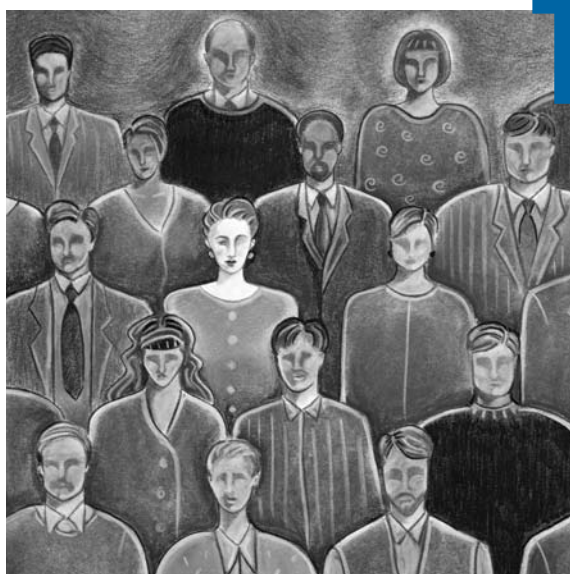


# the Reporter

## Trial by jury

### understanding the jury selection process



*As you enter the courtroom in nervous anticipation, you suddenly realize that 12 pairs of eyes are watching your every move. Your stomach tightens as you make your way to your seat. Your throat is dry and you wish you had some water to ease the discomfort. "All rise . . ." Your medical liability trial is beginning and these 12 people will be deciding your case. They are the jury. by Katie McLaughlin*

While a minority of medical liability claims actually end up in the courtroom, (In 2003, TMLT defended a total of 2,359 claims; 79 of those were taken to a jury verdict \*) it is important for physicians to understand this process in case they ever find themselves facing a jury. How do the people charged with deciding a physician's fate come together? These individuals are not chosen at random. The jury selection process is a well-planned and calculated part of trial. This article will explain what qualifies an individual for jury selection, will define and describe voir dire, and will discuss innovations being used in the jury selection process.

As guaranteed by the U.S. Constitution, an individual has the right to trial by an impartial jury. To ensure impartiality, jury members should reflect a cross section of the community. Jurors must also be unbiased about the case. This excludes individuals who are related to trial participants or someone who may directly benefit from the outcome of the trial. The jurors should be able to base decisions solely on the evidence presented during trial. <sup>1</sup>

Jury panel members are selected randomly, and jury selection procedures vary state to state. In Texas, individuals with a valid Texas driver's license or Texas personal identification card are placed into the county's computer system of potential jurors. A person is qualified to serve on a jury if he/she is:

- at least 18 years old;
- a citizen of the United States, Texas, and the county where the trial is being conducted;
- qualified under the Constitution and local laws to vote in the county where the trial is held;
- of sound mind and good moral character;
- able to read and write;
- has not served as a juror for six days in the preceding six months in a district court or six days in the preceding three months in a county court;
- has not been convicted of theft or any felony; and
- is not under indictment or other legal accusation for a theft or any felony. <sup>2</sup>

*continued on page 2*

*\* TMLT won 74 of 79 cases taken to trial in 2003.*

When potential jurors arrive for the selection process, they are given a brief orientation by the impaneling judge. The judge addresses the disqualifications and exemptions listed on the summons. Jury panel members are then allowed to speak to the judge about possible exemption from jury duty. Reasons for exemption are based on circumstances that may impose a hardship for some individuals. Reasons for exemption include:

- more than 70 years of age;
- having legal custody of children under 10 years of age, which jury service would leave without adequate supervision;
- attending public or private high school or institution of higher education;
- association with a legislative branch or employee of the legislative branch of government;
- having appeared as a juror in the county during the previous two years; and
- being the primary caregiver of those unable to care for themselves.

### Voir dire

Once the preliminaries and instructions are completed, the presiding judge, plaintiff's and defense attorneys question potential jurors.<sup>2</sup> This process of questioning is called voir dire. Voir dire is a French term meaning "to tell the truth," and is used to weed out any biases or prejudices a potential juror may possess which could jeopardize a fair trial. If a juror exhibits some bias or prejudice, then the attorneys have the right to challenge that person as a juror. Attorneys may challenge for cause anyone they feel cannot be fair in rendering a verdict, but the judge ultimately decides whether the person is disqualified. Additionally, each lawyer is allowed a certain number of pre-emptory strikes, which they may use at their own discretion. These are not subject to the approval of the judge, as long as no discrimination is involved in the decision to strike any potential juror(s).<sup>3</sup>

Generally, before voir dire, the potential jurors will complete a questionnaire, which provides the attorneys with demographic information and sometimes personal beliefs, attitudes, and values. This can help attorneys determine which jurors they should strike or challenge during jury selection. More detailed questionnaires, when used, can help attorneys understand how potential jurors process information. Some jurors may be more open and honest on a questionnaire than they would be when questioned in person.<sup>4</sup>

During voir dire, the attorneys are each given a chance to question the potential jurors. Generally, they ask open-ended questions to encourage the jurors to give as much information about themselves as possible. In order to be effective, attorneys often ask specific questions which help them learn more about the jurors and their core beliefs. Questions which could elicit obvious answers from the jurors are generally not valuable in determining whom to strike.<sup>5</sup> For example, if a juror is asked, "can you be a fair and impartial juror in this case?" the juror is likely to respond "yes," even if they have a personal bias. Almost all individuals consider themselves "fair." Also, attorneys will try to build a rapport with the jurors during voir dire, in order to elicit more information and create a good impression for the upcoming trial.<sup>6</sup>

After the jurors are questioned, the attorneys have an opportunity to state their challenges. Once the judge rules on the challenges for cause, the attorneys will decide which of the remaining panel members to strike. The term "jury selection" is really a misnomer, as the jury panel is not chosen. The attorneys eliminate those members from the panel they feel will not be favorable to their side of the case. Those panel members remaining after the strikes will be chosen in number order until 12 are selected. Sometimes, additional jurors are selected, again in number order, as alternates, to serve in case one or more of the jurors becomes ill or otherwise unable to

serve during the trial. Those not selected are excused. Once the evidence has been concluded, alternate jurors not pressed into actual jury service are excused.

