Failure to recognize subtle transient neurologic deficits as a TIA or a harbinger of impending stroke can lead to a claim.

—David B. Troxel, MD

TIA Recognition and Management
by David B. Troxel, MD, Medical Director, Board of Governors

On July 23, a 56-year-old male presented to an urgent care center. While working on his computer, he had suddenly experienced a blank stare, his right hand started shaking, and his fingers began moving involuntarily. The episode lasted five minutes, and he was now asymptomatic. However, the history form completed by the patient was nonsensical—a detail not brought to the physician's attention by office staff. His blood pressure was 140/95.

Our insured found no neurological deficits in the upper extremities. His differential diagnosis was absence seizure versus transient ischemic attack (TIA).

What Would You Have Done?
The insured instructed the patient to see his primary care physician (PCP) and a neurologist that same day and to take an aspirin daily. He did not arrange for a referral to a specific neurologist or call the PCP.

The next day, the PCP saw the patient and noted a tremor in his right hand. The patient was told to follow up with a neurologist and, if symptoms recurred, to go to the emergency room (ER). The PCP did not refer him to a specific neurologist.

On July 26, the patient developed slurred speech and went to the ER. A brain CT showed an early left nonhemorrhagic cerebral infarction in the distribution of the middle cerebral artery (MCA). He was seen by a neurologist, who noted right-sided weakness, facial droop, and expressive aphasia. It was determined he was not a candidate for tPA.

Magnetic resonance angiography (MRA) revealed occlusion of the left internal carotid artery.

He was discharged to a rehabilitation center on July 28 and was found the next day slumped over with weakness of the right upper extremity. His blood pressure was 145/100. He was taken back to the hospital; a brain CT showed that the infarction was slightly larger.

An MRA on July 31 suggested carotid dissection. It was recommended that the patient remain on Lovenox and aspirin for several months. He returned to the rehabilitation center and was discharged two weeks later with use of all extremities, facial weakness, and residual expressive aphasia.

A claim was filed alleging failure to diagnose and treat an acute neurological event and failure to refer to an acute care facility.

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Changing Times, Changing Practices
by Siobhan S. Dunnavant, MD, FACOG, The Doctors Company Virginia Physician Advisory Board Member

In this article, Dr. Dunnavant describes a hospitalist model designed to enhance patient safety, reduce malpractice risk, and improve physician quality of life.

— Robin Diamond, JD, RN; AHA Fellow–Patient Safety Leadership; Chief Patient Safety Officer, Department of Patient Safety

In October 2008, OB Hospitalists, Inc. (OHI) started the first OB hospitalist program in central Virginia at Henrico Doctors’ Hospital (HDH). The program—three years in the making—is a product of many doctors’ dining room conversations, research on sleep data, malpractice risk reviews, and negotiations with Hospital Corporation of America (HCA).

The concept, which is in keeping with the principles of HCA’s Perinatal Safety Initiative, was a huge cultural shift for the community. OHI’s OB hospitalist program, unique in the hospitalist world, is designed for a private practice community.

The OB hospitalists would be in labor and delivery from 8:00 pm to 8:00 am daily to cover all obstetric and gynecologic calls. It was presumed that this is the time period when the greatest risk for patient injury could occur—when physicians are generally off-site, and there is a possibility of impaired judgment from sleep deprivation. The program structure is based on three tenets: enhancing patient safety, reducing malpractice risk, and improving physician quality of life.

One review stated that babies born at night were 12 percent more likely to die. Another study reported that babies born between 9:00 pm and 7:00 am were twice as likely to die in the first week of life. Doctor fatigue was referenced as one of the causes.

The standard of care in obstetrics cites 30 minutes as the time in which a delivery must be accomplished after the onset of an emergency. Physicians who are off site when covering calls risk delaying this window when emergencies arise. OHI believed that patient safety would be positively affected by having a well-rested OB hospitalist on site.

