

The Doctor's Advocate

SECOND QUARTER 2009

IN THIS ISSUE:

PAGE 2

Lessons from Litigation

Who's in Charge?

PAGE 3

An Ounce of Prevention

Hospitalists: New Specialty
and New Risks

PAGE 4

Politically Speaking

Hedonic Damages

PAGE 5

Seeing Red (Flags)

PAGE 7

HIPAA: Round Two

PAGE 8

The Back Page

Industry and Company News

Who's in Charge?

by David B. Troxel, MD, Medical Director, Board of Governors



A 68-year-old female went to the hospital ED on May 8 complaining of left flank pain following recent removal of a left ureteral stone by lithotripsy. An intravenous pyelogram (IVP) was negative for stones, a blood culture grew *E. coli*, and a urine culture grew *E. coli* < 10,000 CFU/ml. She was placed on antibiotic therapy and continued on Coumadin for chronic atrial fibrillation.

On May 10 she was sent back to the hospital by her physician because of worsening left flank pain. She was afebrile, pulse 92, BP 130/70, and respirations 18. A complete blood count (CBC), urinalysis, and blood/urine cultures were ordered. She was admitted by hospitalist A with a diagnosis of probable acute pyelonephritis, placed on IV fluids, and given Dilaudid and Zosyn.

On May 11 the blood culture grew *E. coli*; the urine culture was negative. The urinalysis report was missing and wasn't reordered. That evening the patient fell in the bathroom, subsequently stating that her legs "gave way." The nurse reported this to on-call hospitalist B, who ordered fall precautions but did not examine the patient.

On May 12 at 11:00 AM, hospitalist A saw the patient and learned of the fall.

He assumed it was caused by the Dilaudid and reduced the dosage; he did not perform a neurological exam. At 12:30 PM she fell again, and hospitalist A ordered a head CT scan, which was negative; he did not see the patient. She was seen by physical therapy (PT) at 3:30 PM, who charted she was unable to stand and had diminished left lower extremity (LLE) strength (2/5 vs. 4/5 on the right).

At 5:30 PM the nurse charted that the patient was confused, incontinent, and complaining of severe pain in her back and legs. On-call hospitalist C was notified at 7:00 PM about the PT and nursing notes and gave a phone order to add Percocet and Haldol. At 9:45 PM a nurse charted that the patient had bilateral leg numbness, external rotation of the left leg, and "electric shock" pain in the groin. On-call hospitalist C examined the patient and charted that the patient had good strength in both legs with normal sensation.

On May 13 she complained of severe lower back and left thigh shooting pain. At 3:00 PM, PT charted that the patient was unable to complete her exercises because of pain and bilateral leg weakness. Hospitalist A was notified about the PT findings and ordered a lumbar spine x-ray, which was negative.

On May 14 at 12:15 AM the patient became more confused, hallucinated, could no longer lift her feet, complained of shooting pains in both legs, and was unable to plantar flex on the left. She remained incontinent. She was seen by hospitalist D, but her neurological status was not assessed. At 9:00 AM she was seen by hospitalist A, who noted that the international normalized ratio (INR) was 5.1. The Coumadin was discontinued, and she was given vitamin K. He consulted a neurologist by phone, and a stat cervical and thoracic spine MRI was ordered.

The neurologist saw the patient at 8:00 PM and felt she was developing a progressive T4 myelopathy. The stat MRI had not been performed, so he reordered it ASAP. His differential included epidural hematoma due to the episodes of falling with an INR of 5.1 and epidural abscess. On-call hospitalist D called a neurosurgeon, but the neurosurgeon was unwilling to operate because of the INR of 5.1 and the absence of an MRI.

At 10:30 PM the MRI was attempted, but the patient was unable to cooperate and the study was nondiagnostic. Hospitalist D called the neurologist but spoke with the on-call physician, who said a repeat MRI could wait until morning.

On the morning of May 15, an MRI showed discitis with osteomyelitis at T7-8, with an epidural abscess compressing the spinal cord. The patient was taken to surgery for spinal decompression and fusion. After a lengthy rehabilitation, she remained paraplegic with bowel and urinary incontinence.

What Is the Standard of Care?

