TEXAS MEDICAL LIABILITY TRUST

the REPORTER

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Dave W. Kittrell, MD
Chairman, TMLT Board of Governors

In Memoriam

The chairman of the TMLT Board of Governors, Dr. Dave W. Kittrell, passed away unexpectedly on July 2, 2010.

Dr. Kittrell was born on October 8, 1948 at Mother Frances Hospital in Tyler, Texas. He earned his BA from Trinity University in San Antonio. He went to medical school at The University of Texas Medical Branch at Galveston (MD) and Texas A&M College of Medicine at Scott and White Memorial Hospital where he completed his residency in Obstetrics and Gynecology. He was a Diplomat of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Obstetricians and Gynecologists. Dr. Kittrell began his private ob-gyn practice in San Antonio in 1979.

Dr. Kittrell was very interested in politics, in particular those politics that affected the medical profession. He served various organizations at the local, county, state and national levels. He was a member of the San Antonio Oak Hills Rotary Club and a Paul Harris Fellow. He was a member of the Board of Directors of the Bexar County Medical Society for ten years, serving as treasurer for two of those years. He served on the Texas Medical Association Council on Legislation for nine years and was a consultant to the TMA Professional Liability Committee. As a past president of the Texas Association of Obstetricians and Gynecologists, he served on the TAOG Executive Council and as Chairman of the Texas Section, District VII ACOG.

Dr. Kittrell had a long and distinguished career serving on the Texas Medical Liability Trust Board of Governors. He served on this board from 1989 to 1998, was reappointed in 2001 and served until his death. He was elected Secretary-Treasurer, Vice Chairman and Chairman of the Board at different times for twelve of those years. During his tenure on the governing board, his care and concern for the physicians of Texas ensured that TMLT was fulfilling its obligations to policyholders. Under his leadership, TMLT grew in both number of policyholders and in the scope of services offered to physicians. Dr. Kittrell was also a strong advocate for medical liability reform for health care providers. He was highly respected by the TMLT staff and physician members of the governing board and claim review committee. We are greatly saddened by the loss of this great leader.

10 medical liability myths

by Laura Hale Brockway, ELS

Understanding how medicine and the law intersect is complicated. It can be tedious. Yet, a thorough understanding of medical liability can help keep you out of the courtroom and may even help you practice safe medicine. The following is a list of some common and prevailing myths about medical liability, each dispelled by TMLT claim and risk management experts.

Myth 1

Because of medical liability reform, litigation is no longer a problem for doctors.

Truth: While the rate of litigation has been greatly reduced, medical liability reform did not hinder a patient's ability to sue for legitimate injuries incurred during the course of medical treatment. "It is also important to remember that juries are still willing to award substantial damages when they feel the physician failed to meet the standard of care or failed in communicating with the patient," says Jill McLain, vice president of claim operations with TMLT. The bottom line — litigation is still a concern for physicians.

"Physicians are advised to continue following basic risk management principles to prevent lawsuits and enhance defensibility," says Jane Holeman, vice president of risk management at TMLT. "This includes documenting thoroughly; making sure you track test results and patient referrals; and communicating openly with patients."

Myth 2

I should contact TMLT to report a claim only after I've been officially "served" with a citation and petition.

Truth: Your policy requires you to notify TMLT as soon as reasonably possible after becoming aware of any claim covered by your policy. TMLT claim staff may have limited time to investigate and evaluate the claim, and any delay in reporting could compromise your defense.

Please notify TMLT immediately if you receive any of the following:

- A demand for compensation — any written communication from or on behalf of a patient that seeks monetary payment or other compensation because of a perceived error in treatment or an unexpected outcome.
- A notice of claim letter — a letter that refers to Civil Practice and Remedies Code Section 74.052 or refers to a notice of claim. Upon receipt of a 74.052 letter, a physician and his or her insurer have 60 days to investigate and evaluate the claim.
- A lawsuit — will contain a citation (which informs you of a lawsuit) and a petition (which lists the plaintiff versus the defendant). A lawsuit will also include the allegations made against you. The law sets out a mandatory timeframe in which an answer must be filed on your behalf. Therefore, once you are served with a citation and petition, TMLT has a limited time to respond by retaining a defense attorney to file an answer on your behalf.

Additionally, if you receive a records request from an attorney or a request for a deposition in a case involving medical liability, contact TMLT for advice on how to respond to the request.

Myth 3

A TMB complaint is no big deal — I can just respond by writing a letter.

Truth: It is not advisable to respond to a TMB complaint letter or notice without first contacting TMLT or obtaining legal counsel.

A violation of any of the laws and regulations that govern the actions of physicians can lead to disciplinary action by the Texas Medical Board (TMB). The consequences of a single board action can range from a dismissal to license revocation; enormous expenditure of stress and time; and damage to a physician's professional reputation. Therefore, it is essential that you seek an attorney's expertise early to respond to the TMB and present the information in an appropriate way.

"Many physicians make the mistake of acting as though the complaint against them is so frivolous that they merely need to explain their care and then the TMB will surely see the lack of merit in the complaint and dismiss it. Moreover, you may have the impression that the process is informal and collegial, but in truth, this is serious business."[1]

TMLT policies provide coverage that will reimburse you for reasonable legal expenses and expert witness fees incurred in defending a TMB complaint (up to $25,000 per policy period, subject to the terms and conditions of the policy). The policy states that you have 60 days to report an insured event to receive reimbursement for covered expenses. To preserve coverage, it is extremely important to pay attention to the 60-day window in which to report knowledge of a proceeding.

Myth 4

It's okay to speak with an attorney "off the record" about a medical malpractice lawsuit in which I am not a party.

Truth: Proceed with caution and contact the TMLT claim department any time you are contacted by an attorney about a medical liability case.

"It may seem innocuous and that the attorney only wants to obtain information about a case, but there is always the possibility that based on the information you provide, you could be named as a co-defendant in the case or called as a witness," says Holeman.

Physicians are strongly urged to contact TMLT before speaking with any attorney about a medical liability case.

Myth 5

Physicians are allowed to "correct" past entries in medical records after an unexpected outcome or notice of claim.

Truth: It is never acceptable to alter or correct a medical record after you have been notified of a claim.

Upon reviewing the medical record when served with a notice of claim, you may be tempted to add information that you believe will assist in your defense. Resist this temptation. Plaintiff's attorneys will try to use this information to discredit you, suggesting that you did something wrong and are trying to conceal it.

The TMLT claim staff recommends that you place the medical record in a secure location to protect the authenticity and avoid any temptation to alter information.