Besides the identified nighttime risk, evidence shows that after 16 hours of being continuously awake, a person begins to suffer from decreased mental acuity. This data helped persuade doctors that the way we had always practiced actually increased risk that could result in a bad outcome. Ob/gyns have the longest workweek of any specialty. Quantifying the demands of the OB call schedule further convinced physicians that having relief at night had value to both decrease risk and improve quality of life.

Engaging physician support for the endeavor was perhaps the biggest hurdle. The physician-patient relationship is an imperative component of a successful ob/gyn practice. As doctors began to consider the program, they made it clear that they wanted night coverage only so they could care for their patients during the day. Based on the sleep data, we wanted our OB hospitalists working no longer than 12 contiguous hours.

The mutual desire for 12-hour shifts was helpful in designing the program and engaging physician support. After we proved its value to doctors, we proposed the program to HDH. HDH was willing to take a chance on the program’s cost for the resulting benefits of patient safety, reduced risk, and doctor satisfaction.

The concept was a huge cultural shift for the community.

—Siobhan S. Dunnavant, MD, FACOG
Throughout 2012, The Doctors Company worked on behalf of Michigan physicians to pass legislation to strengthen the state’s medical liability statutes, including the cap on noneconomic damages. The Doctors Company worked closely with the Michigan State Medical Society (MSMS) to draft and lobby for a suite of bills collectively called the Patients First Reform Package. This cooperative effort by The Doctors Company, the MSMS, and our lobbying and advocacy association, the Michigan Insurance Coalition (MIC) succeeded in passing two of the bills in the package, including a bill to reinforce the noneconomic damages cap and another bill to clarify the statute of limitations and the calculation of prejudgment interest. On January 9, 2013, Governor Rick Snyder (R) signed Senate Bills 1115 (Roger Kahn—R) and 1118 (Joe Hune—R), repairing significant erosion by court decisions to Michigan’s medical liability reforms.

Although Michigan has had a statute limiting noneconomic damages since 1993, subsequent court rulings have weakened the reform. In *Thorn v. Mercy Memorial Hospital*, 281 Mich. App. 644 (2008), the Court of Appeals of Michigan ruled that the reform statutes, known together as the Revised Judicature Act, did not prevent a plaintiff from claiming the loss of household services as economic damages not subject to the cap. The Supreme Court of Michigan declined to review the decision, in essence upholding the appeals court ruling.

SB 1115 also amends the act to explicitly provide that loss of household services, loss of society and companionship, and loss of consortium are noneconomic damages subject to the cap. In *Nation v. WDE Electric Company*, 454 Mich. 489 (1997), the Supreme Court of Michigan overruled the appellate court and held that when the legislature enacted section 6306 of the act controlling calculation of future damages reduced to present cash value, since it did not specify that interest be compounded annually, it must have intended that simple interest be used. The result has been confusion among lower courts in calculating awards and larger payouts using simple interest. SB 1115 adds section 6306(a) to the act to specifically require that interest, compounded annually, be used in reducing future damages to present cash value.

SB 1115 also specifies the order in which the components of an award should be calculated; this is commonly known as “set offs.” The order is important because the final amount due to the plaintiff depends on the order in which the calculations are made. For example, the court must reduce the damage award before applying interest.

SB 1118 also provides that, in a medical malpractice action, prejudgment interest is calculated on the amount of the judgment not including costs and attorney fees incurred during the time before a judgment is issued.

We are proud of the contribution made by The Doctors Company toward the enactment of these bills. Our efforts included grassroots support, lobbying, and arranging for a defense attorney and medical liability expert to help draft the bill and testify before the legislature. As always with legislation of this significance, success depends on teamwork and coalition-building. In this case, the passage of these bills is a credit to the collaboration between the Michigan State Medical Society, the Michigan Insurance Coalition, and The Doctors Company. We look forward to continued success working with our partners on behalf of physicians in Michigan and around the nation.
I have been with several malpractice companies over the 35 years of my practice, and I wish I would have discovered The Doctors Company a long time ago.

