

## Year 2000: Are You Ready?

by Judith H. Fine, RN, MSN, Risk Management Representative

**B**y now, almost every physician and practice administrator has heard something about the potential effect of the new millennium on computers, but few have seriously considered its potential effect on their practice. In fact, some "year 2000" effects could be potentially life-threatening computer malfunctions, and some could be just plain annoying. But they could also precipitate professional liability claims.

The first challenge is to locate the source of potential problems. Software, hardware, computer platforms, personal computers, local area networks, mainframe computers, client-server networks, compilers, archived computer data, databases and database queries, software pages (screens), reports, embedded files, applications, software utilities and data are all subject to possible year 2000 difficulties. So is "any piece of machinery that incorporates and relies on a computer chip with date-coded logic."<sup>1</sup> Anything with a chip is suspect—from life support equipment to your watch. Even if no computer or medical equipment is owned, many physicians and groups have contracts with other entities that lease equipment or provide services, which, in turn, could create year 2000 difficulties for them.

### Software 101

Computer software programs commonly compare numbers to determine whether one is greater or less than another. Year 2000 is greater than 1999, *but only if all four digits are compared*. Typically, only the last two digits of the year are compared, with the assumption that the first two digits are "19." This practice has obviously been adequate for a long time, but when the year in question is greater than 1999, date arithmetic and comparisons based on fewer than four digits will fail.

Computer software failure can take several forms. One type of failure is that the software will "blow up"—it simply will not run—and processing stops until a programmer fixes the problem. This may cause long delays in computer processing that result in patient anger, ill will and, perhaps, the filing of a claim. An even more serious form of failure involves a software program generating incorrect information, miscalculating, or otherwise producing erroneous results. This may not be recognized immediately, generating further errors in subsequent processing. Medical billing, appointments and, in some cases, electronic medical records could be compromised, potentially precipitating many forms of errors and professional liability claims.

### Equipment, Devices, Implants

The potential problem with equipment is simply that the year 2000 (and some subsequent years) may not be recognized by the internal logic as valid, causing the equipment to stop working. Life support equipment and implants that contain computer chips, among other equipment, may contain components that can only be obtained or modified by one source, which may not be the manufacturer.

### The Clock is Ticking

Most computer software programs not attuned to the year 2000 will begin to fail on January 1, 2000, but disaster could strike much sooner. Some software programs calculate a date in the future. For example, patients who participate in certain Medicaid programs are assigned a date in the future when they will automatically be transferred to a different Medicaid program. This scenario opens the potential for year 2000 date problems to arise long before the ball falls on New Years Eve, 1999. Century related errors could happen today or tomorrow (or even yesterday!)

Making the necessary changes may take some time. It can be a very simple process or a very complex one, depending on the size of the software system and the number and structure of data files. One important predictor of complexity (and the amount of time needed) is the degree to which software programs share data (how much data passes from one program to another program within a software system). If the same information appears on more than one of your computer software pages, it could indicate that data is being passed between programs.

Some software systems send data to and/or receive data from other computers by means of tapes or electronic file transfers. In these situations, it may be necessary for entire software systems to be converted and tested together before the process is complete. To compound the challenge, leap year changes may be needed because the year 2000 is a leap year.

Replacing a computer chip in medical equipment seems straightforward, but it may take considerable time to locate components, order them and modify the equipment.

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TMLT announces **Practice-Based CME Credits for TMLT Physicians** on page 2. On page 3, TMLT Risk Management VP Scott Berglund describes the problems with **"Predatory Pricing"** in medical liability coverage. On the back cover, an update on regulation changes on **Record Retention Requirements**.

### Pro-Active Solutions

TMLT strongly recommends that physicians and administrators consider taking steps now regarding the potential liability risk of the year 2000. The following actions may be helpful:

