

the Reporter

RISK MANAGEMENT IN ACTION

By Lynne Dakers, JD, Risk Management Representative

For those readers who are not familiar with the process, TMLT offers a free risk management practice review, whereby risk management representatives visit physicians and their staffs at their practice locations in order to offer suggestions and provide tools that might help to avoid potential malpractice suits or make such suits more defensible in court.

In 1994, *the Reporter* published a year-end report that included an overview of the risk management practice review process. An analysis was made of the most frequent recommendations given to physicians and their staffs. With the closing of this millennium, we thought it might be insightful to revisit this topic by updating that article. What follows is a summary of 2000 practice review data.

In 2000, TMLT risk management representatives visited more than 1,000 physicians to help identify liability exposures and suggest methods for prevention or reduction of those risks. Many areas of the practice were reviewed, including topics ranging from confidentiality of patient registration to proper disposal of medical waste. Specifically, 23 areas were covered during the analysis, although in some offices not all sections of the review apply.

In 2000, more than 10,000 recommendations for improvement were made following on-site analysis. A breakdown of the major areas of recommendations is outlined in Figure 1, located on page 2.

It is interesting to note that 4 out of the 23 areas reviewed accounted for over 60 percent of the total recommendations. Each recommendation made, regardless of what area it refers to, is ranked by importance to assist in prioritizing changes to be implemented. The recommendations are labeled as urgent, important, or desirable.

- *Urgent* recommendations are those issues that pose a significant risk for the insured based on current bodies of knowledge in risk management and health care law.
- *Important* recommendations are those issues where the omission or commission may impact the credibility and/or defensibility of medical care.
- *Desirable* recommendations are offered for physicians and office staff to enhance their existing risk management practices.

MEDICAL RECORDS

In the area of medical records, recommendations were made addressing 28 different risk exposures. The top five medical record recommendations made accounted for more than 50 percent of the recommendations made in that area, with the top eight accounting for approximately 75 percent. The major



Figure 1

Summary of TMLT practice review recommendations (2000)

Practice area	Recommendations	% of total
Medical records	1,943	34%
Follow-up procedures/patient appointments	998	16%
Medication administration	913	14%
General office policies and procedures	512	8%
Informed consent	416	6%
Patient visits	368	6%
Emergency procedures	301	5%
Appointments	279	4%

problem areas related to medical records that were either urgent or important are outlined below:

- forms left blank or incomplete (235)
- improper correction of medical record documentation errors (166)
- dates of dictation and transcription not noted in the record (145)
- absence of staff signature or initials after making an entry in the medical record (138)
- use of self-adhesive notes as a permanent part of the medical record (114)
- illegible entries (109)
- missing, buried, or inconsistent documentation of patient allergies (105)

Review the risk management tips below and incorporate changes needed to reduce medical record-related risks in your office.

Risk management tips

- Set up a system for recording after hours phone conversations with patients and assuring that the message is filed in the medical record.

- While preprinted forms may simplify documentation, they do not provide a documentation panacea. When using these forms, it is important to tailor them to your practice and never leave sections blank. For example, if a particular portion of a physical examination is deferred because it is inapplicable, indicate this in the record.

- Any corrections in a medical record should be made by drawing a single line through the incorrect entry, entering the date and initialing the correction. Obliterations and white-out should be avoided as any “masking” or “cover-up” of an entry could lead to questions about record alterations.

- Dictated notes should include the date of dictation and the date of transcription so as to indicate the timely entry of pertinent patient information in the medical record. This practice would be beneficial in the defense of claims involving failure to diagnose in a timely manner.

- So as to identify the source of each entry, all staff members should sign or initial their notes when making an entry in the medical record.

- Self-adhesive notes should never be used as a permanent part of the medical record since they are easily lost or misplaced. Firmly affix such notes or transfer the information to the chart.

- Ensure that written entries are legible. Illegible handwriting can be subject to broad interpretations as to actual meaning as well as may reflect negatively on the quality of patient care.

- Prescribing medications to which a patient has a known allergy remains a frequently litigated issue. Allergy information that is consistently and boldly documented in the medical record can prevent this information from being overlooked.