### Trial consultants and "shadow juries"

Trial consultants are occasionally hired by attorneys to use psychological and other profiling techniques to determine which potential jurors they feel would be most advantageous to their case. Consultants use their prior experience and knowledge to assess — based on the demographics — the attitudes and beliefs of the potential jurors, and which ones are more likely to have similar beliefs and values as their client. Their goal is to determine whether the person would be more sympathetic to the plaintiff or the defense. Also, the consultant may serve as an objective third party observer during voir dire, and may notice subtle nonverbal cues during questioning.<sup>7</sup>

Consultants not only participate in the jury selection process, but may, in certain cases, perform mock trials and convene focus groups before jury selection begins. This is done to determine the desired characteristics of those sought as jurors. Once trial has begun, consultants or attorneys may occasionally hire "shadow juries," groups of people with characteristics similar to those of the real jury. Shadow juries watch the trial as it progresses, and provide feedback about whether or not the message is being delivered as desired. They can help determine what the actual jurors may be thinking or feeling about particular parts of the trial.

For the appropriate case, consultants can be useful, but their thoughts are just educated opinions, like those of the attorneys. As such, they are not proof of one outcome or another. Some attorneys are unsure of the benefits of profiling, claiming that consultants may place too much emphasis on minute matters, which may or may not reflect how jurors will vote on a verdict. Generally, attorneys still rely on their own instincts and experience to make decisions.<sup>7</sup>

### Intense scrutiny

The jury selection process is extremely important to the case, as jurors will weigh all the evidence and make a decision on which side is more credible. Although the selection process is not perfect, good voir dire skills can be developed and are invaluable in helping to get the best possible jury out of each panel.

While it may be unnerving to be eyed when you enter the courtroom, realize that those 12 men and women were also subjected to intense scrutiny before they took their seats in the jury box. Juries are essential to the function of our judicial system, and usually take their jobs very seriously.

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**For immediate release  
Monday, September 20, 2004**

## **TMLT announces additional rate reduction of 5 percent**

Austin, Texas . . . At a press conference at the state capitol today, Texas Medical Liability Trust announced an additional rate reduction of 5 percent for member physicians to be effective January 1, 2005. Since policies are renewed on an annual basis, current TMLT policyholders will see this rate decrease when their policy next renews. January renewals will be the first to receive this reduction as will new policyholders whose policies will be effective January 1, 2005 or later. As a result of House Bill 4 and Proposition 12, TMLT rates have come down 17 percent in just nine months.

“This total rate reduction of 17 percent in a single year, representing \$34 million in savings to Texas doctors, is indicative of the triumph of medical liability reform in Texas,” said W. Thomas Cotten, president and CEO of TMLT. “Thanks to members of the legislature and the voters of Texas, the foundation for a much improved medical liability market has been set, and the medical community and patients will be the better for it. Already, more doctors are practicing in Texas and access to health care for Texas has improved.”

“Today the state of medical liability in Texas has improved significantly,” Cotten said. “Medical liability lawsuit filings in counties considered high-risk for doctors have decreased since House Bill 4 took effect a year ago. Surgeons, ob-gyns and other doctors are being successfully recruited to areas of our state that once had difficulty hiring medical specialists, and that’s good news for patients.”

TMLT is Texas’ largest medical liability coverage provider, serving 48.2 percent of the available physician market or 12,000 Texas physicians. Since TMLT reduced rates by 12 percent earlier this year, the Trust has grown by more than 1,600 new physician policyholders. “In the border region of South Texas, TMLT has far greater penetration than any other medical liability insurance company. Today a full 8 percent of our members practice in the Valley,” Cotten said.

“The historic medical liability reforms that were championed by the combined efforts of Governor Perry, Lt. Governor Dewhurst, Speaker Craddick, Representative Joe Nixon, and many others are working as intended,” Cotten said. “The end result is improved access to health care for Texans.”

If you have questions concerning your TMLT policy and when you will be receiving the additional 5 percent reduction, please check the declarations page of your policy for your renewal date. The additional 5 percent premium reduction will be made at that time. If you still have questions, please visit our web site or contact your underwriter.

# medical liability update

## A detailed look at TMLT CME

by Lesley Viner, MS, education program manager

The recent medical malpractice crisis has increased physician awareness of liability issues. Topics such as medical errors, litigious patients, and tort reform are now routinely discussed in exam rooms, surgical suites, and physicians' lounges across the country. And while the medical liability reforms of 2003 appear to have eased the crisis in Texas, TMLT claim data continue to show that educating physicians on risk management strategies is critical.

For this reason, TMLT offers risk management continuing medical education (CME) programs that allow physicians to apply what they learn in everyday practice and ultimately enhance patient safety. This article will introduce a number of ways physicians can receive CME through programs offered by TMLT, and will also focus on how physician feedback is used in the development of new programs.

TMLT CME activities include live seminars, online courses, publications, and practice-based reviews. Content for programs is designed to increase physician awareness of emerging technologies, risk management, patient safety, and medical-legal issues.

By far, the most popular TMLT CME program is *the Reporter* CME. Since January 2002 — when it was first offered — more than 5,700 physicians have received CME credit through *the Reporter*. This activity has been an overwhelming success, and TMLT will continue publishing CME articles in *the Reporter*. Future topics include bariatric surgery and the care of minors.

Physicians can also earn CME by attending live seminars. TMLT will offer a fall seminar series entitled "Medical errors, mandatory disclosure and you: revisited." This course will address the liability issues surrounding the disclosure and reporting of medical errors. Course dates and locations are as follows:

- October 12 — Dallas
- October 14 — Austin
- October 19 — Houston
- November 4 — San Antonio.

