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THE NEWEST CYBER THREAT: ONLINE FINANCIAL FRAUD

In our digital, interconnected world, it's unsettling to know that a publication called *Data Breach TODAY*[1] even exists. But as more data is available online, data breaches will continue to climb. The array of sophisticated methods used by cyber criminals make staying in front of the attacks more difficult, if not impossible.

Of particular concern to health care organizations are breach threats involving protected health information

(PHI). These threats are expected to increase because cyber criminals view health care entities as "low-hanging fruit," primarily due to the perception that health care organizations lack sufficient cyber security.

Even more troubling, cyber crime has expanded beyond data breaches and privacy claims to online financial fraud. This type of fraud is often associated with social engineering tactics (such as an illicit email phishing campaign or spoofed website) designed to obtain passwords and credentials to steal company funds.

Examples of financial fraud include the following cases—two real and one hypothetical.

EXAMPLE 1 (Real):

An outside hacker created a fraudulent domain name to resemble a physician's website, changing only one letter in the domain name. The hacker used the fraudulent domain name and physician's name to create a familiar email address. The hacker then sent an email to the physician's accountant instructing her to send a wire transfer of $27,780 to a designated account. The accountant did not notice the request came from an email address not belonging to the physician. The accountant sent the money per the fraudulent instructions and the fraud was not discovered until she later mentioned the transaction to the physician. The physician's bank did not reimburse the wire transfer.

EXAMPLE 2 (Real):

The email of a physician employed by a medical group was hacked while he was performing charity work in Peru on behalf of the medical group. The hackers sent two fraudulent requests for wire transfers in the amount of $8,200 and $25,000 to the medical group's accountant. After the wire transfers were sent, it was discovered that the funds were delivered to an account in Hong Kong. The funds were not retrievable.

EXAMPLE 3 (Hypothetical):

A medical practice has online payments set up with their EHR vendor. A disgruntled employee who works for the EHR vendor accesses the medical practice's accounts payable system. Once inside, the employee substitutes her personal bank account information and routing number to divert payments from the practice to her own bank account. Alternatively, the employee may have hacked into the medical practice's bank account to directly steal funds.

Typically, perpetrators of cyber financial fraud have researched their target and are adept at creating messages and websites that appear legitimate. Recipients of deceptive emails need only click on a compromised website or attachment to "infect" an organization's entire computer network.

Therefore, simply installing the latest robust security technology is not enough to prevent these loss scenarios. These breaches often involve some level of human negligence—which IT experts believe is currently the weakest security link in most organizations.

RISK MANAGEMENT STEPS

Developing a culture of information security is the first and primary step a practice should take to thwart financial fraud. Identifying fraud threats must be recognized as a shared responsibility, with all employees attuned to the signs and symptoms of fraud activities. Guidelines for prevention, detection, and response should be introduced to all employees with clear steps to take if any threat is discovered. Creating this kind of awareness may help to avoid a potentially disastrous financial loss.

Implementing the following risk management steps can further mitigate this exposure:

- establish a cyber security budget and integrate cyber security strategies into the cost of conducting business;
- develop and implement robust fraud prevention policies and procedures;
- use the latest information security technologies, including network vulnerability and penetration testing and security monitoring;
- perform regular system back-ups and store the backed-up data offline;
- conduct *ongoing* information security training, particularly for those with access to your financial data;
- limit access to your financial assets to carefully screened employees whose behavior can be tracked and monitored;
- conduct criminal background checks on prospective and existing employees to check for any prior fraud incidents (This is important because some crime insurance forms exclude coverage for *any* employee who is known by the employer to have committed prior dishonest acts.);
- be skeptical of any e-mail message, attachment, or website you do not recognize; and
- monitor all deposit account balances and verify all transfer instructions. Report all cyber fraud activities to your financial institution and appropriate law enforcement authorities. (Most practices will know when money is missing from key bank accounts.)

INSURANCE RISK TRANSFER

Most standard commercial property insurance policies have specific exclusions (or may only provide low limits) for voluntary parting or unauthorized transfers of money, securities, and other tangible property due

to a fraudulent scheme—no matter how legitimate or convincing the fraud. And in most instances, a financial institution will hesitate or refuse to reimburse fraud losses, unlike consumer credit card fraud, which is typically covered by the card-issuing bank. Therefore, having **commercial crime coverage** can be a valuable offset to this type of threat.

Practices are encouraged to meet with their insurance agent to determine if they have coverage for financial fraud committed by employees/insiders and outsiders, and to determine appropriate limits of liability. Practices should also know what their specific loss retentions or deductibles are and the timeline for reporting a claim to ensure coverage is triggered.

COMMERCIAL CRIME COVERAGE POLICIES OFFER A GREAT DEAL OF FLEXIBILITY.

If properly endorsed, they will cover the direct loss of money, securities, and other property caused by voluntary parting and fraudulent instructions.

For example, coverage is available for losses that result from someone using electronic or other communication means to direct a financial institution to carry out a fraudulent transfer of funds, but without the knowledge or consent of the insured. This type of crime coverage is typically known as *Computer Fraud* and *Funds Transfer Fraud.*

In addition, new commercial crime endorsements have recently been filed that cover financial fraud caused by imposters seeking to defraud by pretending to be someone else. These endorsements carry such titles as *Fraudulent Impersonation of Employees* or *Fraudulent Impersonation of Customers and Vendors.*

Some cyber insurance carriers have also added coverage for cyber crime claims. For example, a major cyber insurer added the following coverage agreement to their cyber liability policy to indemnify financial fraud loss (if not reimbursed or reversed by your financial institution or credit card company):

