

# the Reporter

TMLT

TEXAS MEDICAL LIABILITY TRUST  
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## Preventing disaster & reducing risk



*by Jane Mueller, Assistant Vice President, Risk Management*

In the words from his famous 1963 song, Bob Dylan sang, "The Times They Are A-Changin'." Much like the day President Kennedy was assassinated, we will all remember where we were and what we were doing at the exact moment we learned of the terrorist attacks on September 11, 2001. In recent medical journals, physicians have described entering physicians' lounges in hospitals or turning on the radio in their offices only to watch and hear in disbelief the description of the worst catastrophe ever on United States soil.

Some physicians say they practiced little medicine that day, but instead spent their time listening to their patients' fears and pain, offering what comfort they could. Acknowledging those emotions and feelings is possibly the most therapeutic manner to combat terrorism, or at minimum assist patients in healing. It is difficult, if not impossible, to comprehend the enormity of destruction and loss to so many Americans, our patients.

In these difficult times, patients' expectations for medical treatment will continue with an increased anticipation that physicians communicate with patients, not only about their medical problems and concerns, but also about their fears and anxiety regarding terrorism and bioterrorism threats. Fed by media hype and newspaper headlines, fear is not rational but represents what is unpredictable and unfamiliar. While some may argue that we should worry more about the burger we eat than the anthrax bug, patients are showing up at physicians' offices requesting, even demanding, a prescription for an antibiotic to "have on hand" in the event of biological warfare. With the health of many patients already compromised, the additional stress of these recent events may further threaten their well being.

How have the roles of physicians and health care providers changed since that tragic day? How have systems and processes in offices and hospitals changed? What changes need to be made to help ensure the safety of your patients and staff?

## Preparing for disaster

The first step in preventing disasters and minimizing risks involves planning. While prudent risk management practices should always include disaster planning, the September 11th attacks certainly brought this issue to the forefront. If you woke up one morning discovering that your office had been damaged or destroyed, would you know what to do? Some physicians don't even have home telephone numbers for contacting their staffs. As a physician, disaster planning in the form of a safety program will help protect people (patients and staff) and the organization (physically and financially).

Physicians are owners and operators of small businesses; and as such, need a plan to deal with disasters that may disrupt or shut down business. It has been estimated that approximately 25 percent of small businesses that shut down due to a disaster never reopen.<sup>1</sup> Even though you may be a solo practitioner, a simple disaster plan is important. A disaster plan should include the following:

### Policies and procedures

- Severe weather
- Fire
- Flood
- Utility failure
- Hazardous material incidents
- Water contamination or failure
- Civil disturbance
- Hostage situation
- Bomb threats
- Medical equipment failure

### Staff preparedness

- Education and training
- Staffing requirements
- Established staff responsibilities
- Annual drills

### Patient management

- Patient and employee relocation
- Status of medical and billing records
- Control of patient information
- Patient transfer (if applicable)

### Facility preparedness

- Utilities
- Communication system
- Supplies
- Security

For more information on disaster preparedness and sample policies and procedures, contact the risk management department at [www.tmlt.org](http://www.tmlt.org) or 800- 580-8658, ext. 5912.

## Biological and chemical threats

Whether it is anthrax, smallpox or nerve gas, the threat of biological and chemical warfare is real. This has been a concern for decades; however, again, the events of September 11th and the

resulting attention by the media have brought focus on these issues. The preparedness of the public health system in responding to bioterrorism is focused on early detection and response. The sarin gas attack in a Tokyo subway in 1995 resulted in only 12 deaths, but flooded emergency rooms with more than 5,000 panicked patients, most uninjured.

With flu season upon us, patients are presenting to hospital emergency departments and urgent care facilities with symptoms that many fear may indicate they are infected with anthrax. Others contact physicians fearing they have been exposed to anthrax or other biological agents. Some very persistent patients insist on receiving a prescription for antibiotics to safeguard them and their loved ones in the event of a national bioterrorism attack. In December, the FDA called for widespread use of potassium iodide in the event of a nuclear attack to help protect people from some of the ill effects of radioactive fallout. It is important for physicians to remain vigilant but calm. Diagnosis presents new challenges, requiring not only excellent technical skills, but also good communication skills to discuss the facts and calm anxious patients.

