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We anticipated that EHRs would become a contributing factor in medical liability claims.

—David B. Troxel, MD

DIRECTOR’S FORUM

Analysis of EHR Contributing Factors in Medical Professional Liability Claims

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

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hortly after electronic health records (EHRs) began to be widely adopted, The Doctors Company and other medical professional liability insurers became aware of their potential liability risks. We anticipated that EHRs would become a contributing factor in medical liability claims. Due to the three- to four-year lag time between an adverse event and a claim being filed, however, EHR-related claims have only recently begun to appear. In 2013, we began coding closed claims using 15 EHR contributing factor codes (eight for system factors and seven for user factors) developed by CRICO Strategies for its Comprehensive Risk Intelligence Tool (CRIT).

In 2013, The Doctors Company closed 28 claims in which the EHR was a contributing factor, and we closed another 26 claims in the first two quarters of 2014. During a pilot study to evaluate CRICO’s EHR codes, 43 additional claims closed by The Doctors Company were identified (22 from 2012, 19 from 2011, and 2 from 2007–2010). These 97 EHR-related claims closed from January 2007 through June 2014 are the subject of this analysis.

EHR-related factors contributed to 0.9 percent of all claims closed by The Doctors Company from January 2007 through June 2014. User factors contributed to 64 percent of these EHR-related claims, and system factors contributed to 42 percent.

The following tables and representative claims illustrate how the eight EHR system factors and seven EHR user factors contributed to the 97 closed claims. Some claims contained more than one contributing factor.

<table>
<thead>
<tr>
<th>EHR System Factors: Technology, Design, and Security Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Failure of system design.</td>
</tr>
<tr>
<td>9% Electronic systems/technology failure.</td>
</tr>
<tr>
<td>7% Lack of EHR alert/alarm/decision support.</td>
</tr>
<tr>
<td>6% System failure—electronic data routing.</td>
</tr>
<tr>
<td>4% Insufficient scope/area for documentation.</td>
</tr>
<tr>
<td>3% Fragmented EHR.</td>
</tr>
<tr>
<td>0% Lack of integration/incompatible systems.</td>
</tr>
<tr>
<td>0% Failure to ensure EHR security.</td>
</tr>
</tbody>
</table>

Claim: Lack of EHR Drug Alert
An elderly female saw an otolaryngologist for ear/nose complaints. The physician intended to order Flonase nasal spray. Patient filled the prescription and took it as directed. Ten days later, she went to the ER for dizziness. Two weeks later, the pharmacy sent a refill to the physician at his request. It was for Flomax (for enlarged prostate)—which has a side effect of hypotension. When ordering, the physician typed “FLO” in the medication order screen. The EHR matched Flomax, and the physician selected it. Flomax is not FDA-approved for females. There was no EHR Drug Alert available for gender.

Claim: Lack of EHR Drug Alert
A dialysis patient transferred to a skilled nursing facility. There was an active hospital transfer order for Lovenox. A physician evaluated the patient on admission but made no comment about the Lovenox order. During the first dialysis treatment, there was active bleeding at the fistula site. Heparin (anticoagulant) had not been given. Nursing did not inform the physician of the bleeding.

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AN OUNCE OF PREVENTION

Analyzing Bowel Perforation Claims
by Darrell Ranum, JD, CPHRM, Vice President, Patient Safety and Risk Management

Bowel perforation is one of the most common complications of abdominal surgery and other invasive procedures. Perforations can happen during endoscopic, laparoscopic, or open surgical procedures. They can also occur during liposuction from unintended penetration of the abdominal wall. Nonmechanical perforations can result from tissue necrosis due to vascular compromise, disease, bowel obstruction, or bowel torsion.

Overview
In August 2014, The Doctors Company conducted a study of 351 bowel perforation claims that closed from 2007–2013. It revealed the number of cases that occurred during each type of procedure:
- Endoscopic procedures (n = 81).
- Laparoscopic procedures (n = 65).
- Open surgical procedures (n = 142).
- Other causes (liposuction, disease, obstruction, torsion, etc. [n = 63]).

