the Reporter

TMLT
TEXAS MEDICAL LIABILITY TRUST
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THE TRUTH AND NOTHING BUT THE TRUTH

The JCAHO patient safety standard

By Jane Mueller, Assistant Vice President, Risk Management

Patient safety has been a basic tenet of medical practice since Hippocrates proclaimed the principle of "first do no harm." This was relatively simple in Hippocrates' time considering the primitive state of medicine. With the current state of health care and the plethora of diagnostic and treatment options available to physicians, this becomes much more complex. Any medical intervention carries with it a risk that the outcome will not be the one desired. The practice of medicine is, after all, an art and not a science. Under the best of circumstances, with the best of care, patients may not recover or may not achieve the level of function that they and their physician expected.

Whether due to the level of illness of hospitalized patients generally, or the invasiveness of procedures utilized during hospitalization, the risk of an unexpected or unfortunate outcome significantly rises in the hospital setting. By way of illustration, one estimate is 66 percent of medical malpractice claims nationally involve a "loss" that occurred during hospitalization. An analysis of TMLT closed claims from September 1994 through August 1999 indicates approximately 50 percent of incidents involved treatment in a hospital setting.

In a response to the Institute of Medicine (IOM) report of 1999, *To Err is Human: Building a Safer Health System,* federal agencies as well as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) have adopted policies to address patient safety. JCAHO recently released a new accreditation standard for hospitals, effective July 1, 2001, addressing patient safety. This standard [RI.1.2.2] states:

> "Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes." [1]

The accompanying intent provision [RI.1.2.2] indicates:

> "The responsible licensed independent practitioner or his or her designee clearly explain the outcome of any treatments or procedures to the patient, and when appropriate the family, whenever those outcomes differ significantly from the anticipated outcomes." [2]

This requirement has precipitated many questions. What constitutes an "unanticipated outcome?" Who will tell the patient and family about the event? What should be told to the patient and family? Will telling the patient and family constitute an admission of liability? Is it necessary to document the conversation? What should be documented?

The standard reads "outcome of care." It does not say medical errors. Incidents that occur but that have no bearing on the outcome of care are not required to be told to the patient or family under the standard and, in certain situations, may even be detrimental to the patient's well-being. In *Perspective on Disclosure of Unanticipated Outcome Information,* The American Society for Healthcare Risk Management (ASHRM) defines an unanticipated outcome as "a result that differs significantly from what was anticipated to be the result of a treatment or procedure." [3] For example, it is not necessary to report to a patient that an

incorrect dosage of a medication was administered, when there was no associated injury or alteration in the course of care.

The importance of informed consent in this process cannot be overemphasized. If the patient/family is fully informed of the risks and hazards of a given procedure, test or treatment, then the news of an unanticipated outcome, while unfortunate and unwelcome, may be more readily understood. Every patient/family should be told about care outcomes.

The goal of the JCAHO standard is to effect truthful and timely communication of all outcomes, including adverse events (surgery, testing, laboratory, etc.) to the patient and/or family. These conversations, in many cases, will generally be the responsibility of the physician as the "licensed independent practitioner," which is clearly stated in the standard. In discussing the new JCAHO standard, American Medical Association (AMA) Board Trustee, Donald J. Palmisano, MD, stated "The AMA believes it is a physician's ethical responsibility to be candid and truthful with a patient at all times." [4] In addition, empathy, understanding, and showing true concern for the patient and the family can assist everyone in coping with and recovering from the unfortunate outcome.

It is likely this new JCAHO requirement will be the subject of much debate and discussion in the next months and years. Physicians should stay informed and provide input as new policies and procedures are debated and created. The development of hospital procedures and practices to comply with the new patient safety standards should include the involvement of the hospital medical staffs, as all physicians in the hospital will be impacted by the implementation of these rules. At this time it is difficult to determine exactly what will be required of hospitals and hospital medical staffs; however, we anticipate physicians will be actively involved in the process. The following are frequently asked questions regarding disclosure.