For additional information or to register, please contact Natalie Gilmore at natalie-gilmore@tmlt.org or (800) 580-8658 ext. 5911.

Online CME is offered at the TMLT web site, [www.tmlt.org](http://www.tmlt.org). Online programs allow physicians to earn credit at their convenience. Current courses include:

- He's not my patient — is he? Commonly misunderstood situations that may give rise to a physician's duty;
- Fraud and abuse prevention: what physicians need to know (2nd edition);
- How you can stay on the right side of the law: beginning, maintaining and ending physician/hospital relationships;
- Hot topics in risk management; and
- Streetwise! (2002).

CME is also offered through the TMLT practice review, and physicians can earn two CME hours by participating in this practice-based activity. To request a practice review, contact VelDonna Cassens at [veldonna-cassens@tmlt.org](mailto:veldonna-cassens@tmlt.org) or (800) 580-8658 ext. 5959.

### Developing and evaluating CME

TMLT risk management staff develop CME programs under the direction of the CME Advisory Committee. The committee includes appointed members from the Governing Board, and representatives from risk management staff (the vice president of risk management, the education program manager, the senior risk management representative, and the services representative).

To identify policyholder needs, the CME committee reviews the following data:

- policyholder surveys;
- closed claim statistics;
- risk management data;
- input from the Underwriting and Claim Review Committees;
- input from policyholders, the Texas Medical Association and TMLT defense attorneys;
- changes from regulatory and legislative agencies; and
- the consensus of experts.

This information, as well as regular literature reviews, is used to identify and analyze the risk management education needs and interests of participants.

The risk management department is able to incorporate specialty-specific closed claim studies, claim histories, and litigation statistics into CME activities, and receives feedback from audiences requesting more of this type of information.

CME activity effectiveness is determined by regularly reviewing evaluation summaries which assess whether the program and teaching methods met the stated objectives; whether topics and materials were relevant to practice; and whether the participants felt they could incorporate the information into daily practice. Evaluation forms also ask participants to identify areas of improvement for the activity, as well as what specific risk management strategies they plan to implement in their practice after participating in the activity.

Other factors used to evaluate effectiveness include attendance, attendee satisfaction, evidence of attitude shifts related to risk management, as well as evidence of behavioral changes such as improved referral patterns and charting practices.

Overall, the CME committee uses evaluation results to incorporate new topics into programs, re-invite speakers or writers, modify content, add tools and resources to assist with areas identified as problematic, and improve aspects of a course that may have been deficient.

The development of CME programs is a continuous process. Through participation and feedback from physicians, TMLT will continue to improve programs in order to educate physicians, improve the delivery of patient services, and enhance patient safety.

*Lesley Viner can be reached at [lesley-viner@tmlt.org](mailto:lesley-viner@tmlt.org).*

# The TSBME in transition

public criticism, sweeping legislation transform state agency



## Objectives

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

1. Define the scope and purpose of the TSBME.
2. Describe the licensing and discipline processes.
3. Identify the most common types of complaints filed against physicians.

## Course author

Michele Luckie is a risk management representative at TMLT.

## Disclosure

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

## Target audience

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

## CME credit statement

TMLT is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

TMLT designates this educational activity for a maximum of 1 category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

## Ethics statement

This course has been designated by TMLT for 1 hour of education in medical ethics and/or professional responsibility.

## Directions

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

## Estimated time to complete activity

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

## Release/review date

This activity is released on October 1, 2004, and expires on October 1, 2006. Please note this CME activity does **not** meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

## Introduction

*"Our mission is to protect and enhance the public's health, safety and welfare by establishing and maintaining standards of excellence used in regulating the practice of medicine and ensuring quality health care for the citizens of Texas through licensure, discipline, and education."*

This is the mission statement of the Texas State Board of Medical Examiners (TSBME), the state agency responsible for the licensure and discipline of Texas physicians, both MDs and DOs. (TSBME employ-

ees also serve as staff for the Texas State Board of Physician Assistant and Acupuncture Examiners, and have recently been made responsible for licensure and discipline of surgical assistants.)

The TSBME was created by the Texas Legislature to represent and be accountable to the public. The policymaking body of the TSBME comprises 19 members who are appointed by the governor to serve 6-year terms. By law, there are nine physician MDs, three osteopathic physicians and seven public members on the board.

The TSBME has had its share of controversy over the years due to some critical publicity and exhaustive legislative proceedings. More challenges are ahead for the TSBME, and the 16 other state agencies that license health care professionals, as they face review by the Sunset Advisory Commission before the 2005 legislative session.

Before further discussing the TSBME, it is important to discount a common misconception about the agency. The TSBME is accountable to and represents the public, not physicians or organized medicine. The Texas Medical Association (TMA), the county medical societies, and the specialty societies are private membership organizations that represent physicians. While these organizations and the TSBME may have mutual interests, they are separate entities serving different constituents.

To many licensed physicians in Texas, the TSBME — with its disciplinary processes and sanctions — is seen as a necessary evil. But those very processes were questioned extensively in 2002 when the *Dallas Morning News* ran several articles about the failure of the agency to discipline “bad” physicians. This scrutiny and criticism brought sweeping changes to the agency. This article will examine the TSBME today, and what it hopes to become in the future in its three areas of oversight — licensure, discipline and education.

