A Diagnostic Blind Spot

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

And so these men of medicine consulted off and on, each gave his own opinion in both progress notes and song, though each of them was partly right, together they were wrong.

—Director’s version of John Godfrey Saxe’s 1873 poem “The Blind Men and the Elephant”

A 34-year-old morbidly obese female with a history of hypertension, type 2 diabetes, and depression underwent gastric bypass surgery on September 21. She weighed 402 pounds and was 5 feet 6 inches tall. Surgery was uneventful, and she was discharged on September 23.

Two days later, she presented to the ER with epigastric pain; she was placed on a clear liquid diet, prescribed Reglan, and sent home. She was readmitted on October 22 for vomiting, abdominal pain, and dehydration. An upper GI series revealed gastric outlet obstruction. She underwent revision of the gastrojejunostomy and was discharged on October 29, but was readmitted three days later for vomiting with epigastric pain. She was placed on a clear liquid diet and discharged in three days.

She was readmitted on November 9 for hyperemesis and malnutrition and weighed 356 pounds. She received nutritional support with daily multivitamin and mineral supplements. A neurological examination by the surgeon was normal. On November 27, she experienced hallucinations with blurred vision, dizziness, and headaches; her blood pressure was 151/103. A psychiatrist’s impression was “acute episode secondary to a metabolic neurological event with underlying psychological issues.” The following evening, she insisted there were children under her bed. She was given Haldol and Ativan, and the episode resolved.

On December 1, neurologists were consulted. They and their nurse practitioner (NP) briefly discussed the possibility of Wernicke’s encephalopathy (WE) but concluded the patient was suffering from psychological, not neurological, issues because their neurological exam was normal and the classic signs and symptoms of WE (nystagmus, ataxia, and confusion) were absent.

The NP thought the symptoms could have a metabolic etiology and ordered an MRI and EEG plus blood folate, vitamin B₁₂, vitamin D, and the doctor’s advocate

The neurologists and their nurse practitioner concluded the patient was suffering from psychological, not neurological, issues.

—David B. Troxel, MD
Delay in Treatment of Fetal Distress

by Larry Veltman, MD, Member, The Doctors Company OB Advisory Board; and Darrell Ranum, JD, CPHRM, Regional Vice President, Department of Patient Safety, The Doctors Company

The Doctors Company conducted a study of claims and lawsuits involving neonatal injuries occurring in labor and delivery. The purpose was to identify issues associated with the allegation “delay in treatment of fetal distress.” It is hoped that the results of this study will lead to a decrease in these types of injuries.

Of the 247 neonatal injury claims that closed from 2007 through 2011, 89 claims (36 percent) included the allegation “delay in treatment of fetal distress.” (Although the term “fetal distress” is vague and no longer recommended, the allegation of delay in treatment remains an important concept in understanding these claims and lawsuits.)

The final diagnoses for neonatal patients in this category include:

1. Hypoxic-ischemic encephalopathy and severe birth asphyxia (80 percent)
2. Cerebral palsy (6 percent)
3. Subdural/cerebral hemorrhage (6 percent)
4. Conductive/sensory hearing loss (3 percent)
5. Stillbirth of unspecified condition (3 percent)

The claims review revealed the following:

1. Nurses failed to identify the fetal heart rate (FHR) tracing (usually Category II or III) as predictive of metabolic acidemia (11 percent). (Earlier terminology described these tracings as nonreassuring.)
2. Nurses recognized FHR tracing as predictive of metabolic acidemia but failed to timely notify the attending physician (20 percent).
3. Physicians did not go to the hospital after receiving calls from nurses with information about FHR tracings predictive of metabolic acidemia (14 percent). In most cases, it was noted that nurses did not activate the chain of command when physicians did not respond to the request.
4. Physicians who were aware of concerning FHR tracings did not make a timely decision to initiate a cesarean section (43 percent).
5. Patient injury was due to undetermined causes (20 percent).
6. Physicians used other interventions (vacuum extraction or forceps) to facilitate delivery when these concerning patterns were identified (20 percent).
7. Cesarean sections were ordered but delayed (staff or operating room unavailable) (6 percent).
8. The case abstract specifically referenced that physicians disagreed with nurses’ interpretations of FHR tracings (2 percent). This number may be higher based on the number of cases in which physicians failed to go to the hospital when called by the nurse (14 percent).