> **Financial fraud** means any of the following:
>
> 1. An intentional, unauthorized and fraudulent written, electronic or telephonic instruction transmitted to a financial institution, directing such institution to debit your account and to transfer, pay or deliver money or securities from your account, which instruction purports to have been transmitted by you or your employee, but was in fact fraudulently transmitted by a third party without your knowledge or consent; or
> 2. An intentional, unauthorized and fraudulent written, electronic or telephonic instruction transmitted to a financial institution by your employee as the result of that employee receiving intentional, misleading or deceptive telephonic or electronic communications from a third party falsely purporting to be you or your client, vendor, or employee, and which directs the financial institution to debit your account and to transfer, pay or deliver money or securities from your account; or
> 3. The theft of money or securities from your bank account or corporate credit cards by electronic means.[2]

This insurer also added coverage for "phishing attack loss" to cover the "cost of reimbursing your existing customers for their financial losses arising directly from a phishing attack."[2]

Finally, it's important to understand that despite the availability of this coverage, cyber insurers are still reacting to the large health care data breaches that occurred in 2014-2015. Consequently, most insurers will carefully evaluate the risk profile of each prospective practice or client who seeks this coverage.

WHAT DOES THE FUTURE HOLD?

It's uncertain how much financial fraud losses will grow in 2016.

Anecdotally, losses from insider attacks can cost more than those caused by outsiders. It only takes an insider with access to the organization's financial systems and an understanding of system vulnerability to create a fraud loss.

In their *2010/2011 Computer Crime and Security Safety Survey,* the Computer Security Institute found that survey respondents broadly reported more of their financial losses were attributable to non-malicious insiders (making unintended mistakes) than to malicious insiders.

Unfortunately, the health care industry has been an easy target for data breach incidents when compared to other industries and the trend is expected to continue for some time. According to Legaltech news, "the health care industry holds the dubious distinction for having the most number of data breach incidents compared to other industries." In addition, Legaltech warns:

> "…. Health care data still commands a 10x premium over financial and other personal information. At the same time, most health care companies lack the ability to find a network attacker that has circumvented preventative security and is in the process of exploring an unfamiliar network, gaining additional points of control, and getting closer to Protected Health Information (PHI) and Personal Identity Information (PII) records. Even data encryption, greater network segmentation

and additional authentication controls are unlikely to impede a network attacker, as they can steal valid credentials that give them access to critical data to carry out their work. These network attacks will continue to occur in 2016 and will likely continue to represent the industry most victimized by data breaches."[3]

Socially-engineered, targeted email attacks—exploiting both human and system flaws in organizations—are expected to be a major form of cyber attack in the future. These schemes can take the form of targeted cyber attacks designed to:

1. extort monies by using "ransomware" (e.g., CryptoWall and its variants) to take control of and encrypt the data in the victim's computers and then threaten to destroy it unless the victim pays a ransom (aka "cyber extortion"); or
2. destroy valuable data without any intended financial gain or purpose per se (aka "cyber terrorism"). These types of attacks can create significant direct and indirect costs such as legal fees, IT services, notifications, lost revenue and productivity, and reputational harm.

The "hacktivists" in the latter instance often target an organization to promote a social, ideological, religious, or political cause. They do this by intimidating the organization or causing harm to or disabling an organization's information, data, or infrastructure. (A good example is the Sony Pictures attack by North Korea in 2014.)

Today's cyber security is chiefly about financial loss prevention, and it requires a multi-layered approach. Given the sophistication of attack techniques used by cyber criminals, some threats will succeed. Cyber security is a continuous process and an ever-shifting challenge that requires everyone within the organization to be engaged. It seems that cyber security is a team sport and there is no off-season.

SOURCES

1. Data Breach Today. Available at http://www.databreachtoday.com/ Accessed February 4, 2016.
2. NetguardTM Plus Endorsement, Cyber Crime Coverage E1856NCT-0515. NAS Insurance Services. Accessed January 18, 2016.
3. Thompson, David. Your Next Big Break: 2016 Data Breach Predictions." Legaltech news website, Dec. 29, 2015. Available at http://www.legaltechnews.com/id=1202745920330/Your-Next-Big-Break-2016-Data-Breach-Predictions?slreturn=20160015123421. Accessed January 15, 2016.

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CYBER SECURITY SOLUTIONS FROM TMLT

TMLT offers fee-based Cyber Risk Management services and standalone Cyber Liability Insurance, available both in or out of Texas. These resources are intended to mitigate cyber-crimes against your practice and to protect it financially in the event of a computer-related fraud loss. For more information, please contact TMLT's Product Development and Consulting Services Department at ConsultingWebmail@tmlt.org.

By Kassie Toerner, Risk Management Representative

MANAGING PATIENT COMPLAINTS

OBJECTIVES

Upon completion of this course, the physician will be able to:

1. recognize factors that contribute to patient satisfaction;
2. identify the primary sources that drive patient complaints;
3. describe strategies to resolve a patient complaint; and
4. apply communication tips to reduce patient complaints.

COURSE AUTHOR

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DISCLOSURE

Kassie Toerner has no commercial affiliations/interests to disclose related to this activity. TMLT staff, planners, and reviewers have 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 following a CME activity 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.

PRICING

The following fee will be charged when accessing this CME course online at http://tmlt.inreachce.com.

Policyholders: $10
Non-policyholders: $75

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 http://tmlt.inreachce.com. Log in using your myTMLT account information to take the course. Follow the online instructions to complete the forms and download your certificate. To create a myTMLT account, please follow the on-screen instructions.

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 February 22, 2016, and will expire on February 22, 2019.

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

IMPROVING PATIENT SATISFACTION AND DECREASING PATIENT COMPLAINTS

Ideally, a medical practice operates efficiently: appointments are always on schedule; comprehensive, high-quality, patient-centered care is delivered; staff members are engaged and wanting to assist patients; health outcomes improve; and patients never complain.

However, patient complaints are inevitable. And when a patient complaint is not effectively managed, unfavorable or harmful consequences can result—noncompliance, dissolving of the patient-physician relationship, litigation, or reduced compensation. Therefore, strong complaint management is a core component for success worth cultivating and honing.