Absent a notice of claim, it is appropriate to make a late entry or addendum in the medical record, but only with proper identification and the reason for the delayed entry. "The entry should be clearly labeled as "late entry" or "addendum" with the date the addendum was completed and the date to which it relates," says Holeman.

"Correcting' the medical record without clearly indicating that you are doing so is considered altering the medical record; and, altering the medical record seriously jeopardizes your credibility, says McLain. "While there may be no breach of the standard of care, record alterations are difficult to defend at trial and frequently result in settlements out of court."

Myth 6

Implementing electronic medical records (EMRs) can prevent most malpractice suits.

Truth: It is a truth universally acknowledged that any medical record system — be it paper or electronic — is only as good as the person who uses it. The promise of EMRs is a more accurate, legible, and comprehensive medical record available to health care professionals at the touch of a few buttons. However, EMRs come with their own documentation pitfalls. If you are currently using an EMR or plan to implement such a system, consider the following:

- Implement a strict policy regarding passwords and security — staff members should have their own passwords and level of security clearance based on their job functions. Sharing passwords should never be allowed because the identity of the user will be incorrect.
- Ensure patient encounter records are locked — the author of each entry must take specific action to verify that the entry is his or hers and that it is accurate. Once a patient encounter entry is completed, the author should sign it and it should be locked in the system.
- Be aware that templates can import old or inaccurate information — notes should be individualized for each patient encounter, and relevant sections reviewed to avoid importing incorrect, redundant, and irrelevant information.
- Enable tracking mechanisms. Most software programs include a tracking system to help ensure that patients have completed recommended tests or consultant referrals. Employ these tracking systems. Additionally, if you are planning to purchase an EMR, do not buy one without a tracking system.
- Establish a system to appropriately capture paper and other external clinical documents. Optimally, all paper documents should be scanned into the electronic record for easy accessibility. While scanning a patient's entire paper record into the system is preferred, this is not always possible. The important step is to develop a policy for capturing patients' previous medical records and follow it consistently.
- Prescriptions are not always captured in the EMR. If physicians who use EMRs are not e-prescribing, prescriptions should be captured by scanning the paper prescription into the EMR or fully documenting the name, dose, quantity, instructions, and refill amount.
- Ensure records are backed up reliably. Creating a back-up data set is only the first step. The back-up record must be tested regularly to ensure that all appropriate data are being copied, and that data restoration is possible.
- Make sure the records are complete when providing printed copies. Because many physicians using an EMR do not regularly print a patient record, they may be unaware that clicking the print button does not always provide a complete record. [2]
- "Another issue we have seen in claims involves training and familiarity with the system. We have seen cases where wrong boxes were checked and inaccurate information was unintentionally included in the record," says McLain. "Know your EMR and how it functions." (For more information, please see the closed claim study on page 16.)

Myth 7

You can rely on patients to report an accurate and complete medical history.

Truth: For a number of reasons, patients are often poor historians of their medical information. They may not know what is important to share. They may not understand their condition or the seriousness of it. They may not remember the details or may be embarrassed or reluctant to share their health information. Therefore, relying on the patient as the exclusive source for medical history information is ill-advised. Consider the following to help you obtain more accurate medical histories.

- Make it easy for patients to update their medical history forms. Send these to patients in advance or make them available on your practice web site. Patients may provide more accurate information if they are allowed to complete these forms before the appointment.
- Ask patients to bring all of their medications when they visit your office.
- Ask patients to list any other treating physicians on their medical history forms.
- When discussing a patient's medical history, ask open-ended questions (i.e., what has changed in your medical history since your last visit). Patients who are not questioned thoroughly may leave out details.
- If details of the patient's history are unclear, contact the other treating physicians or request the patient's medical records.

Myth 8

Physicians can depend on pharmacists to discuss the risk and benefits of a new medication with the patient.

Truth: It is the duty of the prescribing physician to discuss the risks and benefits of any medication with the patient. The dispensing pharmacist may also provide this information to the patient, but this does not eliminate the physician's responsibility to counsel patients about medications.

It is unwise to rely on the pharmacist for a number of reasons. The patient may not actually receive or review the information the pharmacist provides. Physicians may be unfamiliar with the information the pharmacy is providing. What risks and benefits does it describe? This could lead to communication errors if the patient calls the physician with questions about the information provided by the pharmacy.

"Doctors should also consider that the pharmacist is relying on the package insert to counsel patients. They may have little personal, medical experience with the drug and may not know what is appropriate to share with the patient," says McLain.

When prescribing a new medication to a patient, discuss the risks, benefits, and any alternative treatments with the patient. Patients should also be instructed to call the physician with questions or to report any side effects. This discussion should be documented in the medical record.

Myth 9

You only need to obtain informed consent for surgical procedures.

Truth: Informed consent requirements apply to treatments, tests, procedures, or medications as mandated by the Texas Medical Disclosure Panel. (TMDP)

In Texas, informed consent is governed by statute and is overseen by the TMDP. The panel includes six physicians and three attorneys who review all treatments and procedures to determine which procedures require informed consent and which do not. Procedures and treatments are then assigned to a list. Those requiring disclosure of risks and benefits are put on List A. Those that do not require disclosure of specific risks are identified in List B. The panel periodically examines new treatments or procedures and assigns them to one of the lists. The lists, TMDP rules, and forms can be viewed at Title 25, Texas Administrative Code, Part 7 at http://info.sos.state.tx.us/pls/pub/readtac$ext.viewtac.

When offering any treatment or procedure to a patient, the physician must make these determinations:

- if the treatment or procedure appears on List A, then disclosure specified by the panel must be followed;
- if the treatment or procedure appears on List B, no specified disclosure is legally required;
- if the treatment or procedure does not appear on either List A or List B, the physician must then disclose all material and inherent risks that could influence a patient in making decisions.

"It is also important to realize that informed consent is a non-delegable duty. The physician is responsible for discussing the risks and benefits and obtaining consent," Holeman says. "A signed form is not a substitute for a detailed discussion."

Additionally, it is important to note that, by statute, the TMDP may not require disclosure of the risks of certain surgeries, procedures or medications. However, it is best to disclose those risks that a reasonable person would want to know in making the decision.

Documentation of the informed consent discussion — including the risks, benefits, and alternatives to the surgery — should be included in the medical record.

Myth 10

Anyone who accompanies a child to the office can consent to care for that child.

Truth: The Texas Family Code specifies who can consent to medical care for minors.

A minor is a person under age 18 who has never been married and never been declared an adult by a court. Minors cannot make health care decisions or give informed consent on their own behalf. Consent, therefore, falls to the parent or legal guardian in most situations.

