The following is a compilation of medical malpractice claim data from January 1, 2004 to December 31, 2013, submitted by member companies of PIAA, a trade association of liability insurance companies. PIAA’s member companies insure more than two-thirds of private practicing physicians in the United States.

PIAA created its Data Sharing Project in 1985 to help identify areas of medical practice that have proven most vulnerable to medical liability claims. Participating member companies, such as TMLT, submit claim data semi-annually to the Data Sharing Project.

(Continued on page 2)
All data is reported in a codified manner; the names of physicians are not reported.

While this data provides a valuable overview of claim activity nationwide, TMLT’s own statistics reflect a stronger claim defense with fewer payments. When looking at national data from PIAA, 74% of claims were closed with no indemnity payment between 2004-2013. In a comparable time period (2005-2014), TMLT closed 86% of claims with no indemnity. Since 2002, TMLT has won more than 90% of cases taken to trial.

When looking at the PIAA data, the average indemnity payment between 2004-2013 was $361,340. The total national indemnity paid in medical liability claims over the same time period is $9 billion.1

The following data highlights the three most prevalent “chief medical factors” (formerly termed “medical misadventures”) per specialty along with the three top patient conditions associated with these factors. A “chief medical factor” is defined by PIAA as an “act, or omission, in diagnosis or treatment, by a health care professional that falls below the accepted standards of medical care, thereby triggering a claim or lawsuit for medical and/or legal damages.” The patient conditions are those presented to the physician at the time of the alleged incident.1

What follows is not meant to be an in-depth analysis, but a snapshot of claims by specialty. This information is designed for use as a risk management tool to inform physicians about the nationwide risk trends for their specialty.

### MOST PREVALENT CHIEF MEDICAL FACTORS AND PROCEDURES

The most prevalent chief medical factors and associated patient conditions are listed under each specialty.

#### Anesthesiology

1. Improper performance
   - back disorders, including lumbago and sciatica
   - musculoskeletal disorders and symptoms affecting neck region
   - degeneration of intervertebral disc

2. Problems with patient monitoring in surgery
   - malignant neoplasms of the prostate
   - desire for plastic surgery
   - osteoarthrosis, generalized or localized

3. Intubation problems
   - umbilical hernia
   - symptoms involving abdomen and pelvis
   - appendicitis

#### Cardiovascular and Thoracic Surgery

1. Improper performance
   - coronary atherosclerosis
   - cholecystitis
   - aortic aneurysm

2. Failure to recognize complication of treatment
   - coronary atherosclerosis
   - aortic valve disorders
   - acute pericarditis and other diseases of pericardium

3. Errors in diagnosis
   - malignant neoplasms of the bronchus and lung
   - chest pain, not further defined
   - circulatory system disorder

#### Cardiovascular diseases - nonsurgical

1. Improper performance
   - abnormal function study of cardiovascular system
   - coronary atherosclerosis
   - atrial fibrillation and flutter

2. Performed when not indicated or contraindicated
   - abnormal function study of cardiovascular system
   - coronary atherosclerosis
   - heart failure

3. Errors in diagnosis
   - aortic aneurysm
   - acute myocardial infarction
   - chest pain, not further defined

#### Dermatology

1. Improper performance
   - desire for plastic surgery
   - dyschromia
   - acne

2. Errors in diagnosis
malignant neoplasms of the skin
• disorder of skin and subcutaneous tissue
• malignant melanoma

3. Medication errors
• acne
• contact dermatitis and other eczema
• psoriasis

**Emergency Medicine**

1. Error in diagnosis
• acute myocardial infarction
• chest pain, not further defined
• symptoms involving abdomen and pelvis

2. Improper performance
• symptoms involving abdomen and pelvis
• dyspnea and respiratory abnormalities
• functional disorders of stomach

3. No medical misadventure
• acute myocardial infarction
• appendicitis
• chest pain, not further defined

**Gastroenterology**

1. Improper performance
• symptoms involving abdomen and pelvis
• benign neoplasms of the colon or large intestine
• disorder of esophagus

2. Errors in diagnosis
• malignant neoplasms of the colon and rectal region
• regional enteritis, colitis
• hemorrhage of gastrointestinal tract

3. Failure to supervise or monitor case
• disorder of esophagus
• disorder of liver, excluding cirrhosis
• hemorrhage of gastrointestinal tract

**General and Family Practice**

1. Error in diagnosis
• acute myocardial infarction
• chest pain, not further defined
• symptoms involving abdomen and pelvis

2. Improper performance
• calculus of gallbladder or bile duct
• obesity
• symptoms involving abdomen and pelvis

3. Medication errors
• back disorders, including lumbago and sciatica
• atrial fibrillation and flutter
• bronchitis

**General Surgery**

1. Improper performance
• calculus of gallbladder or bile duct
• cholecystitis
• obesity

2. Errors in diagnosis
• symptoms involving abdomen and pelvis
• neoplasm of the breast, unknown if malignant or benign
• malignant neoplasms of the female breast

3. Failure to recognize a complication of treatment
• obesity
• calculus of gallbladder or bile duct
• cholecystitis

**Gynecology**

1. Improper performance
• disorders of menstruation and other abdominal bleeding from female genital tract
• genital prolapse
• endometriosis

2. Errors in diagnosis
• neoplasm of the breast, unknown if malignant or benign
• symptoms involving abdomen and pelvis
• anemia, not further defined

3. Failure to supervise or monitor case
• benign neoplasms of the uterus
• disorders of menstruation and other abdominal bleeding from female genital tract
• routine gynecological examination

**Internal Medicine**

1. Errors in diagnosis
• symptoms involving abdomen and pelvis
• chest pain, not further defined
• symptoms involving respiratory system and chest

2. Improper performance
• symptoms involving abdomen and pelvis
• chest pain, not further defined
• dyspnea and respiratory abnormalities

PIAA’s member companies insure more than two-thirds of private practicing physicians in the United States.
3. Failure to supervise or monitor case
   - decubitus ulcer
   - symptoms involving abdomen and pelvis
   - diabetes