To illustrate how patient satisfaction and patient complaints can affect a physician and medical practice, this article reviews common elements that can influence patient satisfaction, online complaint trends, and even financial reimbursement. This article also offers useful tips for successfully managing patient complaints.

WHAT CONTRIBUTES TO PATIENT SATISFACTION?

Patient satisfaction is a patient's positive perception of his or her overall experience with a physician or medical practice. While there are many facets to patient satisfaction, the cornerstone of patient satisfaction is the patient-physician relationship. Encounters between patients and physicians are based upon trust and are crucial to the patient's perception of quality care.

However, patient satisfaction also encompasses nonclinical aspects of care, such as ease of scheduling an appointment; ease of parking; comfortable or inviting office space; polite, caring staff; and so on. More often, complaints are made about how patients feel they were treated rather than the medical skills of the physician.

PATIENT COMPLAINTS – EMBRACE THE OPPORTUNITY

"A complaint is a gift." This popular business adage suggests that the message within a customer's complaint offers valuable feedback. For physicians and medical practices, this feedback is an opportunity to understand the patient's experience and use the information provided as a means to strengthen and improve the practice and the patient-physician relationship. Generally, complaints are made because the patient wants a dialogue with the physician—an explanation, an apology, or reassurance.

Dealing with complaints is a dynamic and unique process for each physician and medical practice. When complaints are identified and dealt with promptly and effectively, physicians can:

- cultivate loyal patients;
- improve patient outcomes;
- positively impact the overall performance of the medical practice;
- reduce costs involved with handling a complaint;
- limit complaints that become formal legal claims; and
- reduce stress and staff turnover.

TYPES OF COMPLAINTS

According to a study published in the February 2012 issue of *Health Outcomes Research in Medicine,* patients were more satisfied when they were able to make appointments that allowed them to see the physician quickly after initiating contact; had shorter wait times in the exam or waiting room; and when the physician gave them more than 10 minutes of their time during the patient encounter.[1]

Researchers at Vanguard Communications analyzed 3,617 online reviews of 300 internists and ob/gyns practicing in Austin, Denver, New York City, and San Diego who earned the lowest marks on the Vitals, RateMDs, and Yelp review websites. Slightly more than one half (53%) of the posts were negative. Patients who posted negative reviews were 4 times more likely to complain about a physician's indifference, bedside manner, or customer service than about his or her medical ability.

A breakdown of the online reviews show:

- 43.1% included complaints about poor bedside manner (perceived arrogance, indifference, and poor listening skills);
- 35.3% included complaints about poor customer service; and
- 21.5% included complaints about medical skills, such as wrong diagnoses and surgical mistakes.[2]

BEDSIDE MANNER COMPLAINTS

For patients, bedside manner is most often influenced by or associated with a physician's attitude. Patients want to connect and feel engaged with their physician. A physician's hastiness or short answers can be perceived as poor bedside manner. Patients are often fearful or stressed. Supportive gestures from a physician that convey caring, emotional support, and openness can often neutralize fear, stress, or anger.

Behaviors that can promote positive perception of bedside manner:

- Know the patient's name. As simple as this sounds, it is a fairly common issue. Addressing the patient by name (without checking the chart in front of the patient) immediately personalizes the patient encounter. Find out what name the patient prefers to be called.
- Introduce yourself (at the initial encounter and to family members accompanying the patient) or

extend a kind greeting with established patients. This further sets the tone for the patient encounter.
- Make eye contact with the patient. This shows concern and sincerity. With the use of electronic medical records, some physicians find it challenging to maintain eye contact throughout an entire patient encounter. Fortunately, there are other behaviors, such as good listening skills, that can be used when eye contact is limited. The combination of eye contact and effective communication skills will reinforce the physician's attentiveness and concern.
- Show empathy. Try to get a sense of what the patient is feeling and respond in a way that will comfort and support the patient.
- Invite two-way communication. Be an active listener. Patients want to receive and provide information.

CUSTOMER SERVICE COMPLAINTS

Patients often criticize physicians and medical practices for such deficiencies as long wait times, rude treatment by office staff, poor or limited physical access, and billing disputes. Patients also describe poor follow-up, such as not providing test results or returning telephone calls in a timely manner, as a prime reason for their dissatisfaction.

A national survey asked participants to rate things that bother them during a visit to their physician. The most prominent complaint was unclear or incomplete explanation of a problem. The remaining top complaints were:

- test results not communicated in a timely manner;
- billing disputes hard to resolve;
- difficulty in getting a quick appointment when sick;
- being rushed during an office visit;
- perceived early discharge from hospital;
- issues being discussed within earshot of other patients;
- side effects not fully explained; and
- long wait for physician in the exam or waiting room. (This complaint ranked higher than inconvenient office hours or filling out medical forms.)

More women than men had complaints about private discussions taking place within earshot of other patients and rushed office visits.

Complaints that seemed less bothersome to patients were:

- too quick to recommend tests;
- takes notes on device or not looking at patient; and
- hard to reach by phone or e-mail.[3]

How can wait times be managed to lessen patients' level of frustration? If appointments are running behind or the physician is delayed in surgery, it may be beneficial to instruct staff members to be straightforward with patients about wait times and to apologize for the delay at the onset of the office visit. If it's likely that the patient will endure a long wait once in the exam room, consider having the patient remain in the waiting room where they have the freedom to walk around or even reschedule. Front office staff can also continue to provide updates to patients in the waiting room. Additionally, asking the patient if there is anything that can make them more comfortable while they wait is helpful in managing patient frustrations during long wait times.