How can I express my true regret and sorrow over an adverse outcome without creating the impression that my actions were somehow negligent?

• All agree that discussing an adverse outcome is the appropriate and ethical course of action; however, many physicians are anxious about doing it. Not only is it difficult because of the emotions involved, but in our current environment, doctors naturally fear unwarranted litigation.

• Talk with the patient/family at the earliest possible opportunity after the event. Avoidance by the practitioner may be interpreted by some as a lack of concern and covering up something that was done wrong.

• What is said is very important. Consider the words carefully and speak in simple terms that the patient and family will understand. Be kind and empathetic. Seek input from the family regarding what you might be able to do to help.

• If an obvious error has been made, such as surgery on the wrong body part, being straightforward may be the best approach. An apology usually is expected when there has been a mistake and can be very effective in mitigating a hostile situation. Saying "I'm sorry this happened" is empathetic and expresses your regret. Sometimes the mistake was made by someone else, or more than one person. The goal is to help the patient/family heal and obtain the best possible outcome.

• Similarly, expressing regret for an unexpected outcome or medical error may go a long way towards diffusing a tense situation. When something unfortunate occurs, it is usual to express sympathy and regret. Avoid blaming yourself or others. It is important to convey that an unexpected outcome does not necessarily mean that someone made a mistake.

When an adverse event has occurred as a result of an error by the hospital/hospital staff, who should talk with the patient/family?

• The intent provision that accompanies the JCAHO standard states that this should be "the responsible licensed independent practitioner." There are a number of ways to interpret who is the "responsible" licensed, independent practitioner. Is it the attending physician, who may not have been actually, physically "responsible" for the unanticipated outcome? Is it the allied health professional, for example, the respiratory therapist who administered an incorrect dosage during inhalant therapy? Who is "responsible" when the investigation is incomplete or only preliminary information is available?

• ASHRM's Perspective states:

> "Hospitals must decide how to address the issue of who should be the spokesperson. **Care should be taken not to interfere in the caregiver-patient relationship by substituting someone as the spokesperson. The responsibility for doing so rests with the caregiver"** [5]

• The physician generally is the best-situated person, perhaps with assistance from hospital risk management and/or a patient representative. In difficult situations, it may be prudent to have more than one person involved in the discussion. Whoever is responsible for disclosing the unanticipated outcome should be appropriately trained in that role, their responsibilities and presentation. Training should focus on how to

- disclose based on patient's culture, disability or cognitive skills
- provide empathy or concern without admitting liability
- convey additional and potentially contradictory information as a follow-up, if appropriate

What should be told to the patient/family when there has been an adverse outcome and the reason is unknown?

• If you know what occurred, you can and should relay the information to the patient/family. When accurate information is not available, or when the facts are unclear, never guess, postulate or speculate. Let the family know that an investigation is in progress and information will be provided as more details become available.

• They want to know more. They need to know more. They will have questions. Communicating about an unexpected outcome usually involves several interactions with the patient and/or family. Sometimes additional follow-up is required, perhaps to provide more information or an update on the patient's condition, prognosis or recovery. Often, new information will be brought forth as the investigation continues. Leave a number where you can be contacted. To provide additional information as it becomes available, determine who in the family should be contacted and how.

• If the patient or family asks for more information, share details as appropriate. If you have concern relating to a caregiver's performance during the episode in question, the hospital's disciplinary processes (peer review) are the appropriate places to deal with issues related to health care professionals. Avoid blaming and "finger-pointing."

What should be documented following a conversation with the patient/family when there has been an adverse outcome?

• The JCAHO standard does not require documentation of the disclosure to the patient.

• Some facilities have expressed concern that a detailed note documenting the disclosure of an unanticipated outcome may be construed or misinterpreted as an admission of liability. Other organizations are concerned that the lack of such documentation may cast doubt that such a discussion occurred, especially if the patient or family insists that the results of a treatment were not disclosed. Thorough, accurate and objective documentation of all aspects of care provided will almost always be beneficial in the event of later controversy.

