

# The Doctor's Advocate

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## A Patient with Chronic Atrial Fibrillation

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



This 52-year-old female was diagnosed with hypertension in May 2000 (BP 144/116) by her primary care physician (PCP) and placed on a low dose of hydrochlorothiazide. After starting an exercise program in 2001, her blood pressure returned to normal.

In August 2001, the patient was scheduled for minor surgery, and a pre-operative EKG revealed atrial fibrillation (AF). She was referred to a partner of our insured cardiologist, who placed her on Coumadin prior to elective cardioversion. This was initially successful but lasted only a short time. In October, she was seen by our insured cardiologist with complaints of fatigue. Her blood pressure was normal. In consultation with another associate, an electrophysiologist, the Coumadin was continued, and she underwent two cardioversions. After loading and then increasing the dose of Rythmol (propafenone), she returned to normal sinus rhythm (NSR), but only briefly.

In January 2002, she returned to the insured's associate electrophysiologist. She was in AF and was very fatigued, but

he was reluctant to treat her with amiodarone because of potential side effects. She continued on Coumadin and failed to keep her six-month follow-up appointment. In April, she saw her PCP and was in NSR. Her International Normalized Ratio (INR) was 2.0, and she remained on Coumadin. Ablation was discussed, but she refused because it wasn't covered by insurance.

In October, she saw a new arrhythmia consultant in a different cardiology practice. She was in AF, and he started her on flecainide 50 mg twice daily. Three weeks later the dose was increased to 100 mg twice daily. When seen again in December, she was in NSR with a rate of 60. She remained on flecainide, but the Coumadin was stopped. When next seen by this consultant in October 2003, she remained in NSR, and he advised her to stay on flecainide and return in one year. She returned in May 2005 in NSR and was continued on flecainide.

When she returned in February 2006, she was in AF. He prescribed Coumadin 5 mg daily for the next three days and referred her for a transesophageal echocardiogram (TEE) with immediate cardioversion if the TEE was negative for thrombi. She was instructed to return in one week. She did not keep the TEE appointment and apparently did not take the Coumadin because five days later her prothrombin time was normal and the INR was 1.1. Three days later, she returned to her PCP in AF. When she refused cardioversion or hospital admission, he advised her to find another PCP and to see a cardiologist.

### What Would You Have Done?

The patient returned to our insured cardiologist a few weeks later. She had not

seen him since 2001. She was in AF and said that sometimes her heart rate was too fast. The insured recommended pulmonary vein ablation, stating that it had a 60 percent success rate in eliminating AF. He did not believe she was a candidate for Coumadin because she was less than 60 years of age and did not have clinical or echocardiographic evidence of heart disease ("lone AF"). He calculated her CHADS<sub>2</sub> stroke risk assessment score\* as 0. He felt she fell into the category of "low-risk atrial fibrillation," for which the treatment would be either aspirin or nothing. She was given a prescription for Tenormin (atenolol) to control her heart rate, and when she left the office, she was in NSR. A referral was made for the vein ablation procedure. Two days later, she returned to the insured for a stress test and echocardiogram. Both were normal, and she remained in NSR. The insured never heard from the patient again.

Eight days later, she was admitted to the hospital with a stroke. She now has residual left-sided weakness, limited use of her left upper extremity, left-sided visual impairment, memory loss, and cognitive deficits.

### Expert Opinions

**Plaintiff:** A board certified cardiologist opined that failure to administer anti-coagulant therapy was below the standard of practice.

**Defense:** The case was reviewed favorably by a board certified cardiologist. He opined that the patient's young age, coupled with the lack of structural heart disease, qualified her as having lone atrial fibrillation, for which Coumadin anti-coagulation is not generally recommended and aspirin's effectiveness

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\* CHADS<sub>2</sub> (Cardiac Failure, Hypertension, Age, Diabetes, Stroke) is a stroke risk assessment scheme. The CHADS<sub>2</sub> risk index is based on a point system in which two points are assigned for a history of stroke or TIA and one point each is assigned for age over 75, history of hypertension, diabetes, or recent heart failure.

“It is imperative for physicians to be clear to their patients regarding the status of their relationship.”