—Member, Oregon

2012 Member Experience Survey

As an organization founded by doctors for doctors, The Doctors Company is uniquely aligned with its members’ interests and accountable only to them. Because the physicians we insure are members of The Doctors Company and not just policyholders, we regularly solicit their perspective as we pursue our mission to relentlessly defend, protect, and reward the practice of good medicine.

We reached out to members nationwide with our 2012 Member Experience Survey and received an enthusiastic response—more than 5,000 doctors took the time to reply, and many added comments about their experiences with The Doctors Company.

If you participated, thank you for taking the time to give us your valuable input and for telling us how we can serve you better.

**Member Loyalty**

We’re proud to report that 98 percent of members are likely to renew their medical malpractice policies with us, while 97 percent are likely to stay with us until they retire from the practice of medicine.

The vast majority of members rate us as the finest malpractice insurer in the country. An Oregon member commented, “I have been with several malpractice companies over the 35 years of my practice, and I wish I would have discovered The Doctors Company a long time ago.” A member from Michigan expressed that The Doctors Company is “the best med-mal carrier I have ever been with.”

**Relentless Defense**

We set the standard for aggressive defense—94 percent of members agree that we relentlessly defend them against frivolous lawsuits. Our relentless defense includes Litigation Education Retreats, which help members facing claims to master defense tactics, deliver sound testimony, and cope with the emotional stress of a claim.

A Utah member stated: “The Doctors Company has been stellar when it counts the most: when a patient files a claim that the physician knows is unreasonable. The Doctors Company listened to what we had to say and did the right thing at every turn.”

**Unrivaled Protection**

As the acknowledged industry leader in patient safety, our innovative programs help members reduce risk and avoid claims. Our survey found that a full 91 percent of members are pleased with our efforts to protect them from potential threats to their reputations and livelihoods.

**Unsurpassed Rewards**

2012 marked the fifth anniversary of the Tribute® Plan, an unrivaled benefit that rewards members for their loyalty and their dedication to superior

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Even relatively brief ischemia can cause permanent brain injury.

—David B. Troxel, MD

**Expert Opinion: Plaintiff**

Neurologists opined the insured deviated from the standard of care by failing to perform a complete neurological examination, by not recognizing the TIA, and by failing to address the elevated blood pressure.

The patient should have been admitted to the ER by the insured on July 23 and by the PCP on July 24. The ER physicians would have recognized the TIA and arranged for a neurological consultation with testing to include brain and vascular imaging to identify the internal carotid artery occlusion. With heparin and/or stenting or surgery, it’s likely the stroke could have been prevented. By the time the patient presented to the ER, no treatment would have made a difference in outcome. Considering the high risk of stroke within 24 to 48 hours, it was insufficient for both physicians to refer the patient to a neurologist without ensuring he could be seen that day. Furthermore, if the insured suspected absence spells or TIA, he should not have let the patient drive home.

A neurosurgeon testified that when the patient first presented, he was experiencing ischemia from occlusion of the MCA due to a thromboembolism from the internal carotid artery dissection. Had the dissection been diagnosed, the patient would have been anticoagulated. If his signs and symptoms progressed, endovascular angioplasty and stenting could have been performed. If not, anticoagulant therapy would have continued.

**Expert Opinion: Defense**

Internists opined that TIA is not routinely considered a medical emergency. While the standard of care for TIA requires imaging studies, the insured was not convinced this episode was a TIA because the history that computer work provoked it was consistent with a seizure, and the nonsensical history form was consistent with the postictal phase of a seizure.

If the patient had been referred to the ER initially and was asymptomatic, it is likely physicians would have concluded he’d had a seizure or a TIA and would have obtained a CT scan—which would have been negative at that time. He might not have been admitted for additional studies. Even if the results of a carotid ultrasound showed an occlusion, he was without signs and symptoms and would have been discharged on aspirin with the same outcome.

A neurologist opined that the insured’s differential diagnosis should have included a focal seizure—a more likely explanation for the transient hand shaking. The standard of care for a focal seizure includes referral to a neurologist and a brain scan, because the differential diagnosis includes brain tumor as well as stroke. The insured’s instruction to take aspirin and return to the ER if further events occurred was reasonable.