• Facilities may determine that documentation should occur in the patient record and/or in a risk management report. Documentation should always be simple and objective.

• Since recording accurate details of the discussion is important, it would be preferable to complete any documentation *immediately after* the discussion.

Will the disclosure of unanticipated outcome information be adversely used against me in the peer review and/or credentialing process? Litigation?

• No. The medical peer review process is the evaluation of medical and healthcare services, historically focusing on accuracy of diagnosis and quality of care rendered by the physician.

• If the medical staff bylaws establish physician obligations to disclose unanticipated outcomes, the failure to do so may become a credentialing issue for the reticent physician.

Standards on patient safety may be new. However, prudent risk management practices should always include open, honest discussions with patients and/or families regarding medical treatment, including those situations where there has been an adverse outcome or unanticipated event. Communicating bad news presents some of the greatest challenges physicians are likely to encounter in practicing medicine. Despite all the formal education in medical school, many physicians have little formal training in delivering bad news.

Disclosure involves talking with patients about outcomes of any treatment, procedure, etc., including anticipated and possible adverse effects. This communication should take place routinely as part of the physician's treatment discussion with the patient/family. If a physician only talks with patients about the outcomes of care after there has been a bad outcome, it will be much more difficult for the physician and much less effective.

References

1. American Society for Healthcare Risk Management (ASHRM). *Perspective on Disclosure of Unanticipated Outcome Information.* April, 2001. p 6.
2. Ibid. p 6.
3. Ibid. p 5.
4. Adams, D. Standards Require Hospitals to Report Errors to Patients. *American Medical News.* July 23, 2001. p 15,17.
5. ASHRM. p 11.

New studies confirm medical liability crisis in Texas

Over the past several years, medical liability carriers have been faced with record claim intake, ever-increasing legal expenses and million dollar damage awards. And physicians have been paying the price in the form of double-digit rate increases, coverage restrictions and limited availability. According to information recently released by the Texas Medical Association and the Texas Department of Insurance, these trends are expected to continue. These studies shed light on the current state of medical liability in Texas, and the findings are less than encouraging.

The TMA Medical Liability Data Study -- 2000

In 1999, the Texas Medical Association conducted a data study to determine the cause and prevalence of increased claim activity in Texas. Claim data from three of the state's largest carriers were collected and reviewed. The 1999 study confirmed that more Texas physicians were being sued and that it was costing insurance companies more money to defend those claims.

A second data study was recently completed by the TMA, and the results are increasingly bleak. This year's study looked at claim frequency and severity data from the same three carriers and included 2000 figures. The three companies, TMLT, The Medical Protective Company and the American Physicians Insurance Exchange, represent more than 17,000 Texas physicians.

TMLT claim staff have reviewed the TMA data and offer the following analysis:

- For all three companies, claim frequency — which is the number of claims filed per 100 policyholders — continued to increase. Claim frequency in 2000, excluding mass litigation, was 23 percent. Claim frequency including mass litigation is 25 percent. Out of a total of 17,232 policyholders, 4,327 claims had been filed.
- Among the three carriers, 86 percent of malpractice claims are closed with no indemnity payment. This means that 86 percent of claims filed against physicians can be considered non-meritorious.
- While indemnity is not paid on the majority of claims, carriers still pay legal expenses. These costs are referred to as loss adjustment expenses (LAE). In 2000, the average LAE per policyholder was $4,669, up from $4,056 in 1999. The total amount paid in legal expenses by all three carriers in 2000 was $80.46 million.
- The amount of indemnity paid to plaintiffs also increased in 2000. Indemnity per paid claim was $189,849, a 6 percent increase in one year. The total indemnity paid by TMLT, Med Pro and API in 2000 was $113.5 million.
- As claim frequency, legal expenses and claim payments increased in 2000, so did the premiums paid by physicians. The average premium per policyholder for all three companies was $9,850 in 2000, an increase from $8,135 in 1999.
- Despite these premium increases, the three carriers still experienced losses. In 2000, the companies paid out a total of $193.9 million and took in $169.7 million in premium, a loss of $24.2 million. For the years 1996 through 2000, the three carriers have paid out more than $160 million more than they received in premiums. Even though physicians are paying more for medical liability insurance, these premium increases are not keeping pace with the increasing claim frequency, legal expenses and claim payments.