### Negative publicity brings change

In 2002, *The Dallas Morning News* reported that the TSBME had refused to revoke the licenses of physicians who committed sex crimes or whose repeated mistakes caused the death of patients.<sup>1</sup> The articles — written by staff writer Doug Swanson — criticized the TSBME’s performance, or lack thereof, stating “Beyond dealing with sexual misconduct, the medical board faces a number of other questions about its performance. It has not revoked a single doctor’s license in five years for committing serious, often fatal, medical errors. And it ranks in the bottom third of all states for its

rate of license revocations, surrenders and suspensions. Also, since January, it has failed to investigate the deaths of more than 1,000 patients whose cases resulted in malpractice claims against their physicians.”<sup>2</sup>

The articles further alleged that other types of cases against physicians — some involving serious medical errors — had been lost, abandoned or left unexamined in the medical board’s procedural bureaucracy during the last five years. State Representative Ray Allen (R-Grand Prairie) was quoted, “The board of medical examiners is badly broken. They should understand that the Legislature will be looking very hard at whether they need to continue to exist.”<sup>3</sup>

Donald Patrick, MD was hired as executive director of the board in September 2001. He has stated that this publicity was probably the best thing that could have happened to the board. In an interview for *Texas Family Physician* magazine, Dr. Patrick said, “Of course, our first reaction was ‘That’s a bunch of lies. He’s wildly exaggerated the situation and it’s not true.’ But as we investigated his allegations, we realized it was true . . .”<sup>4</sup>

In the February 2004 issue of *Texas Medicine*, TSBME President Lee Anderson, MD said, “We had started making improvements before the newspaper articles. We were energized and we had a new executive director. The newspaper articles turned the agency around. It made us realize that we really did have a problem with our processes.”

Dr. Anderson went on to explain what was the beginning of a total reorganization. “In the past, a lot of the work was done in little fiefdoms. It had individual memory but not institutional memory. And it became clear during all the turmoil that we needed institutional memory . . . So the board moved from oversight to developing expectations. We didn’t want to get into micromanaging, but we had to look at all of the processes from one end to the other.”<sup>5</sup>

### A renewed commitment

In 2002, the TSBME sought and secured emergency funding from the governor to implement immediate improvements in the agency’s investigation of malpractice complaints. At the insistence of the governor’s office, the board adopted a resolution declaring that it “renews its commitment” to disciplining physicians who have injured or caused the death of patients.

The agency’s performance was already on the road to improvement in all areas of oversight when the 79th Legislature con-

vened. At this critical time, when the very future of the TSBME was at stake, the board members and staff rallied with renewed energy. Although several initiatives were considered that could have negatively impacted the agency’s potency, none were passed. What did pass, unanimously, was Senate Bill 104. This legislation encompassed both licensure and enforcement, and provided the TSBME with the statutory strength and monetary resources to enhance public protection while promoting a fair process for physicians.

### Licensing

One essential responsibility of the TSBME is to protect the public by licensing qualified physicians through reviewing applications for licensure and permits, making determinations of eligibility and reporting its recommendations to the policymaking board. Over the years, the TSBME has received complaints from physicians about the lengthy application process. Shortly after being named executive director, Dr. Patrick completed a licensure application himself. He found the 49-page document full of redundant information. The application has since been reduced to as few as eight pages.

As part of TSBME’s reorganization effort, the licensure division was incorporated into the customer affairs division to further promote customer service within the licensing operations. In addition, the licensure applications carry improved instructions to reduce errors and omissions, which slow the process. The TSBME has developed separate application packets depending on the type of applicant and type of license: U.S. or Canadian graduate; international medical school graduate; relicensure or reissue application; or telemedicine application. These new licensing forms are now available online at the TSBME web site, [www.tsbme.state.tx.us](http://www.tsbme.state.tx.us).

Dr. Anderson told *Texas Medicine* that previously, it could take up to six months for a U.S. medical graduate to obtain a Texas medical license. To address this concern, the TSBME instituted a new triage system that replaced the old first-come, first-served method. This new system identifies uncomplicated applications and routes them for expedited approval. Applications with questionable history or nonstandard documents undergo more comprehensive review and scrutiny.

“We’ve divided licensure applications into low, medium, and high complexity. The typical low complexity person is a U.S. medical graduate. The second one is a U.S.

graduate or graduate from anywhere who has some questions on his or her record like a DWI in another state or probation during training. High-complexity people have multiple malpractice cases, or they're from Iraq or Afghanistan and we can't do primary source verification on whether they went to medical school or not, or they've had substance abuse issues. Getting a low-complexity U.S. graduate licensed right now takes 22 days," Dr. Anderson said.<sup>5</sup>

"The new system will not sacrifice the current quality of the licensure investigation process and will continue to ensure that a license is granted only after adequate background review indicates the physician is competent to practice in Texas," a TSBME statement said.<sup>6</sup>

### S.B. 104 licensure changes

In addition to the licensure process changes initiated by the board, there were also important licensure issues included in S.B. 104. They are:

- implementation of a biennial registration process in 2005;
- a new \$80 license surcharge; and
- revisions to the physician profile reports.

The legislation included requirements for a biennial registration process with expiration dates on the last day of the birth month, and rule and fee cap revisions consistent with a biennial process. The biennial registration will be implemented for permits expiring after January 1, 2005. To distribute the registrations evenly across the biennium, the TSBME will split the total licensed physician population in half (by odd/even license numbers). The transition from four expiration dates per year to 12 will occur after the implementation of biennial registrations is complete. These rules were adopted and became effective on November 30, 2003.

#### License surcharge

Possibly the most important provision of S.B. 104 is the new \$80 fee charged as physicians renew their licenses. Because physicians will begin renewing their licenses every other year, the \$80 surcharge (which affected licenses renewed after January 1, 2004) will cover both years, and will be in addition to the current annual renewal fee. With approximately 55,000 licensed physicians, the surcharge should generate more than \$4 million every two years. The money will be used for the enforcement activities of the board and the expert review panel. TSBME officials say those funds will enable the board to hire an addi-

tional 20 employees, most of whom will be attorneys, investigators, and support staff.