Studying these cases, we have identified multiple factors that may contribute to an adverse outcome and subsequent allegation of delay in treatment of fetal distress. Several emerging themes point to risk mitigation strategies that might help avoid neonatal injuries. These themes include the ability to identify FHR patterns that are predictive of metabolic acidemia, the importance of effective communications between physicians and nurses, the ability to perform a rapid cesarean delivery, the timing and safety of operative vaginal delivery (OVD), and monitoring the newborn after operative delivery. The following is a more comprehensive description continued on page 8
The Doctors Company and its members shared in a significant victory last summer when the California Supreme Court decided Howell v. Hamilton Meats. The court rejected an attempt by the plaintiff in an automobile accident case to have her past medical damages measured by the full amount of the bills calculated by her various medical providers, because those providers and the plaintiff’s private health insurer had already agreed on a lower price for those services. Writing for the majority, Justice Werdegar wrote, “We hold no such recovery is allowed, for the simple reason that the injured plaintiff did not suffer any economic loss in that amount.” Howell v. Hamilton Meats & Provisions, 52 Cal. 4th 541, 548 (Cal. 2011).

Overturning this decision would mean a huge windfall for plaintiffs’ attorneys, both in higher judgments and in settlement talks, where the value of economic damages is often used as a basis for calculating noneconomic damages. Not surprisingly, the incoming president of the Consumer Attorneys of California identified overturning Howell as the association’s highest priority for 2012.

The bill introduced for this purpose, Senate Bill 1528, has the potential to negatively impact all civil defendants in cases with medical damages. It has attracted a long list of opponents, including The Doctors Company. However, defeating this bill involves more than the ordinary strategy of lobbying members, crafting arguments, and gathering data to support those arguments. The chief difficulty with this particular bill is that in its current form it doesn’t refer to the Howell case at all.

Initially, the bill would have directly overturned Howell. It would have made it statutory law that an injured person could recover medical damages “without regard to the amount actually paid” (SB 1528 as introduced). That language was removed, and the bill went through the senate with nothing but intent language about establishing a framework for compensating injured persons. The latest version refers to county lien rights, but there is still nothing about the measure of damages. In this form, the bill has moved through both houses without much debate or controversy. It has also skipped around the fiscal committees in both houses, a considerable advantage during lean budget times when any state cost can be enough to stall a bill.

This year’s legislative session is scheduled to end August 31, so by the time you read this, the outcome will have been determined. It is already clear that this bill will not take its final form until just prior to the end of the session, when the author will deploy a procedural maneuver known as the “gut and amend.”

At the end of August, in the rush of the session’s final days, when many bills are voted on with minimal scrutiny in order to beat the rigid adjournment deadline, the bill will come up for a vote with contents markedly different from the language that went through committee hearings. Almost certainly there will be an amendment explicitly reversing Howell. This kind of last-minute, significant, and substantive amendment excludes the public and interested parties from the deliberative process and limits the ability of opponents to object to the bill’s final contents.

As a partial safeguard against this kind of gamesmanship, the legislative rules require that the senate and assembly both vote on the same final language. We and the bill’s other opponents will be lobbying members far in advance of the final votes, which will take place during prolonged, chaotic floor sessions just prior to adjournment.

To make it more challenging, the language overturning Howell may end up in another bill entirely. In that environment, we and our allies will be on hand to follow this shell game and alert legislators to what they are actually voting on.

In the weeks before those final votes, we will be working to persuade legislators to join us in opposing amendments that have yet to materialize. We will be working to convince state agencies to estimate the increased costs that will inevitably result from enacting language not currently in the bill. And we will continue to build our coalition of opponents to a bill that threatens to dramatically inflate medical damages in all injury cases—just not yet, in so many words.
and homocysteine levels. All were normal except the folate, which was indeterminate. The MRI indicated a symmetric T2 abnormality in the posterior medial thalamus and associated restricted diffusion. The report stated the findings might be due to venous ischemia, a metabolic disturbance, or encephalitis. Acute dural venous sinus thrombosis was ruled out by a normal MRV. The EEG showed frequent generalized delta slowing consistent with generalized cerebral dysfunction. Suggested etiologies included toxic and metabolic conditions. The NP concluded that the patient was suffering from an encephalopathy with low folate and ordered folic acid supplements.