Both defense and plaintiff experts opined that the patient had an epidural abscess at admission caused by the *E. coli* bacteremia, which probably originated from the urinary tract. The physicians failed to consider epidural abscess in their differential diagnosis—and to order an MRI of the spine and a neurology consult. The standard of care required the hospitalists to read nurses' notes and PT assessments and to conduct thorough neurological examinations to evaluate the evolving neurological deficits.

When the patient was admitted on May 10, hospitalist A failed to review the ED record containing the urine culture report < 10,000 CFU/ml and did not perform a neurological examination.

continued on page 6

“The hospitalist field has now become the fastest-growing specialty in the history of American medicine.”

—Susan Shepard, MSN, MA, RN, CPHRM, Kathleen Stillwell, MPA/HSA, RN, CPHRM, and Barbara Worsley, DMA

AN OUNCE OF PREVENTION

Hospitalists: New Specialty and New Risks

by Susan Shepard, MSN, MA, RN, CPHRM, Director, Patient Safety Education, Kathleen Stillwell, MPA/HSA, RN, CPHRM, Patient Safety/Risk Management Account Executive, and Barbara Worsley, DMA, Regional Assistant Vice President, Department of Patient Safety



Robin Diamond

This quarter Susan Shepard, Kathleen Stillwell, and Barbara Worsley discuss the risks of ineffective handoffs and outline ways to help maximize effective communication techniques.

—Robin Diamond, MSN, JD, RN; AHA Fellow—Patient Safety Leadership; Senior Vice President, Department of Patient Safety

Ineffective handoffs can lead to inappropriate treatment, delays in diagnosis, and potentially life-threatening adverse events. All of these elements came into play in the previous article, “Who’s in Charge?” a lesson from litigation by David B. Troxel, MD, medical director of The Doctors Company. Each of the hospitalists in the case study missed opportunities to diagnose the patient’s condition due to communication gaps and inattention to

documentation among the members of the health care team:

- Hospitalist B did not review the medical record and did not communicate to hospitalist A that the patient fell.
- Neither hospitalist A nor B examined the patient following the fall, and the fall was not communicated to hospitalist C.
- Hospitalist C did not communicate with either A or B about the patient’s inability to stand.
- Hospitalist D failed to communicate the urgency of the MRI to the on-call neurologist.

In “Who’s in Charge?” there are many examples of communication and handoff breakdowns that led to the patient injury. Because the hospitalists involved in the case study didn’t use a standard set of critical elements to be communicated with each handoff or interaction, there were delays in diagnostic testing and treatment and failures in recognizing the patient’s neurological deficits, which resulted in the unfortunate outcome.

By understanding the problems that can occur during handoffs and planning effective communications, the hospitalists in this case could have minimized risk and enhanced patient safety.

The Shift Toward Hospitalists

Over the last decade there has been a dramatic shift away from primary care-directed hospital care toward a model in which hospital-based physicians—hospitalists—provide care to inpatients.

In fact, the hospitalist field has now become the fastest-growing specialty in the history of American medicine, skyrocketing from 1,000 physicians nationally in the mid-1990s to more than 28,000 today.

Researchers at the University of Texas Medical Branch (UTMB) at Galveston have produced the first quantitative analysis of the increase in the number of hospitalists. In a paper appearing in the March 12, 2009, issue of the *New England Journal of Medicine*, UTMB Associate Professor Yong-Fang Kuo used Medicare data to calculate that the percentage of internal medicine physicians practicing as hospitalists jumped from 5.9 percent in 1995 to 19 percent in 2006.¹

Hospitalists and Effective Communication

The goal of the hospitalist medicine model is to provide a coordinated approach to the care of inpatients. This requires the hospitalist to be skilled in effective communication between physicians and the rest of the hospital clinical team involved in the care of the patient. The processes and systems within the hospital environment create potential barriers to effective communication, in areas including:

- Key information unknown or not passed along
- Poorly defined roles of hospitalist, admitting physician, and specialist(s)
- High volume of information arising from a multitude of sources
- Lack of standardization of processes within the facility

continued on page 7

Hedonic Damages

by Leona Egeland Siadek, Vice President, Government Relations



Plaintiffs often seek compensation for a category of loss known as hedonic damages. When arguing for hedonic damages, the plaintiff's attorney attempts to convince a jury that reduced or lost enjoyment of life can be objectively measured in dollars and that the value of the damages should be added to any recovery for medical costs, lost wages, or property loss.