It is also important that unusual symptoms be reported immediately to public health and law enforcement authorities. The Texas Department of Health (TDH) has published *Anthrax "Threat" Guidance*, containing guidelines and regulations for testing, diagnosis, treatment and reporting.<sup>2</sup> (The summary on page 3 may be useful as a reference.) Please refer to the TDH web site for complete information regarding biological and chemical agents and required reporting.

**Please note: the TDH does not recommend any prophylaxis or treatment for persons without symptoms or exposure to *Bacillus anthracis*.**<sup>3</sup>

## Remaining vigilant

Following the tragic events of September 11th, with heightened security in our nation's airports, state and federal government buildings and limited access to various other facilities, the times certainly are changing. This doesn't mean a dramatic change in the way physicians practice medicine, but rather an awareness of changing situations that may present an increased danger to patients and threats to their safety and well-being. Now, more than ever before, is the time to plan and implement processes and systems, while remaining informed about current medical information and reporting guidelines, to help ensure best outcomes for patients.

Additional resources can be found on the following web sites:

- [www.ama-assn.org/ama/pub/category/6206.html](http://www.ama-assn.org/ama/pub/category/6206.html)
- [www.ama-assn.org/ama/pub/category/6223.html](http://www.ama-assn.org/ama/pub/category/6223.html)
- [www.hhs.gov/hottopics/healing/011018scrpt.html](http://www.hhs.gov/hottopics/healing/011018scrpt.html)
- [www.bt.cdc.gov/](http://www.bt.cdc.gov/)
- [www.tdh.state.tx.us/bioterrorism](http://www.tdh.state.tx.us/bioterrorism)

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# Data Bank Daze

## Inside the National Practitioner Data Bank

by Laura Hale

In the late 1990s, a consumer information movement swept through health care, and like other developments in the field of medicine, it left an indelible mark. It began when patients, already accustomed to using the Internet to gather health care information, began looking for physician profile information. Consumer advocates, armed with high profile reports on patient safety<sup>1</sup> and media-hyped cases, such as that of Michael Swango, MD, sentenced to life in prison for murdering three patients and suspected of killing as many as 35,<sup>2</sup> began pushing for public access to personal, educational, demographic, disciplinary and professional information about individual physicians.

The response was unprecedented. Currently, more than 35 states now offer online physician profiles.<sup>3</sup> The Texas State Board of Medical Examiners' Physician Profiles Program is in full operation, and as of September 1, 2001, Texas physicians are required to submit profile information. For \$9.95, anyone can access physician disciplinary information from the Federation of State Medical Board's web site, DocInfo.org. In addition, there are a handful of private Internet sites that offer some type of physician profiling, such as SearchPoint.com and healthgrades.com. Most of these sites receive their information from state and federal agencies.<sup>4</sup>

And while consumer groups and lawmakers have been successful in gaining public access to state disciplinary information on physicians, there is one area of information access they have failed to crack — The National Practitioner Data Bank (NPDB). Long considered the "holy grail" by public information advocates, it contains much of the same information found in state databases, except it holds information on physician malpractice payments. Since its creation in 1986, the NPDB has withstood three attempts by lawmakers to allow public access. What follows is a brief introduction to the NPDB, including how physician information is obtained and

distributed, an examination of current issues and the movement to open the NPDB to the public.

### Background

The NPDB was established under the Health Care Quality Improvement Act of 1986 as a flagging system to alert credentialing agencies of malpractice payments or adverse actions taken against the licenses or clinical privileges of health care practitioners. The NPDB was also intended to prevent practitioners who lost their licenses in one state from moving to another state

and setting up practice without disclosing the disciplinary actions.