"The TMA data illustrate how the situation in Texas has continued to deteriorate. It shows the highest claim frequency for the combined companies ever recorded," says Bob Fields, vice president of claim operations at TMLT.

"Now, more than ever, individual physicians, organized medicine, state legislators and policymakers must see that medical liability reform is necessary to solve this problem."

TDI data

A separate study recently completed by the Texas Department of Insurance paints a similar picture. The TDI reviewed annual statements from all the regulated medical malpractice carriers in Texas for the year 2000. More than 100 companies were evaluated in the TDI study. These companies insure doctors, hospitals and nurses. TMLT data were not included in the TDI study because TMLT is not a regulated carrier.

According to the study, Texas carriers paid out $229 million more than they received in premiums for the year 2000. In 1999, the same figure was $103.5 million.

"These companies lost more than $330 million in two years. Virtually every major writer of medical malpractice is suffering," says Fields. "Some companies are raising rates or restricting coverage, while others are backing out of Texas altogether."

What the future holds

As the data from the TMA and the TDI indicate, physicians are paying more for malpractice insurance, but these additional funds are not covering the costs of defending and paying claims. These trends simply cannot continue. Fundamental, long term changes in the legal system must occur.

For this reason, TMLT has been instrumental in the formation of a medical liability consortium whose sole purpose is to achieve medical liability reform in Texas. While still in the formative stages, the consortium represents more than 20 different parties, including the TMA, the county medical societies, specialty societies, insurance companies, defense attorneys, and hospital associations. The consortium is currently researching types of medical liability reform and is formulating an action plan for the 2003 legislative session.

It's an unpleasant fact of life . . . about 25 percent of Texas physicians will face a medical malpractice claim this year. A few other scary facts . . . there are 61,000 attorneys in Texas and 80 million lawsuits filed annually! Your assets are definitely under attack. The lawsuit epidemic will not improve because we are dealing with two basic emotions, revenge and greed. What steps can you take to protect your family and your personal assets?

First, develop a wellness plan for your assets. Just as you encourage patients to take preventive measures to ward off health problems, it is prudent to organize your financial affairs and assets to guard against risks in advance. What is and is not protected under the Texas homestead laws? Should you use offshore trusts, Alaska trusts, family partnerships, partition agreement, annuities, or what? What are the costs of establishing and maintaining an asset protection plan?

Recent data concerning medical malpractice claims and lawsuits in Texas show that malpractice lawsuits have escalated to an unprecedented number. More and more Texas physicians are being sued.

"But I have insurance to cover that." Liability coverage can help protect your practice and your reputation, but it is not a 100 percent solution. What if the judgment exceeds your policy limits or the cause of action falls under the policy exclusions/limitations? Recent malpractice verdicts have included very large jury awards against physicians — $13 million in a pediatrics case; $33 million in an obstetrics case; a little more than $1 million in an allergist's case. Without advance planning, your hard-earned assets may be lost and it will be difficult to start over. It only makes sense to put a "stop-loss" into place on your asset base — a fortress of protection around your important assets. Also, establishing an asset protection program will most likely save you money on your insurance. Perhaps you won't need to purchase as much of it! Additionally, with less insurance and an asset protection plan in place, you become an unattractive target to those who would file frivolous lawsuits.