When the person having the power to consent cannot be contacted and actual notice to the contrary has not been given, other persons and entities can give consent. These include:

- grandparents;
- adult siblings;
- aunts and uncles;
- an educational institution with written authorization;
- any adult who has actual care, control, and possession of the minor with written authorization;
- a court having jurisdiction over a suit affecting the parent-child relationship;
- an adult responsible for the actual care, control, and possession of a child under the jurisdiction of a juvenile court or committed by a juvenile court to the care of an agency of the state or county;
- a peace officer who has lawfully taken custody and has reasonable grounds to believe immediate medical treatment is needed; and
- for immunizations only, a guardian or any person authorized under law or court order to consent for the child or, if these persons are not available, any one of the persons listed above.

When documenting consent by a non-parent, it must be in writing and include: the name of the child; the name of one or both parents, if known; the name of any managing conservator or guardian of the child; the name and relationship of the person giving consent; the treatment to be given; and the date the treatment is to begin.

Conclusion

Physicians and their staffs face daily challenges in the delivery of quality, safe health care. There are no doubt more myths about medical liability, but an informed physician with a conscientious commitment to patients and effective communication skills may avoid complaints and lawsuits.

Sources

1. Simmons S, Ballard D. Surviving a TMB investigation. *the Reporter*. January-February 2008.
2. Brockway L. Potential pitfalls. Risk management for the EMR. *the Reporter*. March-April 2007.

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EXPIRED CME

Cultural competence in health care

by Barbara Rose, senior risk management representative

Objectives

At the conclusion of this educational activity, the physician should be able to:

1. define cultural competence in health care;
2. identify barriers to culturally competent care;
3. discuss the need for cultural and linguistic competence in health care; and
4. describe risk management challenges in providing culturally competent care.

Editor's note: the definition of "minority group" used in this paper is consistent with that of the U.S. Office of Management and Budget (OMB-15 Directive) and includes African Americans, Hispanics, Asian/Pacific Islanders, and Native Americans/Alaska Natives. [1]

Course author

Barbara Rose is a senior risk management representative at TMLT.

Disclosure

Barbara Rose has no commercial affiliations/interests to disclose related to this activity.

Target audience

This one-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

CME credit statement

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

Ethics statement

This course has been designated by TMLT for 1 hour of education in medical ethics and/or professional responsibility.

Instructions

You have two options to obtain CME credit from this activity.

Option 1 – online

Reporter CME test and evaluation forms can be completed online. After reading the article, go to www.tmlt.org/reporterCME. Click on "Earn CME" under "Cultural competence in health care" (July-August 2010). Follow the online instructions to complete the test and evaluation forms. Your CME certificate will be emailed to you. Please allow up to 4 weeks for delivery of your certificate.

Option 2 – on paper

Please read the entire article and answer the CME test questions on the paper test forms on page 14. To receive credit, submit the completed test and evaluation forms to TMLT. All test questions must be completed. Please print your name and address clearly. Please allow four to six weeks from receipt of test and evaluation form for delivery of the certificate.

Questions? Please call the TMLT Risk Management Department at 800-580-8658, ext. 5919.

Estimated time to complete the activity

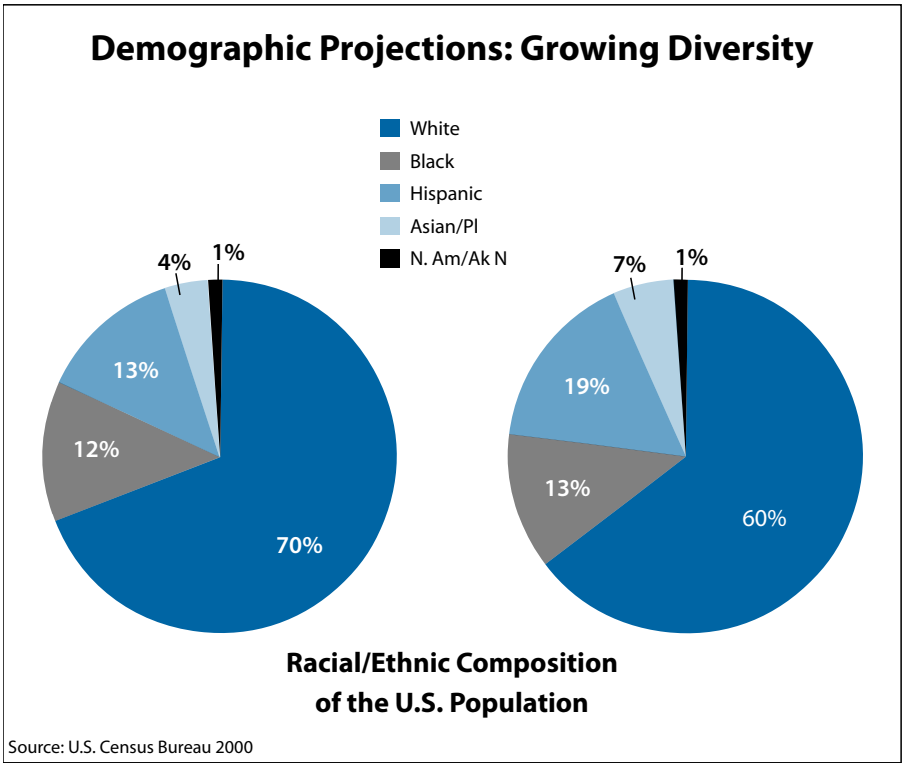
It should take approximately 1 hour to read this article and complete the questions.

Release/review date

This activity is released on August 2, 2010 and expires on August 2, 2012. Please note that this CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

Introduction

"Give me your tired, your poor, your huddled masses yearning to breathe free." This is the first sentence on the tablet in the right hand of the Statue of Liberty. The descriptive term often used to describe America is a "melting pot," a place whose population reflects great diversity comprising people from many other countries. As the 2010 census will no doubt reflect, the racial and ethnic diversity of the U.S. continues to change among the more than 300 million individuals who reside in this country.



Emerging field

The demographics reflecting this diversity have created a need for recognition of cultural differences to achieve competence in the delivery of health care. This emerging field and its significant challenges are being addressed by physicians and other health care organizations across the spectrum of medicine. This article will define cultural competence, identify barriers to, and discuss the benefits of culturally competent care. Key components and a framework for culturally competent care and strategies for implementation will also be discussed.