—Arlene Luu and William J. Oetgen, MD, MBA, FACC

## AN OUNCE OF PREVENTION

# Examining the Provider’s Role

by Arlene Luu, JD, RN, Regional Patient Safety Risk Manager, and William J. Oetgen, MD, MBA, FACC, Clinical Professor of Medicine, Division of Cardiology, Georgetown University, Washington, DC



Robin Diamond

*As a follow-up to Dr. Troxel’s article, Arlene Luu and Dr. Oetgen examine the consulting provider’s role and the risk management and patient safety issues brought to light by the case.*

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

According to a 2008 Physician Insurers Association of America (PIAA) report, the most prevalent misadventures\* for cardiovascular specialists include errors in diagnosis, improper performance of a procedure, failure to supervise or monitor a case, and medication errors.<sup>1</sup> In the preceding *Director’s Forum* article by Dr. Troxel, “A Patient with Chronic Atrial

Fibrillation,” the highlighted case primarily presents the issue of failure to properly supervise or monitor the care of a patient† with the chronic and long-term medical condition of atrial fibrillation.

The case also presents the issue of a consulting provider’s role in the management of a patient’s medical condition. A consulting provider can be involved in the care of a patient for short-term, acute, or episodic management or for long-term management of a chronic condition.

Whatever the level of involvement, the provider must be aware that, once he or she has entered into the physician-patient relationship and there is no evidence that the relationship has ended, he or she owes a duty to the patient to provide care that is within the accepted standard of practice. Moreover, the relationship will continue to exist as long as the patient has a reasonable belief that the physician will provide the necessary medical care to the patient.<sup>2</sup>

The American Medical Association’s Council on Ethical and Judicial Affairs opined that with regard to the physician-patient relationship, “the physician is required to use sound medical judgment, holding the best interest of the patients as paramount.”<sup>3</sup> For the stated reasons, it is imperative for physicians to be clear to their patients regarding the status of their relationship.

The case highlighted by Dr. Troxel also raises a number of risk management

and patient safety issues that merit attention. These issues include adherence to accepted practice standards, appropriate monitoring and follow-up, documentation, and communication.

### Adherence to Accepted Practice Standards

In the prior case, Dr. Troxel noted that the patient was assigned an inaccurate score for the stroke risk, which could have contributed to the provider’s decision not to place the patient on anticoagulation therapy.

As a general rule, providers should stay current with accepted standards of practice for their respective specialties. Membership in the American College of Cardiology and participation in ongoing continuing education programs assist providers in staying current.

### Appropriate Monitoring and Follow-Up

Once the physician-patient relationship has been established, the physician owes a duty to the patient to exercise reasonable care in the treatment of the patient. A breach of duty can be alleged where there has been improper monitoring or follow-up of a patient’s care.

In this case, it could be alleged that our physician failed to properly monitor and follow up with a patient with a chronic “unstable” atrial fibrillation as evidenced by the fact that there was an over four-year

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\* According to the PIAA, a medical misadventure is a descriptive terminology relating to alleged principal departure from accepted medical practice, such as Surgical Foreign Body Left in Patient after a Procedure.

† The PIAA has identified these common conditions involving the failure to supervise or monitor a case: coronary atherosclerosis, acute myocardial infarction, chest pain, not further defined, heart failure, and atrial fibrillation and flutter.

## 2009 in Review

by Sal Bianco, Director, and Hal Dasinger, Director, Government Relations



Leona Egeland Siadek

*During 2009, budget problems dominated state legislative agendas across the nation. Much of our focus was on proposals for federal health care legislation. In addition, a number of important cases reached state supreme courts, and a number of important bills were considered by state legislatures. We highlight some of these below. For more information about medical liability and government, please contact the Government Relations Department at [GovernmentRelations@thedoctors.com](mailto:GovernmentRelations@thedoctors.com) or (800) 421-2368.*

—Leona Egeland Siadek  
Vice President, Government Relations

### Congress

The Doctors Company has been working to insert tort reform into the various health care reform bills in both the House and the Senate and to prevent the creation of new liability. Our staff, our DC lobbyists, and our coalition partners have focused thousands of hours on the health care bills since early spring of 2009.

We have provided language and supporting materials for a variety of effective provisions, including periodic payments and collateral source offsets, to members in both houses who support liability

reform. Early in the process, we assisted a pro-reform member who offered an amendment to the House bill providing for a \$250,000 cap on noneconomic damages. That amendment was ruled “not germane” and was set aside without a formal vote.