Protecting your assets from lawsuits

By Ken H. Vanway, P.C., attorney at law

Besides your own personal exposure to medical malpractice lawsuits, other risk exposures include employment-related lawsuits by your employees against you, lawsuits for vicarious liability (i.e. you are responsible for your partners, your employees, etc.), automobile accidents, joint ownership of property, coaching Little League or participating on a board of directors. Factor in the additional risk to your assets imposed by income tax, capital gains tax, estate death tax, bankruptcy and divorce and you may find yourself running, not walking, to a board certified estate planner who specializes in asset protection planning.

The most useful advice I can give is . . . stop procrastinating! Seek out a trained professional who specializes in this area. A team approach often works best — board certified attorney, CPA, investment advisor, insurance professional and financial planner. The costs involved in setting up an asset protection plan vary with the individual and the complexity of the case but pale in comparison to the exposure you have every day you practice medicine, drive your car, or attend a board of director's meeting without a protection plan in place.

TMAIT will be offering physicians a number of opportunities to attend asset protection seminars in 2002. Watch for further information in your TMA publications and on the TMAIT web site.

Beginning with the September/October issue, The Reporter *will feature a column to answer your most frequently asked questions about asset protection. We invite you to email or write Ken Vanway with your questions, ken@vanway.org or Ken H. Vanway, P.C., First Commercial Bank, 1110 RR 620 South, Suite B, Austin, Texas 78734.*

The information provided in this article is not to be construed as legal advice and should not be relied upon without specific consultation with a professional.

About the author

Ken H. Vanway is board certified in Estate Planning and Probate Law — Texas Board of Legal Specialization. Ken has over 20 years of experience. His firm practices in many areas of estate planning and lawsuit protection including wills, living trusts, insurance trusts, family partnerships, charitable trusts, private foundations and asset protection. For more information, please visit www.estateplanning.com/kenvanway.

closed claim studies

Failure to diagnose and alteration of medical records

by Barbara Rose, Risk Management Representative

Clinical presentation

A 50-year old female presented to the emergency room complaining of severe pain in her lateral rib area. She had a previous history of a lumbar discectomy, gastrectomy, NSAID abuse and a neck injury, which resulted in surgery. Her long-time family physician (the defendant in this case) had prescribed NSAIDs over the years until she was diagnosed with liver problems secondary to NSAID abuse.

Physician action

The patient's family physician left his clinic and came to the ER to see the patient. He examined her, gave her an injection for pain and ordered lab work. He told the patient she needed to go to another hospital in a nearby town by ambulance. He sent the lab work with the patient. The plaintiffs dispute she was instructed to go to the second hospital by ambulance and that the physician sent the patient's lab work. The patient refused an ambulance, went by private car, and was seen in the ER at a second hospital. The lab report showed up in the patient's chart at that hospital. An ER physician at the second hospital examined her and ordered a chest x-ray, which was normal. The ER physician did no lab work because the patient reported that her lab work done at the first ER was normal. The patient was admitted to the hospital that evening.

Three other physicians were consulted, and the patient was taken to surgery two days later for exploratory laparotomy. A perforated duodenal ulcer was diagnosed and closed. During surgery, she suffered a cardiac arrest but was rescucitated. The patient was pronounced dead that evening.

Allegations

- failure to diagnose the perforated duodenal ulcer.
- prescription of NSAIDs contributing to the condition

Legal principle

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

TMLT consultants were supportive of the family physician's care of this patient. He sent the patient on to a facility that could handle her situation, fully expecting her to be admitted through the ER.

There was criticism of this physician in not contacting the second hospital to relay information about the patient's condition. The lab work he ordered and sent with the patient showed dehydration and a 21.8k WBC. The physician says he tried to contact the second hospital, but there was no confirmation of this. He did not fax the lab results or follow up to ensure the patient arrived at the second hospital. However, if the family physician had communicated with the admitting physician, the only pertinent information he could provide was the information contained in the lab results.