On December 4, the patient became depressed and started crying. The NP recommended antidepressants with psychiatric counseling and ordered Celexa 40 mg daily. The psychiatrist opined this was an acute psychotic episode of depression, etiology undetermined. An ophthalmologist was consulted to evaluate right eye pain and noted nystagmus, possibly secondary to medications. Hyperalimentation/total parenteral nutrition (HAL/TPN) was ordered. On December 7, the psychiatrist noted the patient was intermittently confused and mildly agitated and increased maintenance Haldol. A physical therapy evaluation on December 10 documented vertical nystagmus and charted that the neurologists and nurses had been notified. In an infectious disease consultation for a urinary tract infection (UTI), nystagmus was again noted.

On December 14, the surgeon directed the nurses to wean the patient off HAL/TPN and have metabolic support services instruct her on a bariatric diet. The pharmacy’s parenteral nutrition fluid order form dated December 14 indicated that 500 mg of thiamine should be added to the base formula to treat possible thiamine deficiency. However, the surgeon canceled this order because he thought one 500 mg dose of thiamine had already been given before he wrote the order to discontinue the HAL/TPN. On December 15, the physical therapist again noted nystagmus and that the patient was lethargic and unable to stand.

On December 16, the patient was found sleeping on the floor and did not know how she got there; the psychiatrist decreased her Ativan.

On December 18, the HAL/TPN was discontinued, and the internist who managed her hypertension documented horizontal nystagmus. A neurological examination by the neurologists showed bilateral lower and upper extremity strength, no focal deficits, and symmetrical deep tendon reflexes.

On December 23, the patient was lethargic, and the physical therapist documented nystagmus and ataxia. On December 26, she developed fever due to her UTI, and the neurologists’ impression was encephalopathy due to an infectious process, depression, and psychosis. They did not feel further neurological workup was necessary because all tests were normal. On January 18, the patient again exhibited confusion and lethargy; the neurologists found no neurological deficits and concluded that her symptoms were secondary to a metabolic or infectious process.

There was failure to establish a differential diagnosis.

In late January, the nutritionist charted that the patient was not meeting her nutritional needs, and she underwent surgical placement of a feeding jejunostomy. She was then transferred to a long-term care facility where the feeding tube ruptured. She was taken to the university hospital where doctors diagnosed WE and treated her with thiamine. Shortly thereafter, she began to recognize people and was able to walk, brush her teeth, and dress and feed herself.

Expert Opinions
All bariatric surgery, neurology, and internal medicine experts opined that failing to diagnose WE in a

continued on page 6
post–gastric bypass patient, with hyperemesis, who displayed the classic signs of confusion, nystagmus, and ataxia with an MRI abnormality in the medial thalamus was below the standard of care. They were critical of the medical team for failing to seriously consider thiamine deficiency, because it is a well-recognized complication of gastric bypass surgery, and whenever a clinician suspects a metabolic disorder in this setting, thiamine should be given.

Early in her hospitalization, the patient exhibited psychological issues with signs of depression, which may have prevented her physicians from recognizing that the onset of new symptoms was a psychosis related to WE. However, once the MRI report was received and dural venous thrombosis ruled out, thiamine should have been administered. The patient, who failed to improve despite being in the hospital for a long time, should have been seen more often by all specialists. The neurologists saw the patient only four times from December 1 through mid-February, and while their neurological examinations were "normal," they failed to note the nystagmus and ataxia, which were well documented in the chart.

There was failure to establish a differential diagnosis. Although the neurologists considered metabolic issues and prescribed folate, they did not prescribe thiamine. The neurologists, bariatric surgeon, radiologist, psychiatrist, and ophthalmologist all had pieces of information that should have led to the correct diagnosis, but they communicated poorly with one another, and no one took the responsibility to put everything together. All caregivers were criticized for not being more aware that the patient was not meeting her nutritional needs. Without expert support, the claim was settled.