While early attempts to amend the bills to include meaningful and effective liability reforms were, unfortunately, defeated, we were successful in convincing a key House member that any practice guidelines or payment protocols established in the legislation should not expand provider liability by creating new standards of care.

Because our efforts with leaders in the Senate to try to include similar language in the Senate bill were not as successful, our focus now is the process by which the House and Senate versions become a single, final proposal. At the time this article is being written, it appears that the Congress will use informal negotiations rather than a conference committee process to arrive at a final bill.

We will fight to keep our preferred language in the bill during the negotiation stage and will report the results of our efforts in an upcoming issue of the *Advocate*.

### States

As in many states, budget woes pre-occupied the *California* legislature during 2009. No medical liability proposals were introduced, although AB 542 (Feuer-D) drew opposition from The Doctors Company, the California Medical Association, and other advocates of liability reform. The bill dealt with payment for so-called “never events,” errors in the provision of health care services that should never happen. A prominent plaintiff-side law firm’s Web site calls the “never event”

scenario a perfect training ground for inexperienced attorneys. The bill was put on hold.

The Medical Injury Compensation Reform Act (MICRA), California’s landmark medical liability reform, survived a direct challenge on state and constitutional grounds. When the state supreme court refused to review *Van Buren v. Evans*, it essentially endorsed the appellate court’s ruling that MICRA did not violate the plaintiff’s right to a jury trial or to equal protection and did not infringe on the separation of powers. The court described the plaintiff’s argument that MICRA conflicted with public policy as “meritless.”

Another constitutional challenge to MICRA has been filed with the same court that ruled in favor of MICRA in 2009 in *Van Buren v. Evans*. The plaintiff argues that the liability insurance crisis that provided the rational basis for the legislature to pass MICRA no longer exists, and is unlikely to recur because of rate control by the insurance commissioner established by Proposition 103. The case is *Stinnet v. Tam*.

The surprise announcement that *Colorado* Governor Bill Ritter will not run for re-election in 2010 may have implications for that state’s medical liability limits. The Doctors Company has helped defeat bills to drastically increase the cap on noneconomic damages in the last two legislative sessions. Ritter, a Democrat, initially supported efforts to increase the cap. The governor’s late announcement could help a Republican win the office and may add urgency to the personal injury lawyers’ push to get a bill passed in 2010.

The *Florida* Fourth District Court of Appeals in *Raphael v. Shecter*, 18 So. 3d 1152 (2009), ruled that the state’s

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## Introducing CyberGuard<sup>SM</sup>

We are pleased to introduce CyberGuard, a new addition to your medical liability policy and the industry's first complimentary cyber liability coverage.

As policies renew in 2010, our solo and small group members will automatically receive our exclusive CyberGuard benefits.

As a member-driven company, we believe that you are best served when we combine our national strength with our strong local presence. This dual perspective helps us to identify emerging risks and develop innovative solutions to help you address the ever-increasing demands of modern medical practice.

We developed CyberGuard in response to the proliferation of state and federal regulatory changes related to both financial and medical information. For example, as of January 2010, over 45 states have specific laws or regulations requiring patient notification in the event of an actual or apparent breach of medical data, even when it is not the physician's fault.



The federal "Red Flags" rule, set for enforcement by the Federal Trade Commission after June 1, requires customer notification in the event of a financial data breach. CyberGuard will protect you from the financial consequences of these legal changes and relieve you of some of the administrative burdens associated with complying with these rules.

We have also seen a significant increase in media fascination and coverage of breaches, particularly in the health care sector. Whether the case is one of a stolen laptop, an unauthorized employee accessing celebrity patient information, or hackers intruding on a practice network, negative publicity is a distraction at best and a financial peril at worst.

We will mail information regarding this coverage to you subsequent to your renewal in 2010.

To learn more about this complimentary coverage, contact your agent, call The Doctors Company at (800) 421-2368, or visit [www.thedoctors.com/cyberguard](http://www.thedoctors.com/cyberguard). ■

### CyberGuard Provides You with Protection in Four Important Areas

**Patient notification and credit monitoring costs insurance** provides coverage for legal, public relations, advertising, and postage expenses incurred to notify patients of a breach of medical or financial information. In the event of a financial breach, it will also pay the cost of credit monitoring coverage for all affected persons.