Specifically, the NPDB maintains records of licensure, clinical privileges, professional society membership and Drug Enforcement Agency actions taken against health care practitioners and malpractice payments made for their benefit dating back to September 1, 1990. Since 1997, the NPDB has kept reports of exclusions from Medicare and Medicaid programs. At the end of 2000, there were 264,065 reports in the data bank involving 164,320 individual practitioners. Of the individuals listed, 69.7



percent were physicians, and 72.7 percent of all reports in the data bank concern malpractice payments.<sup>5</sup>

The Division of Quality Assurance of the Bureau of Health Professions, Health Resources and Services Administration, the U.S. Department of Health and Human Services manages the data bank. A contractor, SRA International Inc., is responsible for its day-to-day operations. An executive committee, composed of individuals representing the various constituencies of the data bank, advises SRA.<sup>6</sup>

Another data bank falls under the jurisdiction of the Division of Quality Assurance, the Healthcare Integrity and Protection Data Bank. The HIPDB collects information regarding licensure and certification actions, exclusions from federal and state health care programs, health care-related criminal convictions and civil judgements, and other adjudicated actions. While the NPDB and the HIPDB share a web site and use the same querying and reporting service, this article will only discuss the NPDB. For more information about the HIPDB, please visit the web site at [www.npdb-hipdb.com](http://www.npdb-hipdb.com).

## Reports

The NPDB receives three types of information: reports on "adverse" actions, reports on malpractice payments and reports on Medicare/Medicaid exclusion. A report is submitted when:

- a state medical board takes certain licensure disciplinary actions, such as revocation, suspension or restriction of a license
- a hospital, HMO or other health care entity takes professional review actions that adversely affect the clinical privileges of a physician for more than 30 days
- a physician voluntarily surrenders or restricts his or her clinical privileges while being investigated for possible professional incompetence or improper conduct or in return for an entity stopping an investigation
- a professional society takes a professional review action adversely affecting a physician's membership
- the DEA revokes the DEA registration of a physician
- the Department of Health and Human Services excludes a physician from Medicare or Medicaid reimbursement
- an insurance company or self-insured entity makes a payment of any amount for the benefit of a licensed health care practitioner in the settlement or judgement of a malpractice action or claim.<sup>7</sup>

## Malpractice data

Malpractice information comes to the data bank from the 704<sup>8</sup> malpractice payers who are registered with the NPDB. When report-

ing, payers are required to provide a detailed narrative that includes the age and sex of the patient, the patient type, the medical condition of the patient, the procedure performed, the claimant's allegation, associated legal and other issues, and the outcome. The narrative cannot contain patient names or the names of other health care practitioners, plaintiffs, witnesses and other individuals involved in the case.

Once the Malpractice Payment Report has been received by the NPDB, a copy is sent to the subject of the report. The subject is then given the opportunity to submit a statement expressing his/her view of the circumstances surrounding the report. (Subject statements are limited to 2000 characters, including spaces and punctuation.) This statement is disclosed along with the report to those who query the data bank.

A practitioner can dispute any report in the NPDB, but only on the grounds of the factual accuracy of the report or whether the report was submitted in accordance with the NPDB's reporting requirements.<sup>9</sup>

## Who can query

The NPDB, which was created to help state licensing boards and hospitals review of health care practitioners' professional credentials, was never intended for public access. NPDB information is not available to the general public, but public data files can be requested for statistical analysis. The public data files do not contain any information that identifies the subjects of the reports.

Currently, only the following entities can request information from the NPDB:

- a board of medical examiners or other state licensing board
- a hospital
- a health care entity that provides health care services and follows a formal peer review process for the purpose of furthering quality health care
- a professional society that follows a formal peer review process for the purpose of furthering quality health care
- health care professionals can self-query at any time

Hospitals are the only entities required to query the database. They must do so when considering a health care practitioner for a medical staff appointment or clinical privileges, and at least once every two years concerning any health care practitioner who is on medical staff or holds clinical privileges at the hospital. All other eligible entities may request information voluntarily. Medical malpractice payers may not query the NPDB, even though they are required to report.<sup>10</sup>

A plaintiff or plaintiff's attorney in a malpractice action against a hospital may request and receive information from the