Unfortunately, even if the insured had ordered a brain scan and neurology consult, the stroke probably would not have been averted. If, on the day the patient was seen by the insured, a carotid ultrasound or an MRA had been performed and the diagnosis of carotid occlusion made, it’s unlikely he’d have been hospitalized or received emergency treatment, given his asymptomatic state.

**Discussion**

Failure to recognize subtle transient neurologic deficits as a TIA or a harbinger of impending stroke can lead to a claim if a stroke subsequently occurs. The public, increasingly aware of the importance of getting to a stroke center or ER for immediate evaluation and treatment, is likely to be unforgiving with caregivers who fail to act. The following discussion is a summary of the referenced UpToDate review, which I highly recommend.

TIA was originally defined as a sudden onset of a focal neurologic symptom and/or sign lasting less than 24 hours and caused by reversible cerebral ischemia. However, there is risk of infarction even when focal transient neurologic symptoms last less than one hour. Thus, even relatively brief ischemia can cause permanent brain injury.

TIA is now defined as a transient episode of neurologic dysfunction caused by focal brain, spinal cord, or retinal ischemia without acute
infarction. Ischemic stroke is defined as infarction of central nervous system tissue.

Of importance is that patients with TIA (or minor stroke) are at increased risk of subsequent (or recurrent) stroke (4 to 10 percent in the first 48 hours) and therefore require urgent evaluation and treatment, which may substantially reduce this risk. Urgent assessment and management are essential regardless of inpatient or outpatient status.

The 2009 American Heart Association and American Stroke Association (AHA/ASA) guidelines for the definition and evaluation of TIA state that it is reasonable to hospitalize patients with TIA who present within 72 hours of symptom onset based on ABCD² score criteria. The ABCD² score (Age, Blood pressure, Clinical features, Duration of symptoms, and Diabetes) is a prognostic assessment tool designed to identify patients at high risk of ischemic stroke in the first two days after TIA. They recommend routine noninvasive imaging of the cervicocephalic vessels and, for patients with embolic TIA, cardiac monitoring to exclude atrial fibrillation.

The 2006 National Stroke Association consensus recommendations regarding initial management that follow are based on observational studies and clinical experience:

1. Hospitalization should be considered for patients with a first TIA within the past 24 to 48 hours and for patients with the following conditions:
   - Crescendo TIAs
   - Duration of symptoms > one hour
   - Symptomatic internal carotid artery stenosis > 50 percent
   - Known cardiac source of embolus, such as atrial fibrillation
   - Known hypercoagulable state
   - High risk of early stroke after TIA

2. Patients who need urgent evaluation and are not hospitalized should have rapid access to the following studies:
   - Brain imaging with head CT and/or MRI
   - Neurovascular studies, such as CT angiography (CTA), MRA, and/or ultrasound
   - Electrocardiogram

3. All patients with a TIA within the past two weeks who are not hospitalized should undergo investigations within 24 to 48 hours to determine the mechanism of ischemia and subsequent preventive therapy.

4. Patients who are not admitted should be informed they need to go to an ER immediately if symptoms recur. Brain imaging with CT or MRI as soon as possible is indicated in all patients with suspected TIA or minor stroke.

The most important issue in the initial evaluation of TIA and ischemic stroke is whether there is an obstructive lesion in a larger artery supplying the affected territory. Noninvasive options for evaluation of large vessel occlusive disease include MRA, CTA, carotid duplex ultrasonography, and transcranial Doppler ultrasonography. The choice among these studies depends on local availability and expertise. Early evaluation and intervention for symptomatic carotid artery disease are also important aspects of stroke prevention. These measures should be implemented without delay, preferably within one day of the ischemic event, for patients who present with TIA or minor ischemic stroke.

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Reference

The following reference is from UpToDate, Rose BD (Ed), UpToDate, Waltham, MA 2008. Copyright 2008 UpToDate, Inc. Accessed on December 19, 2012. For more information, visit www.uptodate.com.


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Urgent assessment and management are essential regardless of inpatient or outpatient status.