Defining cultural competence

According to a 2002 field report published by the Commonwealth Fund, "Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency."[1]

A definition from the Oregon Department of Human Services is much broader. "Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities and protects and preserves the dignity of each. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes."[2]

The National Medical Association defines health cultural competence as "the application of cultural knowledge, behaviors, and interpersonal and clinical skills that enhances a provider's effectiveness in managing patient care."[3] The U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration, Bureau of Health Professions has the simplest definition. "Cultural competence is defined as the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group."[3] Planning, designing, and implementing effective and culturally relevant care is a daunting challenge for all physicians and health care organizations.

Why the need for cultural and linguistic competence?

The National Center for Cultural Competence (NCCC) has identified six reasons culturally competent care is important.

1. "To respond to current and projected demographic changes in the U.S.;
2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds;
3. To improve the quality of services and health outcomes;
4. To meet legislative, regulatory and accreditation mandates;
5. To gain a competitive edge in the market place; and
6. To decrease the likelihood of liability/malpractice claims." [4]

As revealed in the census graphs on page 7, the need is clearly identified for our diverse population. "Nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people in the United States." [4] Limited progress has been made in recent years, but significant disparities continue in the incidence of illness and death among minority groups in America.

The HHS Office of Minority Health identified cultural competency as one "of the main ingredients in closing the disparities gap in health care. It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can bring about positive health outcomes." [5]

If service and outcomes are to improve, physicians must "understand the beliefs that shape a person's approach to health and illness. Knowledge of customs and healing traditions are indispensable to the design of treatment and interventions. Health care services must be received and accepted to be successful." [4]

Health care organizations and providers have multiple, competing responsibilities to comply with federal, state, and local regulations regarding the delivery of health services. These state and federal agencies increasingly rely on private accreditation entities to set standards and monitor compliance with these standards. Both the Joint Commission and the National Committee for Quality Assurance support standards requiring cultural and linguistic competence in health care. [4]

Barriers and benefits to culturally competent care

Barriers to culturally competent care that may affect quality and contribute to racial/ethnic disparities in health care include:

- lack of diversity in health care's leadership and workforce;
- systems of care poorly designed to meet the needs of diverse patient populations; and
- poor communication between health care professionals and patients of different racial, ethnic, or cultural backgrounds. [1]

"Sociocultural differences among patients, health care providers, and the health care system, in particular, are seen by health care experts as potential causes for disparities." [1]

A study in the *Journal of the American Medical Association* found that resident physicians say their preparedness for delivering cross-cultural care lags well behind their preparation in clinical and technical areas. Residents perceived cross-cultural care as important, but little time was allocated during residency to address cultural issues. Residents reported that training was limited, and that formal evaluation and role modeling were not received during residency training. This report called for significant improvements in cross-cultural education to help eliminate racial and ethnic disparities in health care. [6]

The inability of a provider to understand socioeconomic differences may lead to patient noncompliance, which in turn can affect health outcomes. Experts interviewed for the Commonwealth report "drew links among cultural competence, quality improvement, and the elimination of racial or ethnic disparities in care. While acknowledging many causes for such disparities, they regarded efforts to improve quality through greater cultural competence at multiple levels as especially important. They also stated that culturally competent adjustments in health care delivery would further the quality improvement movement as a whole and should occur at the systemic and clinical encounter levels." [1]

Guidance for cultural competence in health care

As recently as March 2010, the National Committee for Quality Assurance (NCQA) released the publication *Multicultural Health Care (MHC)*. It describes an evaluation program "designed to help health care organizations monitor and reduce health care disparities among racial and ethnic minorities." [1] This program "uses evidence-based standards to evaluate how health care plans and other health and wellness organizations measure, analyze and adjust their services to meet the health care needs of diverse populations." [7]

The Office of Minority Health (OMH) has developed 14 national standards on culturally and linguistically appropriate services (CLAS). They are primarily directed at health care organizations, but individual providers are "also encouraged to use the standards to make their practices more culturally and linguistically accessible." [8] The principles and activities of these services "should be integrated throughout an organization and undertaken in partnership with the communities being served." (See national standards on page 9).

The 2007 article "Language differences as a barrier to quality and safety in health care" addressed the Joint Commission's perspective in acknowledging low health literacy, cultural barriers, and limited English proficiency as the "triple threat" to effective health communication. The Joint Commission is currently "developing hospital standards for culturally competent patient-centered care." Accreditation standards are being developed that

National standards on culturally and linguistically appropriate services (CLAS)

"Standard 1 — Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.**

Standard 2 — Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.**

Standard 3 — Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.**

Standard 4 — Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.*

Standard 5 — Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.*

Standard 6 — Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).*

Standard 7 — Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.*

Standard 8 — Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.**

Standard 9 — Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.**

Standard 10 — Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.**

Standard 11 — Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.**

Standard 12 — Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.**

Standard 13 — Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.**

Standard 14 — Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.***"

* mandated for all recipients of federal funds

** guidelines

*** recommended for voluntary adoption by health care organizations.

will "promote, facilitate, and advance the provision of culturally competent patient-centered care." [9]

The moral dilemma of cultural competence/ perspectives on transcultural care

The premise of transcultural care is "based on a patient-centered approach that allows for variability regarding cultural bio-ecological differences and differences in belief systems, while acknowledging that there are some universals to all, mainly the humanness of all persons." [10] Recognizing the humanness of all is "the foundation that allows nurses [and physicians] to respect differences, resist judgment, and adapt patient care to individual needs." [10] However, one may not avoid the feelings of "moral distress that may occur while respecting cultural practices." [10]

The culturally competent health care professional will respect and incorporate cultural practices into patient care with the understanding that there are limitations imposed by one's own experience and knowledge that will not permit participation in harmful or abusive practices that preclude the rights of others. "Transcultural theory transcends the moral relativism of culture-specific practices because it is based on human needs. With this theory as a framework, respectful communication with negotiation and education are effective tools for compromise." [10]

Cultural generalizations are to be avoided, as they will not fit every patient that a physician encounters. However, "knowledge of broad patterns of behavior and belief can give physicians and other health professionals a starting point from which to provide the most appropriate care possible." [11]

Key components and framework for culturally competent care

Cultural competence in health care "requires an understanding of the communities being served as well as the sociocultural influences on individual patients' health beliefs and behaviors. It further requires understanding of how these factors interact with the health care system in ways that may prevent diverse populations from obtaining quality health care. Finally, it entails devising strategies to reduce and monitor potential barriers through interventions." [1] Based on the literature review, interviews, and site visits, key components have been identified to serve as a practical and effective framework for the implementation of culturally competent practices.The framework addresses organizational cultural competence, systemic cultural competence, and clinical cultural competence.