**Neurology - nonsurgical**

<table>
<thead>
<tr>
<th>1. Errors in diagnosis</th>
<th>2. Improper performance</th>
<th>3. Failure to supervise or monitor case</th>
</tr>
</thead>
<tbody>
<tr>
<td>headache</td>
<td>back disorders, including lumbago and sciatica</td>
<td>convulsions</td>
</tr>
<tr>
<td>occlusion and stenosis of cerebral arteries</td>
<td>displacement of intervertebral disc</td>
<td>headache</td>
</tr>
<tr>
<td>migraines</td>
<td>disc disorder of unspecified region</td>
<td>occlusion and stenosis of cerebral arteries</td>
</tr>
</tbody>
</table>

**Neurosurgery**

<table>
<thead>
<tr>
<th>1. Improper performance</th>
<th>2. Wrong patient or body part</th>
<th>3. Errors in diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>displacement of intervertebral disc</td>
<td>back disorders, including lumbago and sciatica</td>
<td>fracture of vertebral column</td>
</tr>
<tr>
<td>back disorders, including lumbago and sciatica</td>
<td>disc disorder of unspecified region</td>
<td>cerebral degeneration of undeterminable origin</td>
</tr>
<tr>
<td>disc disorder of unspecified region</td>
<td>back disorders, including lumbago and sciatica</td>
<td>congenital anomaly of brain spinal cord and nervous system</td>
</tr>
</tbody>
</table>

**Obstetric and Gynecologic Surgery**

<table>
<thead>
<tr>
<th>1. Improper performance</th>
<th>2. Errors in diagnosis</th>
<th>3. Failure to recognize a complication of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>pregnancy</td>
<td>pregnancy</td>
<td>malignant neoplasms of the pharynx and pharyngeal region</td>
</tr>
<tr>
<td>benign neoplasms of uterus</td>
<td>neoplasm of the breast, unknown if malignant or benign</td>
<td>diseases of upper respiratory tract, including pharynx, larynx, and vocal chords</td>
</tr>
<tr>
<td>disorders of menstruation and other abnormal bleeding from female genital tract</td>
<td>malignant neoplasms of the female breast</td>
<td>sinusitis</td>
</tr>
</tbody>
</table>

**Ophthalmology**

<table>
<thead>
<tr>
<th>1. Improper performance</th>
<th>2. Errors in diagnosis</th>
<th>3. No medical misadventure</th>
</tr>
</thead>
<tbody>
<tr>
<td>cataracts</td>
<td>other specified visual disturbances</td>
<td>cataracts</td>
</tr>
<tr>
<td>myopia</td>
<td>glaucoma</td>
<td>moderate to severe visual impairment</td>
</tr>
<tr>
<td>moderate to severe visual impairment</td>
<td>moderate to severe visual impairment</td>
<td>moderate to severe visual impairment</td>
</tr>
</tbody>
</table>

**Orthopedic Surgery**

<table>
<thead>
<tr>
<th>1. Improper performance</th>
<th>2. Failure to recognize a complication of treatment</th>
<th>3. Errors in diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>osteoarthrosis, generalized or localized</td>
<td>osteoarthrosis, generalized or localized</td>
<td>disorder of the joint, not including arthritis</td>
</tr>
<tr>
<td>disorder of joint, not including arthritis</td>
<td>fracture of the femur</td>
<td>disorders of soft tissue</td>
</tr>
<tr>
<td>fracture of the femur</td>
<td>fracture of the tibia or fibula</td>
<td>injury to multiple parts of body</td>
</tr>
</tbody>
</table>

**Otorhinolaryngology**

<table>
<thead>
<tr>
<th>1. Improper performance</th>
<th>2. Errors in diagnosis</th>
<th>3. Failure to recognize a complication of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>sinusitis</td>
<td>malignant neoplasms of the pharynx and pharyngeal region</td>
<td>malignant neoplasms of the pharynx and pharyngeal region</td>
</tr>
<tr>
<td>desire for plastic surgery</td>
<td>diseases of upper respiratory tract, including pharynx, larynx, and vocal chords</td>
<td>diseases of upper respiratory tract, including pharynx, larynx, and vocal chords</td>
</tr>
<tr>
<td>deviated nasal septum</td>
<td>sinusitis</td>
<td>desire for plastic surgery</td>
</tr>
</tbody>
</table>

While this data provides a valuable overview of claim activity nationwide, TMLT’s own statistics reflect a stronger defense with fewer payments.

While this data provides a valuable overview of claim activity nationwide, TMLT’s own statistics reflect a stronger defense with fewer payments.
- sinusitis
- diseases of upper respiratory tract, including pharynx, larynx, and vocal chords

Pathology
1. Errors in diagnosis
   - malignant melanoma
   - malignant neoplasms of the female breast
   - benign mammary dysplasia
2. Improper performance
   - cardiac or cardiorespiratory arrest
   - female infertility
   - malignant neoplasms of the colon and rectal region
3. No medical misadventure
   - disorder of muscle ligament and fascia
   - drug abuse or dependence
   - general medical examination

SPECIALTY GROUP STATISTICS
Cumulative Data from January 1, 2004 – December 31, 2013. Claims Payment Analysis by Specialty*