We also conducted studies for endoscopic, laparoscopic, and open surgical procedures but excluded bowel perforation cases that resulted from liposuction, disease, obstruction, or torsion.

Findings
Bowel perforations that occur during abdominal surgery or endoscopic procedures are recognized as a possible complication and are not necessarily considered negligence.

Obesity increased the chance that a patient’s abdominal surgery or endoscopy would result in a perforation. It was a factor in almost one in five laparoscopic procedure claims (18 percent) but was less of a factor in open surgical procedure claims (13 percent) and endoscopy claims (7 percent).

Adhesions contributed to bowel perforations in laparoscopic surgeries. Expert reviewers were critical of surgeons who failed to change to an open procedure when faced with extensive adhesions. Adhesions also complicated open procedures, making it difficult to identify and dissect anatomical structures.

If damage was repaired and there were no other injuries, patients rarely filed claims based solely on the fact that their bowel had been punctured.

In almost every case, the patient’s clinical picture deteriorated in the hours or days following surgery (examples include abdominal pain, free air identified in CT scans, vomiting, tachycardia, elevated white blood counts [WBCs], hypotension, and elevated body temperature). At a time when a patient’s condition was expected to improve, symptoms became worse. Some conditions were presumed to be due to postoperative pain. Others were thought to be bowel obstructions or ileus.

In these situations, physicians failed to monitor patients’ WBCs or to order abdominal x-rays or CT scans. Surgeons failed to assess patients who called the office or who returned to the hospital with serious abdominal complaints. By the time a bowel perforation was suspected, patients were suffering from peritonitis, sepsis, septic shock, pneumonia, acute respiratory distress syndrome (ARDS), brain infarcts, or brain herniation, or they had died.

Patient deaths occurred in 16 percent of endoscopy claims, 26 percent of laparoscopy claims, and 25 percent of open surgical procedure claims.

—Darrell Ranum

At a time when a patient’s condition was expected to improve, symptoms became worse.

—Darrell Ranum
A difficult choice arises when two candidates face each other and both support reform.

—Hal Dasinger

GOVERNMENT RELATIONS REPORT

2014: Difficult Election Choices and Notable Legislation

by Hal Dasinger, Vice President, Government Relations

A key function of the government relations department is to identify and support candidates who will, if elected, tend to act in the best interests of our members. Often a candidate’s selection depends on his or her view of medical liability reform. A difficult choice arises when two candidates face each other and both support reform. The choice is made more difficult when the two candidates have each received support from us in prior elections.

There is no single test for deciding which candidate to support in this situation, but there are a number of important factors to consider. We might prefer a strong reform voice in one party caucus or the other, but party and legislative leaders have their own priorities and may take exception to our support for an opposition candidate. We might also have some expectation about which candidate is likely to win, but upsets are common and a wrong prediction can produce a lasting rupture in relations. Key endorsements by our political allies and state leaders matter, as do statistics: Whom does the voter registration favor? Who is better known in the district? One option is to stay out of the race altogether, since the election will inevitably result in a pro-reform winner. However, as legislative races become more expensive—particularly when closely contested—either candidate is likely to view this as a kind of repudiation. Another option is to contribute to both candidates, but this may suggest to each that we are working against him or her.

In the end, we must make the choice we feel is best for our members. Arriving at that choice requires analysis, instinct, experience, and advice from trusted political allies. In the last election cycle, our political action committees (PACs) supported 448 candidates for state and federal office. Of the candidates we supported, 417 won new seats or were re-elected. We appreciate our members’ support of the PACs that allow us to help reform-minded candidates succeed.

Notable 2014 Legislation

In 2014, a number of states enacted laws affecting medical professional liability:

California

The most notable legislation of 2014 was a proposed new law that was not enacted. Plaintiff attorneys qualified Proposition 46, a ballot measure that, if approved by voters, would have gutted California’s Medical Injury Compensation Reform Act (MICRA), increasing the limit on noneconomic damages from $250,000 to over $1.1 million. The measure would also have mandated drug testing for physicians and required the use of a prescription monitoring system that is currently unable to meet the demands of the providers who use it voluntarily. Voters rejected the measure by an overwhelming 67 percent to 33 percent.