"There's no doubt that the monetary impact will be incredibly beneficial," Dr. Anderson said. "To have the dedicated funds that cannot be reappropriated to non-medicine issues will give us the ability to hire the attorneys we need and to develop a better consultant panel, and it will give us the investigative strength not only to shorten the duration of the investigation but also to improve the product."<sup>7</sup>

Wichita Falls pathologist Susan Strate, MD, who chaired the TMA Ad Hoc Committee on Patient Safety, said, "Nobody likes to see more fees, but the majority of licensing fees have not been going to the board, they've been going into the state's general fund, and that's not right. This surcharge will go specifically to providing the expert physician panels to review standard of care and for enforcement."<sup>7</sup>

#### Physician profiles

The TSBME first began publishing physician profiles in 2002. These profiles were designed to improve consumer access to physician information. S.B. 104 revised the physician profile reports in the following ways.

- Reports now carry a description of malpractice claims with jury awards.
- All 10-year limits on reporting criminal and disciplinary history have been eliminated. Because of the staggered registration system, it will be late 2005 before all physicians have registered and provided information in compliance with the new statute.
- The profiles must now contain the text of a formal complaint (filed under section 164.005) or a board order related to the formal complaint, to be updated by the 10th day after filed or issued. Before S.B. 104,

an image of the formal complaint was included on the web site.

Additional changes to the licensing process contained in S.B. 104 are the requirement to collect email addresses, if available, and the automatic cancellation of a license for nonpayment.

### Complaints, investigations and discipline

The TSBME Department of Complaints and Investigations was established in 1954 to investigate complaints received by the board. It is the function of this department to identify those physicians who present a danger to the public, and to provide the necessary evidence and information so the appropriate actions can be taken.

Any citizen, including licensed physicians, may be a complainant or a witness in board proceedings. Any licensed physician could be the subject of a complaint brought before the board. The Medical Practice Act requires all physicians to post a notice in their offices, in both English and Spanish, that explains how a patient can submit a complaint to the board. The Medical Practice Act (section 160.003) also requires physicians to report information to the board about other physicians who may pose a threat to the public through the practice of medicine.

The board receives about 5,000 complaints per year. Approximately 60 percent of those are declared non-jurisdictional, or not having violated the Medical Practice Act. The complaints most frequently received involve non-therapeutic prescribing of a drug or treatment, professional incompetence, unprofessional conduct that may endanger the public, and the inability to practice medicine by reason of mental or physical impairment. Overall, complaints involve five to 10 percent of all licensed physicians.

### Legal expense reimbursement for disciplinary proceedings

Many medical liability insurance policies will provide coverage for legal expenses that occur if the policyholder faces a disciplinary proceeding.

TMLT policies include a special endorsement called Meddefense which provides legal expense reimbursement for disciplinary proceedings, including actions by the TSBME. Meddefense will reimburse up to \$25,000 per claim/per policy period. Meddefense claims are subject to a \$1,000 deductible and there is a 10 percent co-insurance provision (the policyholder will pay 10 percent of legal expenses after application of the deductible). For more information or to find out if you qualify for reimbursement under Meddefense, please call TMLT at (800) 580-8658.

“At least 90 to 95 percent of physicians in Texas are doing what they’re supposed to be doing. They’re getting up, they’re making their rounds, they’re doing their charts. They’re taking CME because they want to not because they have to, and they’re interested in learning,” said Dr. Anderson.<sup>5</sup>

Even the best doctors make mistakes, and almost no one — including the most aggressive plaintiff’s attorney — suggests that a physician should lose his or her license for a catastrophic, but solitary error. Dr. Anderson and other board members say they are most concerned with weeding out the physicians who demonstrate a pattern of problems.

### The complaint process

TSBME investigators review all complaints. If they obtain sufficient evidence to suggest that a violation of the Medical Practice Act has occurred, the case is scheduled for an informal settlement conference or a contested hearing before an administrative law judge.

At this point, the physician receives written notice of the possible violation, and is invited to discuss the matter with the Board. This meeting gives the physician the opportunity to discuss the case and determine, if there is a problem, whether it can be resolved by agreement, or whether an administrative law judge for the State Office of Administrative Hearings (SOAH) must hear the matter. The complainant is also invited to this conference.

If, as a result of the agreement or hearing, the physician is found to have violated the Medical Practice Act, there are several ways the board may discipline the physician. These range from a written reprimand to license revocation. The physician may be placed on probation or other restrictions may be imposed. The physician’s case is then assigned to a board compliance officer.

The board also receives reports of professional liability claims and lawsuits filed against physicians. These reports help the board monitor for patterns of questionable practice.<sup>8</sup>

### S.B. 104 changes

Following the publication of critical articles in *The Dallas Morning News*, the investigations division was extensively overhauled. According to Dr. Anderson, the investigative and disciplinary process had improved significantly before the passage of S.B. 104. However, this legislation brought further changes.<sup>5</sup>

### New investigation deadlines

S.B. 104 set new deadlines for complaint investigations and litigation. Cases must be set for hearing, either for settlement conference or dismissal, within 180 days after a complaint is filed. All complaints must be resolved within one year of being filed, allowing six months after investigation for staff attorneys to either obtain an agreed order or file a formal complaint with SOAH. TSBME has reorganized staff and processes to comply with these deadlines.

### Expert physician panels

Another major provision of S.B. 104 requires the board to use expert physician panels to review quality or standard of care cases. These panels, which include three physicians in the same or similar specialty as the doctor being investigated, will issue written reports on whether the standard of care was violated.

Dr. Strate said that making sure quality of care cases were adequately reviewed by appropriate physician experts was a major priority for the TMA when the legislature was overhauling the TSBME. “Our concern was that physicians who were reviewing cases were not adequately peer-matched.”<sup>7</sup>

To comply with this requirement, the TSBME created a panel of more than 400 physicians in 75 specialties and subspecialties to review standard of care cases. To date, 225 cases have been reviewed by panel members, and those cases are now moving toward resolution through either the litigation process or dismissal by a committee of the board.

### Investigative process changes

S.B. 104 required the TSBME to change the investigative process to improve both the quality and the timeliness of investigations. To accomplish this, the board used additional funding allocated by the legislature to create central nurse investigator positions. In these positions, individuals with both legal and nursing expertise review complaints and assure quality investigations.