<table>
<thead>
<tr>
<th>SPECIALTY GROUP</th>
<th>CLOSED CLAIMS</th>
<th>PAID CLAIMS</th>
<th>% PAID TO CLOSED</th>
<th>INDEMNITY PAID</th>
<th>AVERAGE INDEMNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANESTHESIOLOGY</td>
<td>3,880</td>
<td>1,047</td>
<td>27.0</td>
<td>$385,725,477</td>
<td>$368,410</td>
</tr>
<tr>
<td>CARDIOVASCULAR &amp; THORACIC SURGERY</td>
<td>2,843</td>
<td>697</td>
<td>24.5</td>
<td>$227,746,889</td>
<td>$326,753</td>
</tr>
<tr>
<td>CARDIOVASCULAR DISEASES - NONSURGICAL</td>
<td>2,550</td>
<td>608</td>
<td>23.8</td>
<td>$145,592,815</td>
<td>$239,462</td>
</tr>
<tr>
<td>DERMATOLOGY</td>
<td>1,070</td>
<td>266</td>
<td>24.9</td>
<td>$57,424,609</td>
<td>$215,882</td>
</tr>
<tr>
<td>EMERGENCY MEDICINE</td>
<td>3,651</td>
<td>865</td>
<td>23.7</td>
<td>$287,286,058</td>
<td>$332,123</td>
</tr>
<tr>
<td>GASTROENTEROLOGY</td>
<td>1,870</td>
<td>343</td>
<td>18.3</td>
<td>$114,277,851</td>
<td>$333,172</td>
</tr>
<tr>
<td>GENERAL &amp; FAMILY PRACTICE</td>
<td>8,996</td>
<td>2,243</td>
<td>24.9</td>
<td>$655,301,546</td>
<td>$292,154</td>
</tr>
<tr>
<td>GENERAL SURGERY</td>
<td>9,179</td>
<td>2,722</td>
<td>29.7</td>
<td>$869,173,001</td>
<td>$319,314</td>
</tr>
<tr>
<td>GYNECOLOGY</td>
<td>1,263</td>
<td>305</td>
<td>24.1</td>
<td>$90,255,499</td>
<td>$295,920</td>
</tr>
<tr>
<td>INTERNAL MEDICINE</td>
<td>13,525</td>
<td>2,901</td>
<td>21.4</td>
<td>$978,820,913</td>
<td>$337,408</td>
</tr>
<tr>
<td>NEUROLOGY - NONSURGICAL</td>
<td>1,503</td>
<td>375</td>
<td>25.0</td>
<td>$157,057,121</td>
<td>$418,819</td>
</tr>
<tr>
<td>NEUROSURGERY</td>
<td>2,144</td>
<td>586</td>
<td>27.3</td>
<td>$261,264,192</td>
<td>$445,843</td>
</tr>
<tr>
<td>OBSTETRIC &amp; GYNECOLOGIC SURGERY</td>
<td>11,083</td>
<td>3,500</td>
<td>31.6</td>
<td>$1,478,035,203</td>
<td>$422,296</td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td>2,382</td>
<td>611</td>
<td>25.7</td>
<td>$173,082,267</td>
<td>$283,277</td>
</tr>
<tr>
<td>ORTHOPEDIC SURGERY</td>
<td>7,652</td>
<td>2,048</td>
<td>26.8</td>
<td>$542,977,757</td>
<td>$265,126</td>
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<tr>
<td>OTORHINOLARYNGOLOGY</td>
<td>1,659</td>
<td>577</td>
<td>34.8</td>
<td>$178,575,799</td>
<td>$309,490</td>
</tr>
<tr>
<td>PARAPROFESSIONAL</td>
<td>599</td>
<td>162</td>
<td>27.0</td>
<td>$40,144,435</td>
<td>$247,805</td>
</tr>
<tr>
<td>PATHOLOGY</td>
<td>710</td>
<td>218</td>
<td>30.7</td>
<td>$74,194,796</td>
<td>$340,343</td>
</tr>
<tr>
<td>PEDIATRICS</td>
<td>2,271</td>
<td>584</td>
<td>26.3</td>
<td>$233,224,288</td>
<td>$399,357</td>
</tr>
<tr>
<td>PLASTIC SURGERY</td>
<td>2,842</td>
<td>729</td>
<td>25.7</td>
<td>$135,908,241</td>
<td>$186,431</td>
</tr>
<tr>
<td>PSYCHIATRY</td>
<td>798</td>
<td>123</td>
<td>15.4</td>
<td>$24,175,760</td>
<td>$196,551</td>
</tr>
<tr>
<td>RADIATION THERAPY</td>
<td>329</td>
<td>99</td>
<td>30.1</td>
<td>$37,642,558</td>
<td>$380,228</td>
</tr>
<tr>
<td>RADIOLOGY</td>
<td>6,496</td>
<td>1,796</td>
<td>27.6</td>
<td>$626,388,943</td>
<td>$348,769</td>
</tr>
<tr>
<td>RESIDENT/INTERN</td>
<td>12</td>
<td>2</td>
<td>16.7</td>
<td>$175,000</td>
<td>$87,500</td>
</tr>
<tr>
<td>UROLOGIC SURGERY</td>
<td>2,357</td>
<td>642</td>
<td>27.2</td>
<td>$204,876,227</td>
<td>$319,122</td>
</tr>
<tr>
<td>TOTALS</td>
<td>94,228</td>
<td>24,793</td>
<td>26.3</td>
<td>$8,152,307,946</td>
<td>$328,815</td>
</tr>
</tbody>
</table>

**Pediatrics**
1. Errors in diagnosis
   - meningitis
   - appendicitis
   - pyrexia
2. Improper performance
   - brain damaged infant
   - circumcision
   - premature infant
3. No medical misadventure
   - laceration of eyelid
   - premature infant
   - brain damaged infant

**Plastic Surgery**
1. Improper performance
   - desire for plastic surgery
   - hypertrophic and atrophic conditions of skins
   - other specified disorders of breast
2. No medical misadventure
   - desire for plastic surgery
   - hypertrophic and atrophic conditions of skin
   - blepharitis
3. Failure to recognize a complication of treatment
   - desire for plastic surgery
   - hypertrophy of breast
   - complications of internal prosthetic device implant and graft

**Psychiatry**
1. Failure to supervise or monitor case
   - major depressive affective disorder
   - neurotic disorder, not further defined
   - drug abuse or dependence
2. Medication errors
   - bipolar affective disorder
   - hyperkinetic syndrome
   - major depressive affective disorder
3. Improper performance
   - major depressive affective disorder
   - depressive disorder, not further defined
   - bipolar affective disorder

**Radiation Therapy**
1. Errors in diagnosis
   - fracture of vertebral column
   - malignant neoplasms of the female breast
   - appendicitis
2. Improper performance
   - malignant neoplasms of the prostate
   - malignant neoplasms of pancreas
   - abnormal blood test results
3. Failure/delay in referral or consultation
   - routine gynecological examination
   - benign mammary dysplasia
   - malignant neoplasms of the skin