The Doctors Company led the effort to defeat this destructive and costly measure. We were the first to commit major funding support, and we remained at the top of the donor list throughout the campaign. Behind the scenes, we served on the campaign’s executive committee, enlisted our allies in the state capitol and Congress during the battle over state political party endorsements, traveled the state enlisting civic and business groups into the coalition, and debated the trial lawyers during the 18 months between the filing of the ballot measure and the November 2014 election. The Doctors Company’s commitment was critical to the success of the No on 46 campaign.
Wisconsin
Assembly Bill 120: Wisconsin’s new “I’m Sorry” law is one of the nation’s strongest. The new Section 904.14 makes statements of “apology, benevolence, compassion, condolence, fault, liability, remorse, responsibility, or sympathy” inadmissible in subsequent court action, arbitration, or disciplinary proceeding. While many states have passed similar laws regarding expressions of sympathy or benevolence, this is one of only a few apology laws (Colorado, Connecticut, and Washington enacted the others) that specifically provide that expressions of fault are inadmissible. The new law took effect on April 10, 2014.

Nebraska
Legislative Bill 961: This bill raised Nebraska’s damage limitation for medical liability actions from $1.75 million to $2.25 million. The increase applies to occurrences after December 31, 2014. While many states have implemented caps on noneconomic damages, relatively few limit total damages. Nebraska and Virginia have similar limits; Colorado has separate limits for non-economic and economic damages, but the cap on economic damages is subject to suspension by the court, and requests to do so are seldom, if ever, refused.

Kansas
SB 311: This bill raised the noneconomic damages cap in Kansas to $300,000 for actions occurring after July 1, 2014, and provides for periodic increases. For actions after July 1, 2018, and before July 1, 2022, the cap will go up to $325,000; after July 1, 2022, it will go up again to $350,000. The bill was sponsored by the Kansas Medical Society in response to dicta in a state supreme court opinion indicating that, in order for the cap to remain an adequate remedy under the Kansas constitution, the legislature should increase the cap.

Pennsylvania
SB 1180 (Patricia Vance-R): This bill would create a prescription drug monitoring database called the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) to help physicians identify drug seekers. The bill was sponsored by the Pennsylvania Medical Society. The legislation includes liability protection for prescribers and dispensers who submit information or do not seek information from the program prior to prescribing or dispensing. The system will be administered by the Department of Health and is expected to be operational by June 30, 2015. Mandating the use of a similar system by physicians and pharmacists in California was part of Proposition 46, the ballot measure put on the November 2014 ballot by the trial lawyers to raise the state’s MICRA cap from $250,000 to over $1.1 million with an index going forward.

Idaho
SB 1355 (Judiciary and Rules Committee): This bill adds to existing law to provide that metrics established by the federal government under the Affordable Care Act and by insurers do not establish the standard of medical care in Idaho. This bill was enacted and became effective on July 1, 2014. This bill is Idaho’s version of the Standard of Care Protection Act. Since 2009, The Doctors Company and others have pushed for a federal law to prevent courts and juries from basing the standard of care in medical liability actions on payment guidelines, practice model rules, and other metrics in federal laws (including the Affordable Care Act, Medicare rules, and the Social Security statutes).

The Doctors Company’s commitment was critical to the success of the No on 46 campaign.
During the second dialysis treatment, there was uncontrolled bleeding from the fistula. The patient exsanguinated and expired. Experts were critical that there was no EHR High-Risk Medication Alert.