Strategies for implementation

"Among the strategies suggested for attaining cultural competence were using the influence of health care purchasers (government and private), developing contractual requirements (federal and state), and formulating accreditation standards (e.g., for hospitals and medical schools). Experts agreed that health care purchasers, both public and private, can help stimulate change if they understand the problems associated with health care delivery that lack cultural competence." [1]

For physicians currently in practice, cross-cultural training may not have been a part of their medical school curriculum. Moving forward it should be "a required, integrated component of the training and professional development of health care providers at all levels." [1] Objectives of the curriculum include:

1. an increased awareness of racial and ethnic disparities in health and the importance of sociocultural factors on health beliefs and behaviors;
2. ability to identify the impact race, ethnicity, culture and class have on clinical decision-making;
3. development of tools to assess the community members' health beliefs and behaviors; and
4. learning and developing human resource skills for cross-cultural assessment, communication and negotiation. [1]

Quality improvement tools should include "culturally and linguistically appropriate patient survey methods as well as process and outcome measures that reflect the needs of multicultural and minority populations." [12] Program development is needed to "help patients navigate the health care system and become a more active partner in the clinical encounter." [1]

Outcomes of cultural competency training

A review of available literature examining outcomes of cultural competency training reveals scarce and inconsistent data. An article in the *Journal of the National Medical Association* summarized one such research study. The study demonstrated that "workshops that integrate key topics as recommended by the IOM and through the CLAS standards significantly improve self-reported knowledge and skills among health care providers." [13, 14] As a result of this training, "participants self-reported not only an enhanced understanding of the health care experiences of patients from diverse backgrounds, but also an improvement in the skills necessary to effectively work in cross-cultural situations." [13]

The authors of this study stated that cultural competency training has emerged as an important strategy for better informing key health care stakeholders (e.g. providers, administrators, insurers, and policymakers) "about the sociocultural dynamics inherent in health care-seeking behavior. It can serve as a means for improving the self-reported knowledge and skills required to effectively care for patients from diverse backgrounds." [13]

Closed claim study— failure to obtain full informed consent

The following closed claim study illustrates the challenges created by language differences in the health care setting.

Presentation

A 62-year-old woman whose first language was Spanish came to her ob-gyn with complaints of a urinary tract infection. She listed a history of lower abdominal pain, urinary urgency, and flank pain. The patient had been seen by the ob-gyn six months earlier with these same complaints. At this second visit, the

ob-gyn found the patient had a thickened endometrium and a uterine mass. The ob-gyn was concerned about the possibility of cancer in this patient.

Physician action

Three days after this visit, an endometrial biopsy revealed no endometritis, hyperplasia, or malignancy. A sonohystogram performed three weeks later showed a thickened endometrium and a 1- to 4-cm fibroid. Over the ensuing six weeks, multiple tests and procedures were completed to rule out cancer. In order, these included hysteroscopy, pelvic ultrasound, CA 125 testing, another pelvic ultrasound, and suction D&C. Four days later, another pelvic ultrasound and repeat CA 125 were done. Due to concerning results and complaints of continued bleeding, the physician discussed treatment options including an endometrial ablation procedure versus vaginal hysterectomy.

A hysteroscopy and D&C with frozen section were recommended. The physician also recommended a vaginal hysterectomy and bilateral salpingo-oophorectomy (BSO) if the pathology results were positive for cancer. This discussion was documented in the medical record, along with the patient clearly expressing her desire to avoid a hysterectomy if possible. She was given the option of waiting for the pathology result and then scheduling a hysterectomy if cancer was diagnosed. The patient expressed her preference to avoid two anesthetics and two procedures and acknowledged her consent for vaginal hysterectomy with the first surgery if based on a finding of cancer.

Six days later, the patient came to the ob-gyn's office and watched two videos. One video described the endometrial ablation procedure, and the second discussed vaginal hysterectomy/BSO procedures. Before watching the videos, the patient signed forms for viewing the videos and indicated in writing on the forms that she did not understand why she might need a hysterectomy. Because of the patient's written comments, the ob-gyn — with her medical assistant acting as an interpreter — discussed the procedures in the patient's native language to ensure that she understood the proposed plan of care. After this discussion, the patient signed consent forms for the surgical procedures in the physician's office and again at the hospital.

Eight days later, the patient underwent surgery. With hysteroscopy, a large uterine fibroid was identified. The fibroid was broad-based and fixed to the fundal area of the uterus. Because it could not be safely removed vaginally, the physician performed a total vaginal hysterectomy and BSO. Postoperatively, the patient developed mild central hydronephrosis of the right kidney and ureter that required ureteral stenting. The pathology report indicated a 2.5 cm endometrial polyp from the uterine cavity that was benign with no evidence of malignancy.

The patient was discharged on the fifth postoperative day with a prescription for oral antibiotics. Three weeks after discharge, a urologist removed the stent after ureter stricture dilatation. Another stent was placed. Despite continued complaints of right-sided pelvic pain, three follow-up excretory urograms were reported as normal.

Allegations

The patient filed a lawsuit against the ob-gyn alleging that the hysterectomy and BSO were performed without her full consent. She also claimed that the defendant failed to treat her with the least invasive means, and failed to refer her to a sub-specialist qualified to perform a less invasive procedure. The patient further alleged that the surgery damaged her genital/urinary system causing loss of employment and the inability to work and perform household tasks. She claimed that these side effects destroyed her marriage.

Legal implications

The physicians who reviewed this case for the defense were concerned that the communication between the physician and the patient was suboptimal. They also expressed concern that the defendant did not perform the least invasive procedure to remove the fibroid in order to avoid a hysterectomy. Additionally, the medical necessity for anterior and posterior vaginal repairs and the enterocele repair were not discussed during the preoperative visits. The patient did not consent to these procedures.

The ob-gyn's dictated operative report did not describe in detail the intraoperative difficulties encountered when trying to remove the fibroid. The ob-gyn dictated the patient's discharge summary two months after the surgery, when the patient's dissatisfaction with the procedure was known.

Disposition

This case was settled on behalf of the ob-gyn. The patient testified at her deposition that the ob-gyn did not fully explain all the treatment options. This testimony was difficult to dispute because these options were not addressed by the defendant. The patient also clearly expressed her wish to avoid a hysterectomy if possible.