This category of loss greatly increases indemnity payments and puts additional burdens on the tort system. If, for example, the hedonic value of a life is calculated at \$8 million and testimony shows there has been a 50 percent reduction or loss in the value of that life, the hedonic damages would be \$4 million.

Assigning a dollar value to hedonic damages is widely disputed. Some experts claim to be able to calculate the value of hedonic damages while others have conducted studies that undercut the credibility of pricing hedonic damages.

Court observers believe that hedonic damages first emerged in 1987 as a theory of recovery during testimony by economist Stan V. Smith in *Sherrod v. Berry*, 827 F.2d 195. A frequently cited article weighing in on the side of hedonic

damages is "The Plausible Range for the Value of Life—Red Herrings Among the Mackerel" by Ted R. Miller published in the *Journal of Forensic Economics* in 1990. At the time, Miller put the value of life's enjoyment at between \$1.5 and \$3.5 million. This figure has gone as high as \$8 million in more recent years.

Testimony claiming a dollar amount of the value of life falls short of the Daubert standards for scientific evidence. In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 113 S. Ct. 2786 (1993), the Supreme Court said that the trial judge has to decide whether the evidence offered by expert testimony is based on reasoning or methodology that is scientifically valid.

Various state court discussions from 1994 to 1996 have found hedonic damages testimony severely inadequate. Courts nationwide have allowed testimony, but judges have discretion as to the testimony's admissibility. Some states, including Arkansas, Connecticut, Georgia, Hawaii, and New Hampshire, allow recovery for hedonic damages in wrongful death cases. In Kentucky, William Gregory, who was convicted and later exonerated, won \$4.5 million in hedonic damages after serving seven years in prison. A similar case in Texas paid \$385,000 to an inmate of 15 years.

There is no insurance basis in the tort system for providing compensation for hedonic losses. People are usually not willing to purchase insurance for lost future pleasure of life. Nevertheless, formulas presented in court are based on the willingness-to-pay (WPT) concept. This would be the amount of money a person pays to purchase such things as smoke or carbon monoxide detectors or dead bolt locks. Somehow experts can, from this, extrapolate the value a person places on his or her life.

Hedonic damages experts are vague about how they arrive at the values they put on life, but the way they evaluate claims is clear. Most claims require a psychological evaluation to help determine the percentage of loss of enjoyment sustained. The experts look at the plaintiff's functioning levels for social emotional and occupational pursuits, his or her ability to do daily tasks, and the ability to live without problems, to make independent choices, and to interact with others.

Recently, *Quintero v. Rodgers*, 543 Ariz. Adv. Rep 29, was heard by the Arizona Court of Appeals Division One. The contention was made in this case that hedonic damages survive the death of a patient. The outcome was favorable to the defense, and, so far, the Arizona Supreme Court has not accepted a review of this issue.

In legislation, hedonic damages have surfaced in connection with wrongful death acts where each type of recovery is spelled out and in tort reform bills where there is a list of what constitutes noneconomic damages (pain, inconvenience, impairment, anguish, disfigurement, and loss of enjoyment, society, or consortium).

Clearly, examples exist in medical care where services and products decrease a consumer's total exposure to the risk of dying from a disease. But the services and the products used are still subject to malpractice liability. Hedonic damages would fit into the category of noneconomic damages. Without a cap on noneconomic damages and without a finite way to determine the value of the items listed within the category, the amount of damages requested continues to be whatever the plaintiff's attorney can convince the jury is adequate. This amount will depend more upon the extent of injury than on whether

continued on next page

continued from previous page

the result was due to negligence or a less-than-expected outcome.

Federal Issues

The Office of Health Reform was established in early April by executive order from the White House. The stated purpose of the office is to coordinate the development of health reform policy and integrate the policies adopted in all departments and agencies. Nancy-Ann DeParle, President Obama's White House health care adviser, will be the new director. DeParle served as head of the Health Care Financing Administration in the Clinton administration and has most recently been a fellow at the Institute of Politics at Harvard's John F. Kennedy School of Government.