Claim: Insufficient Area for Documentation; Drop-Down Menu
A female had a bladder sling inserted for urinary incontinence. Her surgeon was assisted by a proctor surgeon who was representing the product manufacturer and training the patient’s surgeon on the procedure. The patient was informed that another physician would be assisting. In the recovery room, there was blood in the Foley catheter, so the patient was returned to surgery. The bladder had been punctured by the sling. The proctor had approved the sling’s placement. The circulating nurse did not document the proctor’s presence in the OR due to lack of an option in the EHR drop-down menu. There was no space for a free-text narrative to document that the patient was informed of the proctor’s presence.

Claim: Incorrect Information in EHR
A patient was seen by her cardiologist for hypertension. In the written medical record, her blood pressure medication had been increased to 25 mg once a day. Office staff entered the order into the EHR as twice a day. The prescription was filled. The patient missed her follow-up appointment. Seven months later, she went to the ER with numbness and weakness. Her potassium level was low. The cardiologist corrected the prescription error and gave her potassium.

Claim: Copy and Paste
A toddler was taken to a country where tuberculosis was prevalent. After the trip, he presented with fever, rash, and fussiness. The physician considered bug bite or flu and treated the child with fluids, antibiotics, and flu meds. His office EHR progress note indicated there was no tuberculosis exposure. The physician copied and pasted this information during subsequent office visits with no revision to note travel to a country with tuberculosis. Two weeks later, the child was diagnosed in the ER with tuberculous meningitis. He had permanent and severe cognitive defects.

Claim: Drop-Down Menu
A patient was seen by her physician for pain management with trigger point injections of opioids. The physician ordered morphine sulfate (MS) 15 mg every eight hours. In the EHR, the drop-down menu offered MS 15 mg followed by MS 200 mg. The physician inadvertently selected MS 200 mg and did not recheck before completing the order. The patient filled the prescription, took one MS along with Xanax, and developed slurred speech—resulting in an ER visit with overnight observation.

Claim: Incorrect Information in EHR
A patient with Tourette’s syndrome was treated with Haldol 0.5 mg documented in the written record. The patient called the office requesting a refill. The nurse entered “Haldol 5.0 mg” in the new EHR for an electronic script. This refill request showed up as a task for the physician to complete. The EHR was new, and it was the first script for this patient. The intended dose (0.5 mg) was therapeutic. The patient took the new dose (5.0 mg) for six months before the office staff discovered the error. The patient had side effects: cough, weight loss, and not feeling well.

Claim: EHR Training
A pregnant non-English-speaking female with gestational diabetes was referred for an ultrasound (US) to estimate fetal weight. Her physician had planned a C-section if the baby was >4500 grams. The US report was sent by the laboratory to the hospital’s EHR. The next day, the patient went to the hospital in labor. Her physician reviewed his six-week-prior prenatal written record but was not trained on the hospital’s EHR and had no password—so he did not see the US report. He performed a vaginal delivery, complicated by shoulder dystocia that resulted in brachial plexus injury. The baby’s weight was 4640 grams.

Claim: EHR Training
A female with gestational diabetes was referred for an ultrasound (US) to estimate fetal weight. Her physician had planned a C-section if the baby was >4500 grams. The US report was sent by the laboratory to the hospital’s EHR. The next day, the patient went to the hospital in labor. Her physician reviewed his six-week-prior prenatal written record but was not trained on the hospital’s EHR and had no password—so he did not see the US report. He performed a vaginal delivery, complicated by shoulder dystocia that resulted in brachial plexus injury. The baby’s weight was 4640 grams.

Claim: EHR Conversion; Incorrect Information in EHR
A patient with Tourette’s syndrome was treated with Haldol 0.5 mg documented in the written record. The patient called the office requesting a refill. The nurse entered “Haldol 5.0 mg” in the new EHR for an electronic script. This refill request showed up as a task for the physician to complete. The EHR was new, and it was the first script for this patient. The intended dose (0.5 mg) was therapeutic. The patient took the new dose (5.0 mg) for six months before the office staff discovered the error. The patient had side effects: cough, weight loss, and not feeling well.

Claim: EHR Training
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MRSA infection. The gynecologist had not been trained on the new system so did not find the new CT scan that was available.