The family physician admitted adding notes to the patient's chart sometime after she left the hospital, indicating instruction to go by ambulance to the second hospital. Plaintiff's counsel produced a copy of the ER record obtained from the hospital without a reference to the advice to transfer by ambulance. The copy provided by the defendant had the additional note.

Disposition

This case was settled for $72,500 on behalf of the family physician. The physician's failure to follow up and alteration of the medical record were major factors in the settlement in this case.

Risk management considerations

This physician's actions were appropriate according to a review by TMLT consultants. As so often happens, events have occurred that were not documented in a timely manner or not at all, and years later become a test of memory for all involved. Not documenting that the lab results were given to the patient, that efforts were made to reach the physician in the other city to expect notice from the Emergency Department of her arrival made verification of physician actions impossible.

The action that made this case difficult to defend was the late entry in the record regarding the physician's advice to the patient to travel by ambulance. A late entry or addendum are allowed in the medical record only with proper identification and the reason for the delayed entry. The entry must be clearly labeled as a "late entry" or "addendum" with the date it was done and a reference to the date concerned.

Completing the medical record notes for each patient in an accurate and timely manner assures a correct chronology of physician findings and actions. It reflects a commitment to best practice and quality patient care, and protects physicians when the record is reviewed pursuant to a claim. In the event of a malpractice claim, that comprehensive record becomes a physician's best defense.

Sailing in rough seas

by Marshall Wyatt, Senior Underwriter

When learning to sail, you develop trust in your vessel's capabilities. You also learn to keep an eye on the weather because of the effect sudden storms can have on your safety at sea. These disciplines are good for sailors, and these same disciplines also serve physicians well in today's medical malpractice coverage marketplace.

Has something like this happened to you? One morning recently, you met with colleagues for breakfast at the hospital and conversation turned to claims and medical malpractice insurance. Your friend is describing his surprise after getting his malpractice renewal policy… the price had almost doubled! He goes on to tell about his discussion with his agent. The agent told him that there was a "hard market" right now and the renewal premium was the best deal he could expect. What does this mean and does this have an effect on you?

A "hard market" ensues when most of the sellers of coverage begin increasing prices, restricting or declining coverage, implementing more rigid acceptability guidelines or any combination of these actions simultaneously. In times of extreme profit shortfalls, some companies will choose to leave the market entirely, so that they can utilize their assets elsewhere (perhaps in other lines of business or in other states) rather than continuing to participate in the unprofitable line of business. Their business plan may be that when the market conditions improve, they hope to reenter the market.

During the last several years, many malpractice companies have independently concluded that there is a "storm on the horizon." They perceive that the market in Texas is suffering from increasing claim activity due to several factors that modest rate increases alone will not correct. Some of these factors are a need for real medical liability reform, a need for more reasonable expectations by patients, a need for better patient education, a need for better record keeping by care providers and a need for better access to care. Many companies (including TMLT) believe that it is primarily these issues that are driving recent Texas claim results.

What does this mean to you? First of all, you should anticipate an increase in your renewal policy premium. If you are unfortunate and have suffered claim activity, you may find that your carrier imposes large premium increases, restricts your coverage or even non-renews your coverage. As markets for preferred coverage shrink, the options provided by standard and non-standard markets may become more attractive.

Some companies offer both "preferred" and "standard" programs for coverage. For example, TMLT policyholders with troubled claims experience may be given the option of continuing their coverage with Texas Medical Insurance Company. The TMIC premiums are higher and coverage may differ somewhat, but the same professionals who handle TMLT's claims handle TMIC claims. After a few years of improved experience, you can apply for coverage in TMLT's preferred market once again. Since the purpose of buying coverage is to protect your assets in the event of a claim, you should only accept coverage from companies in which you have confidence.

What else can you do? Take a careful look at your practice, your policy and the company that provides your coverage before you make any drastic changes. Perform a self-examination of your practice to determine if you can identify practices (such as record-keeping) that need to be updated.