**Radiology**
1. Errors in diagnosis
   - neoplasm of the breast, unknown if malignant or benign
   - malignant neoplasms of the female breast
   - screening for malignant neoplasms
2. Improper performance
   - symptoms involving abdomen and pelvis
   - neoplasm of the breast, unknown if malignant or benign
   - back disorders, including lumbago and sciatica
3. No medical misadventure
   - malignant neoplasms of the bronchus and lungs
   - malignant neoplasms of the female breast
   - screening for malignant neoplasms

**Urologic Surgery**
1. Improper performance
   - calculus of kidney and ureter
   - malignant neoplasms of the prostate
   - disorder of kidney and ureter
2. Errors in diagnosis
   - disorder of urethra and urinary tract
   - malignant neoplasms of the prostate
   - disorder of male genital organs
3. Failure to recognize a complication of treatment
   - calculus of kidney and ureter
   - disorder of kidney and ureter
   - malignant neoplasms of the bladder
Sources

7. As defined by PIAA, no medical misadventure occurs when there is no allegation of inappropriate medical conduct, but the claim has legal merit because of associated issues, such as problems with medical records, consent issues, communication between physicians, vicarious liability, product liability, etc.

When looking at the PIAA data, the average indemnity payment between 2004-2013 was $361,340.

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CME: Online reputation management for physicians

COURSE AUTHOR
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DISCLOSURE
Laura Hale Brockway has no commercial affiliations/interests to disclose related to this activity.

TARGET AUDIENCE
This 1-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for medical liability.

CME CREDIT STATEMENT
Physicians are required to complete and pass a test in order to earn CME credit. A passing score of 70% or better earns the physician 1 CME credit.

TMLT is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. TMLT designates this enduring material for a maximum of 1 AMA PRA Category 1 Credit.™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ETHICS STATEMENT
This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

INSTRUCTIONS
the Reporter CME test and evaluation forms must be completed online. After reading the article, go to https://tmlt.inreachce.com. Log on with your myTMLT user name and password to access the course. Follow the online instructions to complete the forms and download your certificate. If you do not have a myTMLT account, please call customer service at 800-580-8658 ext. 5050.

Questions about the CME course? Please call TMLT Risk Management at 800-580-8658.

ESTIMATED TIME TO COMPLETE ACTIVITY
It should take approximately 1 hour to read this article and complete the questions and evaluation form.

RELEASE/REVIEW DATE
This activity is released on April 6, 2015, and will expire on April 6, 2018.

Please note that this CME activity does not meet TMLT’s discount criteria. Physicians completing this CME activity will not receive a premium discount.

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Policyholders: $10
Non-policyholders: $75

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KNOW YOUR ONLINE PRESENCE

Have you ever taken the time to Google yourself or your practice? What did you find? Was the information accurate? Did you find a “review” of your practice among the results? What would a patient conclude about you based on those Google results?

A Google search is fast becoming the first method of contact patients have with your practice. With more patients online, your reputation is being built and managed on the Internet. And like it or not, your online reputation plays a role in acquiring new patients and maintaining trust with existing patients and colleagues.

Physician review sites are among the most popular destinations for patients. Yelp is used most frequently, followed by Healthgrades, RateMDs, Vitals, and ZocDoc, according to a survey on how patients use online reviews.1 The survey also found:

• Of those responding to the survey, 61 percent read online patient reviews before choosing a physician, and 20 percent use online reviews to evaluate their current physician.
• 85 percent of respondents said they were “moderately likely” to choose one physician over another based on positive reviews.
• Patients are cautious about negative reviews and feel that they “can tell a valid complaint from an overreaction.” Of the respondents, 34 percent cited “exaggerated reviews” as the main reason for disregarding a review.1

Though negative reviews can be painful to read, they do not appear to have an overwhelming influence on patients’ choices of physicians. Patients are swayed more by positive reviews and many of them still prefer recommendations from family and friends.9

Nevertheless, online patient-generated content is here to stay, says Sue Mills, senior vice president of claim operations at TMLT. “That’s why it’s crucial for physicians to plan and focus on maintaining their online reputation.”

Online reputation management is the process of preventing and repairing threats to your online reputation. It is done by tracking what is written about you online and using techniques to address or moderate that information. The goal is to promote positive or neutral content while suppressing negative content.

For physicians, online reputation management involves addressing information in three areas:

1. information found on search engine results pages (Google, Bing);
2. information found in social media (LinkedIn, Facebook, Glassdoor, blogs); and
3. information on rating sites, such as Yelp, Vitals, HealthGrades, and Rate MDs.

KNOW WHAT’S BEING SAID

The first step in managing your reputation is awareness. Visit the most popular physician rating sites — Yelp, Healthgrades, RateMDs, Vitals, and ZocDoc — and monitor your reviews. Conduct web searches on yourself and your practice regularly. One way to monitor yourself is through Google Alerts. Set up an alert for your name, practice name, and any other possible way you could be found online. Google will send you free email alerts when you have been mentioned online.

KNOW WHAT YOU CAN AND CANNOT DO ABOUT NEGATIVE REVIEWS

What should you do if someone posts a negative review about you? Because of health care privacy laws, you cannot respond to online reviews. The fact that a patient’s identity is protected information directly hinders your ability to refute a complaint. Simply acknowledging publicly that the complaining party is a patient breaches confidentiality and violates HIPAA.

To avoid violating HIPAA laws, many physicians respond to the comments anonymously. This is not advisable. There is no such thing as anonymity on the web. IP addresses — the unique numbers that identify computers accessing the Internet — act as fingerprints and can identify the user’s computer.

“Physicians should also consider that whatever you write cannot be taken back and may remain on the Internet for a very long time,” says Mills.

If the complaints indicate that the patient is considering legal action, contact your medical liability insurance company as soon as possible. “If a patient makes an accusation of medical malpractice, it is even more important that the physician does not reply online,” says Mills. “Anything said in response could be used in the claim against the physician.”

Dealing with online complaints can be frustrating. You may be asking what you can do in the face of this type of criticism.