Analysis of Location, Specialty, and Top Allegations
We also analyzed the 97 EHR claims to determine where the claim events occurred, which specialties were involved, and the most common allegations. The tables that follow outline our findings.

Recap of the Reported Risks of EHRs
The 2011 Institute of Medicine report, Health IT and Patient Safety: Building Safer Systems for Better Care, concluded that the information needed to analyze and assess health IT (HIT) safety and use was not available and that our understanding of the benefits and risks of EHRs was anecdotal. The report recommended creating a government agency that would systematically and uniformly collect data to investigate harm and safety events related to HIT. The Office of the National Coordinator for Health Information Technology is now developing a plan to create a Health IT Safety Center.

In the second quarter 2012 issue of The Doctor’s Advocate, I outlined the EHR benefits and corresponding risks reported in the medical literature. Here is a recap:

- EHRs improve medical record documentation and legibility. However, point-and-click lists, drop-down menus, templates, canned text, and autopopulation of data fields from personalized or packaged templates (for both procedure notes and the history and physical [H&P]) produce redundant, formulaic information that makes it easy to overlook significant clinical information.

- EHRs facilitate medication reconciliation and management and include alerts for improper drug dosages and drug allergies. However, frequent drug-drug interaction alerts lead to “alert fatigue,” sometimes causing physicians to override or disable them.

- EHRs facilitate e-prescribing—which also creates exposure to community medication histories where drug-drug interactions are time-consuming to trace.

- EHRs improve presentation of data for clinical decision making. However, providers often copy and

### Locations Where EHR Claim Events Occurred

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Clinic/Doctor’s Office</td>
<td>43%</td>
</tr>
<tr>
<td>Ambulatory/Day Surgery</td>
<td>12%</td>
</tr>
<tr>
<td>Patient’s Room</td>
<td>10%</td>
</tr>
<tr>
<td>Operating Room</td>
<td>9%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>7%</td>
</tr>
<tr>
<td>Labor and Delivery</td>
<td>5%</td>
</tr>
<tr>
<td>Radiology/Imaging</td>
<td>4%</td>
</tr>
<tr>
<td>Dentistry/Oral Surgery</td>
<td>2%</td>
</tr>
<tr>
<td>Pathology, ICU, Neonatal ICU, Radiation Therapy, and Special Procedures</td>
<td>1% each</td>
</tr>
</tbody>
</table>

### EHR Claim Events by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine Specialties—Cardiology/Hospitalist/Oncology/GI</td>
<td>20%</td>
</tr>
<tr>
<td>Primary Care—Family/Internal Medicine</td>
<td>16%</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>15%</td>
</tr>
<tr>
<td>Surgical Specialties (other than cardiac surgery)</td>
<td>14%</td>
</tr>
<tr>
<td>Nursing</td>
<td>7%</td>
</tr>
<tr>
<td>Radiology</td>
<td>5%</td>
</tr>
<tr>
<td>Anesthesiology and General Surgery</td>
<td>4% each</td>
</tr>
<tr>
<td>Pediatrics, Emergency Medicine, Psychiatry, and Orthopedics</td>
<td>2% each</td>
</tr>
<tr>
<td>Pathology</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Top Allegations in EHR Claims

<table>
<thead>
<tr>
<th>Allegation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis-Related (Failure, Delay, Wrong)</td>
<td>27%</td>
</tr>
<tr>
<td>Medication-Related:</td>
<td>19%</td>
</tr>
<tr>
<td>Ordering wrong medication</td>
<td>7%</td>
</tr>
<tr>
<td>Ordering wrong dose</td>
<td>5%</td>
</tr>
<tr>
<td>Improper medication management</td>
<td>7%</td>
</tr>
</tbody>
</table>

To share the articles in this issue, visit www.thedoctors.com/advocate.
Data
The most common allegation in malpractice claims was improper performance of surgery or the procedure (endoscopy, 83 percent; laparoscopy, 77 percent; and open surgery, 71 percent).

When there is a bowel perforation, a patient’s condition can deteriorate rapidly unless there is an intervention.