EFFECTIVE, QUALITY PATIENT-PHYSICIAN COMMUNICATION

Quality physician-patient communication is the primary factor associated with patient satisfaction and the likelihood of a patient returning to a physician or medical practice. Effective physician-patient communication encompasses such skills as active listening, empathy, nonverbal cues, and the ability to foster a collaborative exchange of information. A review of studies published between 1949 and 2008 found that patients were significantly more compliant with medical care provided by physicians whom patients deemed to be good communicators compared with those lacking communication skills.[4]

Effective communication skills not only result in improved patient outcomes, but several studies have established that physicians who communicate well with their patients find that their work is less stressful and more fulfilling than those who do not communicate effectively. Conversely, poor communication is linked to lower patient satisfaction, diminished patient outcomes, and lower physician job satisfaction. The vast majority of malpractice lawsuits are also linked to poor communication.

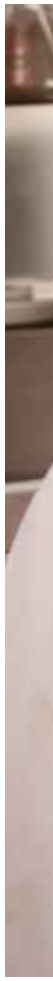
LISTENING

A study published in the *Annals of Internal Medicine* found that, on average, physicians interrupt the patient 18 seconds into the patient's explanation for the visit.[5] While it is common for physicians to interrupt a patient as a way of keeping the clinical interview on track, patients perceive interruptions as impolite. Patients may also infer that the physician does not care what he or she has to say.

Studies have shown that patients will rarely talk for more than two minutes. Allowing the patient to talk demonstrates that the physician is interested and not rushing the patient. Once the patient has shared his or her statements or feelings, physicians may tell the patient that they have provided important information and ask to take a moment to document it.

NONVERBAL COMMUNICATION

Nonverbal cues are as important as verbal communication. Sitting down to discuss the patient's exam and findings has



a dramatic impact on a patient's perception of the quality of the patient-physician interaction. A physician's eye contact with the patient, tone of voice, speed of conversation, facial expressions, and body posture can all reinforce concern and attention to the patient.

EMPATHY

Cultivating and demonstrating empathy is an essential aspect of providing quality patient care. Research studies show that genuine empathy for patients is associated with fewer medical errors, better patient outcomes, fewer malpractice claims, and happier physicians.[6] Physicians who have had training in empathy tend to interrupt their patients less, maintain better eye contact, and are better able to maintain composure with dissatisfied patients.[7] Physicians have reported that awareness of empathy, while challenging at times, can diminish some of the dehumanizing effects now prevalent in health care and restore more personal interactions with patients.[8]

A study in the *Journal of General Internal Medicine* in June 2012 reported that patients were more than twice as likely to describe a physician's level of empathy rather than their level of knowledge or expertise. Terry Canale, at the American Academy of Orthopaedic Surgeons' vice presidential address, said, "The patient will never care how much you know, until they know how much you care."[9]

Patients want to feel like they are regarded as human beings and not just another medical case. With some effort, showing empathy is easily accomplished. Ask patients about their daily lives; how the injury or illness is affecting them; and how they're coping. Engage their feelings, show respect for their efforts to cope, and promote their dignity as a human being. Most patients, regardless of personality or background, will respond to the respect and kindness of empathic messages.

A recent survey from the Cleveland Clinic reported that, overall, patients want empathy from their physicians more than anything else. Eighty-two percent of survey respondents said that physician empathy was important, and many were even willing to overlook common grievances—like rescheduling shortly before an appointment or a long wait—if the physician is empathetic.[10]

Examples of empathetic messages include responding to a patient's complaints with:

- "This must be very difficult for you."
- "Anyone in your situation would feel that way."

Asking the patient for more information with:

- "Would you tell me more about that?"
- "Is there anything else you'd like to tell me?"

Clarifying patient statements with:

- "Let me see if I have this right."
- "Are you OK with that?"

CASE STUDY

Jack, a 62-year-old, disabled, former steelworker saw an internist for intermittent chest pains, dizzy spells, and a recurrent cough. The internist did a full work-up that revealed a resting blood pressure of 190/115 mm Hg; serum cholesterol of 360 mg/dL with a high density lipoprotein fraction of 40; an ischemic heart; fasting blood glucose of 236 mg/dL; chronic bronchitis; and obesity. Jack's mother and father both died in their 50s of heart disease.

Jack was annoyed with the internist's advice to quit smoking and lose weight. The internist prescribed a blood pressure-lowering medication, but Jack stopped taking it within a week. He stated that he had been told by some of his co-workers that the medication could make him impotent.

The internist attempted to get Jack on a low-fat and low-sodium diet. However, Jack argued that he did not believe foods like steak and eggs could be bad for him, as "people have been eating that way for generations." Jack had a negative response to all of the internist's treatment suggestions and refused to follow any of her recommendations.

Jack returned for follow up with the physician after two weeks and his condition had not improved. Jack complained that the internist was "harping" about his smoking and diet. The internist referred Jack to a cardiologist who recommended cardiac catheterization. Jack refused the catheterization, as he felt it was "an excuse for a surgical procedure," while claiming the physicians did not know what they were doing.

Jack returned to the internist seven times in the following five months. He continued to refuse to follow her recommendations and openly blamed her for his failure to improve.

Eventually, Jack suffered a myocardial infarction and proceeded to sue the internist and cardiologist. Due to the internist's excellent documentation, the claims representative was confident the case could be defended successfully. After protracted litigation, the case was eventually settled.[11]

It is unknown if any empathetic communication took place between Jack and his physicians. But the results make one question if the outcome could have been changed if effective, two-way communication and empathy had been achieved during Jack's five months of treatment. Unfortunately, patients like Jack are all too common.

In 2011, *Consumer Reports* published a survey of 660 primary care physicians entitled, "What Doctors Wish Their Patients Knew." The number-one complaint, by a wide margin, was: "Patients didn't take the doctors' advice or otherwise follow treatment recommendations."[12] The number of patients who are noncompliant has reached epidemic proportions, and the inability to provide optimal care as a result has mushroomed into one of the most pressing problems in health care today. In the United States, 3.8 billion prescriptions are written every year, yet more than 50% of them are taken incorrectly or not at all.[13]

TIPS WHEN HANDLING A PATIENT COMPLAINT

Dealing directly with a patient complaint employs many of the same principles as previously addressed in this article. While being proactive to reduce complaints is ideal, complaints may be unavoidable. Dealing promptly with complaints is beneficial.