NPDB in limited circumstances. This is possible when independently obtained evidence submitted to DHHS demonstrates that the hospital failed to make a required query. If this is demonstrated, the attorney or plaintiff will be provided with the information the hospital would have received had it queried. However, this information on the practitioner can only be used in legal action against the hospital and not the practitioner.<sup>11</sup>

Federal statutes provide criminal penalties, including fines and imprisonment, for individuals who fraudulently query or report to the NPDB. The Office of Inspector General is authorized to impose penalties of up to \$11,000 against each individual, entity or organization for each improper disclosure, use or access. According to the NPDB, the OIG has issued fines against two entities for violating confidentiality provisions.<sup>12</sup>

## Current issues

In recent years, the NPDB has been the subject of several studies exposing serious flaws in the information it has collected. In November 2000, a report from the General Accounting Office found that a significant amount of the data bank's information is "incomplete," "inappropriate," "inconsistent," and "inaccurate." The GAO found nearly all malpractice records they reviewed were incomplete, and about one-third of the reports they examined contained inaccurate information on clinical restrictions.<sup>13</sup>

Investigators from the Office of Inspector General came to similar conclusions. In a study released in May 2001, the OIG found that managed care organizations and hospitals seldom report disciplinary actions to the NPDB, as required by law. In the data bank's first 10 years of operation, 84 percent of managed care groups and 60 percent of hospitals have never reported adverse actions.<sup>14</sup> In response to the OIG report, the American Association of Health Plans emphasized that health plans do not generally identify quality problems and take action, but instead rely on group practices, hospitals and state licensure boards to identify incompetent providers.<sup>15</sup> The American Hospital Association said hospitals report required events to the data bank, but they often use remedies that do not require reporting, such as education programs and suspensions of less than 30 days.<sup>16</sup>

In addition to underreporting by managed care organizations and hospitals, another study found the DEA is underreporting to the NPDB. Public Citizen, a consumer advocacy group that is fighting to have the data bank open to the public, claimed that nearly 2,600 physicians who have voluntarily surrendered their DEA registrations over the last 11 years have not

been reported to the NPDB. Public Citizen discovered the non-reporting when it compared information in the NPDB's public use file with DEA actions.<sup>17</sup>

### The move toward public access

In the spring of 2000, a U.S. House of Representatives Commerce Committee panel held two hearings on opening the NPDB to the public. At the hearings, the AMA provided testimony opposing the opening of the data bank, arguing that the existence of a malpractice action does not help patients assess the competency of a physician. The data bank was not designed to provide patients with information about physicians but rather as a supplement to comprehensive professional peer review of a practitioner's credentials. The AMA urged continued physician oversight at the state level.<sup>18</sup>

During the hearings, testimony was also given by the federal administrator who manages the data bank. Tom Croft, a director in the DHHS Health Resources and Services Administration, stated "Nothing in the data bank's information is intended to produce an independent determination about the competency of an individual practitioner."<sup>19</sup> Croft also told the panel to carefully consider any action that could jeopardize the data bank's confidentiality and thereby discourage hospitals and other entities from reporting. More than 30 medical specialty societies, investigators who participated in the Institute of Medicine report on patient safety, members of President Clinton's Health Care Quality Commission, the Joint Commission and the American Health Quality Association all opposed the opening of the data bank.<sup>20</sup>

Testimony was also given by Anderson Smart who related the circumstances surrounding his wife's death during surgery at a New York hospital. One of the surgeons was on probation for professional misconduct and had been sued several times for malpractice. Further testimony came from Liana Gedz, whose physician carved his initials into her abdomen during a cesarean section. Despite this act and the known fact the physician had frontal lobe disorder, he was able to work for five more months after being suspended from a New York hospital.<sup>21</sup> Also asked to testify was James Stewart, the author of *Blind Eye: the Terrifying Story of a Doctor Who Got Away with Murder*. The book details the case of Michael Swango, MD.<sup>22</sup>

The following fall, then U.S. Commerce Committee Chair Thomas Bliley, (R-Virginia) introduced legislation that would open the NPDB to the public. The bill died with the closing of Congress in 2000, and there has been no further legislative action to allow public access to the NPDB.