—David B. Troxel, MD
When OHI began coverage at HDH, four board certified ob/gyns were employed, each having at least five years of practice experience. Additionally, there is one doctor in-house and one readily available on backup for every shift. On weekends, OHI covers 12-hour shifts from 8:00 PM Friday until 8:00 AM Monday.

The 12-hour coverage system resulted in continuity challenges. Because the OB hospitalist starts three hours after the offices close, there were forgotten sign-outs, leaving the OB hospitalist to find the doctor or muddle through with the information on the chart. To facilitate sign-out, there is a 24-hour call line where doctors can leave messages if they can’t sign out in person. In the morning, the OB hospitalist signs out reports of laboring or delivered patients, consults, surgery, admissions, or ER visits.

At times, some of the private doctors continued to oversee their patients’ care even after signing out. They would call to check on their patients and to speak with the patient’s nurse, making suggestions or giving orders. The OB hospitalist would be unaware of these interventions. It became an area of conflict and risk. This issue was resolved by getting everyone together and making a commitment to have only physician-to-physician conversations.

OHI had to find ways to accommodate the natural variations between the clinical management styles of the private doctors and the OB hospitalists. Working together required surrendering some autonomy on both sides.

To clarify expectations and clearly communicate practice standards, OHI published a handbook of best practices that the OB hospitalists would follow. These standards, consistent with safety initiatives the OB department had already developed, were reviewed and vetted by the HDH perinatologists. Creating consistency in practice patterns, expectations, and communication eventually facilitated a cultural shift, and everyone adapted well.

Patient satisfaction was a concern for many doctors because they believed their patients would object to receiving care from unfamiliar doctors. In fact, patients were quick to recognize the safety improvement and to embrace the program with a high level of satisfaction. Patients were already aware that a practice partner they might not know could deliver their baby. Shifting to an unfamiliar but well-rested doctor who could review all labor data was an easier transition than expected. Additionally, the OB hospitalists participate in hospital antepartum classes to meet as many patients as possible.

Although HDH had a very low historical incidence of malpractice claims, by the third year of the program, the rate had fallen by half. It’s hard to say what part of that drop is related to OHI; there have been ongoing safety initiatives to reduce risk. However, there is a long list of amazing response times during emergent situations. Several patients who required emergent cesareans for placental abruption, cord prolapse, fetal distress, and uterine rupture had delivery of the infant completed within six to 10 minutes of arrival to the unit or after the onset of the concerning fetal heart rate tracing. Having well-rested, in-house board certified ob/gyns ensured the highest possible standard of care.

Patient safety has always been the preeminent goal of the program. OHI covers for emergencies—regardless of whether the patient’s physician participates in the program—they thereby reducing risk of remote care for all doctors and patients. In fact, many of the emergent interventions have been for patients of nonparticipating physicians who were at home or on route to the hospital during the emergency.

This OB hospitalist program has been cited by several doctors and a large practice as an important reason they have relocated to our hospital from a competitor. While deliveries nationwide and in our community are down, they are up at HDH. Participating doctors frequently remark, “I don’t know what I would do if the OB hospitalists weren’t here.”

When the program was started, OHI identified three clients who needed to be served in order to ensure success—patients, doctors, and the hospital. We identified the obstacles to patient safety that occur in traditional

AN OUNCE OF PREVENTION
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Patient safety has always been the preeminent goal of the program.

—Siobhan S. Dunnavant, MD, FACOG
obstetric practices and developed a program to correct for remote care and sleep deprivation.

Outcomes at least partially attributable to the program include exceeding the standard of care based on time to delivery in emergency situations, decreasing malpractice cases, achieving excellent patient satisfaction, increasing delivery volume, and attaining excellent physician satisfaction and increased participation in the program.

References

Patients were quick to recognize the safety improvement and to embrace the program with a high level of satisfaction.

—Siobhan S. Dunnivant, MD, FACOG

New Tools to Protect Patient Data on Mobile Devices

The U.S. Department of Health and Human Services has launched an education initiative and a set of online tools for health care providers and organizations that use mobile technology.