**Network security and privacy insurance** provides a legal defense and payment of damages in the event of a claim against you related to breach of privacy or failure to prevent identity theft. It will also protect you if your practice network is used to attack another network with a virus, denial of service attack, and more.

**Regulatory coverage** provides for your defense of an alleged "Red Flags" violation, HIPAA privacy, or other investigation by a government agency resulting from a regulatory breach. It also covers regulatory fines and penalties.

**Data recovery costs insurance** pays costs required to recover or replace data that is compromised, damaged, erased, or corrupted.

### POLITICALLY SPEAKING

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cap on damages could not be applied retroactively. However, the decision did not address the constitutionality of the cap.

In 2009, Florida enacted Senate Bill 2252 (Baker-R). The bill defines when a claim exists and creates new reporting criteria for medical malpractice carriers, eliminating duplicative claims reports and improving the claims data collected by regulators. The Doctors Company supported the bill.

The Doctors Company is supporting 2010 legislation proposing sovereign immunity for emergency room physicians and is opposing any bills jeopardizing

the current physician-patient arbitration process.

Georgia's 2009 legislative session saw no further erosion of enacted medical liability reforms. The 90-day 2010 regular session has commenced. The state budget shortfall dominates legislative deliberations, leaving little time to debate tort reform.

The Georgia State Supreme Court has heard arguments in two pending challenges to the state's reform laws. In *Pottinger v. Smith*, 293 Ga. App. 626, 667 S.E. 2d 659 (2008), the court will decide whether evidence of gross negligence is required to claim negligence against an

emergency room physician, as the statute now requires. In *Atlanta Oculoplastic Surgery v. Nestlehutt*, the court will decide an appeal of a February 2009 trial court ruling that the \$350,000 cap on noneconomic damages is unconstitutional.

The state supreme court in *Kansas* heard oral arguments in October 2009 in a direct challenge to the state's \$250,000 cap on noneconomic damages. The court has not indicated when it will issue a decision.

The *Ohio* State Supreme Court issued two favorable decisions in 2009. In *Hodesh v. Korelitz*, 2009 Ohio 4220, the court decided that "high-low

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remains controversial. The fact that she frequently was in NSR decreased her embolic risk further. He stated the standard of care did not require use of anticoagulant therapy.

A board certified cardiologist specializing in cardiac electrophysiology was initially critical of not putting the patient on Coumadin because her history of hypertension took her out of the lone atrial fibrillation category and out of the low-risk group for thromboembolism as defined in the risk-stratification scheme in the 2001 *Guidelines for the Management of Patients with Atrial Fibrillation*.<sup>1</sup> However, on reflection he stated that physicians must consider each patient individually to decide if a history of hypertension is clinically significant because anticoagu-

and history of hypertension) to guide anticoagulant therapy. New guidelines released in August 2006 include additional risk factors for stroke (previous stroke, TIA or embolization, mitral stenosis, prosthetic heart valve, and heart failure) without mention of history of hypertension. The 2001 guidelines apply to this case because the insured initially saw the patient in October 2001, at which time he continued her Coumadin and next saw her in March 2006, when he did not. The insured's office records document her history of hypertension—so her CHADS<sub>2</sub> stroke risk score was 1 (not 0, as the insured calculated).

Expert support was marginal, and damages were significant because the plaintiff was a relatively young woman

related errors involved monitoring, and one-third of these involved failure to properly monitor Coumadin. Thus, 1.4 percent of claims contained Coumadin monitoring errors. In a review of 130 closed internal medicine claims containing repetitive clinical events, six claims involved the mismanagement of anticoagulants in patients with atrial fibrillation—resulting in hemorrhage (four) or embolization (two).

These reviews highlight the malpractice risks associated with use of anticoagulants, particularly Coumadin—and the importance of properly monitoring Coumadin with the INR. When either hemorrhage or embolization occurs in a patient on Coumadin, the plaintiff's experts will scrutinize the medical record to see if the patient's INR was in the therapeutic range.