These nurse investigators are part of a new initial 30-day evaluation period implemented to allow greater scrutiny of each complaint before the complaint is actually filed. In most cases, the subject physician is invited to provide a response to the allegation before the complaint is filed. The complainant is also usually contacted to ensure that all information about the complaint is discovered. This system allows board staff to eliminate frivolous complaints, and to focus resources on cases where a violation of the Medical Practice Act is alleged.

Once a complaint has been filed, the board staff begins the new 180-day investigative process. Work is closely tracked to ensure cases are completed in a timely manner. In cases where standard of care is at issue, the investigators obtain the opinion of the expert physician panel. That opinion is incorporated into the Summary of Allegations and is forwarded for appropriate action. This process allows for a thorough medical review of every case, and gives board members additional information on which to base their disciplinary decisions.

### Temporary suspensions and restrictions

S.B. 104 gave the TSBME the authority and resources to strengthen and accelerate the disciplinary process. The board now has the authority to take action in the following situations:

- The board can now act against physicians who present a danger to the public as well as those who are a danger to patients.
- A physician no longer has to be a “present” danger for the board to act.
- The board now has the ability to temporarily restrict a license as well as to suspend it.
- The board can convene ex parte hearings, without the respondent present, allowing for immediate action when necessary.
- Procedures were clarified when temporary suspension orders were challenged in district court.

Since the effective date of S.B. 104, the TSBME has convened temporary suspension hearings on 11 physicians. The board removed nine physicians from practice through agreed orders, voluntary surrender, or temporary suspension. The other two physicians were not suspended, but had their licenses significantly restricted. The suspended physicians included a physician who was handing out prescriptions in a discount store parking lot; a physician who was involved with patients outside appropriate boundaries; and a physician with a long history of poor standard of care and multiple egregious malpractice cases.

The TSBME has convened ex parte hearings to take immediate action in four cases. These cases illustrate the value of the new statute allowing TSBME to take immediate action to protect the public. These four physicians who were suspended ex parte remain on suspension pursuant to the findings described as follows:

Case 1

The TSBME received evidence from the Drug Enforcement Agency and the district attorney that a local physician was writing multiple prescriptions for narcotics to patients without valid medical histories, examinations, or diagnosis. The physician's license was temporarily suspended seven days later.

Case 2

The TSBME received evidence that a physician was actively helping another suspended physician to continue to see patients. The physician's license was temporarily suspended a few weeks later.

Case 3

A peer review entity presented the TSBME with evidence that a physician's cardiology intervention practice had an alarmingly high rate of dangerous and fatal outcomes. Seventeen days later, the physician's license was temporarily suspended.

Case 4

The board received new complaints and information about criminal allegations involving indecency with a child against a physician who was already on an interim order. (The interim order had restricted the physician from treating boys under the age of 18 without a chaperone, pending completion of the investigation.) Within one week, the physician's license was temporarily suspended

Following these ex parte hearings, the board held or is scheduled to hold temporary suspension hearings with notice and will provide the opportunity for the physicians to appear and present evidence.

**Nondisciplinary rehabilitation**

The 74th legislature gave the TSBME a new mechanism for dealing with physician impairment. The board is now authorized to use a nondisciplinary, confidential order for physicians who seek help from the board for their drug or alcohol abuse problems. The intent of the law is to allow impaired physicians, under certain circumstances, to voluntarily come forward and receive proper treatment without fear of a public reprimand from the TSBME.

To be eligible for a rehabilitation order, a physician must self-report to the TSBME before any complaint against the physician has been received. The physician must not have been the subject of a previous substance abuse-related order of the TSBME. A

nondisciplinary rehabilitation order may be available to a physician who self-reports intemperate use of drugs or alcohol during the last five years which could adversely affect the physician's ability to practice medicine safely. In addition, a nondisciplinary rehabilitation order may be available to any physician for intemperate use of drugs or alcohol from habituation or addiction caused by medical care or treatment provided by another physician.<sup>9</sup>

**Educating the public and physicians**

Two divisions are charged with helping the TSBME protect the public through education. The Customer Information Center (CIC) is the front line of the agency. CIC representatives provide information about licenses, programs, rules, and statute to the public and other customers. They provide this information by telephone, electronically and in writing. The CIC is also responsible for the agency's web site.

The Public Education program serves as the major point of contact with the news media, and as the primary source for information regarding agency programs.<sup>10</sup>

In its continuing efforts to educate physicians, TSBME collaborated with the Texas Medical Foundation in 2003 to produce a video that will promote greater understanding among physicians about the regulation of the practice of medicine in Texas. The video, *The TSBME: A Glimpse of Licensure and Discipline*, is offered free of charge and can be downloaded or ordered from the TMF web site at [www.tmf.org/tsbme/index.htm](http://www.tmf.org/tsbme/index.htm).

S.B. 104 has allowed the TSBME to broaden their educational efforts. According to Jill Wiggins, public information officer, the TSBME wants to improve physician education as well as public education. "We need to make sure our licensed physicians have the knowledge necessary to keep their licenses in good standing, to be successful physicians. In addition the public needs to be educated regarding the board's scope and responsibilities. If we can educate the consumer in what the board's powers and duties are, we can reduce the number of invalid complaints and focus on the valid ones. This benefits the consumers and the doctors."

While acknowledging that the TSBME was created to serve the citizens of Texas, Wiggins says she hopes physicians will come to view it as more of an advocate than an adversary.<sup>11</sup>

**Conclusion**

The TSBME is an agency in transition. Sweeping changes to processes, personnel and organizational structure have occurred in the past few years. Some of the changes were initiated by the board in response to public criticisms, but even greater changes were mandated by S.B. 104. That legislation made changes affecting all agency programs. Implementing the legislation has required extensive rule changes.