If the reviewer posted enough information for you to identify the patient, you can contact the patient personally to discuss his or her concerns. This should be done in person or over the phone. (Do not use email, since it could be copied and pasted into further online complaints. Your email message could even be altered.) Often, this is enough for the patient to edit or remove the negative review.
If you are not sure who the patient is, you can reply publicly with a general statement, such as:

“Because of privacy regulations, we can’t discuss any specifics about your comments. However, we are committed to providing high quality care and we take your feedback seriously. If you are a patient and wish to discuss your concerns with the physician, please contact our office directly.”

or

“We apologize that this occurred. We’re committed to providing the best experience possible, so please call our office and we will make this right.”

Again, a direct, public reply should be avoided.

UPDATE YOUR PROFILE INFORMATION
While you cannot respond to or control patient reviews on online rating sites, there is information on those sites that you can control. Many sites include basic information about each physician — education, training, specialty, location, office hours — and allow you to submit information for your profile. Make sure your information is up-to-date on review sites, and work to keep it current.

OFFER CONSTRUCTIVE WAYS TO GIVE FEEDBACK
If patients are unhappy and are not given the opportunity to speak up, they may respond by posting negative comments online and going to another physician. Give patients the opportunity to talk to you with patient satisfaction surveys. Knowing that they have the opportunity to offer feedback — and that you will acknowledge the issues — patients will speak up and feel empowered.

Survey questions may include asking about their experience with the office, parking, wait times, and appointment availability. Ask patients to give details on their perception of their care. Were their questions answered during the visit? Did the physician and staff provide adequate medical education and resources? Ask about physician communication style. Ask patients if they would refer someone to your practice. If not, ask why.

FIX WHAT YOU CAN
It is also a good idea to investigate the patient’s complaints. Is the complaint legitimate? Are people complaining about a long wait time? Did they feel your front desk staff was rude? Do they feel it is difficult to schedule an appointment? Consider improving on the general concerns about the practice.

“These reviews can help identify problems with your practice and when corrected, can lead to an improved overall experience,” says Mills.

ASK PATIENTS TO REVIEW YOU
The next time you receive a thank you note or email from a patient or family member, encourage that person to post their comments on your website, on your LinkedIn profile, or on physician rating sites.

“There’s no rule against asking patients to write an online review. Just don’t cherry-pick who you ask . . . rather than only ask the patients you suspect will write a positive review, contact patients (through their preferred, HIPAA-approved method) 48 hours after their visit and encourage them to let you know how you’re doing.”

OPTIMIZE YOUR WEBSITE FOR SEARCH ENGINES
Optimizing your website for search engines will help ensure that anyone typing in your name or your practice name will see your site at the top of the search list. Search engine optimization (SEO) involves creating comprehensive and targeted meta tags and website page titles that help search engines index your site.

More sophisticated techniques include editing your site’s content, HTML, and associated coding; removing barriers to the indexing activities of search engines; increasing inbound links; or purchasing related web addresses. Here’s how some of these techniques work:

Page titles
A title tag — which is simply a title given to a page of your website — tells both users and search engines what a page within your website is about. Ideally, each page of your site should have a unique title that accurately describes the content of your page. Search engines use your title tags to index your site.

For example, your home page title tag should be “Northwest Medical — primary care in Burlington, Texas” rather than “Northwest Medical home page” to enhance your site’s SEO. This first title tells Google more about your home page.

Meta tags
Pages on your site can also be assigned a description meta tag. While page titles may be a few words or a phrase, a page’s description meta tag might be a sentence or a short paragraph. Again, search engines use the information in your meta tags to index your site.

So, if your home page meta tag contains the words “Burlington pediatrician,” Google will rank your site higher in search results when someone searches for “pediatricians in Burlington.”
**Create keyword-driven content**

Create content centered on your patients’ needs. Think about the words a patient might search for to find your website and integrate those words into your content. Use a good mix of keywords and phrases.

For example, if you are an ophthalmologist in San Antonio, Texas, what would patients type into a search engine to find you? Maybe “San Antonio eye doctor” or “ophthalmologist San Antonio.” The more of those exact words or phrases that are in your site content, the higher you will rank on the search results page.

**CREATE YOUR OWN CONTENT**

Remember that reputation management also involves promoting positive or neutral content while suppressing negative content. Another technique is to create your own positive content that will outrank the negative content. Take control and tell your own story.

**CREATE A LINKEDIN PROFILE**

Your LinkedIn profile is one aspect of your online presence that you create.

LinkedIn is the world’s largest professional network with more than 300 million members in over 200 countries.

LinkedIn is to your professional contacts (including patients) what Facebook is to your friends. Make your LinkedIn profile public, and patients and potential patients can learn about you in a way you can control. Since LinkedIn is a professional networking site, the context of the connection is always professional. Your profile should include such information as where you went to school, your specialty, and your practice.

LinkedIn is not just a site for posting your CV. Post practice updates, health care news, or announcements that would be helpful to patients. Your connections can then comment or “like” your posts and updates. Again, keep your posts and interactions strictly professional. If your patients ask to “friend” you on Facebook, tell them to connect with you on LinkedIn instead.

**CONSIDER VIDEO**

Why should you consider video? Because surveys of online habits suggest that people are reading less and watching more. YouTube is now the number two search engine, after Google. More people conduct searches on YouTube than Yahoo or Bing combined.

And they are not all searching for videos of cats playing the piano. They are searching for videos to answer specific questions, such as “What can I expect after my colonoscopy?” or “Should I have a PSA screening?”

Corporations, retail stores, hospital systems, and physicians have been using YouTube — in addition to their websites and blogs — to educate their audiences. The Mayo Clinic YouTube channel currently has more than 3,600 videos with more than 20 million views.

Adding video to your website or blog is not complicated. Use the camera on your smartphone to create a video introduction of yourself and your practice. Is there a health topic you feel strongly about? Create a video explaining why the topic is important and what steps you want your patients to take. Adding a new service? Create a video...
explaining it to your patients. Upload the video to YouTube and link it to your site. You now have content on the number two search engine and you have increased your site’s ranking on Google.