FOLLOW-UP PROCEDURES & PATIENT APPOINTMENTS

Perhaps in no area of risk management has the climate changed more than the standard of care expected of the physician to assure continuity of care. Risk management recommendations in this area will, if implemented, not only help prevent abnormal reports and conditions from “falling through the cracks,” but will also prove significant in defense of an allegation of failure to diagnose or failure to treat in a timely manner.

Risk management tips

- Indicate physician review of incoming test results and referral reports by placing physician initials and date of review on the report. All reports should be reviewed prior to filing. When appropriate, documentation regarding actions or inactions on specific results and the rationale should also be noted.

- A system for tracking consultant referrals and outside tests is recommended to ensure that the patient is seen and results are received.

- A process for follow up on cancellations and no-shows will assist in identifying patients whose conditions require a revisit. Efforts to contact patients, either by phone or letter, should be documented in the medical record. This provides evidence that the patient has been made aware of the importance of continuing to seek medical care.

- Documentation of the recommended return visit in the progress note both enables office staff to schedule the return visit as well as provides a system which may prevent or defend against allegations of failure to diagnose and treat.

MEDICATION ADMINISTRATION

Of the 13 specific medication-related recommendations for office practice, two areas received the majority (75 percent) of the recommendations: prescription refills and sample medication. Review the tips below to reduce these areas of liability in your office.

Risk management tips

- Document samples dispensed to patients in their medical record. Dispensing samples from an office is no different than dispensing medication from a pharmacy. An accurate record of the medication, dose, route and number should be recorded. Also, document the discussion of possible side effects and potential adverse reactions.

- Samples should be maintained in an organized manner in the office to allow for a regular (monthly is recommended) review of all sample medications to purge those that are expired or no longer used in your practice. Avoid accepting medication samples that you will not use.

- Receipts for samples of prescription drugs are required to be kept for a period of two years.

- If “routine” medications are refilled by your office staff, without prior physician approval, the entry in the medical record should be co-signed by the physician. If a co-signature is not feasible, establish a written policy and procedure in your office which outlines specifically which medications can be refilled and defines parameters for when the patient needs to be seen before a refill can be given. Protect yourself and your staff from allegations related to prescribing without a license.

GENERAL OFFICE POLICIES AND PROCEDURES

Most practices, despite their size, require some form of written policy and procedure manual. For even the smallest, most nuclear practice, the risk management department recommends a minimum of written policies. These include: telephone communications with patients, prescription medication refills by office staff, and emergency procedures. For those offices where an unlicensed employee is responsible for triage of incoming phone calls from patients, written protocols are also recommended.

Policies should be adapted to the office, approved by the physician, reviewed at least annually, and revised where appropriate.

INFORMED CONSENT

The issue of informed consent is “old news” in medical risk management circles. However, documentation of informed consent remains as important as ever. Perhaps even more so, since, although perhaps not the primary allegation in a suit for medical malpractice, plaintiff’s attorneys are increasingly including informed consent as an alternate theory for recovery. Of the seven potential recommendations which relate to informed consent, more than 80 percent of the recommendations made referred to two forms of documentation which, if included in the office record, would provide increased defensibility should an adverse event occur.

Risk management tips

- Providers should obtain informed consent for procedures performed in the office, even such mundane procedures as wart removal. The informed consent discussion should either be referenced in the procedure note or a written procedural consent should be obtained.

- The informed consent discussion held with patients seen in the office for their pre-op visit should be documented in the office chart. The office provides a more conducive environment such that documentation of this discussion may prove more persuasive of informed consent than the written form obtained at the hospital. This responsibility cannot be delegated to others but rests with the physician.

PATIENT VISITS, EMERGENCY PROCEDURES AND MEDICAL RECORD RELEASE

These areas comprised 15 percent of the total recommendations made. Of the patient visit recommendations, 75 percent pertained to documentation of patient education. Emergency procedures recommendations included the need for an emergency plan and emergency equipment (80 percent of recommendations), and medical record release recommendations centered on compliance with statutory requirements as well as attention to issues of patient confidentiality.