Some proactive processes that may assist with managing or reducing complaints include creating policies and procedures that outline how complaints are handled; maintaining a system to track complaints and outcomes; and initiating communication skills training for staff and physicians.

Keep in mind that most patients do not like to complain. If they have a complaint that they want to share, they will likely experience high levels of anxiety or anger when attempting to share their experience.

The following suggestions may be helpful with directly handling a patient complaint.

Location

Find the right place to discuss a complaint. An office or exam room is more ideal than the waiting room or check-out area of the practice. Invite the patient to an area where the physician and/or staff can have a confidential discussion.

Listen

Use active listening skills and put away any distractions such as a phone, patient chart, or computer. Be mindful of nonverbal communication, such as facial expressions, gestures, and posture. Allow the patient time to share his or her complaint without interruption.

Empathize

Showing empathy does not imply that the physician or staff member agrees with the patient's complaint; agrees to the

patient's terms of resolution; or admits guilt or wrongdoing. Offering statements of empathy (such as, "I understand that this is important to you") reinforces to the patient that you are hearing and acknowledging his or her concerns. Once the patient perceives he or she is understood and valued as a person then emotions will likely settle. This allows the physician or staff to better negotiate a reasonable solution. Be mindful of tone when offering statements of empathy as to not appear sarcastic or condescending.

Clarify

Try to understand as much as possible about the situation and identify the root of the problem. Identifying and understanding the real concern will help you resolve the complaint.

For example, if a patient complains that he or she does not feel valued or respected, ask clarifying questions to understand what the patient experienced. Examples of clarifying questions include "Would you tell me more about that?" or "How could we have handled that better?" To ensure you understand your patient's complaint and that you acknowledge your understanding, reflect or restate the complaint back to the patient with the statement, "What I am hearing you say is . . . ."

Once the problem is identified, suggest solutions that you or a staff member can attain or perform. Ask the patient for his or her approval of the solution: "Is that okay with you?" If time is needed to resolve the complaint, ask the patient if you can follow up in a set number of days or weeks. When appropriate, express your sincere regret that the patient suffered or was disappointed without blaming another person or situation. For example, "I'm so sorry the wait was frustrating to you."

Appreciate

Thank the patient for taking time to notify you of their concern. Remind the patient that his or her satisfaction is important and reiterate your intention to resolve any issues. Keep in mind that if one of your patients has a complaint, there may be others experiencing the same issues that have not come forward. Your patient is actually doing you a favor in helping you to solve problems that may affect current patients and avoid mishaps with future patients.

Document

After discussing the complaint, it may be helpful to summarize the conversation and any agreed upon resolutions. Record the necessary information in a complaint tracking system.

Track patient complaints

Tracking complaints can be a useful tool to identify patterns that may be consistently stemming from the same physician, employee, situation (wait times, call backs, lack of adequate information, billing inquires), time of day, or

CAHPS PATIENT SURVEYS AFFECT CMS REIMBURSEMENT

Patient complaints may also affect physician reimbursements, based on results of patient surveys initiated by the Centers for Medicare & Medicaid Services (CMS). CMS administers several different patient surveys that focus not on quality of care, but a patient's experience of the physician or the practice.

Many of the CMS patient experience surveys are in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) family of surveys. HC-CAHPS is the survey for hospitals; CG-CAHPS is for offices or group practices. CAPHS surveys include such topics as access to care, physician communication, and office staff interactions. Because CAHPS surveys are standardized, health care providers are able to use the results to compare and assess their performance against similar organizations and pinpoint strengths and weaknesses.

In 2011, health care reform legislation passed by Congress created a CMS Physician Compare website. Physician Compare provides consumers with physician ratings based on data collected through CMS' Physician Quality Reporting System (PQRS). Legislation also requires that patient ratings of physicians be considered for inclusion on the Physician Compare website. The website rates a provider as high quality, average quality, or low quality based on average CAHPS scores.

CMS requires CG-CAHPS data collection for medical practices with more than 100 providers under one tax identification number who are submitting PQRS through the Group Practice Reporting Option (GPRO) website. In 2015, CMS initiated voluntary participation in CG-CAHPS for groups with at least 25 eligible professionals. Eligible professionals or groups that did not satisfactorily report in the 2014 PQRS program year will be subject to a payment adjustment in 2016.

Both Pioneer Accountable Care Organizations (ACOs) and Medicare Shared Savings Program (MSSP) ACOs are required to participate in annual CG-CAHPS data collection as part of the ACO CAHPS program. For Pioneer and MSSP ACOs, 25% of their "quality results" will be based on CG-CAHPS and ultimately affect their ability to share in savings. For medical practices affected by CG-CAHPS, at least 16.7% of value-based dollars will be based on CGCAHPS as part of the Value-Based Payment Modifier (VM), which provides for differential Medicare payments to a physician or group based upon quality of care.

More information on CGCAHPS, including sample surveys, can be found at https://cahps.ahrq.gov/Surveys-Guidance/CG/index.html.

day of week. Tracking provides an opportunity to identify trends and develop improvement efforts to correct a potential patient complaint.

As complaints are tracked, ongoing review of complaints should be a standard process for physicians and medical practices. Having a process in place to track and respond to complaints can reassure patients that the physician and medical practice are committed to addressing concerns and improving processes.

Consider the following to track complaints:

- How are complaints gathered? Is there a patient feedback mechanism in the office (surveys, patient comment box, online, social media, staff reporting)?
- What are the roles and responsibilities of staff when dealing with complaints? Is everyone trained on appropriate responses and actions regarding complaints?
- How are complaints monitored or reviewed? Is a system in place to generate action? Who is responsible for this process?