Congress has remained focused on the economic stimulus package. A total of \$20 billion was approved for "health information technology initiatives," but details on the implementation of these initiatives have not been released.

Increasing the number of Americans with health insurance coverage is a major

element of the federal budget for 2009. The House plans to have a health care reform package ready for debate and vote by August. It is expected that the House Energy and Commerce and the Ways and Means Committees will hold public hearings prior to that time. The Senate leadership initiated individual discussions with key senators and specific interest groups to seek opinions for their version of a health care reform compromise package.

In an April letter to President Obama, the American Medical Association outlined its suggested eight goals for health reform: protecting families' financial health, making health coverage affordable, aiming for universality, providing portable coverage, guaranteeing choice, investing in prevention and wellness, improving patient safety and quality, and maintaining long-term fiscal sustainability.

Congress has three medical liability reform proposals to consider this session. Senator John Ensign (R-NV) authored S.45, and Representative Phil Gingrey (R-GA) authored H.R.1086; both bills

propose California's model of a medical liability statute. Representative Michael Burgess (R-TX) authored H.R.1468, which would adopt the Texas model of medical liability reform. The Doctors Company supports all three measures.

On another front, the Office of Inspector General has announced that it has expanded its search for providers involved in improper agreements with device makers or drug companies. Conviction will result in removal from Medicare and Medicaid as well as criminal penalties.

State Issues

State actions are under scrutiny by The Doctors Company's Government Relations Department. Currently we are fighting against negative bills in at least six states: California, Colorado, Nevada, Oregon, Texas, and Washington. Some positive legislation is pending in a few states. We will provide a detailed report on state bills in the next issue of *The Doctor's Advocate*. ■

Seeing Red (Flags)

In November 2007, the Federal Trade Commission (FTC) issued rules requiring "creditors" to develop practices to identify and act on "red flags" signaling theft of consumers' personal information. In a controversial decision, the FTC determined that most physicians qualify as creditors under the Red Flags Rule. According to the FTC, "the definition of 'creditor' is broad and includes businesses or organizations that regularly defer payments for goods or services or provide goods and services and bill customers later."

The new requirements, which take effect on August 1, 2009, have spawned an intense lobbying effort to move the FTC from its position. Legislation and litigation challenging the FTC's process

for enacting the rules as they pertain to physicians remain possibilities.

Until the situation changes, physicians should plan to comply by having "reasonable policies and procedures in place." What constitutes "reasonable" will depend on the physician's specific situation.

Physicians have a number of resources available to help them develop simple identity theft prevention and detection systems that comply with the new requirements. The FTC's Web site provides guidelines, and the American Medical Association's site includes a sample policy and checklist of possible procedures. The Red Flags Rule requirements are not complex, and most practices should think carefully before purchasing services from vendors offering compliance assistance.

Compliance for most physicians will mean taking additional time to review and implement procedures that will largely overlap with the protections and practices currently in place to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you have questions about the Red Flags Rule, please contact our Patient Safety Department at (800) 421-2368, extension 1243.

Additional Resources:

www.ama-assn.org/ama/no-index/physician-resources/red-flags-rule.shtml
www.ftc.gov/redflagsrule

On May 11 he failed to reorder the missing urinalysis, which would not have supported the diagnosis of acute pyelonephritis—and when the admission urine culture was negative, he should have considered the possibility of epidural abscess. On May 12 he failed to examine the patient after receiving a call about the second fall and failed to conclude that the patient was deteriorating neurologically.

Hospitalist B failed to review the chart and nursing entries from admission and the ED visit. He should have examined the patient on May 11 when her legs “gave way” and she fell.

Hospitalist C should have examined the patient when first notified on May 12 of her 2/5 LLE weakness and bowel and bladder incontinence. When he examined her later that night, he failed to detect the neurological deficits in her legs.

Hospitalist D’s failure to do a neurological assessment, order an MRI, and obtain a neurology consult after midnight on May 14 delayed the diagnosis by nine hours, thereby decreasing the patient’s chance to regain neurological function.