**BEWARE OF REPUTATION MANAGEMENT SERVICES**

In recent years, you may have received an email or seen ads from companies offering online reputation management services. There are hundreds of companies offering these services; however, physicians are urged to use extreme caution when choosing a reputation management company. Some companies engage in questionable techniques that could lead to disciplinary action by the Texas Medical Board (TMB).

Specifically, these companies may offer or promise to “post reviews for our clients to over 40 social media websites . . . We post up to 25 reviews per month.”

This claim is alarming in the context of medical practice. How are they managing to post reviews from the patients of a particular physician? Are the reviews made up?

It is unethical and dishonest to post reviews on these sites that are not from actual patients. Physicians are held to a different standard than other businesses, and posting fake patient reviews is problematic. Doing so would also violate TMB advertising rules, as this type of advertising (and the TMB does consider this to be advertising) would be considered “misleading.”

“There are legitimate reputation management companies out there; you just need to ask the right questions before you employ them,” says Mills.

**CONCLUSION**

Online reputation management is an ongoing process. By monitoring what patients are saying about you, taking their feedback seriously, and telling your story through relevant content, you can make sure your online reputation continues to be positive.

**Sources**


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Reputation management terms

**Blog** — combine the words “web” and “log” and you get blog. A blog is a discussion or informational site consisting of discrete entries called posts.

**Facebook** — a social networking website that allows registered users to create profiles, upload photos and video, send messages, and keep in touch with friends, family, and colleagues.

**Flaming** — posting personal attacks and insults in an online discussion, or what often happens when an Internet argument grows heated. A “flame-war” is the end result of online flaming. Flaming is discouraged on most Internet forums.

**Flickr** — a social network that allows users to store and share photos online.

**Google cache** — as Google crawls the web to index sites, it takes snapshots of each page as a back up in case the current page is not available. These pages become part of Google’s cache. A user who clicks on a link that says “cached” will see a previous version of the site. Even if you succeed in removing information from a website, the Google cache copy may still exist for weeks and allow Google users to see the deleted information.

**Google+** — Google’s version of Facebook. The focus of Google+ is not on sharing with a mass group of friends, but on targeted sharing with groups.

**Healthgrades** — a health care rating site that allows users to “research, compare and connect with physicians and other healthcare professionals.”

**Instagram** — a smartphone app that lets users take photos, apply filters, and share those photos on Instagram or other social networks, like Facebook or Twitter.

**Link equity** — the value that Google and other search engines give to a website, based on the history of a site, the number of inbound links, and other measures of the site’s authority. Link equity tells you how much power your links have to influence search engine results.

**LinkedIn** — a business-oriented social networking site. LinkedIn is to your professional contacts what Facebook is to your friends. Think of it as your professional Facebook page.

**RateMDs** — a health care rating site that provides “reviews and ratings on everything from cleanliness of hospital and care center facilities and amenities, to physician knowledge, as well as giving patients the ability to share their own personal experiences.”

**Search engine optimization (SEO)** — a strategy for ensuring that anyone typing your name or your practice name into a search engine will find you at the top of the SERP, or search engine results page. SEO techniques include link building, content optimization, and creating specific meta tags and page titles.

**Search engine results page (SERP)** — the web page where the user is directed after conducting an Internet search. SERP lists the results of the search in order of relevance as determined by that specific search engine’s algorithm.

**Slideshare** — a social network for sharing presentations and documents that allows users to embed, comment on, and share presentations.

**Twitter** — a platform that allows users to share 140-character long messages. Users can follow each other as a way of subscribing to each other’s messages. Users can also use the @username command to send a direct message to another Twitter user.

**Trolls** — digital bullies who create conflict in online communities by starting arguments and posting inflammatory or off-topic messages. Trolls deliberately attempt to upset other users, provoke an emotional response, or disrupt normal on-topic discussion.

**Vitals** — a physician review site that claims to have “over 1 million doctor, dentist and medical facility profiles and over 5 million doctor ratings and reviews.”

**Yelp** — a social network and local search website that provides users with a platform to review, rate, and discuss local businesses and services. There are 26,380 Yelp reviews posted every minute.

**YouTube** — a video-sharing website on which users can upload, share, and view videos.

**ZocDoc** — an online service that allows patients to view a physician’s schedule and make appointments. The site also provides information on the physicians’ specialties, range of services, office locations, photographs, education, and user-submitted reviews.
On January 16, 2015, the Texas Medical Board (TMB or the Board) published emergency rule 190.8(1)(L) that prohibits physicians from using telemedicine consults to remotely prescribe dangerous drugs or controlled substances without first performing and documenting a physical examination by either a face-to-face visit or in-person evaluation. The emergency rule was in response to a decision by the Austin Court of Appeals that invalidated an informal agency statement from the Board that threatened discipline for physicians who engage in telemedicine. On April 10, the board formally adopted the rule, effective June 3.

TEladoc v. The Board Lawsuit: Round 1
Teladoc, a network of physicians who practice exclusively through Internet and phone consultations, has opposed the Board’s informal agency statement for several years. Under Teladoc’s business model, a patient may create an account online that provides Teladoc with access to the patient’s personal information, history, and medical records. When a patient requests a consult from Teladoc, the responding physician accesses and reviews the patient’s information; confers with the patient over the phone; dispenses medical advice; and prescribes medications as needed.

In 2011, the Board determined these practices were inconsistent with the public health and welfare. Citing Rule 190, the Board sent a letter to Teladoc threatening discipline against any Teladoc physician who participated in these consults. Teladoc then sued for a determination on whether the content of the letter was a substantive “rule” or a mere restatement of Rule 190. Teladoc
maintained that if the letter’s content was determined to be a rule, then it was invalid because the content had not gone through the formal rulemaking process.

The Board admitted that it did not provide the public with either notice of this letter or any opportunity to comment, as would be required for formal rulemaking under the Administrative Procedure Act. The Board also acknowledged that the telemedicine rules did not include “telephone consults.” Thus, the legal case turned on whether the agency pronouncement was a new rule or a substantive amendment to Rule 190.

The Austin Court of Appeals agreed with Teladoc’s position and found the letter was equivalent to a substantive rule and was thus rendered invalid because it had not gone through proper administrative rulemaking, including providing notice and opportunity for public comment. Undeterred, the Board recently voted to seek review in the Supreme Court of Texas.