**Discussion**

Wernicke’s encephalopathy is a neurologic complication of thiamine (vitamin B₁) deficiency. It is characterized by the classic triad of mental confusion, oculomotor dysfunction, and gait ataxia. Punctate hemorrhages around the third and fourth ventricles are characteristic. While most often associated with chronic alcoholism, in one autopsy series, non–alcohol abusers accounted for 23 percent of cases. Other conditions associated with WE include anorexia nervosa, prolonged intravenous feeding without proper supplementation, prolonged fasting or starvation, dialysis, and gastrointestinal surgery (especially bariatric surgery).

The classic triad is recognized in only one-third of patients. In one study, mental status abnormalities were present in 82 percent, ataxia in 23 percent, oculomotor abnormalities in 29 percent, and polyneuropathy in 11 percent. The encephalopathy is characterized by confusion, disorientation, indifference, and inattentiveness. The oculomotor dysfunction includes nystagmus and lateral rectus palsy. Nystagmus is the most common finding and is typically evoked by horizontal gaze; vertical nystagmus can also occur. Ataxia primarily involves stance with a wide-based gait and slow, short-spaced steps.

WE is primarily a clinical diagnosis. Laboratory and neuroimaging studies are helpful, but the biggest barrier to diagnosis is a low index of suspicion. While there are no diagnostic laboratory tests, measurement of serum thiamine or thiamine pyrophosphate may be useful. However, results from these tests are not necessary for patient management, and whenever WE is considered in the differential diagnosis, immediate thiamine replacement is indicated. Only half of patients demonstrate EEG abnormalities,

The neurologists, bariatric surgeon, radiologist, psychiatrist, and ophthalmologist all had pieces of information that should have led to the correct diagnosis.

—David B. Troxel, MD
Diagnostic testing should not delay treatment, which should immediately follow consideration of the diagnosis.

—David B. Troxel, MD

usually diffuse slow wave activity. CT may show symmetric, low-density abnormalities in the diencephalon, midbrain, and periventricular regions. However, a normal CT scan does not rule out the diagnosis. MRI is more sensitive than CT, and typical findings include areas of increased T2 and decreased T1 signal surrounding the aqueduct and third ventricle and within the medial thalamus and mammillary bodies.

Treatment with intravenous thiamine is safe, inexpensive, and effective. Diagnostic testing should not delay treatment, which should immediately follow consideration of the diagnosis. A recommended regimen is 500 mg of thiamine intravenously, infused over 30 minutes, three times daily for two consecutive days and 500 mg intravenously or intramuscularly once daily for an additional five days. Oral administration of thiamine is an unreliable initial treatment.

WE is a well-known complication of bariatric surgery and typically occurs four to 12 weeks following surgery; female patients with vomiting appear to be at higher risk. Since WE may be precipitated by glucose loading in patients with unsuspected thiamine deficiency, thiamine should be administered prior to or along with glucose infusion in patients who are at risk for thiamine deficiency. ■

Reference
The following reference is from UpToDate, Rose BD (Ed), UpToDate, Waltham, MA 2008. Copyright 2008 UpToDate, Inc. Accessed on June 7, 2012. For more information, visit www.uptodate.com.

Charness ME, So YT. Wernicke’s encephalopathy. Literature review current through April 2012; last updated November 2009.

RxEvent
Approximately 500,000 adverse drug events (ADEs) are reported annually to the U.S. Food and Drug Administration (FDA) — according to FDA data, this number is growing rapidly. However, published studies indicate that as few as one in 10 ADEs are actually reported by health care professionals, largely due to the time-consuming and inefficient processes involved.

RxEvent, a HIPAA-compliant service available to all U.S. health care professionals, provides quick, convenient online access for reporting ADEs. Designed by PDR Network and its partners to improve reporting convenience, RxEvent is an online network that collects information on adverse drug events and distributes it to the manufacturer and/or the FDA.

If you have encountered an ADE, please report it to RxEvent at www.rxevent.org/Partner/00001. ■
of the components associated with these themes:

1. Ensure preparedness.
   a. Every physician should become familiar with National Institute of Child Health and Human Development (NICHD) nomenclature and participate in regular fetal monitoring learning activities with the nursing staff. This includes the identification of patterns that are predictive of metabolic acidemia associated with the loss of moderate variability and absence of accelerations.
   b. Establish the technology to view monitor tracings when the physician is out of the hospital.
   c. Conduct drills/simulation training in the performance of emergency cesarean delivery in less than 30 minutes, if needed.
      i. Establish a system of anesthesia coverage, backup surgical assistant availability, and operating team and room readiness for performance of rapid cesarean delivery in less than 30 minutes.
      ii. Consider the value of having in-house physicians as a safety net for obstetrical emergencies.
   d. Hold CME programs for the entire staff with up-to-date information about safety and the technical skills of operative vaginal delivery.