Risk management tips

- Remember to capture all forms of patient education in the medical record. Take credit for what you do! Forms of patient education include pamphlets, videos, handouts, and pre-and post-op treatment instructions. To facilitate documentation, consider developing a standardized list of educational materials that you routinely provide to be incorporated in the medical record.

- With regard to physicians’ offices, the standard of care expected to be able to respond to medical emergencies is higher than other businesses. Historically, the standard of care is defined as what would be “reasonably foreseeable under the circumstances.” Therefore, your level of response must be measured against the procedures performed in the office and the type of patients you serve. All offices, however, are urged to maintain, at a minimum, the equipment necessary to perform basic CPR (including having at least two people currently certified in CPR); formulate an emergency plan; and ensure that staff members are familiar with their individual responsibilities.

- Patient confidentiality is a “hot topic.” In addition to complying with the statutory regulations for release of patient records, consider the following:

- Staff members should be oriented to the need to maintain patient confidentiality and sign a confidentiality statement.

- If the design of your office affords the opportunity for conversations to be overheard, frequently and as appropriate, reinforce with staff the need to modulate voice levels and avoid discussing sensitive patient information where it can be overheard.

- For records released by facsimile, always use a cover sheet that indicates that the information is confidential.

As mentioned, this is not an exhaustive list of risk management suggestions, but rather an overview of the most frequent recommendations of the past year. Risk management representatives are available to our policyholders to further explain the above recommendations as well as provide resources and practice management tools that will help offices implement these recommendations.

Physicians and staff who are interested in scheduling a risk management review for their practice can contact Carol Bowser at 1-800-580-8658 ext. 5910 or any other member of the risk management department and we will be happy to assist you.

Failure to diagnose:



By Laura Hale

Breast cancer — and delays in diagnosing it — account for more medical malpractice claims than any other disease or condition. ¹ This fact was widely publicized in 1995, when the Physicians Insurers Association of America released a report on the prevalence of breast cancer claims. ¹ The study, which evaluated more than 125,000 malpractice claims and a subset of 487 breast cancer claims, reported that delays in diagnosis were most commonly caused by the following:

- failure of the physician to be impressed by the physical findings (35 percent)
- failure to follow-up with a patient in a timely manner (31 percent)
- mammogram results that were false negative (25.8 percent)

Additionally, the report also found that more than 30 percent of the patients who filed suit were younger than 40, and 60 percent were younger than 50.

The 1995 study brought much-needed attention to the causes and prevalence of breast cancer claims. Researchers followed suit, publishing articles on false-negative mammograms, perceptual errors, and screening versus diagnostic mammograms, which highlight the complexities involved in these cases.

However, six years later breast cancer remains at the top of the list for malpractice claims, and the problem continues to plague physicians.

“Some of the reasons for delay in diagnosis are unavoidable, beginning with the absence of clinical or imaging features of malignancy and extending to limitations of sufficiently specific features to prompt intervention. On the other hand, other reasons are avoidable and attention to many of these causes should lessen the incidence of such delay.” ²

According to a 1997 PIAA/American College of Radiology study, 62 percent of breast cancer lawsuits involve errors in diagnosis and 71 percent involve communication failures. ³

Errors in diagnosis

The level of accuracy achieved in mammography has been well documented in the medical literature, although the specific error rates vary greatly. A 1992 study published in *Radiology* showed 24 percent of cancers are missed on mammography. ⁴ Researchers at Yale University claim the miss rate for breast cancer on mammography ranges from 15 to 63 percent. ⁵ An article published in the *American College of Radiology Bulletin* states that 30-70 percent of breast cancers detected during a follow-up mammogram are visible in retrospect on mammograms that had been reported as normal. ⁶ A meta-analysis of published literature found that between 5 to 17 percent

of breast cancers are missed on mammography. ⁷

“The radiology community is virtually unanimous in its recognition that the accuracy of mammography is considerably less than 100 percent and, in fact, radiologists acknowledge that review of mammograms interpreted initially as normal in women who later develop breast cancer discloses that many of the cancers can be seen retrospectively.” ⁸

Research has shown a number of other factors are involved in cases with diagnostic error. In 1995, the Task Force on Early Diagnosis of Breast Cancer, which was composed of physicians from the Florida Society of Internal Medicine, Florida Academy of Family Physicians and the Florida Obstetric-Gynecologic Society, identified six common diagnostic delays that occur in the primary care setting. These include:

- discounting patient complaints
- unremarkable physician examination
- negative or ambiguous mammogram
- denial induced by false reassurance
- lack of a tracking system to ensure follow-up
- neglecting breast screening ⁹

Communication failures

Errors in diagnosis, however, represent only part of the problem. As the PIAA/ACR data demonstrate, 71 percent of

BREAST CANCER

breast cancer cases involve communication failures.