Challenges for Texas physicians/risk management strategies

In 2005, the U.S. Census Bureau identified Texas as the fifth state with a majority of the population (50.2%) comprising minority groups. An article in *Texas Medicine* stated "Texas physicians, facing increasingly diverse patients as heretofore minority populations become the majority, need to take cultural differences in account to help address mounting concerns over racial and ethnic disparities in health care."[15]

"Lack of awareness about cultural differences may result in liability under tort principles in several ways. For example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also, health care organizations and programs face potential claims that their failure to understand health beliefs, practices, and behavior on the part of providers or patients breached professional standards of care."[4]

The ability to communicate well with patients has been shown to be effective in reducing the likelihood of malpractice claims. A 1994 study in the *Journal of the American Medical Association* indicated that physicians who were frequently sued experi-

enced the most complaints from patients about communication. Physicians who had never been sued were likely to be described as concerned, accessible, and willing to communicate. "When physicians treat patients with respect, listen to them, give them information and keep communication lines open, therapeutic relationships are enhanced and medical personnel reduce their risk of being sued. Effective communication between providers and patients may be even more challenging when there are cultural and linguistic barriers." [4]

"Communication barriers continue to pose legal risks if doctors fail to provide adequate language assistance to patients who don't speak English or are deaf." [16] There are obligations created by state and federal anti-discrimination laws to address effective communication with patients who have language difficulties. The standards are included in two areas of federal law — The Americans with Disabilities Act and The Rehabilitation Act. In addition, Title VI of the 1964 Civil Rights Act "prohibits discrimination on the basis of national origin, which the Department of Health and Human Services has interpreted to include language." [16]

More information about these federal requirements is available at the following web sites:

- Department of Health and Human Services Limited English Proficiency resources: www.hhs.gov/ocr/civilrights/resources/specialtopics/lep
- Department of Justice guidance on Americans with Disabilities Act: www.ada.gov/publicat.htm

Some suggestions for a physician in his/her practice to communicate effectively with patients and decrease liability risk include:

- maintain an open dialogue with patients regarding how they prefer to communicate;
- be aware of relevant anti-discrimination laws;
- develop policies for language assistance;
- create a list of interpreter or translation services in your area and explore partnerships with other health care professionals;
- inquire with state agencies or health insurance plans regarding reimbursement;
- document agreed-upon methods of communication or refusals for interpreter services; and
- discourage the use of family members as interpreters. [16]

The Texas Medical Association's Patient Safety Resource Center has created a summary of links, literature, tools, and research about cultural competency. This information is available at https://texmed.org/template.aspx?id=4654.

Improving the caregiver/patient relationship across cultures

The American Medical Student Association offers the following information on improving cultural competency.

- "Do not necessarily treat the patient as you would want to be treated. Culture determines roles for polite, caring behavior.
- Begin by being more formal with patients born in another culture.
- Do not be insulted if the patient does not look you in the eye or ask questions.
- Do not make assumptions about the patient's ideas about how to maintain health, the cause of illness or the means to cure it. Allow the patient to be open and honest.
- Do not discount beliefs not held by Western biomedicine.
- Do not discount how beliefs in the supernatural may affect the patient's health as it may result in failure to follow medical advice and comply with a treatment plan.
- Inquire indirectly about the patient's belief in the supernatural or use of nontraditional cures, e.g. "Many of my patients from _____ believe, do, or visit _____. Do you?"
- Try to ascertain the value of involving the family in the treatment. In many cultures, medical decisions are made by the immediate or extended family.
- Whenever possible, incorporate into the treatment plan the patient's folk medication and folk beliefs that are not contraindicated. This will help develop trust and compliance with the treatment plan." [17]

Conclusion

How do we move forward and what can we do to improve cultural competence in the delivery of health care? The challenges are immense and the financial resources abysmally lacking to identify, design, and implement effective programs. An extreme challenge is that faced by the ambulatory physician practice with little or no funding to pay for the resources required to effectively address the cultural/linguistic demographics typical in a Texas medical office.

"The practice of medicine in today's increasingly multicultural world requires more than just clinical expertise; it requires cultural competency as well. Understanding of and sensitivity to the cultures of the patient population can help health care providers provide more effective care while avoiding the frustration that stems from a lack of understanding." [18]

The Commonwealth report identified the stakeholders and their role in this challenge. Legislators ask what policies can foster the cultural competence of our health care system. Administrators want to identify what they can do to make hospitals or managed

care organizations more culturally competent. Academicians postulate what our health care professions students should be taught about cultural competence. And, finally providers ask how we can deliver more culturally competent care at the community level.[1]

It is important that physicians realize that cultural competency/sensitivity does not assume they should "possess full knowledge of the practices, beliefs, values or customs of every culture or individual." Most people will share their beliefs with those who are willing to listen.[19]

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The author of this article, Barbara Rose, has retired from TMLT. Please send any questions or feedback about this article to jane-holeman@tmlt.org.

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CME test questions

Instructions: Using black ink, read each question, select the answer, and then clearly mark your selection. Please fax the completed test and evaluation forms to the Risk Management Department, attention Stephanie Downing at 512-425-5996. You can also mail the test and evaluation forms to the TMLT Risk Management Department, attention Stephanie Downing, P.O. Box 160140, Austin, Texas 78716-0140. A certificate of completion will be mailed to the address you provide on the CME evaluation form.

This form can also be completed online. Visit www.tmlt.org/reporterCME

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1. The 2000 U.S. census reflected the total population of minority groups to be

- O a. 25%
- O b. 30%
- O c. 22%
- O d. 28%

2. The National Center for Cultural Competence identified decreasing the likelihood of liability claims as one reason for achieving cultural and linguistic competence.

- O a. true
- O b. false

3. Barriers to culturally competent care include:

- O a. poor communication between providers and patients of varying racial, ethnic and cultural backgrounds
- O b. lack of diversity among the health care industry's leaders and workforce
- O c. health care systems poorly designed to meet the needs of diverse populations
- O d. all of the above

4. The U.S. Census Bureau's updated statistics in 2005 listed Texas as the fourth state with minority groups exceeding 50% of the population.

- O a. true
- O b. false

5. The ability to communicate well with patients has been shown to be effective in reducing the risk of being sued.

- O a. true
- O b. false

Statement of completion

I attest to having spent _____ hours in this CME activity.

Physician signature _____ Date _____

Cultural Competence in Health Care

7582212478

EXPIRED CME

CME evaluation form

1. The objectives for this CME were met. O Yes O No

2. The material will be useful in my practice. O Yes O No

3. Did you perceive any evidence of bias for or against any commercial products? If yes, please explain.

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O .5 hr O .75 hr O 1 hr O 1.25 hrs O 1.5 hrs

5. On a scale of 1 to 5, with 5 being the highest, how do you rank the effectiveness of this activity as it pertains to your practice?

O 1 O 2 O 3 O 4 O 5

6. What will you do differently in your medical practice after reading this article?

7. Suggestions for course improvement are:

8. Suggestions for future topics include:

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Cultural Competence in Health Care

Failure to diagnose Churg-Strauss Syndrome

by Barbara Rose and Laura Hale Brockway, ELS


Click to listen to this closed claim study.