2. Communicate in real time.
   a. Have the ability to view the tracing (by computer, fax, or other technology) if a nurse calls with a concern about the tracing.
   b. Engage in dialogue about the tracing, and assign a category and care plan that both the physician and the nurse agree upon. Pay attention to the presence of moderate variability and accelerations when assigning Category II or III.
   c. Ask the nurse if he or she wants the physician to see the patient. If the answer is yes, the physician should go to the hospital without delay. If the answer is no, the physician should ask, “Are you sure?”
   d. Develop an effective chain-of-command policy that will be readily activated if conflicts cannot be resolved by conventional means.

3. Avoid second-stage traps.
   a. When the patient is in the second stage, do not regard tracings that would be of concern in the first stage of labor as normal for the second stage. This applies especially to recurrent variable decelerations.

4. Implement a vacuum bundle as advocated by the Institute for Healthcare Improvement (IHI) with modifications:
   a. Consider alternative labor strategies.
   b. Prepare the patient.
      i. Discuss the risks, and document consent.
      ii. Ensure physical preparedness (empty bladder).
   c. Determine if there is a high probability of success.
      i. Estimate the fetal weight (EFW), and determine the fetal position and station.
      ii. Document this information.
   d. Predetermine the maximum application time and number of pop-offs.
      i. Establish communication codes. (These codes are communication tools used by physicians and nurses to show safety concerns and the need for reevaluation of the situation without alarming the patient.)
      ii. Communication codes are determined.

5. Use the five “T”s as another approach similar to the IHI vacuum bundle for establishing an operative vaginal delivery policy:
   a. Timing—when and under what conditions to consider OVD. Use ACOG’s recommended definitions of a prolonged second stage as a guideline:
      i. For nulliparous women, a lack of continuing progress for three hours with regional anesthesia or two hours without regional anesthesia. (ACOG Practice Bulletin #17, June 2000, Operative Vaginal Delivery)
      ii. For multiparous women, a lack of continuing progress for two hours with regional anesthesia or one hour without regional anesthesia. (ACOG Practice Bulletin #17, June 2000, Operative Vaginal Delivery)
   b. Technique—have established expertise in use of instrumentation and skills in application.
   c. Traction—determine the maximum number of pop-offs and total time of application.


d. Talking—teamwork interaction with regard to OVD.

e. Termination—when to stop and implement an exit strategy.

6. Be reluctant to attempt instrumental delivery in the face of a Category III tracing or a tracing that does not have moderate variability and accelerations.

7. Have an exit strategy (i.e., the ability to perform a rapid cesarean delivery) before an instrumental delivery is attempted. Ascertain the ability to perform a cesarean delivery in less than 30 minutes.

8. Implement a protocol for care of the newborn after vacuum delivery. a. Monitor the infant’s vital signs, color, and behavior.

b. Do not place a cap on the infant’s head for 24 hours.

c. Measure the newborn’s head circumference at birth and at hourly intervals for four hours.

d. Examine the newborn for scalp swelling consistent with caput, subgaleal hematoma, or cephalohematoma.

e. If physical signs demonstrate possible newborn compromise, notify the physician and monitor blood pressure, heart rate, and vital signs.

f. Check the newborn’s hematocrit.

**Conclusion**

Our study revealed recurring themes in cases with adverse outcomes alleging delays in treatment of fetal distress.

Addressing these themes proactively and in real time should become a strategic activity for physicians and nurses who staff obstetrics departments. Increased readiness for and recognition and management of complications, improved communications, and required technical skills should all work in concert to reduce the likelihood of these difficult and tragic outcomes.