Should This Claim Be Tried?

While the admission diagnosis of acute pyelonephritis was reasonable, the urine culture was negative, and when the pain became more severe and progressive neurological symptoms developed, spinal epidural abscess should have been considered. An MRI of the spine and a neurology consultation would have led to the diagnosis, and definitive treatment could have been performed prior to developing irreversible neurological deficits. Despite progressive neurological findings, the insureds failed to order an MRI or neurology consult until May 14. Defense expert reviews were nonsupportive for both the standard of care and causation. At the hospitalist group’s request, the claim was settled within their policy limit.

What Can Be Learned from This Claim?

Spinal epidural abscess (SEA) requires prompt diagnosis and treatment to

prevent serious neurological complications. While infrequently encountered in clinical practice, SEA is not infrequently seen in malpractice claims. The alleged negligence is usually a delay in diagnosis resulting in paraplegia with urinary and/or bowel incontinence. The delay typically results from failure to consider SEA in the differential diagnosis in a patient with progressive neurological deficits and severe low back pain. Some claims result from a delay in obtaining an MRI when SEA is considered, either because the hospital doesn’t have an MRI and there is delay in transferring the patient to another facility or because an MRI can’t be done at night or on weekends.

SEA is rare among the many causes of back pain. Fever is an important diagnostic clue because it is not present in most cases of musculoskeletal back pain, such as herniated disc. Fever in a patient with severe, localized back pain, especially if the pain is worsened by percussion, suggests the diagnosis of SEA. Routine laboratory studies are seldom helpful; the leukocyte count may be elevated or normal. Once the diagnosis is considered, spinal imaging is imperative. MRI is preferred because it is positive early in the infection. CT scanning with gadolinium contrast is an acceptable alternative. Plain radiographs of the spine may reveal osteomyelitis or discitis but are rarely diagnostic of SEA.

The classical diagnostic triad consists of fever, spinal pain, and neurological deficits. However, few patients have all three components at presentation. Over time, if untreated, symptoms progress in a typical sequence:

- *Back pain*, often focal and severe, then
- *Root pain*, described as “shooting” or “electric shocks” in the distribution of the affected nerve root, then
- *Motor weakness, sensory changes, and bladder or bowel dysfunction*, and then
- *Paralysis*, which may quickly become irreversible. Irreversible paraplegia occurs in up to 22 percent of patients, and recovery is unlikely if paralysis is present for more than 24 hours prior to surgery.

SEAs typically begin in the thoracolumbar spine as an infection involving the vertebral disc or the junction between the disc and the vertebral body. The abscess then extends longitudinally in the epidural space, and damage to the spinal cord results from direct compression, thrombophlebitis of epidural veins, or interruption of the arterial blood supply.

Epidural catheter placement is a common risk factor for SEA (risk is lower when catheters are placed for short time periods). Other risk factors include diabetes mellitus, HIV infection, trauma, tattooing, acupuncture, local spinal injections, and bacteremia secondary to distant infection or intravenous drug use.

The approximate frequency of the bacterial causes of SEA (excluding mycobacteria) is *Staphylococcus aureus*, 63 percent; Gram negative bacilli, 16 percent; *Streptococci*, 9 percent; coagulase-negative staphylococci, 3 percent (mostly in patients with prior spinal instrumentation); and anaerobes, 2 percent.

Approximately one-third of patients have no identifiable source for the infection. Among the two-thirds with an identifiable portal of entry, the most common sites are infections of the skin and soft tissues and complications of spinal surgery or other invasive procedures, including epidural catheters left in place for pain control. Up to one-third arise from hematogenous infection. With SEA, the approximate frequency of positive cultures in abscess contents is 90 percent; venous blood, 62 percent; and cerebrospinal fluid (CSF), 19 percent (Gram stain of CSF is usually negative). Surgical decompression and drainage with systemic antibiotic therapy is the treatment for most patients. ■

Reference:

The following reference is from *UpToDate*, Rose BD (Ed), UpToDate, Waltham, MA 2008. Copyright 2008 UpToDate, Inc. Accessed on March 16, 2009. For more information, visit www.uptodate.com.

Durack DT, Sexton DJ. Epidural abscess.