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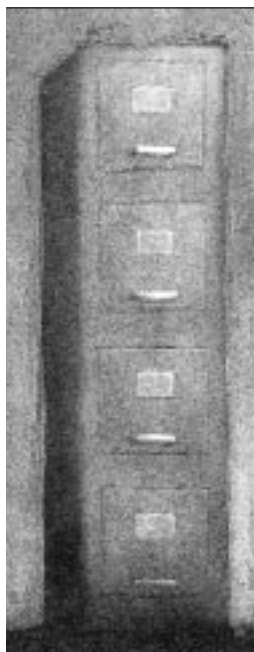
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## The Massachusetts Physician Profiles project

Representative Bliley's proposal for the NPDB was modeled after a state data bank in Massachusetts, which became the first state to enact a physician profiling system in 1996. The Massachusetts Physician Profiles System is often cited as one example of a successful state profiling system, and its development was supported by the Massachusetts Medical Society.

Included in a Massachusetts profile:

- business and professional demographics
- education and training
- hospital affiliations
- insurance plans accepted
- paid malpractice claims
- hospital disciplinary actions

- board disciplinary actions
- criminal history

Not included in a Massachusetts profile:

- number of suits filed against a physician
- patient mortality rates
- malpractice settlement amounts

The system incorporates malpractice data into its physician profiles, but that information is put into context. The malpractice data is presented based on how an individual physician's record compares to those of other physicians in that same specialty and explaining whether payments fell above or below the average for the specialty.<sup>23</sup>

# 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 presented.*

### Clinical presentation

Due to a change in medical insurance, a male kidney transplant patient was transferred to the care of a nephrologist approximately two years after the transplant surgery. The patient's kidney failure was attributed to hypertensive nephrosclerosis. His medical history included hepatitis C and positive cytomegalovirus titre. Lifestyle choices included drinking more than a six pack of beer daily and smoking two packs of cigarettes weekly. After the transplant, the patient experienced delayed function of the graft and required hemodialysis for seven days. In the two years following surgery, the patient was followed by physicians at the hospital where the transplant occurred. His serum creatinine was in the range of 1.5-2 mg/dl, and serum cyclosporine level was maintained in the range of 300-400 ng/ml.

### Physician action

Based on a managed care contract, the new nephrology group served as a preferred provider in nephrology, exclusive of transplant management. The patient's new nephrologist referred him to a transplant clinic and intended for that clinic to follow the patient's transplant treatment. It was noted in the medical record that the patient was to see the physicians at the transplant clinic, in addition to the defendant nephrologist. (It is unclear from the record, however, who was to monitor the patient's levels.) At this time, the nephrologist assumed the patient would also

be followed by the transplant clinic. During the initial visit, the patient was found to have elevated blood pressure and the nephrologist asked him to return to his office for blood pressure checks on an as-needed basis.

The nephrologist next saw the patient five months later. At this appointment, the SMAC showed a creatinine of 2.6, elevated liver enzymes and elevated glucose. No cyclosporine level was obtained at this visit. The nephrologist noted in the medical record for this visit that he would confirm the lab results, however there was no follow up on the abnormal lab values. The physician later stated that if he had been responsible for follow up on the patient's kidney function, he would have repeated the creatinine test, ordered an ultrasound and a renal perfusion scan. However, he assumed the transplant clinic was following up on these values.

The patient returned four months later. His creatinine level was 3.5 and glucose was 383. No cyclosporine level was obtained. The nephrologist planned to check the creatinine and potassium again in one week, but the patient did not follow up.

The patient was next seen four months later by another nephrologist in the defendant's practice. The patient's creatinine level was 5.4, glucose was normal and cyclosporine level was 802. Upon referral the patient was subsequently seen by the transplant clinic, and a biopsy showed a grade 3 rejection. After five months of dialysis and a hospitalization for pneumocystic carinii pneumonia, the patient underwent right kidney reimplantation. He has returned to his previous level of health.