Nevertheless, not everyone is convinced that the TSBME will hold up its end of the bargain. When it comes to fulfilling the TSBME's mission, it is rare for all parties concerned to agree on any one issue. Forever caught in the crossfire, public protection is and must remain its first priority.

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# risk management consult

## Q: What are the risks of prescribing a medication for off-label use?

**Answer:** Because a particular use of the drug may be beneficial but uncommon, many drug manufacturers chose not to seek FDA approval for an off-label use due to cost and time factors. The U.S. Congress has not prohibited the prescription of medications for non-FDA-approved (off-label) use.

Prescribing a medication for off-label use is not without risk, particularly in pediatrics. Physicians are still responsible for practicing prudent medicine. Physicians should familiarize themselves with the available literature and the practices of similarly situated physicians when considering off-label medication use. This would provide evidence of compliance to the standard of care in the event of a claim related to the off-label use. In addition physicians are encouraged to obtain a signed, written consent indicating the rationale for the use of the medication, its risks, benefits, and alternatives. Information is available at [www.fda.gov](http://www.fda.gov).

## Q: Did the 2003 legislature change the statute of limitations regarding suits by minors against physicians?

**Answer:** Yes. In House Bill 4, (subchapter F, Section 74.251, Statute of Limitations on Health Care Liability Claims) the language states “(a) Notwithstanding any other law and subject to Subsection (b), no health care liability claim may be commenced unless the action is filed within two years from the occurrence of the breach or tort or from the date the medical or health care treatment that is the subject of the claim or the hospitalization for which the claim is made is completed; provided that minors under the age of 12 years shall have until their 14th birthday in which to file, or have filed on their behalf, the claim. Except as herein provided this section applies to all persons regardless of minority or other legal disability.

(b) A claimant must bring a health care liability claim not later than 10 years after the date of the act or omission that gives rise to the claim. This subsection is intended

as a statute of repose so that all claims must be brought within 10 years or they are time barred.”

According to a defense attorney familiar with the language of House Bill 4, “Ch 74.251 has both a statute of limitations and a statute of repose. The statute of limitations is two years for the occurrence of breach or tort or from the date the medical treatment is completed. The statute of repose is 10 years from the act or omission. A statute of limitation affords a plaintiff a period of time that the legislature deems reasonable to present claims. Under a statute of limitations, a party still possesses the claim but is prevented from asserting it. A statute of repose differs from traditional statutes of limitation because they cut off a right of action before it accrues. A statute of repose has been said to be a substantive definition of one’s rights whereas a statute of limitations is a procedural limitations of one’s rights.”

## Q: Am I required to keep receipts of sample medications accepted from pharmaceutical representatives?

**Answer:** Yes. The Texas Administrative Code Section 169.7 requires that all physicians maintain a copy of each signed request form for sample dangerous drugs for two years from the date received. Dangerous drugs are defined as any medication that requires a prescription. Establish a practice protocol with the pharmaceutical representatives to ensure a copy of each receipt is provided to the practice.

## Q: In a previous Reporter article, about informed consent, you mentioned the Texas Medical Disclosure Panel lists were available online. I am having trouble finding those lists. What is the web address again?

**Answer:** Current versions of List A and List B are published in the *Texas Register* and in

the Texas Administrative Code, Title 25, Part 7, Section 601.4. The exact web address is: [http://info.sos.state.tx.us/pls/pub/read-tac\\$ext.ViewTAC?tac\\_view=3&ti=25&pt=7](http://info.sos.state.tx.us/pls/pub/read-tac$ext.ViewTAC?tac_view=3&ti=25&pt=7).

## Q: I am considering developing a web site for my practice, and have heard from a colleague that a disclaimer is advised. What does this mean and are there other factors to consider for a web site?

**Answer:** HIPAA guidelines state “a covered entity must prominently post and make available its Notice of Privacy Practices on any web site it maintains.” It is also recommended that a disclaimer be posted on the site that explains information provided is not meant to render medical/surgical advice or recommendations. The intent of the web site, whether for commercial gain or providing general information, must be clear to users upon entering the site. All information must be kept current with dates posted to reflect when updates are made to the site. It is always advisable to have an attorney familiar with the legal implications of a web site review your site.

Here is a sample web site disclaimer: “[Your name/the name of the practice] offers and maintains this web site to provide information of a general nature about the practice and conditions requiring the services of a [your specialty]. The information is provided with the understanding that [your name/practice name] is not engaged in rendering surgical or medical advice or recommendations. Any information in the publications, messages, postings, or articles on this web site should not be considered a substitute for consultation with a [your specialty] to address individual medical needs. Individual facts and circumstances will determine the treatment that is most appropriate.”

Please email your risk management consult questions to [barbara-rose@tmlt.org](mailto:barbara-rose@tmlt.org).

# closed claim study

## Failure to diagnose and treat cornual pregnancy

by Barbara Rose and Katie McLaughlin

*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. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.*

### Presentation

A 33-year-old woman came to the emergency department complaining of bilateral abdominal pain, back pain and shortness of breath. She reported that she was nine to 10 weeks pregnant. The patient also had a history of pelvic inflammatory disease (PID) and sickle cell anemia.

The patient's vital signs were normal, but she had tenderness along her abdomen. Blood work indicated she had a WBC count of 8,000 and mild anemia. The emergency medicine physician ordered an ultrasound to determine if the pregnancy was normal.

### Physician action

The radiology technician completed the ultrasound and contacted the on-call radiologist at his home at 3 a.m. The technician told the radiologist that the images were of poor quality even though the ultrasound had been done twice. The radiologist had the technician send him a copy of the images via teleradiology. After reviewing the images, he determined that the pregnancy was intrauterine but "abnormal." He reported this finding by phone to the ED physician. However, the ED physician claimed that the radiologist reported that the ultrasound showed a normal intrauterine pregnancy. "Normal intrauterine pregnancy" was written in the ED records.