In addition to tracking complaints as they arise, proactively gathering patient feedback can minimize additional consequences. The Medical Group Management Association (MGMA) discovered that nearly 80% of the practices they identified as "better-performing" used patient satisfaction surveys. These practices were more likely to survey their patients, and to do so more frequently when compared to other physicians or medical practices.[14]

Some practices have found it valuable to provide patients with surveys to complete at the end of their appointments. Knowing if a patient is dissatisfied before leaving your office provides an opportunity to promptly address the issue and potentially reduce any negative comments the patient may wish to share with friends and family or via social media and online reviews.

IMPORTANCE OF STAFF

A patient generally has more contact with staff members than with a physician. Given that, staff has a significant impact on the patient's perception of the medical practice.

STAFF MEMBERS HAVE THE POWER TO CREATE A POSITIVE EXPERIENCE OR TO BE THE REASON A PATIENT DOES NOT RETURN.

Staff members also have the ability to diffuse a complaint when they are attentive and empathic to the patient. If staff members are rude or indifferent to a complaint or concern, this could fuel a patient's dissatisfaction with the physician and erode the patient-physician relationship.

Some research suggests that the job satisfaction of staff members is highly correlated with patient satisfaction, even more so than the correlation of satisfaction between physicians and patients. This research further promotes the hypothesis that patients are extremely sensitive to the nonclinical aspects of care and that a patient's experience with staff members can factor heavily when he or she evaluates the quality of care received.[15]

ONLINE COMPLAINTS

Every patient wants a physician with medical expertise who offers a high quality of care. While these factors may drive overall patient satisfaction, they do not seem to drive online reviews of physicians.

Health care is now rated online like retail services, and patients expect the same service and experience from a physician that they would from any consumer-oriented business, such as a restaurant, hotel, or retail outlet. Patients who post negative reviews on rating sites, such as Vitals, RateMDs, or Yelp, are often less vocal about clinical matters and more focused on the nonclinical aspects of care, such as long wait times, difficulty obtaining appointments, billing errors, a physician's poor bedside manner, or unprofessional staff.[16]

How should a physician respond to a negative online review? However strong the impulse may be to respond to a negative online review, physicians are prohibited from doing so by health care privacy laws. "If a patient makes an accusation of medical malpractice, it is even more important that the physician does not reply online," says Sue Mills, senior vice president of claim operations for TMLT. "Anything said in response could be used in the claim against the physician."

Mills continues, "Physicians should also consider that whatever you write cannot be taken back and may remain on the Internet for a very long time." If the complaints indicate that the patient is considering legal action, contact your medical liability insurance company as soon as possible.

For more on online reputation management, please refer to TMLT's article "Online reputation management for physicians" at www.tmlt.org in *the Reporter* section.

WHEN A PATIENT CONTINUES TO COMPLAIN

At times, successful resolution of a complaint may not occur. When a physician is faced with this situation and the patient continues to complain, the physician may choose to dissolve the patient-physician relationship. When patients are abusive or threatening, it is appropriate to dismiss them from the practice. Physicians will want to follow appropriate steps when planning to terminate the

physician-patient relationship.

CONCLUSION

Although patient complaints are an unavoidable part of any health care practice, the ability to actively listen, identify the underlying issue, and communicate with empathy can reduce the impact of a complaint. Effectively managing complaints can also help cultivate meaningful patient-physician relationships.

The majority of patient complaints are related to nonclinical areas of care. Therefore, being proactive to identify potential sources of patient dissatisfaction before a complaint occurs can save time and resources and reduce staff and physician stress. Efforts to proactively improve patient satisfaction and successful management of complaints yield significant benefits to patients, medical staff members, and physicians.

SOURCES

1. Michael Adolph et al.: Who Will Take Care of Us? Exploring Differences in Respondents' Satisfaction with Primary Care vs. Specialty Care Physicians. Health Outcomes Research in Medicine. 2012. Abstract.
2. Online doctor reviews: four times as many patients peeved about service & bedside manner than medical skills. Vanguard Communications. April 2013. Available at http://vanguardcommunications.net/online-doctor-reviews. Accessed January 27, 2016.
3. What Bugs Americans Most About Their Doctors. Consumer Reports. June 2013. Available at: http://www.consumerreports.org/cro/magazine/2013/06/what-bugs-you-most-about-your-doctor/index.htm. Accessed August 7, 2015.
4. Kelly B. Haskard Zolnierek, M. Robin Dimatteo: Physician communication and patient adherence to treatment: a meta-analysis. Med Care. 2009.
5. Howard B. Beckman, Richard M. Frankel: The effect of physician behavior on the collection of data. Annals of Internal Medicine. 1984.
6. Troyen A. Brennan et al: Incidence of adverse events and negligence in hospitalized patients - results of the Harvard Medical Practice Study I. The New England Journal of Medicine. 1991. Available at http://www.nejm.org/doi/full/10.1056/NEJM199102073240604#t=article. Accessed January 27, 2016.
7. Michael Krasner et al: Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. Journal of the American Medical Association. 2009. Available at http://jama.jamanetwork.com/article.aspx?articleid=184621. Accessed January 27, 2016.
8. Melanie Neumann et al: Empathy decline and its reasons: a systematic review of studies with medical students and residents. Academic Medicine, Volume 86, Issue 8, August 2011. Available at http://journals.lww.com/academicmedicine/Fulltext/2011/08000/Empathy_Decline_and_Its_Reasons__A_Systematic.24.aspx. Accessed January 27, 2016.
9. John R. Tongue et al: Communication skills for patient-centered care: research-based, easily learned techniques for medical interviews that benefit orthopaedic surgeons and their patients. Journal of Bone & Joint Surgery. March 2005. Available at http://healthcarecomm.org/wp-content/uploads/2011/05/Tongue-2005-.pdf Accessed January 27, 2016.
10. The Most Common Gripes Patients Have About Their Doctors. Huffpost Healthy Living. January 25, 2014. http://www.huffingtonpost.com/2014/01/17/patients-doctors-gripes-aggravate-annoy-bother_n_4604434.html. Accessed August 31, 2015.
11. James Schutte. Troublemakers: how to spot and get rid of them. Preventing Medical Malpractice Suits. Kirkland, Wa. Hogrefe & Huber Publishers. 1995: 133-145.
12. What doctors wish their patients knew. Consumer Reports. March 2011. http://www.consumerreports.org/cro/magazine-archive/2011/march/health/doctors/overview/index.htm. Accessed August 31, 2015.
13. David Cutler, Wendy Everett. Thinking outside the pillbox - medication adherence as a priority for health care reform. The New England Journal of Medicine. April 29, 2010. Available at: http://www.nejm.org/doi/full/10.1056/NEJMp1002305. Accessed January 27, 2016.
14. MGMA benchmarking report: almost 80 percent of practices deemed 'better-performers' conduct patient-satisfaction surveys. Medical Group Management Association. November 13, 2013. Available at http://www.mgma.com/about/mgma-press-room/press-releases/mgma-benchmarking-report-almost-80-percent-of-practices-deemed-better-performers-conduct-patient. Accessed January 27, 2016.
15. Joachim Szecsenyi et al: Is the job satisfaction of primary care team members associated with patient satisfaction? BMJ Quality & Safety. January 24, 2011. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3102541/. Accessed January 27, 2016.
16. Charles Ornstein. On Yelp, doctors get reviewed like restaurants - and it rankles. National Public Radio. August 6, 2015. Available at http://www.npr.org/sections/health-shots/2015/08/06/429624187/on-yelp-doctors-get-reviewed-like-restaurants-and-it-rankles. Accessed January 27, 2016.