THE BOARD RESPONDS BY ENACTING EMERGENCY RULE

Less than three weeks after the appellate court ruling, the Board published emergency rule 190.8 (1) (L) based on their letter. The Board stated that, in its opinion, prescribing drugs remotely, without first evaluating and examining the patient face-to-face, makes it impossible for physicians to:

• ensure proper and accurate diagnosis and treatment;
• ensure proper prescribing practices; and
• ensure that the medications prescribed are actually needed or proper for the condition.

In its statements regarding the emergency rule, the Board also expressed concern that remotely prescribing dangerous drugs could occur based on a patient’s subjective complaint. In sum, the Board remains committed to its position that these consultations are not a generally accepted medical practice and do not meet the standard of care.

The emergency rule is effective until May 20, 2015, and could be extended once for up to 60 days. Teladoc immediately challenged the emergency rule and sued to stop its enforcement.

TELADOC V. TMB: ROUND 2

A Travis County District Court has temporarily stopped enforcement of this emergency rule. The court has also sealed the proceedings, so it is unclear what grounds were asserted to challenge the emergency rule.

FORMAL RULEMAKING

On April 10, the board formally adopted this emergency rule, requiring physicians to conduct an in-person visit with a patient before diagnosing or prescribing drugs by phone or video. Once the diagnosis is made in person, the physician may treat the patient’s condition via telemedicine for up to a year. Physicians may only use telemedicine with patients they haven’t met in person if the patient is currently visiting a health facility and are in the presence of another health care worker. Physicians may provide mental health service via telemedicine to the patient’s residence without a health care provider physically present with the patient. Teladoc supporters are expected to try to overturn the measure.

Sources

1 See 22 Texas Administrative Code Section 190.8, 1 (L)(i) (2)

2 See Texas Government Code Section 2001.029

3 The pertinent telemedicine rules are set forth at Chapter 174 of the Texas Administrative Code. On February 12, 2015, the TMB’s Telemedicine Committee voted to approve changes to the telemedicine rules. The substance of those changes was not available as of the date of this paper.

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Wrong-site surgery

By Wayne Wenske, Communications Coordinator, and Louise Walling, Senior Risk Management Representative

PRESENTATION

A 67-year-old man with left knee pain and a history of arthritis came to an orthopedic surgeon on referral from his primary care physician.

PHYSICIAN ACTION

The orthopedic surgeon examined the patient’s left knee, and suspected a torn meniscus. An MRI of the left knee was ordered and revealed a complex tear of the posterior horn of the medial meniscus; Grade 3 chondromalacia patella with moderate effusion; and tri-compartmental arthritis.

The orthopedic surgeon recommended arthroscopic partial medial and lateral meniscectomy; resection of the medial kneecap; and abrasion arthroplasty. On March 10, the patient signed a consent form for a left knee arthroscopic medial meniscectomy. The next day, the surgeon prepared a preoperative physician order for left knee surgery. On March 17, the patient returned to the surgeon’s office for a preoperative examination. The preoperative diagnosis included Grade 3 arthritis, and lateral and medial meniscus tear. At this appointment, the patient signed a consent form for left knee arthroscopy that was co-signed and witnessed by the surgeon’s nurse.

On March 20, the patient was admitted to a surgical center. Upon admission, the physician orders and surgical consent form reflected that surgery was to occur on the right knee. The patient informed the admitting nurse that the surgery was supposed to occur on the left knee. The nurse contacted the surgeon's office to verify the surgery site. The surgeon faxed over an amended physician order and surgical consent form reflecting left knee surgery. However, the initial order and consent reflecting right knee surgery was not discarded, and the patient’s right knee was prepped and draped.

The surgical center incorporated a “time out” procedure with all surgeries to verify all information and details of surgery prior to a procedure. However, the orthopedic surgeon did not participate in the time out for this surgery. She performed the procedures on the right knee, which showed pathological changes consistent with osteoarthritis.

When the patient woke up in the recovery unit, he noticed that the right knee was bandaged. He informed the surgical center staff that the surgery occurred on the wrong knee. The orthopedic surgeon told the patient and the patient’s family that she took full responsibility for the error.

In April, the patient fell and injured his right knee. No fractures were found on x-ray, and he was treated conservatively with medications. In a follow-up visit, the patient did not report any pain in the right knee, but said that pain in the left knee continued.

In a follow up visit in June, the patient reported right knee pain. An MRI indicated a horizontal oblique tear of the posterior horn of the medial meniscus in the right knee. The orthopedic surgeon then recommended and performed a right knee arthroscopic medial meniscectomy. In follow up visits, the patient still reported right knee pain and the orthopedic surgeon administered cortisone injections in the right knee. She ultimately
recommended right total knee replacement.

In October, the patient consulted with a second orthopedic surgeon. The patient reported significant pain in both knees, worse on the left, with a grinding sensation between the bones of the right knee joint. He also informed the surgeon that he did not have problems with the right knee prior to the erroneous surgery.

The second orthopedic surgeon took x-rays that revealed evidence of advanced arthritis of the medial compartment of both knees. The right knee was now considered worse than the left knee. The surgeon recommended a right total knee replacement. The patient agreed to the surgery and continued to follow up with the second orthopedic surgeon. A total left knee replacement has also been recommended.

ALLEGATIONS
A lawsuit was filed against the first orthopedic surgeon. Allegations included:

- unnecessary surgery on the right knee;
- rapid progression of osteoarthritis that resulted in need for total knee replacement of the right knee; and
- failure to treat the left knee.

LEGAL IMPLICATIONS
The primary weakness in this case was the fact that surgery took place on the wrong knee. In addition, the orthopedic surgeon never treated the knee that initially required surgery, even after erroneous surgery on the wrong knee. The surgery also precipitated the need for total knee replacement of the right knee.

Physicians and experts who reviewed this case were critical of the orthopedic surgeon. They all agreed that the orthopedic surgeon did not meet the standard of care. Testimony from the second orthopedic surgeon suggested that the first orthopedic surgeon’s initial recommendations should have been total knee replacement on the left, which is still required for this patient.