### Allegations

The main allegations in this case included failure to monitor and properly treat leading to delay in diagnosis/treatment of renal transplant rejection and requiring re-transplant. The plaintiff alleged he lost a transplanted cadaver kidney because of cyclosporine toxicity and the defendant failed to properly monitor the cyclosporine level.

### Legal implications

Experts in this case were divided on causation. When the slides from the patient's kidney biopsy were reviewed by pathologists, one pathologist said the biopsy showed chronic rejection and another pathologist found the same slides showed changes consistent with cyclosporine nephrotoxicity. Consequently, plaintiff experts claimed the retransplant was needed due to chronic rejection which was caused by the "substandard nephrology care" rendered by the defendant in this case. The experts further argued that had the chronic rejection been diagnosed in a timely manner, the kidney may not have been rejected. They were also critical of the sparsity of lab studies and the lack of evaluation of the creatinine level changes.

Defense experts maintained that the kidney failed because of a less than ideal match resulting in chronic rejection, and the care provided by the nephrology group did not cause the patient's kidney to fail. After the transplant, the patient showed delayed graft function and was at increased risk for chronic allograft rejection. When the patient initially presented with an elevated creatinine, the chronic rejection process had already begun, and this could not have been reversed. The experts also felt the patient's chronic hypertension and other health problems were a factor in the rejection.

### Disposition

This case was tried before a jury and a defense verdict was rendered. The jury found no negligence on the part of the defendant. However, more than \$60,000 in defense costs and legal expenses were incurred.

### Risk management considerations

The outcome of this case is viewed as a success for the defendant and it is meaningful to feature a claim that went to trial and concluded with a jury exoneration of the defendant. The history of the case still offers

*continued on page 10*

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](mailto: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.

### **Offshore trusts — serious protection**

For physicians who are serious about protecting their assets from malpractice claims and other attacks, the foreign asset protection plan (also called an offshore trust) is one of the most protective planning devices a client can utilize. All other alternatives (family partnerships, partition agreements, homestead protection, domestic trusts, etc.) rely upon the uncertainties of the very legal system (domestic U.S. judicial system) that created the legal problems.

### **Misconceptions**

There is a lot of misinformation out there and clients have a lot of misunderstandings about offshore trusts.

- You do not have to transfer the assets offshore. During non-crisis mode, most if not all of the assets remain invested within the U.S. Only during crisis mode would you need to have the assets transferred offshore. Most physicians who utilize an offshore trust also have a family limited partnership (FLP). The FLP holds title to your unprotected assets (i.e. brokerage account, etc.) which remain invested within the U.S. Only interests in the FLP are transferred to the offshore trust. The actual assets remain invested within the U.S. during non-crisis mode.

- You have continued use of the assets as distributions can be made to the trust beneficiaries which includes yourself and can include other family members.

- You can have continued control over the trustee actions by being the “trust protector.” A trust

# Protecting your assets from lawsuits

By Ken H. Vanway, P.C., attorney 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 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](http://www.estateplanning.com/kenvanway).

How do offshore trusts work? Creating an offshore trust is very similar to creating any type of domestic trust (i.e. revocable living trust, insurance trust, children's trust, etc.). As with any trust planning (domestic or offshore), you would be the trustmaker (sometimes called “trustor” or “grantor”) and your attorney would create a written trust agreement. Our firm can assist you with this process. The trust agreement merely contains your written instructions about: who you choose to select as initial trustee; how the trustee can be removed and replaced; what trust beneficiaries can receive trust distributions (You can be a beneficiary); when the trust terminates; and who will be the initial and successor “trust protector” (see below).

### **Do offshore trusts work — case study**

In a study of over 1,000 offshore trust cases created between 1988 and 2000, about 6 percent came under some form of attack (i.e. lawsuit, etc.). Of those, 100 percent of the cases resulted in either having the claim dropped or a quick, favorable settlement.

