record, the patient declined cardiac catheterization and wanted to be discharged home. He was to return to the gastroenterologist in five days and the cardiologist in approximately three weeks.

The day after his discharge, the patient suffered an MI and died.

Allegations

- Failure to properly care for and/or treat
- Failure to properly and timely evaluate and/or diagnose
- Failure to properly and timely order other diagnostic studies.

The plaintiffs alleged the patient should have undergone cardiac catheterization and that failure to treat was negligent and resulted in the patient's death.

Legal principle

Negligence is the failure to use ordinary care, that is, failure to do that which a health care provider of ordinary prudence would or would not have done under the same or similar circumstances.

One of the main issues in this case was documentation. Essentially the case became a debate regarding a conversation with the cardiologist and the decedent whether cardiac catheterization was offered and refused. The physician admitted at deposition that he made a mistake in not documenting the patient's refusal to have a catheterization. However, he was adamant that he did discuss the matter with the patient and the patient refused the procedure.

The plaintiff attorney found expert opinion to support the allegations, claiming the patient's death could have been prevented with appropriate diagnostic tests and revascularization. Had the disease been too extensive, bypass surgery might have been appropriate. However, defense experts believed the patient was not a surgical candidate and were supportive of the cardiologist's decision not to perform a cardiac catheterization in accordance with the patient's wishes. It was entirely within the standard of care for a physician

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SAMPLE

Informed refusal

Your letterhead

In order to diagnose/treat my condition, a ____
test/procedure

was ordered for me on ____________________. The reasons for ordering this test/procedure
date

have been carefully explained to me. I understand the potential benefits are ________________

____

and the alternatives include ____

In addition, Dr. ______________________ has informed me of the risks involved in not having a

________________________ performed. These risks include ___________________________
test/procedure

____

After careful consideration of the benefits and risks concerning the above, I am refusing

________________________. My reason(s) for refusing is: _____________________________
test/procedure

____

Signed this _____________ day of ______________________ by:

____________________________________ ____________________________________

Patient signature Witness signature

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not to push extreme measures when there was little expectation of success, and it was not unreasonable for a patient in such poor health to refuse additional heroic measures.

Disposition

This case was tried before a jury with plaintiffs' request for an award totaling $ 2.1 million. The verdict was rendered in favor of the plaintiffs, the decedent's four adult children. The jury found the physician negligent and awarded damages of approximately $50,000 for funeral costs, medical expenses and past mental anguish.

Risk management considerations

Every patient has the right, after full disclosure, to refuse medical treatment and the physician is then ethically prohibited from proceeding. Prudent practice involves comprehensive documentation. Just as written and signed consent is required for the performance of procedures, a written and signed refusal of treatment should be completed and a part of the medical record.

Juries are often more sympathetic toward plaintiffs when reports of care rendered are based solely on the memory of the physician and are unsubstantiated by documentation in the medical record. The plaintiff's attorney had the advantage in this case with a deceased patient, grieving children and an undocumented patient decision of great importance.

A signed refusal for heart catheterization including the risks, benefits and options, with the patient's signature witnessed and filed in his medical record may have prevented this claim. Physician practice protocols should include detailed documentation of the informed refusal in the progress notes. Physicians should also consider the use of an informed refusal form, as the patient's signature will add merit to their defense. (Please see sample above.)

TMLT

the Reporter

TEXAS MEDICAL LIABILITY TRUST

P.O. Box 160140
Austin, TX 78716-0140
800-580-8658 or 512-425-5800
Fax: 512-425-5998
E-mail: dana-leidig@tmlt.org
Web address: www.tmlt.org

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