AN OUNCE OF PREVENTION

continued from page 3

In fact, studies have indicated that lack of communication is the single most common root cause that can lead to liability claims. However, all of the above concerns can be minimized with effective communication techniques and processes.

Handoffs

The primary objective of a handoff is to provide accurate information about a patient's care, treatment, current condition, and any recent or anticipated changes. Handoffs are *interactive* communications allowing the opportunity for questioning between the provider and the recipient of patient information. For hospitals, the handoffs that occur during the time when a patient is moved to another unit, sent for a diagnostic test, or transferred to a new physician can create continuity of care issues.

Hospitalists can use the following tips to improve effective communication during handoffs.

Tips for Effective Handoff Communication

- Use standardized communication tools such as the mnemonic "HANDOFFS."²
- Allow interactive communication for questions/discussion and require repeat-back of the exchanged information.
- At a minimum, include the following during handoffs: diagnoses, current condition, recent changes in condition or treatment, anticipated changes, and warning signs of changes in the patient's condition.
- Limit interruptions during handoffs.
- Use the following questions for guidance in organizing communication during the handoff:
 - What is important to communicate?
 - Who needs to know what information?
 - When should communication occur?
 - How should the information be transmitted?
 - How can I validate the communication was successful?

Conclusion

The hospitalist is responsible for the co-management of patients involving a wide range of physicians and other clinicians. It is critical for the hospitalist to communicate effectively with the health care team, the patient, and the patient's family to limit risks and enhance patient safety. ■

References

1. Kuo Y, Sharm G, Freeman J, Goodwin J. Growth in the care of older patients by hospitalists in the United States. *N Engl J Med*. 2009;360(11):1102-1112.
2. Brownstein A, Schleyer A. The art of HAND-OFFS: a mnemonic for teaching the safe transfer of critical patient information. *Resident and Staff Physician* [serial online]. 2007;53(6).

Additional Resource

The Institute of Healthcare Improvement: www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral

HIPAA: Round Two

As part of the recently enacted federal stimulus package, a number of aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were amended. The most significant change was to expand sanctions to business associates for noncompliance. Penalties for failing to comply with HIPAA were also substantially increased, and the prospect of requiring some form of encryption for medical records in some practices appears to have increased significantly. The Secretary of Health and Human Services is directed to work with stakeholders over the next 18 months to develop standards.

Also added are breach notification requirements that will overlay the current patchwork of state patient notification laws. The notification requirement rests with the covered entity even if the breach involves protected health information entrusted to a business associate. The

media must be notified of breaches involving 500 or more patients. All breaches must be reported to the Secretary of Health and Human Services, who will maintain a log and post a list of breaches involving 500 or more individuals.

For practitioners who have been covered entities since HIPAA was first enacted, life will not change dramatically. Practitioners may find that third parties with whom they share protected health information (PHI) become more scrupulous in complying with requirements. This would be the salutary effect of increasing potential fines and extending the penalties to business associates.

While a number of significant fines have been assessed for failure to comply with HIPAA, they have generally been directed at larger entities in cases involving significant breakdowns. For example, earlier this year, CVS, the nation's largest retail pharmacy chain, agreed to pay the

government \$2.25 million and to take corrective actions following an investigation by the Office for Civil Rights. The investigation revealed that many of CVS's more than 6,000 retail pharmacies violated the HIPAA Privacy Rule by throwing pill bottles bearing patient information into dumpsters that could be accessed by the public.

Practitioners should ensure that HIPAA training and processes are in place. With the overlay of new requirements and any turnover in staff, it is a good time to ensure that your practice is still complying with HIPAA as effectively as when it was first promulgated more than five years ago. HIPAA has been and will likely remain a significant component of the practice of medicine.

If you have questions about HIPAA, please contact our Patient Safety Department at (800) 421-2368, extension 1243.

ABOUT US

The Doctor's Advocate is published by The Doctors Company to advise and inform its members about loss prevention and insurance issues.

The guidelines suggested in this newsletter are not rules, do not constitute legal advice, and do not ensure a successful outcome. They attempt to define principles of practice for providing appropriate care. The principles are not inclusive of all proper methods of care nor exclusive of other methods reasonably directed at obtaining the same results.