You may find that your company offers educational and risk management programs that may even reduce your premiums. Additionally, these programs may meet continuing education requirements arising from other professional educational commitments, so you can often "double dip" with one course. TMLT offers several continuing education courses, some of which are available online. TMLT also offers an office practice review that costs you nothing other than a few hours of your time. In exchange for your time, our risk management professionals will visit your office and review various aspects of your practice and procedures with you and your staff. Both TMLT's practice review and continuing education coursework offer opportunities for policy premium discounts.

In conjunction with your "self examination" and after considering the information provided by your underwriter or agent, you may decide to change your activities or lower your policy's liability limits to seek lower premiums. You may find that a particular procedure you occasionally perform is the sole reason for your premium being much higher than it would be otherwise. We have found that in many cases, when our policyholders are aware of such circumstances, they often choose to cease the particular procedure because it is not an efficient use of their time and resources.

Establish a dialogue with your underwriter (or your agent) about your coverage. Ask questions about options that may be available to you. Your underwriter can keep you apprised of what the company is doing, what the company anticipates in the marketplace and opinions about what may happen in the near term.

Sometimes during the course of a hard market, physicians in groups may find that their group is promised lower premiums with other carriers. Such offers may be real opportunities, but be cautious when navigating around deals that sound too good to be true… often they are no deal at all. Ask questions about the company's plans and their commitment to your profession. Ask if they are satisfied that their current rates are adequate and ask about their long-range premium projections. Determine if the company really supports issues such as medical liability reform which impact your profession. Ask about their professional experience. Ask your peers if any of them have had any relationship with the company and, more importantly, ask your peers who have had claims if they were satisfied with the way the company handled their claims. TMLT is confident that when the value of all these issues is considered, coverage with TMLT will clearly be your preferred choice.

Just like a sailor, keep an eye on the storms and plan ahead. The sailing may be a little rough for a while; but if you chart a good course, there is smooth sailing ahead.

TMLT

the Reporter

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TMF education conference to focus on systems change

The Texas Medical Foundation will present "Change Strategies for Improving Health Outcomes," on Friday, November 2, 2001, at the Hilton Austin Airport.

Improvements in health outcomes can only be achieved through patient behavior change, changes in health care provider behavior, and changes in health care systems. Learn about different change theories and their application to health care, including a focus on improving outcomes for diabetes. These concepts can also be applied to efforts to reduce risk and liability.

The 2001 conference will feature James Prochaska, PhD, Director of the Cancer Prevention Research Center and Professor of Psychology at the University of Rhode Island. He has been principal investigator on more than $60 million in research grants on the prevention of cancer and other chronic diseases. In his presentation, "Transtheoretical Model of Change: A Stage Model of Behavior Change," he will address the stages of change along with the processes and principles for progressing through the stages.

The second speaker will be Reuben R. McDaniel, EdD, the Charles and Elizabeth Prothro Regents Chair in Health Care Management and a professor of Management Science and Information Systems at the University of Texas at Austin. His primary research areas are health care and organizational change. Dr. McDaniel will relate the management of organizational change to characteristics of complex adaptive systems, and identify specific strategies for managing complex change in his presentation "Changes in Systems and Individuals: Barriers and Strategies."

The final speaker is Sheldon Greenfield, MD, Professor of Medicine at Tufts University School of Medicine and Director of the Primary Care Outcomes Research Institute at the New England Medical Center. He pioneered research in increasing patient participation in care and using outcomes to determine the value of that participation. He is currently the chair of the Diabetes Quality Improvement Program and will discuss the need for adapting office systems and physician behavior to chronic disease management objectives, in his presentation "Improving Diabetes Outcomes: A Study in Changing Systems and Individuals."

General registration fee is $159 before October 15 or $199 after October 15. Registration fees are waived for TMF physician members. Employees of TMF physician members may attend for $99. TMF has applied for continuing education approval for physicians, including one hour of ethics credit. For more information, please visit the Texas Medical Foundation web site at www.tmf.org or call 1-800-725-9216 and ask for business development.