This case also illustrates the importance of being familiar with practice guidelines. While it isn't essential to always follow guidelines or to follow them exactly (after all, they are "guidelines" and will not be applicable to every patient in every clinical setting), if you decide not to follow them, you should document your reasons in the medical record. Otherwise, should a claim arise, the plaintiff may argue that you were unfamiliar with the applicable guideline and that your failure to follow it was below the standard of practice and caused patient injury. ■

**“Physicians must consider each patient individually to decide if a history of hypertension is clinically significant because anticoagulation with Coumadin carries risks.”** —David B. Troxel, MD

lation with Coumadin carries risks. He stated that the current 2006 *Guidelines*<sup>2</sup> do not require Coumadin for atrial fibrillation when there is a history of hypertension and that either Coumadin or aspirin can be used. Nevertheless, he believed that had she been put on Coumadin, she would not have had the stroke, adding that many experts would state that she needed to be on Coumadin.

### Analysis

The issues in this claim became whether or not the insured cardiologist should have put the patient on Coumadin and if doing so would have prevented her stroke. The 2001 *Guidelines for the Management of Patients with Atrial Fibrillation* recommended using risk factors (age, gender, diabetes, coronary artery disease, left ventricular dysfunction, hypertension,

in generally good health prior to her stroke. A trial would become a “battle of experts” in a venue that often produced high verdicts. The insured was on the verge of retirement. He was likeable but didn't appear to be up to date on current medical practices. At his deposition, he was easily confused by the plaintiff's attorney's questions and testified that if the patient had a history of hypertension, he would have placed her on Coumadin. Her history of hypertension was documented in his office chart—and he had not placed her on Coumadin. At the insured's request, the claim was settled.

### Discussion

In a review of 363 consecutive closed claims at The Doctors Company, 9.6 percent contained medication-related errors. Forty-three percent of the medication-

### References

1. Fuster V, Rydén LE, Asinger RW, et al. ACC/AHA/ESC guidelines for the management of patients with atrial fibrillation. *Circulation*. 2001;104(17):2118–2150.
2. Fuster V, Rydén LE, Cannom DS, et al. ACC/AHA/ESC 2006 guidelines for the management of patients with atrial fibrillation. *J Am Coll Cardiol*. 2006;48:e149–246.

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gap between visits. He saw the patient in October 2001 and did not see her again until March 2006.

The inherent patient safety implication is that the physician may no longer be familiar with the patient or the patient's interim medication and treatment plan. The practice of continuing to treat a patient after an extended absence can also result in allegations of delayed or missed diagnosis when the patient reappears with a worsening condition or a condition that the physician originally failed to detect.

To avoid such issues, it is advisable for a provider to terminate the relationship with the patient if the patient repeatedly fails to follow up for care, has a long history of noncompliance with treatment recommendations, or after an extended period of time has elapsed.

### Documentation

The importance of thorough, accurate, and objective documentation cannot be overstated for the defense of a case and in ensuring that the patient receives safe care. As one physician stated aptly, "Write every note like it's eventually going to be read by the patient and many other people... including a 12-member jury panel."<sup>4</sup>

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agreements" need not be disclosed to a jury. A high-low agreement is a form of settlement agreement that, contingent on a jury's award of damages, sets a minimum amount to be paid to the plaintiff if the award is below that amount and a maximum to be paid if the award is above that amount. In *Roe v. Planned Parenthood Southwest Ohio Region*, 2009 Ohio 2973, the court upheld a state law providing that the physician-patient privilege generally forbids disclosure of non-party medical records without patient consent.

The standard of care does not require that a provider follow every treatment recommendation for a particular condition; thus, thorough documentation regarding the physician's rationale for proceeding with a particular course of action is crucial. In addition to thorough treatments and plan of care notes, all conversations (by phone or in person), failed appointments, noncompliance with care, education provided, and follow-up plans should be documented.

### Communication

Poor communication is at the heart of a significant number of medical errors. For this reason, it is imperative that physicians continually strive to improve communication with patients and with other providers as a necessary patient safety strategy.

In the highlighted case, one or more communication breakdowns could have contributed to the patient's injury. First, communication between the primary and multiple consulting physicians appears to have been inadequate. The lack of documentation and information exchange among the multiple providers could have led to the poor monitoring of the patient's atrial fibrillation and ultimate poor

outcome. In addition, having accurate and thorough information about the patient's present and prior course of treatment and medication history could have helped our insured physician in making the most appropriate treatment recommendations.