The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

The Doctor's Advocate is published quarterly by Corporate Communications, The Doctors Company. Letters and articles, to be edited and published at the editor's discretion, are welcome. The views expressed are those of the letter writer and do not necessarily reflect the opinion or official policy of The Doctors Company. Please sign your letters, and address them to the editor.

The Doctors Company
185 Greenwood Road
PO Box 2900
Napa, CA 94558-0900

(800) 421-2368
info@thedoctors.com

The Doctor's Advocate
©2009 The Doctors Company
All rights reserved.

www.thedoctors.com/advocate

To view this publication online, to see past issues, or to subscribe to this publication via e-mail, visit us at www.thedoctors.com/advocate.

2009 Dividend Declared

The Board of Governors has declared that beginning in July, eligible members will receive a dividend credit toward their policy renewals.

The dividend credit will provide a premium reduction to members in Colorado, Florida, Georgia, Idaho, Maryland, Ohio, Oregon, Virginia, Washington, and Wyoming. Members in eligible states who belong to the national specialty organizations that endorse or sponsor The Doctors Company will receive a dividend in addition to their extensive program benefits.

Our multiyear dividend is just one way we recognize and reward our members for their loyalty and partnership.

Ronald H. Wender, MD, FACA, Appointed to Board of Governors

We are pleased to announce the appointment of Ronald H. Wender, MD, FACA, to The Doctors Company's Board of Governors.

A Los Angeles-based anesthesiologist, Dr. Wender is co-chairman of the Department of Anesthesiology at Cedars-Sinai Medical Center, where he also serves as academic chair of the Cedars-Sinai anesthesia residency program and director of anesthesia training programs. He is a diplomate of the American Board of Anesthesiology, fellow of the Federation of State Medical Boards, and former president of the Medical Board of California.

Prior to joining The Doctors Company's Board of Governors, Dr. Wender served on the Board of Directors of SCPIE Holdings, Inc.

"Dr. Wender is a recognized leader in the field of anesthesia. His extensive research has been documented in numerous publications and presentations," said Richard E. Anderson, MD, FACP, chairman and CEO of The Doctors Company. "His unique combination of medical expertise and medical liability insurance knowledge will further our company's goals to aggressively defend claims and advance leadership in patient safety."

"I am proud to join the board of the largest and most respected physician-owned medical liability company in the nation," added Dr. Wender. "I look forward to using my years of experience to make a contribution to The Doctors Company and its 45,000 members across the country."

New Exclusive Endorsement

We are proud to announce that The Doctors Company has received the exclusive endorsement of the Ohio State Medical Association (OSMA) as the preferred medical liability insurer for its membership.

"We appreciate that the OSMA recognizes The Doctors Company's long-standing commitment to the Ohio physician marketplace. With the largest professional liability staff dedicated exclusively to the state's physicians, we deliver unparalleled service, aggressive legal defense, and member benefits no other insurer can match," said Thomas G. Luffy, regional vice president of underwriting for The Doctors Company.

For more on the OSMA's endorsement of The Doctors Company, visit our Press Room at www.thedoctors.com/news.

Physician Advisory Board Expands to Georgia

Georgia physicians recently gathered for the first Georgia Physician Advisory Board meeting, held in Atlanta. The physicians represented various specialties, including obstetrics and gynecology, internal medicine, and family practice. Three cases were presented by panel members, and defense counsel led a discussion on how standard of care and causation would apply. One case involving complex interaction of multiple prescribed narcotics created a vigorous debate. The panel members provided valuable insight into medical causation.

Defense counsel also provided the board members with an overview of Georgia tort reform, and Patient Safety's Susan Marr highlighted the case studies and outlined strategies to prevent malpractice claims.

Georgia's new Physician Advisory Board is off to a lively start. We look forward to future meetings.

Paying Tribute® to Members

Our innovative Tribute Plan is a financial benefit that rewards members for their continuing loyalty to The Doctors Company and for their commitment to providing outstanding patient care.

We have distributed career rewards to approximately 435 qualifying members.

You can check your personal award balance or learn more about the Tribute Plan at www.thedoctors.com/tribute.