### **Why do they work — the “ugly defendant”**

Having your unprotected assets (i.e. stocks, cash, etc.) owned by an offshore trust requires that the legal battle be moved abroad to a different, non-U.S. legal system. This move creates financial, geographical and psychological barriers to creditors trying to collect a judgment. Several foreign jurisdictions do not recognize U.S. judgments. This results in the requirement of a new trial. The increased fees and costs of litigating in a foreign jurisdiction make you an ugly defendant. The proper jurisdiction can provide a short statute of limitations and can also shift a more difficult burden of proof to the judgment creditor.

protector has the ability to remove and replace the trustee, change jurisdiction, veto investment and distribution decisions.

- Tax reporting requirements are nil during non-crisis mode. Most offshore trusts are drafted to be tax neutral for income, gift and estate tax purposes. The trust is treated by the IRS as a “grantor trust” and ignored as a separate tax entity for income tax purposes. The transfers to the trust are incomplete gifts for gift tax purposes and do not trigger any gift tax.

- Offshore trusts are not just for the “super-rich.” There are two primary costs to consider: the initial setup cost can range from \$10,000-20,000 depending upon the planning structure and the continued operating costs range from \$950-2,500.

### **Selecting a foreign jurisdiction: anybody want to go to the Bahamas?**

Legislation governing offshore trusts has been enacted in about 20 offshore jurisdictions. There is not a “best jurisdiction,” as each has their pros and cons. Clients and their advisors must look at a variety of factors including: protective trust laws; stable economic, political and social environment; favorable tax laws; minimal language barriers; quality professional services; modern telecommunications; reputation in the global financial community; and community property provisions. Currently, some of the better jurisdictions are Cook Islands, St. Lucia, Nevis, and the Isle of Man.

Consider us as a resource for assisting your planning team in developing a comprehensive and integrated asset protection plan. TMAIT will be offering physicians opportunities to attend asset protection seminars in 2002. Watch for information about a seminar near you in your TMA publications and on the TMAIT web site, [www.tma.org](http://www.tma.org).

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## TMLT offers discounts for TexMed tracks

TMLT policyholders can earn a 3 percent premium discount (not to exceed \$1000) by attending one of the following educational tracks at TexMed 2002:

- bioterrorism
- cardiovascular disease/stroke
- cancer
- pain medicine
- practice management

Note that two educational tracks may be attended for a maximum discount of 6 percent.

TexMed 2002 will be held April 18-20 in Dallas. For more information, please visit [www.virtual.texmed.org](http://www.virtual.texmed.org). For questions regarding the TMLT discount, contact Lesley Lopez at 800-580-8658, ext. 5908.

## closed claim study continued

the opportunity to feature some practice protocols that could be implemented or improved and, if consistently followed, may prevent a basis for allegations of negligence. These processes serve to ensure comprehensive documentation in the medical record demonstrating communication and follow up that assures continuity of care. These documented actions in turn lay the foundation for the opportunity to close a claim without indemnity because the record has been shown to be the physician's best defense.

Two issues are of note in this case. With so many specialties and sub-specialties in medicine today, physicians listed as a managed care plan's "preferred provider," i.e., a nephrologist in this case, must know every

detail of their contract. Some confusion and miscommunication occurred regarding whose responsibility it was to monitor the patient's post-transplant condition, order labs, etc. Always take the time to determine these guidelines with the managed care plan, the primary physician, the transplant center in this example, the patient, and document this information. It is always dangerous to make assumptions.

The second issue concerns a weakness discovered in the defendant's practice. The practice lacked a well-defined, consistently observed process for follow up with reference to ordered tests and referrals to other health care providers for timely continuity of care. Physician notes indicating a plan to

order lab studies should trigger several steps. The order should be clear, requisition prepared, and the patient informed of the steps necessary to comply with the physician's directive. Every practice needs a process in place to know results are received, reviewed in a timely manner by a physician and acted upon as required for continuity of care with notice to the patient and further follow up as needed. Document all of these actions to verify the protocols were followed. If applicable, document lack of response or noncompliance by the patient as poor patient accountability had some bearing on the evidence presented in this case.