The initiative, Mobile Devices: Know the Risks, Take the Steps, Protect and Secure Health Information, includes online resources and practical tips for protecting the privacy and security of health information on mobile devices such as laptops, tablets, and smartphones. For more information, visit www.HealthIT.gov/mobiledevices.
The most recent meeting of the Florida Physician Advisory Board took place in Orlando, with physicians from around the state representing multiple surgical and medical specialties—all with a common interest and background in patient safety and risk management. Representatives of The Doctors Company from legal, claims, patient safety, and business development were also present. The following outlines some of the meeting highlights.

**CMS Audits**

Associate general counsel Richard Cahill discussed increased audit activity by the Centers for Medicare and Medicaid Services (CMS). The government is expected to continue its aggressive approach in recouping existing overpayments and preventing future overpayments. Mr. Cahill said the Department of Health and Human Services Office of the Inspector General estimates current overpayments to be in the many billions of dollars. This amount is expected to rise as more patients are covered under the Affordable Care Act.

He noted that The Doctors Company’s medical professional liability policy covers legal fees that may be incurred during an audit appeal. This MediGuard coverage can be enhanced to provide higher limits and expanded protection from the potential high costs and exposure related to regulatory proceedings, including Medicare and Medicaid, RAC and ZPIC audits, and fraud allegations. He also advised members to call their agent or the company directly if they receive an audit letter.

**Liability Update**

Malpractice attorney Ralph Martinez covered current litigation and liability trends relating to electronic medical records (EMRs). He cautioned that EMR templates force practitioners to fit findings and symptoms into a fixed format. Patient care and physician defense could be affected unless additional information and documentation are attached. He added that the large volumes of paper generated by these formats can make reviews costlier and potentially less accurate. Mr. Martinez also advised physicians to use automatic data trending and to be vigilant about keeping patient records up-to-date. On the latter point, he stressed that incomplete records can make it easier for plaintiffs to argue that full disclosure was not met—resulting in a potential request for extending a statute of limitations.

Mr. Martinez also discussed increased physician liability from relying on physician extenders. He noted that if laws are changed to permit physician extender independent practices, coverage costs for physicians may decrease while costs for extenders will likely rise. On the topic of patient portals, he outlined how practitioners who encourage patients to enter their own protected health information (PHI) are discovering inaccuracies in the data. This has been identified as a new source for medical errors.

**Litigation Education Retreats**

Liz Holzman, claims regional manager, discussed the company’s Litigation Education Retreats for members who are in the process of a malpractice claim. The program helps physicians become effective members of their own defense team and includes tools for coping with the stress that accompanies a lawsuit. It emphasizes the partnership between the physician and The Doctors Company throughout the process.

**Clinical Case Reviews**

The meeting also included several clinical case presentations. Discussions were thoughtful and serious and covered possible liability exposures. Physician attendees benefit from hearing about claims being litigated, while representatives of The Doctors Company benefit from the analyses and comments from the physicians.

The company’s local physician advisory board meetings foster an open dialogue that is critically important for both The Doctors Company and physicians.

—Robert A. London, MD
The doctors company and physicians. The meetings also reflect the company's philosophy, which is to serve as a close adviser and partner to its physician members. This philosophy is unique in the industry.

Robert A. London, MD, is an anesthesiologist and partner in JLR Medical Group in Orlando. Dr. London is a Certified Healthcare Quality Manager and is a Diplomate of the American Board of Quality Assurance and Utilization Review Physicians, Inc. He has long been active in patient safety and risk management.

2012 Member Experience Survey
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patient care. Every year, Tribute grows and becomes more popular with our members—the highest award to date is $88,708. Currently, 92 percent of members agree that our efforts to reward them are unmatched.

Additional Survey Results
- 91 percent of members agree that we treat them like members, not just policyholders.
- 94 percent of members are pleased with our handling of phone calls, questions, and requests.
- 94 percent of members are satisfied with our billing accuracy.
- 92 percent of members agree that we communicate well with them.