1. Increase your awareness of the potential problem. Enlist the assistance of software vendors and contractors in identifying areas of potential vulnerability related to year 2000.
2. Determine what responsibility for year 2000 modifications will be assumed by your vendors or contractors for software and for equipment. Examine existing contracts for disclaimers, exclusions, and indemnity agreements. Begin making arrangements for analysis and modifications immediately. Your request will be one of many, many others being received by vendors and contractors.
3. Document in writing your intention and your overall plan to become year 2000 compliant.
4. Attempt to obtain assurance that problems will be analyzed and resolved, either by the vendor or by someone else. Request a written plan for bringing software and equipment into year 2000 compliance, including a timeline that is realistic and appropriate. The plan should include a detailed plan for testing the changes made. Experienced computer programmers acknowledge that testing is the most critical and time-consuming phase of year 2000 conversion activities. Do not knowingly accept untested software or equipment, and do not agree to test it "live."
5. As the year 2000 approaches, consider notifying patients that you have made every attempt to ensure that potential computer problems will be addressed. Request that patients be understanding, cooperative and tolerant.
6. Make peace with the knowledge that this is an aspect of your practice that you may not be able to control directly. Few computer programmers are qualified to practice medicine, and few physicians are qualified to program computers. If there are difficulties, remember to act with unfailing courtesy toward the people whose help you may continue to require.

1 Cashman, M.R., Health Care—Are You Playing Russian Roulette with the Year 2000 "Bug"? Millennium News Network.

### Announcing

## Practice-Based CME for TMLT Physicians

Traditionally, continuing medical education (CME) has been provided at seminars and workshops or as self-paced programs, such as videotapes and home-study programs. To augment traditional CME, TMLT has developed an innovative, practice-based CME program that incorporates optional CME activities into the currently available Risk Management Practice Review to provide practical, individualized CME for TMLT insured physicians.

Beginning April 1, 1998, Risk Management Practice Reviews that are performed at the request of a TMLT insured physician will include an opportunity for the physician to earn up to 2 hours of Category 1 CME credit in addition to the premium discount currently available. The education theory supporting the awarding of Category 1 CME credit for practice-based activities is that the learning process takes place when the physician reflects on and analyzes his or her practice.

One hour of CME credit will be awarded if the physician personally completes an

optional preassessment survey tool. This tool must be requested at the time the Practice Review is scheduled and returned to the TMLT Risk Manager prior to the Practice Review. It will not be available on the day of the actual Practice Review. This part of the CME program is presently available only for physicians with office-based practices, but an announcement will be made when this becomes available for hospital-based, laboratory-based and other physicians.

The TMLT Risk Management Practice Review includes on-site completion of a more detailed questionnaire, a tour of the premises, and a review of medical records. The process takes an average of 5 hours.

At the conclusion of the Risk Management Practice Review, a second hour of CME credit can be obtained if the physician participates in a one-hour discussion with the TMLT Risk Manager, regarding identified areas of potential liability, recommended risk management interventions and other

pertinent risk management issues. All TMLT insured physicians may participate in this part of the CME program, and doing so is highly recommended in order to gain maximum benefit from the Practice Review. (For less than one clock hour of participation, CME credit will be granted at the discretion of the Risk Manager.)

Evaluations of the CME program will be conducted and data from these evaluations will be used to improve the effectiveness of the program. Because of ACCME regulations, CME will be available only to physicians who request a Risk Management Practice Review on or after April 1, 1998.

For more information on Risk Management Practice Reviews and the associated CME program, call Shanna Homann at 800-580-8658, Ext. 5910.

# The Problem of “Predatory Pricing”

by Scott R. Berglund, Vice President, Risk Management

There’s an old adage that states “If it looks too good to be true, it probably is.” Most of us say that we believe it, but when a “great deal” shows up our perspective can radically change. As consumers, we realize that competition is our friend. What great fun it is to read about the latest glut of oil producing cheaper gas prices or a new round of computer wars dropping the price of a brand new more powerful computer to what we paid for our pitiful machine only a year ago.

It’s in this very competitive environment that medical professional liability carriers find themselves presently. Because of mergers, acquisitions and other alliances, some carriers are deciding to enter new fields of products and services as well as new geographical locations in which to sell them. Texas, specifically, has historically been an area which has seemed fearsome to liability carriers out of state for several reasons: high jury awards, strange litigation laws and wide variance in the cultural and socioeconomic climate. It has been easy for these carriers to concentrate on other, more understandable locations in which to do business.

Since the passage of new tort reform legislation a few years ago, there appears to have been a decrease in the number of malpractice claims filed in Texas. Some of us feel that the decrease in claims intake is not primarily attributable to tort reform. We have been waiting for the other shoe to drop and, in one sense, it has. While the filing of non-meritorious suits has dropped, the more serious, potentially high-dollar suits are holding their own. Legal expenses continue to rise, and the size of jury awards has not shown much, if any, improvement.