The ED physician discharged the patient at 6:40 a.m. after giving her meperidine, promethazine and antibiotics. The final diagnosis was abdominal pain due to intrauterine pregnancy, gastroenteritis or possible PID. She was told to rest at home and follow up

with her obstetrician. The ED physician later stated that the patient was discharged because she refused hospitalization, but this was not indicated in the medical records.

A second radiologist reviewed the ultrasound images when he arrived at 8 a.m. He noted that the ultrasound showed an intrauterine cornual pregnancy, a pregnancy in which implantation occurs in the uterus at its junction with the fallopian tube. He recommended that the patient be brought back in for further studies to evaluate the position of the pregnancy. According to his testimony, he asked the radiology technician to call the patient and have her return. The patient was never called. The technician stated that the radiologist never requested that she call the patient.

The patient continued to suffer from abdominal pain at her home before calling EMS at 9:44 a.m. When she arrived at the hospital, she complained of acute pain and difficulty breathing. Ten minutes later she coded and CPR was started. She was sent to the OR for an emergency laparotomy due to suspected ruptured ectopic pregnancy. CPR was continued throughout the surgery. The surgeon located and removed the cornual pregnancy from the left side of the uterus and noted between 1.5 and 2 liters of blood in the abdominal cavity. Despite CPR and several defibrillations, the patient was pronounced dead at 12:17 p.m. The pathologist found the cause of death to be ruptured ectopic cornual pregnancy complicated by acute shock and exsanguination.

### Allegations

A lawsuit was filed against the radiologists and the ED physician. The allegations included:

- failure to properly interpret the ultrasound resulting in a premature discharge from the ED (first radiologist);
- failure to provide the diagnosis to the ED in a timely manner resulting in failure to call patient back to the hospital (second radiologist); and
- failure to perform a pelvic exam, failure to call for an OB consult and prematurely discharging the patient (ED physician).

### Legal implications

Cornual pregnancies are extremely rare and some physicians may never encounter them in their careers. They also have a high mortality rate and, according to radiology experts reviewing this case, are very difficult to diagnose.

While acknowledging the poor quality of the ultrasound films, the plaintiff's radiology expert stated the final diagnosis of intrauterine pregnancy was incorrect. The patient did not have an obvious extrauterine ectopic pregnancy, but a pregnancy in an unusual position that was neither extrauterine nor intrauterine. In any case, according to the plaintiff's expert, the misdiagnosis of the cornual pregnancy led to the patient's inappropriate discharge from the hospital and her eventual death.

TMLT radiology consultants had mixed opinions about the first radiologist's interpretation, but all agreed the images were consistent with a cornual pregnancy. One reviewer commented that the radiologist should have asked for a repeat exam or should have come to the hospital to review the ultrasound. Another consultant stated that the radiologist did not rule out ectopic pregnancy just by advising the ED physician that this was an abnormal pregnancy.

The second radiologist's interpretation of "an intrauterine pregnancy of questionable location" was considered appropriate, but consultants were concerned that he dictated the need to call the patient back rather than contacting the ED physician. In his deposition, the radiologist said that if he had been certain the patient had an ectopic pregnancy he would have contacted the patient immediately. Since this diagnosis was a "gray area" and since he was informed that the patient had been discharged from the ED, he asked the technician to contact the patient.

Regarding the actions of the ED physician, plaintiff's experts stated there was not enough information about the patient's condition to discharge her. Even after receiving word that the pregnancy was not ectopic, he should have performed a pelvic

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*closed claim study . . . continued from page 11*

exam and obtained an ob-gyn consult. A pelvic exam would have yielded additional information to make the diagnosis. An ob consult should have been ordered because he had a pregnant patient in severe pain without an ectopic pregnancy. Defense experts argued that a pelvic exam was not necessary since an ultrasound had been ordered. An obstetric consult was also not necessary because the patient was already under the care of an obstetrician and it was determined, based on the ultrasound, that her condition was not life threatening.

Of great concern in this case was the communication between physicians and the apparent lack of documentation about what was discussed. The first radiologist should have documented his interpretation by faxing a report to the hospital immediately. Though the ED physician did document that the radiologist reported a “normal intrauterine pregnancy,” he did not document that he wanted to hospitalize the patient but she refused. For the second radiologist, a call to the ED physician advising him of the need for follow-up studies would have been more appropriate than dictating the need for call back in the report.

## Disposition

This was a complex case involving multiple physicians. Finger pointing became a concern, as each party to the suit gave differing versions of the events. These facts, along with the lack of documentation and the communication issues, led to the decision to settle the case on behalf of all three physicians. The total settlement amount was in the high six figures, with the ED physician contributing 50 percent and each radiologist contributing 25 percent. The physicians made no admission of liability and settled only to avoid the uncertainty of litigation.

## Risk management considerations

In hindsight, actions that might have made a difference in the outcome of this claim have been mentioned above. None of these actions are extraordinary in nature, but reflect a commitment to the delivery of quality patient care and the documentation of that care. Are oral reports acceptable in teleradiology? Was the impression clearly understood in physician-to-physician communication? It seems unlikely the ED physician would ignore the word “abnormal.” That is not what he heard. A report emailed or faxed would alert him to

“intrauterine but abnormal.” Are images of poor quality satisfactory for interpretation away from the facility? What protocols are in place to determine when the on-call radiologist comes in?

Timely action may influence outcomes when studies are abnormal and follow up is needed. The practice of radiology lends itself to well-defined systems that guide when the ordering physician is told of abnormal findings and any recommendations for further studies. Document this contact. Practicing prudent risk management and implementing well-designed systems to observe the standards of care may impact the exposure a radiologist encounters on a daily basis.

Documentation in the medical record will strengthen a physician's defensibility. Relying on memory months or even years after an event is dangerous. The recommendation for admission and the patient's refusal should be in the record. In addition, asking the patient to sign an informed refusal form reflects their part in the decision making process. If the patient is leaving against medical advice, that decision needs to be clearly and objectively documented.

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