Likewise, effective communication between the provider and the patient is an important patient safety strategy. Good communication with the patient can have a dramatic result. It can even lead to a patient's decision not to sue the physician despite a bad outcome. ■

### References

1. *Physician Insurers Association of America Cumulative Data Sharing Reports*. 072 ed. January 1, 1985–December 31, 2007. Rockville, MD: Physician Insurers Association of America; 2008.
2. Silva FJ, Meghriqian AG, et al. Physician/Patient Relationship, Establishment of the Physician Patient Relationship *California Physician's Legal Handbook 2009*. Sacramento, CA: California Medical Association; 2009:chap 36.
3. *Ibid*.
4. Zurad EG. Don't be a target for a malpractice suit. *Fam Pract Manag*. 2006;13(6):14.

*Maryland's* highest court, the Maryland Court of Appeals, has overruled a trial court decision that would have allowed a plaintiff attorney to avoid the state's cap on noneconomic damages simply by refusing to submit a case to arbitration. The decision in *Lockshin v. Semsker*, 2010 Md LEXIS 4, is a big win for physicians and supporters of the cap.

Former *Montana* legislator Mike Wheat (D) has been appointed to the state supreme court to fill a vacancy. Justice Wheat will have to run for election in 2010. Wheat was chair of the Senate

Judiciary Committee and a candidate for state attorney general, after a long career as a plaintiff attorney.

In *Virginia* the \$2 million cap on total damages stopped increasing in 2008, as directed by the cap statute. Efforts by the trial bar to increase the total cap did not succeed in 2009, and now, with the election of a Republican governor and a net increase of six Republican seats in the Virginia House of Delegates, it should be even more difficult to pass a similar measure in 2010. ■

### 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.

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### Retiring Member Physicians Receive \$1 Million in Tribute® Plan Rewards

We are pleased to announce that, as of November 30, 2009, The Doctors Company has paid over \$1 million in Tribute rewards to retiring member physicians.

"Only The Doctors Company honors a lifetime of member service with a significant financial award," said Richard E. Anderson, MD, FACP, chairman and CEO. "This unprecedented payment to our members is another example of our commitment to them and a demonstration of our belief that when we work together to promote the practice of good medicine, we all win."

To date, we've distributed career rewards to 580 retiring members. For your individual balance, visit [www.thedoctors.com](http://www.thedoctors.com) and click the Tribute Plan link. You will need to sign in by entering your user ID and password, or you can sign up if you have not yet registered. You can also access our iTribute Plan Calculator or download our iPhone application.

### Responding to Haiti Relief Efforts

The Doctors Company has provided financial support to Doctors Without Borders for aiding earthquake victims. Doctors Without Borders is working to provide both emergency medical care and to avert a catastrophic outbreak of communicable diseases in the wake of Haiti's devastating earthquake.

### Update on Our Recent Florida Physician Advisory Board

The Florida Physician Advisory Board recently met in Fort Lauderdale. Our panel members presented three cases selected to match their specialties. In one of the cases, panel members provided valuable insight by emphasizing the need to closely examine respiratory monitoring after surgery and to consider an entirely different explanation for the patient's demise.

Following each presentation, Karen Meehan, our patient safety/risk management account executive, led the discussion by highlighting lessons that could be learned from each situation. One of the cases illustrated the difficulties encountered by not considering alternative diagnoses, and another case emphasized the importance of communication among the primary care physician, the anesthesiologist, and the surgeon when "clearing" a patient for surgery.

We asked participants to step into the shoes of a jury and predict the outcomes for the major defendants in the three cases. We told them only that one physician had won at trial and another physician had settled before trial, and one trial had resulted in a large judgment against the physician. Panel members' answers varied widely—which illustrates that many variables affect the outcome of a claim.

### PLICA Operations Suspension

On October 22, 2009, the Illinois Department of Insurance suspended the operations of Professional Liability Insurance Company of America (PLICA), a New York-domiciled medical liability insurer that writes business in Connecticut, Illinois, Maryland, Missouri, Ohio, and Texas.

The suspension was stayed through a temporary restraining order. We will update you as information becomes available.

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