Presentation

On November 12, a 44-year-old man was admitted to the hospital under the care of Family Physician A. The patient had asthma, a rash on his legs accompanied by swelling, and a urinary tract infection. Tests revealed that the patient had elevated liver function and proteinuria. He had previously been prescribed ciprofloxacin and furosemide, but these medications were only temporarily effective.

Physician action

A nephrologist and an infectious disease physician saw the patient during his 6-day hospitalization. He was diagnosed with non-specific vasculitis and was started on prednisone. The patient was discharged on 40 mg of prednisone for seven days.

The patient followed up with Family Physician A on November 21. The assessment remained vasculitis. A week later, Family Physician B (Family Physician A's partner) saw the patient. The examination revealed abdominal pain and abnormal gait. He was diagnosed with fatigue and vasculitis. Family Physician B ordered prednisone 20 mg-5 mg tapering dose for four days. The patient was to return in two weeks, but he was seen the next day by Family Physician A. He was referred to a pulmonologist and rheumatologist. The patient did not see the rheumatologist and did not return to the Family Physician, as instructed.

Family Physician A next saw the patient on December 29 when he was consulted to care for him in the hospital due to exacerbation of asthma and weakness in his arms and legs. Three months passed, and the patient was again seen by Family Physician A. It was noted that he had been diagnosed with thromboembolic disease and Churg-Strauss Syndrome (CSS) by consulting physicians during his last hospitalization. Examination revealed the patient had contraction of his fingers and a 3 x 2 cm open wound on his left leg.

Over the next several months, the patient's condition deteriorated, and he required the use of a wheelchair and home health care. Family Physician A's note of March 24 described significant muscle atrophy. The patient's judgment was noted to be "abnormal," but his mood was improving. Medications included prednisone 30 mg daily, adjusted to 10 mg in July. In September the patient was noted to be depressed, in significant pain, and unable to work. He refused a counseling referral. On February 27, the patient committed suicide.

Allegations

A lawsuit was filed against Family Physician A alleging failure to diagnose CSS and failure to appropriately treat the patient. Specifically, the plaintiffs alleged the patient should have been prescribed higher doses of prednisone for up to six weeks without tapering.

Legal implications

Plaintiffs' expert criticized the defendant for failing to diagnose CSS during the patient's initial hospitalization, alleging that Family Physician A recognized that the patient had vasculitis and glomerulonephritis, but failed to diagnose the specific type in order to properly treat. This expert also believed that Family Physician A should have consulted a rheumatologist. Regarding the Prednisone, plaintiffs' experts stated that the medication was tapered to a dose that would not be adequate to treat Churg-Strauss vasculitis.

Physicians who reviewed this case for the defense were relatively supportive of Family Physician A in that CSS is an extremely rare condition that can mimic other diseases. It was noted that four different specialists treated the patient during his initial hospitalization. The patient was followed timely after his hospitalization and some improvements were noted. However, they were not supportive of the dosage of the prescribed steroids, or the length of time for which they were prescribed. The medical literature suggests that a patient with Churg-Strauss should be medicated with 60-90mg of Prednisone for at least 6 weeks and perhaps much longer. In this case, the patient was given Prednisone (120mg IV daily) for part of the time in the hospital; however, the dosage was lowered to 40 mg of oral Prednisone daily before and at discharge. Family Physician B further reduced the dosage to 20 mg a day, followed by a tapering dose to 5 mg over four days. Family Physician A did not change that prescription when he saw the patient in follow up.

Additionally, while in the hospital, Family Physician A performed a skin biopsy. He admitted that while he knew how to perform a skin biopsy, such procedures were not in his area of expertise. He did it in this case because he could not get a surgeon to do so. An argument that Family Physician A failed to properly perform the biopsy, resulting in a delay in the diagnosis of Churg-Strauss syndrome, was anticipated.

The defense of this case was further complicated by a documentation issue. Family Physician A used an electronic medical record (EMR) that allowed the user to print the records in various formats. When Family Physician A was notified of the claim and asked to produce the patient's medical records, his office staff printed the records in a format that listed the most recent diagnosis of CSS first, rather than printing the records in their original format as they looked when they were created. Plaintiffs argued that the produced copy of the chart proved that the diagnosis of CSS was considered earlier in the patient's care and that the patient's condition was not properly/timely treated.

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Failure to timely review lab results

Click to listen to this closed claim study.

by William Malamon and Barbara Rose

Presentation

A 60-year-old man came to Orthopedic Surgeon A complaining of right knee and heel pain. The patient reported that the pain had intensified over the past three years. His medical history included multiple sclerosis, congestive heart failure, and hypertension. The patient's surgical history included left foot and right knee surgery 30 years earlier, and a heart catheterization with pacemaker implantation seven years earlier.

Physician action

Orthopedic Surgeon A recommended a night splint and physical therapy for the knee and Achilles tendon. The patient returned four weeks later with continued pain in the knee and foot. Orthopedic Surgeon A diagnosed a medial meniscal tear in the right knee and right Achilles tendinosis with plantar fasciitis. He recommended custom orthotics for the patient's feet and an MRI of the right knee.

An MRI could not be completed because of the patient's pacemaker. Orthopedic Surgeon A discussed the options for treatment with the patient. The patient consented to surgical repair of his right knee with partial medial meniscectomy.

The patient was admitted to a local hospital and Orthopedic Surgeon A found a radial tear of the patient's posterior horn that was unstable when probed. He debrided it to a stable rim and after reprobing, the meniscus was stable. The surgeon closed the portals and withdrew the arthroscopic instruments. At the first postoperative appointment seven days later, there was no sign of infection. Orthopedic Surgeon A removed the sutures, ordered physical therapy for four weeks, and recommended a return appointment after therapy.

The patient returned four days later complaining of knee drainage for two days from the lateral port. Surgeon A found the lateral port open and serous drainage was noted. He probed the open portal and found no penetration into the joint. Minimal edema, no erythema and free range of motion were documented at this visit. A muscle relaxant, cefadroxil and local wound care were prescribed and a return appointment in two days.

Two days later, the patient was seen by Orthopedic Surgeon A's physician's assistant (PA). The PA noted that the lateral portal site was still open and fluid was draining at the knee. The PA observed no erythema or other signs infection. The patient reported pain and a feeling of heat in his knee.

The PA contacted Orthopedic Surgeon B, who examined the patient. Orthopedic Surgeon B instructed the PA to suture the incision and to order lab work. He instructed the patient to follow up with Orthopedic Surgeon A the next week, and to go to the emergency department if his symptoms did not improve.