**References**


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**Reasons for Delay in Treatment of Fetal Distress**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses failed to identify patterns suggestive of metabolic acidemia</td>
<td>11%</td>
</tr>
<tr>
<td>Nurses recognized FHR tracings predictive of metabolic acidemia but failed to timely notify physician</td>
<td>20%</td>
</tr>
<tr>
<td>Physicians did not go to hospital when called</td>
<td>14%</td>
</tr>
<tr>
<td>Physicians aware of concerning FHR tracings did not make timely decisions to do cesarean sections</td>
<td>43%</td>
</tr>
<tr>
<td>Physicians used vacuum delivery or forceps when concerning FHR tracings were identified</td>
<td>20%</td>
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<tr>
<td>Cesarean sections were ordered but delayed (staff or operating room unavailable)</td>
<td>6%</td>
</tr>
<tr>
<td>Physicians disagreed with nurses’ interpretations of FHR tracings*</td>
<td>2%</td>
</tr>
<tr>
<td>Patient injury was due to undetermined causes</td>
<td>20%</td>
</tr>
</tbody>
</table>

*This category was counted only when a disagreement was specifically referenced in the clinical description. Note: Claims total more than 100 percent because some fall into more than one category.
The Doctors Company Foundation provided a grant to the University of Illinois Institute for Patient Safety Excellence to support the Eighth Annual Telluride Patient Safety Educational Roundtable, “Transforming Mindsets.”

This year, the Foundation expanded its grant to include two weeklong sessions—allowing a total of 40 medical students and residents to participate. The sessions brought together student scholars with leaders in patient safety, health science education, and medicine to explore open, honest communication and transparency in the delivery of care.

“Amidst all of the challenges faced by our health care system, it is difficult not to be inspired by the passion, sophistication, and commitment of the next generation of America’s physicians,” said Richard E. Anderson, MD, FACP, chairman and CEO of The Doctors Company, who participated in the final week’s roundtable. “I was extremely proud of The Doctors Company Foundation’s contribution to this signal conclave.”

Learn more about the Foundation’s work at www.tdcfoundation.com.

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- **October 25** HIPAA: Yesterday, Today, and Tomorrow
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- **November 14** Risk Prevention Tips for the Digital Age: E-mail, Texting, and Social Media

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- **October 25** Dayton, Ohio
  Dayton Marriott
- **October 30** Wenatchee, Washington
  Eye and Ear Clinic of Wenatchee
- **November 5** Cheyenne, Wyoming
  Holiday Inn

Scan here for dates, topics, and registration information, or visit www.thedoctors.com/cmeschedule.
New Mexico Physician Advisory Board Update
by Stephen H. Haynes, MD

The Doctors Company’s New Mexico Physician Advisory Board met recently in Albuquerque. The board members represent a wide variety of physician specialties, including orthopedics, obstetrics and gynecology, internal medicine, family practice, and anesthesiology. Several representatives from The Doctors Company also attended the meeting.

The physicians heard an informative report from the New Mexico Medical Society attorney and lobbyist on the results of the recently concluded 2012 30-day session of the New Mexico Legislature in Santa Fe. The attorney focused on the status of proposed medical tort reform in New Mexico. The board was informed that the New Mexico Medical Malpractice Act remains unchanged currently, with ongoing debate among the interested parties as to the likelihood of future amendments or separate legislation being pursued during the next session in 2013. However, the New Mexico Court of Appeals has issued its opinion that medical corporations are entitled to coverage under the act.

The board was informed that the constitutional amendment regarding the State Department of Insurance passed the legislature, and, if passed by voters this November, will result in the removal of the department from the supervision of the State Public Regulatory Commission. It will be placed directly under the supervision of the governor’s office, an action thought to streamline the functioning of the Insurance Department.

Members were provided with separate timely reports on a number of New Mexico underwriting, marketing, and claims matters. Discussion took place after each report, and questions from the physicians were answered.

A number of the current advisory board members have served on this board since its inception in 1997. All are active and involved leaders in their respective medical communities in New Mexico. Many are past presidents of the New Mexico Medical Society.

Our board members are very appreciative of and responsive to the variety of relevant and useful information they receive and take back to their medical communities.

Stephen H. Haynes, MD, is board certified in general surgery. Dr. Haynes has been in private practice for the past 30 years in Clovis, New Mexico. He has held multiple positions in the state medical community, including president of the New Mexico Medical Society. He was a member of the American Physicians Capital Board of Directors. He served as governor of the New Mexico Chapter of the American College of Surgeons. Dr. Haynes leads The Doctors Company’s New Mexico Physician Advisory Board.