Because of the increased amount of cash in the banks of many carriers, Texas is now being targeted for some potentially fierce price competition. Some of these carriers have essentially stopped underwriting the business they seek in order to attract new clients. There have even been cases of faxed advertisements offering premium discounts, sight unseen, to tempt physicians

to change insurance carriers. This “opportunity” for Texas physicians to save premium dollars also creates some questions that physicians and administrators should consider seriously.

**1. Is malpractice insurance a commodity just like other goods and services?**

Decidedly not. Ask any TMLT physician who has been sued, and you will be told how extremely competent, caring and professional were all of the people involved, from the person who first answered the phone to the claims personnel and the defense counsel. Individuals like these are hard to find and keep, and they make the difference between success and failure almost on a daily basis. Professional liability coverage is certainly not a commodity where cheaper is necessarily better.

**2. Does it make a difference whether or not the carrier has fully staffed offices in Texas?**

Absolutely! An 800 number from somewhere in somewheresville makes no difference on the phone, but it affects virtually every other facet of service: investigation and preparation of the case; meetings with the defendant and potential witnesses; knowledge of local judges, plaintiff attorneys and juries; and many other important issues. It can certainly affect the choice of defense counsel.

**3. Does being located in Texas affect other important services?**

Yep! TMLT’s risk management services, for example, are developed around city, county, and statewide issues and needs. Our Risk Management Practice Reviews and educational activities revolve around well thought out statewide as well as local pre-assessment data and are continually being reviewed and modified for relevance and effectiveness. TMLT’s risk management department even has its own ACCME accreditation to provide Continuing Medical Education hours for our insured doctors. Our Education Coordinator works with the Texas Nurses Association

to accredit risk management programs for nurses.

Underwriting is also an important component that is positively affected by being located in Texas. Because TMLT is a not-for-profit trust, established by Texas Medical Association in 1978, we fully realize that we are doing business with our insured physicians’ premium dollars. It is important that we provide coverage in such a manner that our financial strength remains solid. Thoughtful underwriting also allows us to maintain sufficient reserves, so that no corners have to be cut when choosing defense counsel or financing other operational costs. The idea of writing business with no regard to important underwriting principles is ludicrous and an affront to physicians who deserve a company that won’t cut and run as several carriers did a few years ago.

**4. Are Texas doctors taking chances by “taking advantage” of predatory pricing battles?**

While everyone likes a deal, all of us should consider carefully what we may actually be buying and whether we can be certain that we will not regret our decisions later on. TMLT continues to compete powerfully in the professional liability arena in Texas. We have already seen misguided efforts among the merged and the acquired. Costs get cut. Needed staff are laid off. Poor underwriting, claims handling and risk management causes problems. We have watched as well known carriers made management and operational decisions we considered unwise. Some are no longer in business.

TMLT insured physicians now number in excess of 9,000. By continuing to do what we do well, we have had solid growth in 1997, a year in which many companies saw little growth because of increased competition. Because TMLT has, and will continue to have, people who are dedicated to the long-term success and satisfaction of our insured physicians, we will remain the best real deal in the business.

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## Medical Records Revisited

### New Record Retention Requirements for Texas Physicians

"How long must I keep my charts?" is one of the questions most frequently posed by TMLT's insured physicians to the Risk Management Department. Until recently there was no all-encompassing legal requirement governing physicians' retention of records. In December, 1997, the Texas State Board of Medical Examiners issued rules pursuant to the Texas Medical Practices Act that effectively standardize medical record retention requirements:

1. All records must now be kept for at least seven years from the date of the last treatment. (Hospitals are required to keep records for ten years, so some

physicians may choose to keep office records for ten years also.)

2. For minor patients, records must be kept for at least seven years from the date of last treatment or until the child turns twenty-one, whichever is longer.

### Releasing a Deceased Patient's Records

It is not uncommon for the physician's office to be asked for a copy of the patient's medical records following a death. Rather than comply unquestioningly with a request of this sort, ascertain that you have the written authorization of the right person. Ask for evidence of the person's legal capacity to obtain the deceased's records. Often the duly authorized representative will have court-

issued papers, called Letters Testamentary or Letters of Administration, reflecting his or her appointment as legal representative on behalf of the deceased.

Just as likely, however, such legal documents will not exist because the deceased's estate, for one reason or another, does not require probate proceedings. In the absence of court papers appointing the authorized representative, the patient's next-of-kin would be the proper person to consent to release of the records. If the physician does not personally know the family, it would be prudent to require an affidavit from the next-of-kin attesting to the familial relationship with the deceased patient.