This information corresponded with the most common factor identified by expert reviewers as contributing to patient injury: technical performance (endoscopy, 78 percent; laparoscopy, 74 percent; and open surgery, 71 percent). Bowel perforation is a risk of these procedures. In most cases, our reviewers did not find that the perforation was caused by poor technique. Poor technique was identified in only a minority of claims. (See Table 1.)

Diagnosis-related allegations were commonly made (endoscopy, 15 percent; laparoscopy, 32 percent; and open surgery, 21 percent) when there was a delay in diagnosing bowel punctures, peritonitis, and sepsis. This allegation is closely related to patient assessment issues (endoscopy, 16 percent; laparoscopy, 37 percent; and open surgery, 32 percent). (See Table 2.) This factor refers to failure to establish a differential diagnosis, order diagnostic tests, address abnormal findings, and consider available clinical information.

Preoperative Patient Safety Recommendations
- Assess each patient preoperatively to determine if he or she is an appropriate candidate for a surgical or procedural intervention. Patient factors could affect the outcome.
- Review all of the information. For endoscopic procedures, it is important to consider the history of surgeries, complications of previous endoscopies, and the results of diagnostic studies. Without this information, the surgeon is more likely to be unprepared for adhesions, obstructions, tumors, or fragile tissue.
- Ensure that the operating room or procedure room is ready to convert from laparoscopic to an open surgical procedure if a patient’s medical history shows the likelihood of extensive adhesions.

Use a shared decision-making process when discussing a patient’s individual risk factors, such as obesity, cardiac or pulmonary disease, and diabetes—in addition to discussing the typical risks, benefits, and alternatives of the proposed procedure.

Postoperative Patient Safety Recommendations
- Ensure that the patient and family understand their responsibilities for monitoring the patient’s condition to determine whether any pain, fever, or nausea is a normal part of recovery or a complication that must be addressed by the surgeon.
- Assess and treat a patient promptly when there is a complaint of severe pain and the patient’s temperature is elevated. When there is a bowel perforation, a patient’s condition can deteriorate rapidly unless there is an intervention.

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paste information from prior notes into new notes (and, hopefully, edit as appropriate). This contributes to irrelevant, sometimes erroneous, over-documentation.

- Templates with drop-down menus facilitate data entry but are often integrated with automated features elsewhere in the EHR, where errors can be easily overlooked and disseminated. If an item is selected above or below the one desired, for example, “qd” can become “qid.”

- Clinical Decision Support (CDS) systems provide alerts, warnings, and reminders for medication and chronic disease management. This information may conflict with a medical specialty’s clinical standards of care or practice guidelines—and with the information in FDA-approved drug labels. EHRs document clinical decision making, including all departures from CDS guidelines. A physician should always document why a CDS prompt was overridden.

- Meaningful Use 2 (MU2) requires delivery of clinically relevant, disease-specific educational and drug safety materials to patients. Providers are responsible for the content of these materials.

- Vendor contracts may shift liability resulting from faulty software design or CDS from the vendor onto the user. Read all contracts carefully.

- During discovery, lawyers will request EHR metadata that documents logon and logoff times, what was reviewed and for how long, what changes or additions were made, and when the changes were made. All physician interactions with the EHR are time-tracked and discoverable.

- Transitioning from paper to EHRs can be risky. You must comply with federal and state record retention laws before destroying any written records.

To see the complete article that appeared in The Doctor’s Advocate, go to www.thedoctors.com/advocate and select the second quarter 2012 issue from the drop-down menu. ■

Special thanks to Lisa McCorkle, MSN, CPHRM, Patient Safety Risk Manager, The Doctors Company; and Darrell Ranum, JD, CPHRM, Vice President, Patient Safety and Risk Management, The Doctors Company.
As an organization founded and led by 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 asked members nationwide to respond to our 2014 Member Experience Survey. We received an enthusiastic response, with almost 5,900 members replying and many adding comments about their experience with The Doctors Company.