Our board members are very appreciative of and responsive to the variety of relevant and useful information they receive and take back to their medical communities.

—Stephen H. Haynes, MD
The Doctors Company Named a Ward’s 50 Top-Performing Company

We are pleased to announce that The Doctors Company has been named a 2012 Ward’s 50th top-performing company. This year’s selection marks the 11th time that we have achieved top-performing status. Ward Group, an insurance industry management consulting firm and provider of benchmarking and best practices services, makes its selections after analyzing the performance of over 3,000 property-casualty insurance companies based in the U.S.

“We are pleased that Ward Group has recognized The Doctors Company’s financial strength and consistently excellent performance,” said Richard E. Anderson, MD, FACP, chairman and CEO.

“This award is an affirmation of our operational excellence and our mission-driven commitment to our members. We are firmly positioned to provide the industry’s most aggressive claims defense and financially reward our physician members for their delivery of outstanding patient care.”

Dr. Anderson added: “During the five-year review period, our strength and performance were enhanced through strategic acquisitions and organic growth. Because of this success, we’ve reduced operating expenses while continuing to offer competitive premium rates. These factors make it possible to protect and reward our members with more power and financial resources than ever before.”

A.M. Best Recognizes Our Financial Strength

We proudly announce that A.M. Best Company has assigned a financial strength rating of A (Excellent) and an issuer credit rating of “a” to the FPIC Insurance Group, a wholly owned subsidiary of The Doctors Company. The upgraded ratings apply to the following FPIC Group members: First Professionals Insurance Company (FPIC), Anesthesiologists Professional Assurance Company (APAC), and Intermed Insurance Company. The Doctors Company completed its acquisition of FPIC and its subsidiaries in October 2011.

A.M. Best also affirmed The Doctors Company’s financial strength rating of A (Excellent) and its issuer credit rating of “a.” The A (Excellent) rating is assigned only to select companies with excellent ability to meet ongoing obligations to policyholders.

“We are pleased that the strength of this partnership has been recognized,” said Richard E. Anderson, MD, FACP. “Our combined organization provides FPIC policyholders with the financial strength of a physician-owned insurer with multiple A ratings and a commitment to relentlessly protect, defend, and reward its members.”

A.M. Best says the rating reflects FPIC’s supportive risk-adjusted capitalization, strong historical operating performance, high policyholder retention levels, and the benefit of both implicit and explicit support provided by The Doctors Company.

The ratings agency also recognized The Doctors Company’s excellent capitalization, long-term underwriting profitability, favorable reserve development, and leadership position in the medical professional liability market across multiple jurisdictions. An additional positive factor, A.M. Best said, is the company’s dedication to sharing its financial success with members through dividends and the Tribute® Plan.

Top Medical Malpractice Attorneys Sharpen Defense Strategies at Summit

We recently convened the West’s top medical malpractice defense attorneys to share information about litigation trends and successful defense strategies.

Now in its sixth year, our Legal Summit West is an assembly of nearly 100 of the region’s most experienced senior legal teams and industry experts. This year’s meeting included attorneys from California, the Northwest, and the Southwest, and as far away as Wyoming and Nebraska.

The sessions are central to our dedication to providing the industry’s most aggressive claims defense by keeping leading authorities up-to-date on local and national trends, plaintiff’s strategies, and best practices.

“The Doctors Company is fiercely committed to defending member physicians,” said David McHale, senior vice president and general counsel. “The Legal Summits demonstrate the company’s commitment to providing our physicians with a comprehensive defense that takes advantage of our understanding of issues both at a local and national level. It’s a perspective that belongs only to The Doctors Company.”

The summit was the first of two organized by The Doctors Company in 2012. The second session will be held in October in the Southeast region.

Our Medical Director Contributes to EHR Strategies Animated Video

PDR Network has created a short video calling on physicians to optimize the functions and benefits of electronic health records. The video, which includes comments by Medical Director David B. Troxel, MD, was developed with key points taken from a recent PDR Strategies Webcast. View the video at www.thedoctors.com/ehr.