“In nearly 71 percent of the cases, the referring physician was not directly contacted for notification of an urgent or significant unexpected finding. In almost 90 percent of the cases, the interpreting physician failed to document any attempt to make direct contact with the referring physician,” the report says. “In almost one-third of the cases, the radiologist did not have an established policy or procedure in place to identify and communicate significant findings to referring physicians.”¹⁰

Other factors

In addition to diagnostic errors and communication failures, Berlin believes public perception of breast cancer diagnosis and prognosis has played a role in increased breast cancer litigation.¹¹ “The public’s perceptions — or misperceptions — related to breast cancer fall into three categories: the perception that women are at extraordinarily high risk of developing and dying from breast cancer, the perception that mammography is 100 percent accurate in detecting breast cancer, and the perception that the capability of mammography to diagnose cancer in early stages guarantees a cure.”

These misperceptions, he says, explain why it is difficult to defend breast cancer cases in which any kind of error was made.

Other studies have demonstrated that the extent of a patient’s injury determines the outcome of the claim. In a 1996 study published in the *New England Journal of Medicine* researchers found that neither physician negligence nor an adverse event determined the outcome of malpractice claims. The severity of the patient’s injury, not the physician’s negligence, is predictive of payment to the patient.¹²

TMLT experience

In addition to being one of the most common types of malpractice action filed against TMLT policyholders, failure to diagnose cancer cases are often the most costly. In 2000, TMLT experienced four multi-million dollar verdicts in cases involving failure to diagnose cancer.

“The issues in the cases we’ve seen involve documentation, miscommunication between multiple caregivers, follow-up. The specialists most often involved are primary care physicians, radiologists, OB/GYNs, emergency room physicians and pathologists,” says Jill McLain, assistant vice president of claim operations.

According to claim executive staff, documentation is usually the weak link in breast cancer cases. “A major component in the defense of a malpractice case is the medical record. If we have a thorough, well-reasoned medical record, we can defend the case. If the record is incomplete or has been altered in some way, our ability to defend the doctor is undermined,” McLain says.

“With these types of cases, it is usually not the technology that is the problem,” says Sue Mills, assistant vice president of

claim operations. “It is the documentation and follow-up. If the records don’t document that a physician told the patient to follow-up, then it becomes a swearing contest in front of a jury of 12 patients.”

TMLT claim staff believe the key to reducing the number of cancer claims lies in accurate and comprehensive documentation. “Implement a follow-up system to ensure patients get the recommended tests. Document exactly what you tell the patient. Document that the patient understands what you said. Document all attempts to contact the patient. Document no-shows. Document any non-compliance,” she says. “Every bit of documentation helps.”