“Best decision I made since finishing residency is to join you,” a member from Texas stated about The Doctors Company, “and I recommend your company to all my associates.”

Again, thank you to all of our members who participated in this year’s survey. Your answers and comments help us deliver the highest-quality member service.

What Your Peers Nationwide Are Saying About The Doctors Company

“Without a doubt, one of the most consistently ‘spot-on’ organizations I have ever worked with. Proactive, professional, reasonably priced, and conscientious. Keep setting the example for others to follow!”
—Member, Florida

“The doctors company excels at three issues most important to me: fair pricing, efforts to defend me, and rewarding loyalty—you’re great!”
—Member, California

“I am very satisfied and hope to continue the relationship ‘til the end of my practice.”
—Member, Georgia
Study Shows Malpractice Claims Consume Years of Physicians’ Careers

We provided the RAND Corporation and other researchers unfettered access to our claims database with over 40,000 physicians who had faced malpractice claims between 1995 and 2005 in every U.S. state and the District of Columbia.

In the video, “Pending Malpractice Claims Consume Physicians’ Careers,” Richard E. Anderson, MD, FACP, chairman and CEO of The Doctors Company, discusses the RAND study, finding that the average physician spends 50.7 months, or over four years, of a 40-year career fighting malpractice claims—the majority of which end up with no indemnity payment. High-risk specialists such as neurosurgeons and cardiovascular surgeons spend nearly a quarter of their careers defending themselves against this litigation onslaught.

“We are pleased to share our unique claims database for this significant research,” Dr. Anderson said. “These findings by the RAND Corporation are objective evidence that the litigation system needs to be fixed so physicians can spend their time practicing good medicine instead of fighting claims, the majority of which are fruitless, if not frivolous.”

To view the video and to subscribe to The Doctors Company YouTube channel, go to www.youtube.com/doctorscompany. To view more extensive data on the time spent by physicians on malpractice claims, go to www.thedoctors.com/claimsfrequency.

Richard E. Anderson, MD, FACP
Chairman and CEO, The Doctors Company

The Back Page—Industry and Company News

Earn Free CME Credits with Our Webinars

Our 2013 schedule of complimentary Webinars—open to all doctors and staff—can help you earn continuing medical education (CME) credits. Here’s a sample of the topics we’re covering:

Upcoming Webinars (Earn 1.0 CME Credit)

- **April 11**  
  *FAQs: Answers to Common Patient Safety Questions*
- **April 17**  
  *Sexual Harassment: A Ticking Time Bomb*
- **April 23**  
  *Managing Risks in Anesthesia*
- **April 29**  
  *Health Literacy: Do Your Patients Understand?*
- **May 1**  
  *Keeping Children Safe During Radiology Procedures*
- **May 13**  
  *Adverse Outcome Disclosure: What to Do When the Unexpected Occurs*
- **May 21**  
  *HIPAA: Yesterday, Today, and Tomorrow*
- **May 29**  
  *“But I’m Only the Nurse”: Understanding the Nurse’s Role in Patient Safety*
- **June 4**  
  *RAC Audits*
- **June 11**  
  *Lessons Learned When the Power Goes Out*

Go to www.thedoctors.com/2013webinars to register or to see a complete list of topics and dates.

YouTube Video Series Continues to Expand

Our Executive Advisory Board Speaker Series features short videos posted on YouTube. The videos deliver insights from industry thought leaders who cover topics of importance to medical practices in the evolving health care environment.

New videos in the series include “Liability Implications of Health Care Delivery Changes,” with James W. Saxton, Esq., of Stevens & Lee Health Care Litigation and Risk Management Group, discussing how accountable care organizations and individual physicians may face increased risk with health care reform.

In “Sharing Data to Manage Quality and Reduce Costs,” Laura P. Jacobs, MPH, executive vice president of The Camden Group, outlines how electronic health records can be a key to success in managing quality of care and reducing costs.

To view all of the videos in our series and to subscribe to The Doctors Company YouTube channel, go to www.youtube.com/doctorscompany.

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