DISPOSITION
This case was settled on behalf of the orthopedic surgeon.

RISK MANAGEMENT CONSIDERATIONS
The Joint Commission has established Speak UP guidelines, or a universal protocol, for preventing wrong site surgery. The initial process is to address missing information or discrepancies prior to starting the procedure. The patient’s oral report and the signed consent reflected contradictory surgical sites.

In the subsequent post-op visits, the medical care focused on the right knee with little documentation noted about the left knee, the original proposed site of surgery. If this site initially warranted surgery, documentation that included a plan of care and the patient’s response to the plan would have helped to complete the medical record.

Sources
1 The Joint Commission
Available at: www.jointcommission.org/facts_about_speak_up_initiatives/. Accessed March 6, 2015.

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The Joint Commission has established Speak UP guidelines, or a universal protocol, for preventing wrong site surgery.
Incorrect dosage of chemotherapy medication

By Wayne Wenske, Communications Coordinator, and Louise Walling, Senior Risk Management Representative

PRESENTATION

A 60-year-old man underwent a parietal craniotomy due to a brain tumor that was determined to be a Grade 4 gliosarcoma. Surgery was followed by radiotherapy and chemotherapy treatment with temozolomide at 140 mg daily for approximately two months. In the third month after surgery, the patient was given temozolomide at 400 mg daily for five days. He then received a second cycle of temozolomide in the fourth month after surgery.

Due to recurring seizures and a return of the brain tumor, the man was admitted to a hospital six months later for a repeat brain tumor resection. This surgery was intended to provide the patient with a reasonable quality of life for the remainder of his life expectancy, determined to be six to eight months.

Three days after admission, the patient underwent surgery. During this time, the patient received temozolomide. Five days later, the patient was transferred to the hospital’s rehabilitation unit. Transfer orders included all preoperative medications from the EHR. A new medication reconciliation form was generated, and the rehabilitation physician, Physician B, ordered the continuation of temozolomide at 400 mg per day. The patient received this dose until his hospital discharge 10 days later.

The patient was admitted to a different hospital two days later due to persistent seizures. The admitting physician, Physician C, reviewed the records from the first hospital and discovered that the patient had been overdosed with temozolomide at over three times the recommended length of treatment. The patient deteriorated rapidly with severe pancytopenia; rash; oral and periorbital
ulcerations; respiratory failure; liver failure; multiple Staphylococcal infections; Candida infection; Cytomegalovirus viremia and pneumonia. The patient developed dehiscence of the craniotomy wound with subsequent infection. The patient's white blood count fell to 0.9 and his platelet count fell to 14. The patient required multiple transfusions and continued antibiotic administration. He underwent debridement and revision of the scalp wound. The patient's health continued to deteriorate until his death, 11 months after the brain tumor resection by Physician A.

**ALLEGATIONS**
A lawsuit was filed against Physician A, Physician A's APN, Physician B, and the hospital where they were employed. Allegations against Physician A included:

- inappropriate authorization, use, and dosage of temozolomide;
- failure to recognize or be knowledgeable about temozolomide while it was being administered to the patient;
- failure to adequately supervise medications being ordered by the APN;
- failure to consult with an oncologist who specialized in the administration of chemotherapy drugs; and
- failure to review medications when the patient was transferred to the treating hospital's rehabilitation unit.

**LEGAL IMPLICATIONS**
Chemotherapy drugs are usually not given to patients surrounding surgery due to the immunosuppressive tendencies of the drugs. The patient received approximately seven doses of temozolomide under Physician A's care and an additional 16 doses under the care of Physician B. The hospital's pharmacy had no appropriate measures in place to “red flag” the improper administration of this medication, and the oncology pharmacists failed to recognize the error.

The hospital's EHR system was still being implemented during the patient's hospitalization. Physician A stated that the system was awkward and difficult to use and may have contributed to the medication error. Physician A also stated that the medication error would have been difficult to identify by any staff members unfamiliar with the new EHR. It is also apparent that temozolomide was entered into the EHR system erroneously by the admitting nurse as a current medication when it should have been entered as a previous medication.

**DISPOSITION**
This case was settled on behalf of Physician A, Physician A's APN, and the hospital. It is unclear whether the case was settled on behalf of Physician B.

**RISK MANAGEMENT CONSIDERATIONS**
A patient medication reconciliation review is an important process of a patient's hospital admission or visit to a physician's practice. In this case, the APN had an opportunity to compare the EHR medication list with the list documented by her supervising neurosurgeon, but instead she only accessed one source, which led to a succession of errors. Checking the medication list at various junctures in the patient's care (transfer to a new facility, hospital discharge, or at each office visit) provides a check and balance system for an error to be caught. If there is a question about the medication and a clarification is needed, it is recommended to call the prescribing physician. If the reader is unfamiliar with the medication while checking the medication list, there are websites that quickly identify drug information:


Medication reconciliation is prudent risk management and maximizes patient safety.

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What can I blog about?

Creating a blog for your practice starts with writing content that is valuable and relevant to your patients. Here are six ideas to help get you started.

1. **Practice changes** — keep your patients updated on any practice changes, such as adding a new physician, change in office hours, new practice services added, etc.

2. **What you do** — provide some background on your specialty or practice. For example, if you are a family physician and you offer sports physicals for students, explain what you look for during a sports physical. If you offer travel medicine exams and immunizations, explain why these are important.

3. **FAQs** — keep track of the questions your patients ask and answer those in-depth.

4. **Health in the news** — provide brief commentary on current health news. For example, let’s say a new study has been published on colon cancer screening and the media has misconstrued the results. Set the record straight for your patients by posting the correct information about the study on your website and encouraging your patients to see you if they have any concerns about colon cancer.

5. **Health topics relevant to your patient base** — think about your patients and what most concerns them. What top 10 patient conditions do you treat? Write a short blog post about each of them and encourage patients to seek treatment for these conditions from you.

6. **Importance of immunizations** — there is a lot of misinformation out there about vaccinations. Explain to your patients why vaccines are important and how they should discuss their concerns with you. Provide links to reputable websites and credible information about immunizations.