Sources

1. Physician Insurers Association of America. Breast cancer study. Rockville, MD: Physicians Insurers Association of America, 1995.
2. Brenner RJ. False-negative mammograms. Medical, legal and risk management implications. *Radiol Clin North Am.* 2000; 38 (4): 741-57.
3. Physicians Insurers Association of America and American College of Radiology. Practice standards claims survey. Rockville, MD: Physicians Insurers Association of America, 1997.
4. Bird RE, Wallace TW, Yankaskas BC. Analysis of cancers missed at screening mammography. *Radiology* 1992; 184: 613-17.
5. Elmore JG, Wells CK, Lee CH, Howard DH, Feinstein AR. Variability in radiologists’ interpretation of mammograms. *N Engl J Med* 1994; 331: 1493-99.
6. Can false positives be reduced without endangering patients? *ACR Bulletin* 1998; 54 (6): 15-17, 28.
7. Mushlin AI, Kouides RW, Shapiro DE. Estimating the accuracy of screening mammography: a meta-analysis. *Am J Prev Med* 1998; 14: 143-153.
8. Berlin L. *AJR Am J Roentgenol.* 1999; 173 (5) :1161-7.
9. Harris G, Bartlett, EE, Rehmar, M, Holman I, Derhagopian R, Eytel C, Kallos N, Mitchell K, Weible D, Machnowski G. Early diagnosis of breast changes. Risk management and quality of care approach. *J Fla Med Assoc.* 1996; 83 (7): 466-9.
10. Physicians Insurers Association of America and American College of Radiology. Practice standards claims survey. Rockville, MD: Physicians Insurers Association of America, 1997.
11. Berlin L. The missed cancer: perceptions and realities. *AJR Am J Roentgenol.* 1999; 173 (5): 1161-7.
12. Brennan TA, Sox CM, Burstin HR. Relation between negligent adverse events and the outcomes of medical-malpractice litigation. *N Engl J Med.* 1996; 335: 1963-67.

closed claim study

Failure to diagnose prostate cancer

by Robin Bowles, Risk Management Representative

The following closed claim study is based on an actual malpractice claim from TMLT. This case illustrates how action or inaction on the part of a physician led to allegations of medical malpractice, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. An attempt has been made to fictionalize the material in order to make it less easy to identify. If you think you may recognize your own case, please be assured it is set forth solely for the purpose of emphasizing the issues presented in order to assist and educate Texas physicians. It is our intention to keep confidential any identifying information that is not already part of public record.

Clinical presentation

A 52-year-old man presented to a urologist in 1991 with an abnormal prostate. The physician felt a nodule on the prostate during the exam.

Physician action

The urologist suggested a prostatic ultrasound with possible biopsy. The patient said he was busy and would have a relative (a radiologist) do the ultrasound and return with the results. The physician did not hear from the patient until 1994, when he returned for a follow-up exam. The patient stated the ultrasound had been done in 1991 and the results were normal. He also indicated he had a normal PSA level, per his family physician.

During the physical examination, the urologist determined there was still a small nodule in the left lobe, unchanged in three years. The patient was asked to forward the previous ultrasound and PSA results to the urologist's office.

The patient returned 10 months later, March 1995, complaining of urinary frequency and decreased flow rate. The physician noted the prostate was enlarged and the PSA was slightly elevated to 4.04. Believing the elevation was due to prostatitis, the physician prescribed Floxin and asked the patient to return in two weeks.

The patient returned in April 1995 with a PSA of 4.3. The physician felt the increase was insignificant and due to infection. He wrote in his chart on a lab slip that the patient was to return in three months for a repeat PSA and exam. He did not document the repeat PSA in his progress note.

Three months later (July 1995), the patient

returned complaining of a cyst on his scrotum. The physician did not recheck the PSA or perform a digital rectal exam as he indicated he would three months earlier. The cyst was described as benign.

The physician next heard from this patient in April 1996 when he called in for a prescription refill. The refill was authorized and the patient was instructed to come in for an annual exam. In July 1996, the patient called in for another refill and was told if he did not return for his annual exam, no more refills would be approved. The patient returned in August 1996. The prostate was still enlarged, but without a distinct nodule. During this visit, the patient stated he had been self-treating his symptoms with Floxin samples obtained from a urologist friend in Tennessee. The physician did not check the patient's PSA, but instructed him to return in one month.

A month later (September 1996), the patient called in for a prescription refill, which was filled over the phone by the urologist's partner. During this time, the patient had been to the gastroenterologist who took a PSA. The PSA was now 9.0. The gastroenterologist faxed the PSA results to the urologist, and told the patient to see his urologist due to the possibility of prostate cancer.

The patient did not return to the urologist, but called in for another refill in February 1997. At this time, the physician authorized the prescription and told the patient to come in for an exam. One month later, the patient returned to the urologist with a PSA of 12.0. A biopsy was scheduled for April 1997, and the patient later called and cancelled the appointment. After the physician personally called the patient and urged him to keep his appointment, he came in for the biopsy. The biopsy revealed a very aggressive form of prostate cancer. It was later found the disease had metastasized into the lymph nodes.

