





# MAPLES' MUSINGS

## WE NEED MORE DOCTORS. REALLY?

by Michael D. Maples, MD, Medical Director

I hear and read this pleading as if it is an undeniable truth, and I am puzzled. I am puzzled by the evidence that abounds here at MACM and in my world, and I am particularly skeptical knowing the main drivers of medical care.

In economic circles there is a dictum: "If the Federal Government were in charge of the Sahara Desert, there would soon be a shortage of sand." It may not be a reality we are dealing with; it may be a perception. At my current age and station in life, I have grown weary of people telling me what is obviously false as if it were the truth. I will proceed with my case.

If we truly need more doctors to take care of sick people, why are there so many doctors who are treating cosmetic problems? Are there not enough sick people? We have family physicians and obstetricians and all manner of physicians who are waging a war against wrinkles and unsightly spider veins. We have healthy, highly trained, experienced physicians working 30 hours a week. We have physicians writing narcotic prescriptions and getting paid in cash. We have physicians promising to make old people young and to give them *young* levels of sex hormones. Really? We need more doctors?

The demographics indicate a lot more old people in the population and, therefore, a lot more wrinkles and a lot less testosterone. We obviously need more doctors to take care of this aging population, but what of the sick people in the ICU. Doctors now want nurse practitioners to perform even the most technically challenging procedures on critically ill patients. It seems counter intuitive. I guess we need more doctors.

## HAVE YOU SEEN "THE RISK MANAGER ALERT"?

In February of this year, the MACM Risk Management Department distributed its first e-newsletter to insureds – *The Risk Manager Alert*. By offering this communication avenue, the staff of Risk Management hopes to provide insureds with information that physicians are interested in as quickly as possible.

"We regularly receive updates from other health care organizations, such as the Board of Licensure or the Mississippi State Medical Association, and we need to get the information out to our insureds quickly," Director of Risk Management Maryann Wee said. "Why wait for a print newsletter to be ready in order to get useful information to our insureds."

Back to my problem with the *truth*. The Parthians were purported to have valued three things: the ability to ride well; shoot the arrow straight; and to speak the truth.

It seems that society values what is rare. I believe the truth must have been rare in the age of Parthians and perhaps today. When somebody glibly tells me something, I would like to know the supporting facts and whether they have a personal or professional interest in the conclusion. I do not have the space to delve into all of the various interests desiring more physicians, but you better think about it before you sign on.

It seems that we may need more doctors that will take care of sick people, wrinkled people and hypogonadotropic people. If a significant portion of our doctors are going to *cure* wrinkles and unsightly spider veins and pass out narcotics and give testosterone to old men, then I suppose the bureaucrats and insurance companies and hospitals are correct, we do need more doctors.

One should not conclude that I do not appreciate smooth skin, youthfulness or money. These are all important things to some patients and doctors. But if the goal is to have a healthy productive population and a good return on the health care dollar, then just having more doctors may not be the answer.

I do know that MACM can more easily defend well-trained, compassionate doctors taking care of sick people and, first, doing no harm.

*The Risk Manager Alert* will be distributed on an as-needed basis and will feature information important to MACM insureds right away.

"We want our insureds to communicate – with their patients, with other providers, with their staff. Why shouldn't we do the same thing for them? *The Risk Manager Alert* gives us the opportunity to communicate with our insureds quickly and at no cost," Wee said.

If you have not received *The Risk Manager Alert* and would like to be included, please send your current email address to Wendy Powell in the Marketing Department at wendyp@macm.net. If there is someone else in your clinic that you would like to receive *The Risk Manager Alert*, send their name and email address as well.



# MARYANN WEE NAMED DIRECTOR OF RISK MANAGEMENT

Since Maryann Wee, RN came to MACM as Loss Prevention Manager in the summer of 1989, she has driven enough miles to cross Mississippi 1,302 times – a lot of time spent behind the wheel promoting Risk Management to physicians.

With the retirement of JoAnn Bienvenu in January, Wee was named Director of Risk Management and will lead the department she originally started. Well known throughout Mississippi for her nursing abilities and risk management knowledge, Wee had worked for both another professional liability company and a hospital quality assurance program prior to coming to MACM. She was recruited by former MACM Medical Director C. G. “Tanny” Sutherland, MD to create the Company’s loss prevention program. Now, almost 25 years later, she finds herself with another opportunity to manage the Company’s risk management efforts.