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CLOSED CLAIM STUDY *1*

By Laura Hale Brockway, ELS, Director of Marketing Communications, and Louise Walling, Senior Risk Management Representative

FAILURE TO PERFORM CESAREAN DELIVERY

PRESENTATION

A 32-year-old woman came to the labor and delivery unit at a local hospital at 5:45 p.m. She was 38 weeks pregnant and noted to be in active labor with strong contractions every six to seven minutes. Examination revealed the patient's cervix to be 2-to-3-cm dilated and 50% effaced. The patient's membranes were intact and fetal heart tones (FHTs) were normal.

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PHYSICIAN ACTION

Family Physician A — who was the partner of the family physician the patient had been seeing for prenatal care — saw the patient at 10 p.m. The patient's cervix was dilated to 6-to-7-cm and 70% effaced. Her contractions had intensified and were occurring every two to three minutes. An epidural was placed at 11 p.m.

At 12:17 a.m., Family Physician A performed a vaginal exam and artificially ruptured the membranes. By 2:30 a.m., the patient's cervix was completely dilated, 100% effaced, and the infant was in the -1 station. The patient was instructed to start pushing.

At 3:15 a.m., Family Physician A tried to apply a scalp electrode for better FHTs. He documented "poor descent of the presenting part." At 3:43 a.m., he applied a vacuum extractor, but it popped off. The vacuum extractor was unsuccessfully attempted three more times. The patient was instructed to keep pushing.

A shoulder dystocia secondary to compound right hand presentation was encountered and the infant was subsequently delivered at 4:32 a.m. The infant was described as gray and floppy, and he was slow to respond to oxygen and stimulation. A transport team from a larger, regional hospital came to transfer the baby. He became bradycardic and apneic before being transferred. Resuscitative efforts were unsuccessful and the baby died.

An autopsy reported the cause of death to be hypovolemic shock due to a large cephalohematoma with history of vacuum-assisted delivery.

ALLEGATIONS

A lawsuit was filed against Family Physician A. The allegations were failure to perform a cesarean delivery when the patient had more than 3.5 hours of failure to dilate and descend. If an earlier cesarean delivery had occurred, there would have been no need to use the vacuum extractor. They further alleged that the vacuum extractor caused the baby to develop a large cephalohematoma, which led to hypovolemic shock and the baby's death.

LEGAL IMPLICATIONS

Physicians who reviewed this case for the defense did not support the actions of Family Physician A. They stated that overuse of the vacuum extractor led to the cephalohematoma. According to one reviewer, the standard of care requires an immediate cesarean delivery when vacuum delivery fails.

Further, when the vacuum popped off, it broke blood vessels in the baby's scalp that caused a hematoma. As the mother kept pushing, the elevated blood pressure and the pressure created by the contractions forced the blood to the head and into the scalp. This led to hypovolemic shock and the baby's death.

Another reviewer questioned why vacuum extraction was even attempted, as the infant's condition was stable and the fetal heart strips were "not worrisome." Medication could have been given to stop or slow the labor. There was also plenty of time to have a cesarean delivery team in place before the vacuum delivery was attempted.

Family Physician A agreed with the reviewers and was unable to explain why he did not perform a cesarean delivery.

The defense of this case was further complicated by documentation issues. Family Physician A's delivery notes were not comprehensive and offered no explanation or reasoning for his actions.

DISPOSITION

This case was settled on behalf of Family Physician A.

RISK MANAGEMENT CONSIDERATIONS

Lack of documentation in the delivery note record created a challenge for the defense. Details noting the progress of labor and management of the patient that included the baby's station during key events, and at periodic exams were absent from the record. Also missing were the baby's estimated weight and positioning before the physician placed the vacuum extractor. Shoulder dystocia was not documented.

Although it could have been anticipated that the medical record would be scrutinized, the adverse outcome discussion by the physician with the patient and her family was not part of the record. For a difficult delivery, a detailed procedural note is recommended that accurately reflects an accounting of the events.