Allegations

Failure to diagnose prostate cancer in a timely manner.

Legal principle

Initially, this case appeared defensible due to the patient's noncompliance. However, the weakness in the case was the physician's deviation from the standard of care in July 1995 by not following his own treatment plan and rechecking the patient's PSA. TMLT con-

sultants were supportive of the urologist's actions, only criticizing his action in July 1995.

The plaintiff experts argued that, had the physician performed a PSA in July 1995, the cancer may have been detected, thus preventing the spread to the lymph nodes. However, it is impossible to tell what the PSA would have been in July 1995 and whether or not the cancer would have spread.

Disposition

Deviation from the standard of care and lack of proper follow-up contributed to the difficulty in defending this case, and resulted in a six-figure settlement during trial.

Risk management considerations

The physician had no system to track diagnostic tests, in this case, both the ultrasound in 1991 and the repeat PSA test in 1995. Initially, the patient either failed to have the ultrasound or failed to forward the results to the physician. In April 1995, the physician noted the repeat PSA test on the lab slip, but failed to document it in his progress note or on a tracking system and it was overlooked at the next office visit. This, as well as failure to perform a digital rectal exam, was a deviation from the standard of care.

It is recommended that offices develop a tracking system to ensure that tests are performed and results are received. Physicians may wish to maintain a "diary" system to determine if results have been received by certain dates. Additionally, schedule test appointments for patients, and request that you be advised if the patient does not keep the appointment.

The patient was noncompliant and did not keep appointments. Physicians should develop a protocol for follow-up on cancellations and no-shows to assist in identifying patients whose conditions require a revisit. This reminds patients that it is important to follow through with appointments. Patients should be notified, either by telephone or mail. Documenting these calls or letters also demonstrates your efforts to contact patients should a problem subsequently occur.

Additionally, it is important for continuity of care, to document the return visit in the medical record. This process enables office staff to schedule the return visit while providing a system, which may prevent allegations of failure to diagnose and treat.

ADA

accommodations for the physician's office practice

By Barbara Rose, RN, BSN
Risk Management Representative

Recently, the TMLT risk management department received three calls from physician offices in different areas of Texas regarding accommodations required for patients with hearing disabilities. The following information has been found on the Americans with Disabilities Act (ADA) and Risk Management Foundation web sites and is printed here for your review.

What am I required to do in order to accommodate patients with sensory disabilities?

Health care providers need to provide reasonable assistive services and auxiliary aids to patients with disabilities. Blindness and deafness are disabilities covered by the ADA. Providers who cannot demonstrate that the required aids and services impose an "undue burden" could be subject to potential liability for violation of the provisions of the ADA. The nature of the assistive actions needed, the costs to be borne by your medical practice, and your financial resources are considered in any determination by a court of what is reasonable or an undue burden. The failure of a medical practice to make reasonable modifications to ensure that a person known to be disabled is not denied its services is also considered discrimination under the federal law. As ADA cases emerge nationally, at least one finding has ruled in favor of the plaintiff over the issue of provision of an interpreter for a hearing-impaired patient in a primary care physician office. Many office settings have evaluated their facilities relative to physical access for the disabled; an assessment of the needs of the practice's patient population to meet any sensory disabilities identified should also be considered.

Are there any limits on the kinds of modifications in policies, practices, and procedures required by the ADA?

Yes. The ADA does not require modifications that would fundamentally alter the nature of the services provided by the public accommodation. For example, it would not be discriminatory for a physician specialist who treats only burn patients to refer a deaf individual to another physician for treatment of a broken limb or respiratory ailment. To require a physician to accept patients outside of his or her specialty would fundamentally alter the nature of the medical practice.

What kinds of auxiliary aids and services are required by the ADA to ensure effective communication with individuals with hearing or vision impairments?

Appropriate auxiliary aids and services may include services and devices such as qualified interpreters, assistive listening devices, notetakers, and written materials for individuals with hearing impairments; and qualified readers, taped texts, and brailled or large print materials for individuals with vision impairments.

Are there any limitations on the auxiliary aids requirements?