Health care is changing fast and Wee wants to make the work of the Risk Management Department even more relevant to physicians. She plans to build on the good programs and processes that have been developed in the past and, at the same time, be mindful of the liabilities physicians face now and in the future. The Risk Management staff is constantly learning about EMRs and electronic communications and assisting insureds with the challenges of doing more with less.

“One priority that we will continue to work on is the standardization of the work of this department,” Wee said. “One Risk Management Consultant may do a chart review based on her knowledge and expertise. Another one could review the same chart and see things totally different based on her experience. Our insureds have had to become more standardized in their practice to meet government regulations and reimbursement requirements and we appreciate what they are going through to do this. For us to be able to help them, we need to standardize our systems and surveys so that our entire department is working together under the same guidelines – all for the benefit of our insureds.”

Wee considers the services and advice of the Risk Management Department to be of great value to MACM insureds, but at the same time realizes that physicians are busy and the demands on their time grow every day.

“We don’t want to be another burden to our insureds – one more thing that they have to deal with,” Wee said. “I want our information to be relevant to physicians. This department will use a team approach with our insureds. We want to do more statistical analysis to spot trends in

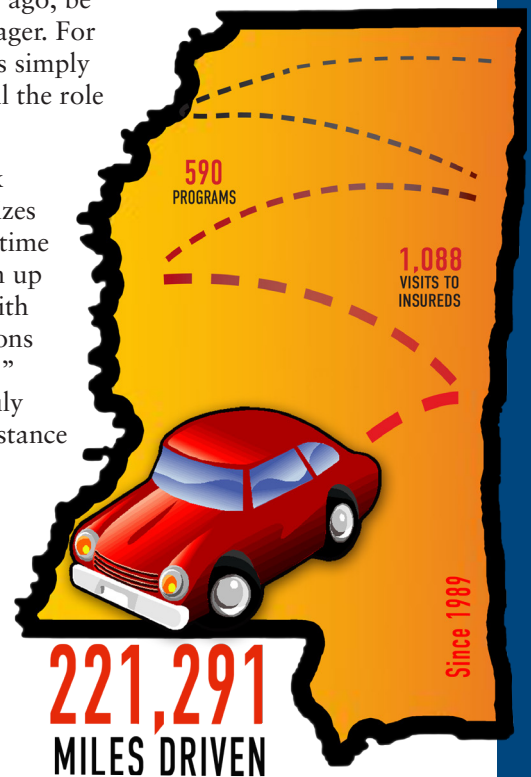
risk management and claims issues. We want to continue our CME programs and even expand it to meet the CME needs of our insureds.”

It is hard to know where health care is going admits Wee, but her goal is for the Risk Management staff to be astute enough with the changes to understand and meet the needs of insureds.

“We want to listen to our insureds and be there to assist them,” Wee said. “At the same time, we have to be conscious of the financial stability of MACM.”

Before Bienvenu’s retirement, Wee spent the majority of her time on the road working with insured physicians – relationships developed over many years. Her hope is that once the transition of responsibility settles down, she can get back on the road to see physicians and work with clinic managers. This is the part of the job that Wee enjoys and the reason she recommended that Bienvenu, whom she hired 18 years ago, be promoted to manager. For now, however, it is simply time for Wee to fill the role once again.

“Everyone in Risk Management realizes that a physician’s time and staff are eaten up more and more with rules and regulations and requirements,” Wee said. “We truly want to be of assistance to and work with our insureds to develop good systems to help provide safe patient care for all of Mississippi.”







# THE GOOD THE BAD THE UGLY OF EMRS

*How an electronic system can help, hurt, or destroy a physician's appearance in the courtroom*

*by Maryann Wee, Director of Risk Management*

As everyone's experience with EMR grows, we are learning that this electronic form of documentation has many different facets. A physician's (and the staff's) use of an EMR can be broken into categories and simply described as *THE GOOD*, *THE BAD*, and sometimes the downright *UGLY*.