Thank you for taking the time to give us your valuable input and for telling us how we can better serve you.

Member Loyalty
We’re proud to report that 92 percent of members are likely to renew their medical malpractice policies with us, while 91 percent are likely to stay with us until they retire from the practice of medicine.

Relentless Defense
We set the standard for aggressive defense—93 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.

Unrivaled Protection
As the acknowledged industry leader in patient safety, The Doctors Company delivers innovative programs to help members reduce risk and avoid claims. Our survey found that a full 89 percent of members are pleased with our efforts to protect them from potential threats to their reputations and livelihoods.

Unsurpassed Rewards
Last year marked the seventh anniversary of the Tribute® Plan, an unrivaled benefit that rewards members for their loyalty and their dedication to superior patient care. Every year, Tribute grows and becomes more popular with our members—the highest distribution to date is $138,599. Currently, 90 percent of members agree that our efforts to reward them are unmatched.

Additional Survey Results
• 90 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.
• 93 percent of members are satisfied with our billing accuracy.
• 90 percent of members agree that we communicate well with them.

Again, thank you to all of our members who participated in our 2014 survey. Your responses help us deliver the highest-quality member service.

WHAT YOUR PEERS NATIONWIDE ARE SAYING ABOUT THE DOCTORS COMPANY

“The Doctors Company treats me with respect, and the Tribute program makes me feel like I am getting something back for my good record and loyalty.”
*Psychiatry—Ohio*

“The support I received and the dedication to protecting physicians is unlike any other company I have experienced. I had a lawsuit filed against me that was later dropped with prejudice, but the amount of time and effort The Doctors Company spent preparing me and the dedication to defend was outstanding.”
*Dermatology—Idaho*

“The Doctors Company has helped me through tough times, and those who were involved were very professional and caring. Thank you.”
*Anesthesiology—California*

“The Doctors Company is the most efficient and pro-physician company I have ever been involved with.”
*Internal Medicine—Florida*

Source: 2014 Member Experience Survey
Include bowel perforation in the differential diagnosis when a post-op patient complains of pain and other signs of infection.

—Darrell Ranum

**AN OUNCE OF PREVENTION**

*continued from page 8*

- Help a patient who suffers an injury understand his or her condition, treatment plan, and prognosis. If the injury resulted from a known risk, remind the patient of the pre-op informed consent discussion, and help him or her understand the connection. The patient may not be happy with the result, but he or she may be less likely to attribute the injury to negligence.

- Confirm that the patient is aware of symptoms that require medical assessment and treatment. Surgeons, nurses, and office staff need to be sensitive to a patient’s questions and concerns. This type of call is often the first opportunity for a surgeon to identify and address a bowel perforation.

**Conclusion**

Bowel perforation is a recognized risk of abdominal procedures or surgeries. Include bowel perforation in the differential diagnosis when a post-op patient complains of pain and other signs of infection. Listen to the patient’s concerns, and don’t hesitate to make an assessment when the clinical picture is different than anticipated. Give your patients the best chance of surviving by quickly recognizing perforations and infections and acting swiftly to repair and address them.

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**At Your Service Online**

We offer a paperless option for members who prefer to receive *The Doctor’s Advocate* by e-mail. Update your notification settings by signing in at www.thedoctors.com and selecting Edit User Profile from the drop-down menu.
William C. Rupp, MD, Appointed to Board of Governors

We are pleased to announce the appointment of William C. Rupp, MD, to the Board of Governors. Dr. Rupp is recently retired as chief executive officer of the Mayo Clinic in Florida and a board certified physician with 32 years of experience in the fields of hematology and medical oncology.

Dr. Rupp’s other leadership positions within the Mayo Health System have included president and chief executive officer of Immanuel St. Joseph’s in Mankato, Minnesota, and president and chief executive officer of Luther Hospital/Midelfort Clinic in Eau Claire, Wisconsin. He has also served as medical director of Midelfort Health Plan and as chief of staff at Sacred Heart Hospital in Eau Claire.