Yes. The ADA does not require the provision of any auxil-



ary aid that would result in an undue burden or in a fundamental alteration in the nature of the goods or services provided by a public accommodation. However, the public accommodation is not relieved from the duty to furnish an alternative auxiliary aid, if available, that would not result in a fundamental alteration or undue burden. Both of these limitations are derived from existing regulations and case law under section 504 of the Rehabilitation Act and are to be determined on a case-by-case basis.

Are businesses entitled to any tax benefit to help pay for the cost of compliance?

Yes. As amended in 1990, the Internal Revenue Code allows a deduction of up to \$15,000 per year for expenses associated with the removal of qualified architectural and transportation barriers. The 1990 amendment also permits eligible small businesses to receive a tax credit for certain costs of compliance with the ADA. An eligible small business is one whose gross receipts do not exceed \$1 million or whose work force does not consist of more than 30 full time workers. Qualifying businesses may claim a credit of up to 50 percent of eligible access expenditures that exceed \$250 but do not exceed \$10,250. Examples of eligible access expenditures include the necessary and reasonable costs of removing architectural, physical, communications, and transportation barriers; providing readers, interpreters, and other auxiliary aids; and acquiring or modifying equipment or devices.

The calls received in risk management described a demand from hearing impaired persons to use contract interpreter services of their choice with charges per hour and a two hour minimum. One practice had an employee skilled in sign language who would be available during the patient's visits. The patient knew sign language and this service would seem to qualify as a "provision of reasonable assistive service."

The other practice wanted to communicate with written notes but felt intimidated by the patient's demands for a contract interpreter. What action is required to satisfy the intent of the law? As we so often hear, the law is "subject to interpretation" on a case by case basis. There is no one size fits all and that makes your choice of action especially challenging.

- Research your community for availability of volunteer or reasonably priced services to meet the needs of sensory impaired patients and develop a resource list for the practice.

- Designate a staff member(s) to serve as note taker or reader and develop this process as office policy.

- If costs are incurred to be in compliance with the ADA, keep detailed records with receipts to claim any tax credits allowed.

For more information, please visit the following web sites: www.rmf.org and www.usdoj.gov/crt/ada/adahome1.htm.

the Reporter



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TMLT wishes to acknowledge the important contributions of Scott Berglund, vice president, risk management, to the advancement of risk management education for Texas physicians. Mr. Berglund passed away on February 6, 2001.

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In memoriam: Samuel C. Waters, MD

Dr. Samuel C. (Sam) Waters, 53, died February 19, 2001, in Dallas. Dr. Waters served on the TMLT Board of Governors for four years, two years as secretary/treasurer and was vice chairman at the time of his death.

Dr. Waters was born November 15, 1947, in Pampa, Texas. He was a 1966 graduate of Pampa High School, and completed his bachelor's degree and medical school at Tulane University. After completing his internship and residency in internal medicine at the Methodist Hospital of Dallas, he completed his fellowship at the Cardiovascular Institute, the University of Texas Southwestern Medical School, Methodist Hospital of Dallas and Veterans Administration Hospital of Dallas.

Dr. Waters was an active member of the Texas Medical Association and, in 1997 served as president of the Wichita Falls County Medical Society. He was also a member of the American Medical Association, the American Heart Association, the American College of Cardiology, the and American Society of Internal Medicine. He was the current president of the North Texas Medical Foundation.

WHAT'S COOKING? *Recipes for Risk Management*

WHO SHOULD ATTEND:

This seminar is intended for medical office staff, including nursing staff, office managers, front office staff and medical records personnel.

TOPICS INCLUDE:

Risk Management Ingredients for a Safe and Successful Practice
Medical Errors: A Cookbook for Prevention

REGISTRATION:

\$45 TMLT insured
\$60 all others

For additional information or to register, please call the Risk Management Department at 800-580-8658 or send email to natalie-gilmore@tmlt.org.

SEMINAR DATES:

Tuesday, April 3 Austin, Texas	Tuesday, April 24 San Antonio, Texas
Tuesday, April 10 Houston, Texas	Tuesday, May 1 McAllen, Texas
Tuesday, April 17 Dallas, Texas	Tuesday, May 8 Fort Worth, Texas

SEMINAR TIME:

1:30-4:30 p.m.