Medical offices are starting to reap some of the benefits of *THE GOOD* side of EMRs – improving patient safety and producing more complete records that are legible. At the same time, there is *THE BAD* side where documentation may be legible, but does not really add to patient care. Then, unfortunately, there is *THE UGLY* side where the potential is there to compromise patient care and safety and the EMR becomes an obstacle to overcome in the event of litigation.

Regularly, we are asked if there is an EMR system that we recommend. We do not recommend any one EMR system over another due to the numerous technical aspects and business integrations that must be considered by an individual clinic. Our expertise is in working with our insureds to defend the records generated by their EMR system in the courtroom. Our goal is to work within the various EMR systems and to share the data gathered from working with many different systems and in many different clinic-based settings.

When EMRs became increasingly used in the clinics of MACM insureds, we began a database with information from our on-site surveys. This database was designed and is maintained by Senior Risk Management Consultant Kathy Stone. The MACM Risk Management department has had the following experience with EMRs during surveys conducted from January 2009 through December 2012.

- Our consultants have surveyed 99 different clinics and practices.
- We have reviewed the charts of 456 individual health care providers, *i.e.* physicians, NPs, and PAs.
- 53 percent of the clinics and practices surveyed had an EMR system.

Through these surveys, the MACM Risk Management Consultants have reviewed 26 different EMR systems.

Through this database, we are starting to look at data comparing the differences between paper chart documentation and EMR system documentation. Following are some anecdotal findings, which eventually we hope to back up with statistics.



## “THE GOOD” OF EMRS

*Definition: Improves patient safety and documentation.*

- **Allergy Information** – Now present and prominent. The alert system for potential interaction is also a plus.
- **Vital Signs** – Thanks in part to meaningful use requirements, vital signs are now present and we are seeing more documentation of BMIs.
- **Initial visits** – Templates to prompt physicians and staff to document more complete exams and histories in the initial visit.
- **Patient Education** – Increased documentation of patient education with computer-generated sheets for patients.
- **Medical History** – Templates are prompting more complete medical history, now including more family and social history.
- **Ability to trend diagnostic testing and vital signs** – Able to trend test results that are digitally inputted. Can quickly give insight to physicians to make clinical decisions.
- **Medications/E-prescribing** – Great improvement now especially maintaining a list of medications and seeing past medical history. *For example*, this aspect would be invaluable when a drug is recalled by the FDA and a physician has to track which patients are on the medication.
- **Electronic task list or queues** – We can now electronically track who has viewed information and signed off on it.

## “THE BAD” OF EMRS

*Definition: Does not improve patient safety and documentation and may even make it worse.*

- **Initial versus follow-up visits** – All effort appears to be placed on the initial visit to the detriment of subsequent visits and the information is not updated.
- **Lack of individuality** – The templates are being filled in, but all patient visits appear similar. The unique problems and character of an individual patient’s problem is lost. There is an art to the practice of medicine, but EMR is diminishing this art and is turning it into a technical exercise. Especially lacking is the documentation of patient/family and physician discussions.
- **“Note Bloat”** – Documenting extensive physical exams on every system that are not really pertinent to the patient’s condition or the physicians’ specialty. The templates and drop boxes are being checked, but was the exam really performed?
- **Placing of Information** – Difficult to find information that is not placed in the same area of the EMR by everyone. This can lead to information being overlooked. Worst problems are seen with telephone calls; “nurse” visits for blood pressure checks; suture removal; and medical records or consultations received from other providers.

## “THE UGLY” OF EMRS

*Definition: Compromise of patient care and difficult to defend in the event of litigation.*

- **Medication given in the office/ordered over the phone** – This information is consistently missing. Especially IM injections given by office staff to the patient. We can find the order, but when the injection was given and the site of the injection is not documented. If a patient were to allege injury after an injection, our defense is weakened. Another issue – The medication order by the physician in the office is documented, but medication ordered after hours or refills over the phone is not getting into the system.
- **Abnormal findings on physical exams/history/review of systems** – Abnormal findings are being dutifully recorded and carried over on each visit, but no one is addressing the abnormal finding. What is the significance and impact of the finding on the patient care that is provided?
- **Limited ability to document occurrences** – When things go wrong or do not follow the usual pattern, such as a serious allergic reaction to the medication given in the office, the EMR does not easily lend itself to this documentation. There may be no area in which to place the information about the event or the field has limited character capacity. Documenting an untoward occurrence fully may be the crux of defending the actions of the physicians.