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By Wayne Wenske, Communications Coordinator

FAILURE TO DIAGNOSE MELANOMA

PRESENTATION

A 63-year-old woman came to an ophthalmology group with complaints of pain in her left eye. The patient had a history of complete blindness in her left eye for 12 years due to hypertensive eye/glaucoma. Her medications included acetazolamide 250 mg and timolol maleate eye drops 0.25%, but the patient reported she only took the timolol maleate periodically.

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PHYSICIAN ACTION

Ophthalmologist A examined the patient and noted intraocular pressure in the left eye at 44 mm (normal pressure is 10-21 mm). A slit-lamp exam in the left eye was documented as "anterior chamber: neovascular occlusion; iris: rubeosis iridis; lens: mature cataract; anterior vitreous: no view." The impression was noted as blind, hypertensive eye (absolute glaucoma) and stable nuclear sclerosis cataract. The diagnosis was uncontrolled glaucoma. The patient was prescribed latanoprost eye drops to control the progression of glaucoma by reducing the intraocular pressure.

The patient continued to see Ophthalmologist A for regular follow up and treatment.

Two years later, the patient returned to Ophthalmologist A on an emergent basis. The night before, the skin surrounding the left eye had turned black and blue accompanied by intense eye pain. Ophthalmologist A referred the patient to Ophthalmologist B in the same group for a surgical consult.

Ophthalmologist B examined the patient and documented "cornea: diffuse punctate stain; anterior chamber: neovascular occlusion, but 3+ turbidity, hyphema ¼ depth" in the left eye. Ophthalmologist B also documented that he discussed enucleation surgery with the patient, including the risks, benefits, and alternatives. The patient elected to proceed with surgery, and left eye enucleation with implantation was scheduled for the next day.

Ophthalmologist B performed the enucleation surgery as scheduled, but documentation describing the events and outcome of surgery was not completed. Within six weeks, procedures to place an orbital implant and finally prosthesis were also performed.

Two days after the enucleation surgery, a pathology report was created and noted that the enucleated left eye contained a "small malignant melanoma of the posterior choroid, spindle cell type, with a small nodule of extraocular extension of the tumor." The pathologist stated in the report that the presence of a malignant melanoma in a phthisis bulbi, or shrunken, non-functional eye, is very rare. He asked if there was a complete ophthalmologic exam of the eye including A or B scans.

Post surgery, the patient continued to have pressure, pain, and feeling of retrobulbar growth in the eye socket. Nine months later, the patient returned to Ophthalmologist B with the complaint that "there is a growth pushing the prosthesis out." At this visit, the physician noted inferior, lateral dislocation of the orbital implant. A second implant surgery to replace and exchange the existing orbital implant was performed.

The patient's pain continued. Ophthalmologist B referred the patient to his partner in the same group, Ophthalmologist C, for a second opinion. Ophthalmologist C recommended an MRI. The results revealed an irregular soft tissue mass that was diagnosed as orbital melanoma.

Resection and reconstruction procedures were performed several months later. Postoperatively, irradiation therapy was performed. The patient eventually recovered with no signs of systemic or metastatic disease.

ALLEGATIONS

The patient filed a lawsuit against Ophthalmologist B alleging failure to diagnose orbital melanoma, resulting in a delayed diagnosis and additional extensive surgeries.

LEGAL IMPLICATIONS

A consultant for the defense reviewed the case and was highly critical of Ophthalmologist B for not ordering radiology reports to rule out intraocular tumor. The consultant expressed that, due to the patient's continuing pain, the ophthalmologist deviated from the standard of care by not ordering additional radiology studies. He also questioned why the physician did not order imaging studies after the patient's implant was dislocated.

The consultant also criticized Ophthalmologist B's lack of documentation of the enucleation surgery. He noted that the physician's documentation of post-surgery examinations lacked important details, such as descriptions of the socket, fornix, or conjunctiva.

The consultant's greatest criticism was Ophthalmologist B's failure to address the pathology report created two days after the enucleation surgery that noted the presence of a melanoma. The consultant pointed out that there was no evidence that Ophthalmologist B ever read or acknowledged the findings.

DISPOSITION

This case was settled on behalf of Ophthalmologist B.

RISK MANAGEMENT CONSIDERATIONS

Ophthalmologist B was heavily criticized for his lack of documentation in the care of this patient. The allegations of a delayed diagnosis may have been countered by any documentation that supported his decisions. For example, if documentation existed that noted the patient had objected to additional imaging studies, the physician's actions may have been more understandable.

When a physician properly documents his or her reasoning behind treatment plans, it helps in understanding his or her thought processes and decisions for patient care. Thorough documentation of patient interaction, assessments, and treatment plans can provide valuable support for the

physician if his or her actions are questioned. Complete documentation also assists subsequent physicians in providing quality patient care.

Proper documentation is also a requirement of the Texas Medical Board (TMB). According to the TMB, each licensed physician of the board shall maintain "an adequate medical record for each patient that is complete, contemporaneous and legible." Among other requirements, the records should include "the rationale for and results of diagnostic and other ancillary services."[1]

The ophthalmologist was also criticized for disregarding the pathology report. There is no notation that the report was ever read. The consultant for the defense questioned if the group that employed Ophthalmologist B had a protocol for accepting, reading, and signing off on reports.

A good risk management practice is for an office or group to have a process in place in which internal and external reports or test results are tracked when they are received and read. Results for labs or diagnostic imaging studies may be initialed and dated by the physician, so it is clear that they were reviewed in a timely manner. If reports are not read immediately, an administrator can step in to ensure the report is read as soon as possible. Had the group in this case enforced such a policy, Ophthalmologist B would have seen the report of the melanoma and may have expedited the patient's care.

SOURCE

1. Texas Administrative Code. Title 22, Part 9, Chapter 165, Section 165.1: Medical Records. Available at http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=9&ch=165&rl=1. Accessed October 21, 2015.

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