Dr. Rupp earned his bachelor of arts degree in economics at Dartmouth College. He received his medical degree from the University of Minnesota Medical School and completed his residency and fellowship at the University of Cincinnati Medical Center. He serves on the Board of Directors of Jacksonville University and recently completed a term as chair of the board of the Jacksonville, Florida, Area Chamber of Commerce.

“We are pleased to start the new year with Dr. Rupp on our Board of Governors,” said Richard E. Anderson, MD, FACP, chairman and CEO. “Dr. Rupp is a recognized industry leader on Integrated Delivery Systems, and an expert on patient safety. He brings strong strategic and operational skills, developed during his administrative medicine work at one of the most renowned medical institutions in the world and through his work on many nonprofit boards. His expertise is a strong asset to the board as we strive to ensure our members’ best interests are protected and pursued.”

“I am proud to join the board of a company dedicated to defending and protecting the practice of good medicine,” Dr. Rupp said. “I am eager to contribute to advancing the company mission alongside the executive leadership and other esteemed board members.”

OB Advisory Board Meeting

Experts from around the nation recently came together at our fifth annual OB Advisory Board meeting to address the prevention of maternal and infant injury or death in childbirth.

Problems with monitoring fetal heart rate and missing early warning signs of maternal collapse are serious potential malpractice risks and threats to patient safety, according to two physicians invited to present at the meeting.

“Poor communication of abnormal fetal heart rate monitoring is a serious malpractice risk,” said Michael Nageotte, MD, a member of the Perinatal Quality Foundation Board, past president of the Society of Maternal Fetal Medicine, and medical director, Obstetrix Medical Group of Southern California. “Credentialing, in which practitioners demonstrate both knowledge and judgment of fetal heart rate monitoring using definitions established by national consensus, may lessen this risk.”

Many early warning signs of impending maternal life-threatening illnesses go unrecognized because they are so rare, according to Jill Mhyre, MD, of the Council on Patient Safety in Women’s Health Care and associate professor of anesthesiology and director of obstetric anesthesia at the University of Arkansas.

“Centers need to start working on their response systems, defining steps to take when a physician is not present,” Dr. Mhyre said. As an example, she outlined an early warning system initiated by Stony Brook (NY) University Medical Center that involves scoring patients’ vital signs and other symptoms, leading to a staged response.

Other ob/gyn patient safety issues discussed at the meeting were:

- Water birth, by Larry Veltman, MD, FACOG, perinatal safety and risk management consultant and advisory board member.
- Morcellation and cancer link, by Marcus Tower, MD, FACOG, Hillcrest Hospital, Cleveland Clinic Foundation, and advisory board member.
- The use of nitrous oxide for labor analgesia, by Pamela Willis, BSN, JD, RN, patient safety risk manager with The Doctors Company.

Visit www.thedoctors.com/specialtyboards to learn more about how our specialty advisory boards help us advance the practice of good medicine.

New Videos on Business Risks Faced by Medical Practices

In today’s changing healthcare environment, the challenges of running a medical practice are complex. Our new YouTube playlist, “Medical Practices: Be Aware of Top Business Risks,” includes short animated videos that discuss three main business risks beyond medical malpractice lawsuits: billing errors and omissions, employment-related lawsuits, and data breaches. The videos also provide steps that practices can take to reduce their exposure, including ensuring they have adequate insurance coverage.

The videos feature case studies that give examples of the severity of these risks, such as:

- On average, it costs healthcare providers $80,000 to defend themselves in billing errors and omissions cases, and fines and penalties can be hundreds of thousands of dollars.
- The median award in employment practices lawsuits in 2012 was $325,000, and even a frivolous charge results in expensive defense costs.
- The healthcare industry suffers 51 percent of all data breaches—and the average cost of dealing with a breach was $2.4 million in the last two years.

Each video takes less than five minutes to watch. Go to www.youtube.com/doctorscompany to access the playlist and subscribe to our YouTube channel.

You can also follow us on Twitter @doctorscompany and find us on LinkedIn and Facebook.