The patient reported to an off-site lab later that day for the ordered CBC, Sed rate and CRP. Initial results showed an elevated WBC at 15.1 (normal 4.0-10.5). This preliminary report was faxed to the orthopedic surgeons' office early the next morning (Friday). A follow-up report — showing a Sedimentation Rate-Westergren of 59 (high-normal range 0-30) — was faxed to the office an hour later. Another hour passed and a final report with a C-reactive protein at 150.3 (normal 0.0-4.9) was faxed to the office. Medical records show that there was no direct contact between staff at the lab reporting the abnormal results and staff at the orthopedic surgeon's office. The lab results were faxed to a machine at the "back" of the practice and not the practice's primary fax machine. The lab results were placed in the patient's medical record to be reviewed during his next office visit. No immediate action was taken.

The following Tuesday the patient returned to Orthopedic Surgeon A. He complained of pain and swelling. Orthopedic Surgeon A reviewed the lab reports and diagnosed septic arthritis in the right knee. Orthopedic Surgeon A performed an urgent irrigation and debridement of the right knee the next day. Ten ccs of purulent drainage was removed and the knee irrigated with four liters of antibiotic solution, and visual reinspection found no abnormalities. The portals were closed and a dressing applied. Consults were requested with an infectious disease physician to manage IV antibiotic therapy. A family physician was consulted to monitor the patient's anemia and low sodium levels. The patient improved and was transferred to a rehab facility on the 7th postoperative day.

The patient saw Orthopedic Surgeon A two more times with continued right knee pain. X-ray results were reported as normal and lab work revealed a WBC of 7100. The patient continued to experience right knee pain. Nearly seven weeks after the last appointment with Surgeon A, the patient sought care with

continued on page 20

These closed claim studies are based on actual malpractice claims from Texas Medical Liability Trust. These cases illustrate how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physicians' defensibility. The ultimate goal in presenting these cases is to help physicians practice safe medicine. An attempt has been made to make the material more difficult to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

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For more information, please contact

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at 800-580-8658.

Churgg-Strauss syndrome ... continued from page 16

Disposition

This case was settled on behalf of Family Physician A.

Risk management considerations

As the implementation of EMRs increase, the design weaknesses in some record systems are being discovered when lawsuits are filed against physicians. When using the function to print a complete EMR, the format may look different from that seen on the computer screen. As this closed claim study demonstrates, this can lead to conjecture by a plaintiff's attorney about when a patient reports symptoms or when a diagnosis was made.

Printing a complete medical record during the implementation of a new EMR system can help determine how printed records are formatted. Review each page to determine content accuracy and relevant dates. If the date that new information is added is not visible, then enter the date in the field next to the addition. Lists will most likely organize with most recent entries at the top. Dating each entry will reflect accuracy and avoid conjecture about when information was added to the record.

Laura Brockway can be reached at laura-brockway@tmlt.org

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August 2010

TO ALL TMLT PARTICIPANTS

RE: TMLT Trustee Nominations and Elections for the 2011 Board Year

One of the benefits of being a TMLT participant is the right to nominate and vote in the annual election process to select eligible Successor TMLT Trustees. This is each participant's chance to have an appropriate voice in the operation of the Trust. I urge everyone to participate.

TMLT is governed by nine Trustees. The terms of the Trustees are three years. The terms are staggered and three places are up for election each year. The three positions up for election in 2010 for the 2011 year are Places 4, 5 and 6. The current Trustees holding positions in Places 4 and 5 are eligible for re-election. The Trustee who has held Place 6, Dave Kittrell, MD passed away on July 2, 2010.

Pursuant to the Trust Instrument and Bylaws, the Trustees have nominated three physicians for these positions. These have been submitted to and approved by the TMA House of Delegates. They are:

(1) Place 4 – David Joseph, MD

(2) Place 5 – Stuart D. McDonald, MD

(3) Place 6 – John Holcomb, MD

The Trust Instrument and Bylaws provide that any eligible voting participant may be nominated as follows:

A. Any nomination by any eligible voting participant must be in writing and supported in writing with the signatures of at least four other eligible voting participants. All nominees must be qualified to serve under the Trust Instrument and Bylaws.

B. Nominations MUST be made for a SPECIFIC Place and designated as a nomination for Places 4, 5 or 6.

C. Nominations must be submitted to the Secretary of the Board of Trustees, TMLT, P.O. Box 160140, Austin, Texas 78716-0140. They must be received by TMLT in Austin, Texas **no later than September 10, 2010.**

After all the nominees have been determined, ballots and candidate biographical sheets for the election will be mailed to eligible participants. Ballots will state the deadline for their return. A candidate for any place up for election must receive a majority vote for those participating in the election of such place.

Again, I strongly encourage you to participate in this election to elect Trustees to fill Places 4, 5, and 6.

Sincerely,

Bob R. Fields
President and CEO

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Review lab results ... continued from page 17

another orthopedic surgeon for complaints of significant stiffness and inability to extend the right knee. The patient was later diagnosed with a right knee dislocation and underwent a total knee replacement.

Allegations

A lawsuit was field against the orthopedic group. It was alleged that the group was vicariously liable for the acts/omissions of the employed physician's assistant when the right knee portal was sutured while the knee was still draining. The group was allegedly directly negligent for improper and inadequate policies and procedures that led to a failure to timely address abnormal lab reports.

Legal implications

The plaintiffs alleged that the lab results were not reviewed promptly, which led to a delay in the identification and treatment of the patient's bacterial infection. The plaintiffs also stated that the PA fell below the standard of care by prematurely suturing the incision.

Physicians who reviewed this case for the defense argued that the closure of the incision made no difference in the patient's infectious process because the joint capsule had already been closed.

It was also argued that the delay in reading lab results would have made no difference in the patient's outcome. The defense was also skeptical that a joint infection caused the dislocation of the patient's knee.

Disposition

This case was settled on behalf of the orthopedic group.

Risk management considerations

The practice's lack of policies and procedures for handling abnormal reports received via fax presented a challenge, as no one recalled reviewing the lab results. There was no "fail-safe" system to review incoming reports and make relevant and timely treatment decisions.

Every practice, irrespective of specialty, needs to develop, implement and consistently follow guidelines to confirm that physician orders and subsequent reports are monitored in a timely manner. When key staff (e.g. the physician's medical assistant) are out of the office, a second and even third tier of staff coverage should be in place. Abnormal test results requiring evaluation, and medical orders should not go unnoticed for several days.

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