The entire medical community and health care system is experiencing the pains of changing the manner in which health care is delivered. The computerization of medical records is a large part of that change. The reality is that EMR is here to stay. It is imperative that all health care providers adopt their practice

to incorporate the strengths of EMR. But, at the same time, be aware of the weakness and work within the framework of their computer systems and practice to improve the EMR for patient care and safety. Physicians need to lead this transformation and become part of the solution.



# 2012

## Risk Management Analysis of Claims Committee Files

*By referencing the allegations of these lawsuits, we are not stating that the allegations are true. We are only providing the allegations in order to show what the plaintiffs claimed, which were generally unsupported as shown by the defense verdicts.*

by Beth Easley, RHIA – Senior Risk Management Consultant

Every month, the MACM Claims Department prepares an agenda of files for review by one of the two physician-membered Claims Committees. During the Claims Committee meeting, a physician, who belongs to the same specialty as the defendant physician, or is otherwise familiar with the applicable standard of care, thoroughly reviews the case and informs the committee members of clinical concerns. But, prior to, during, and after this monthly meeting, staff from the Risk Management Department review these same claims and questions in order to monitor the risk management issues associated with the cases.

Each claim from the monthly Claims Committee meeting is reviewed and by the end of the year, the Risk Management staff has collected cumulative information identifying trends and issues. The purpose of this review is to identify risk management issues that contributed to the claim and/or impact the defensibility of the claim.

We currently have 17 years of data which includes 1,218 cases to consider and from which to draw conclusions. With this data we have been able to analyze trends from the perspective of risk management to see how we, as a department, can work with our insureds to prevent and/or mitigate future lawsuits.

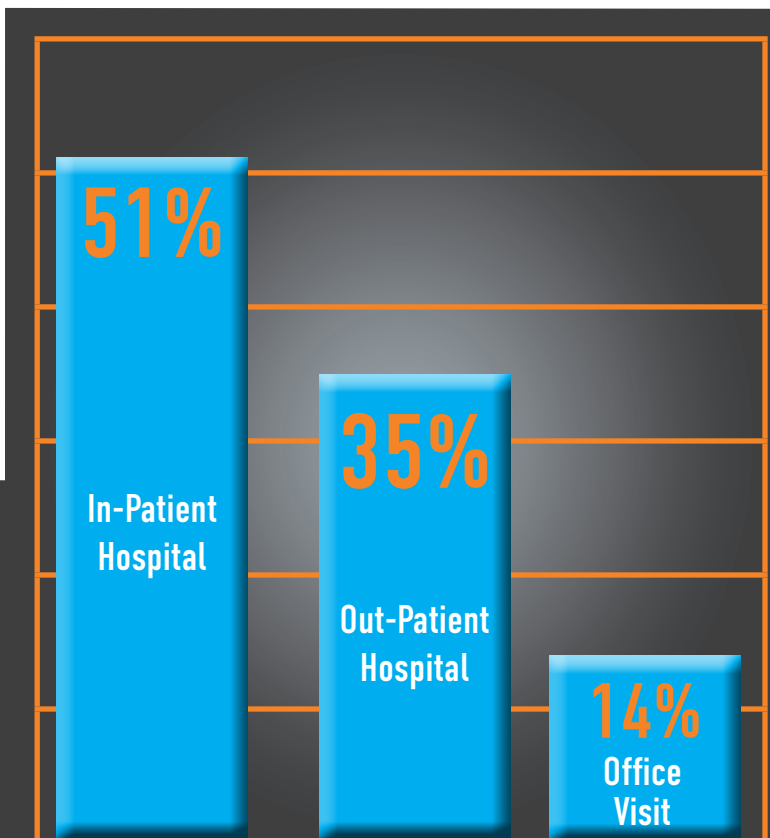
For 2012, 52 files from the monthly Claims Committee meetings were reviewed and, for the most part, the issues and trends that we have seen in the past stayed true to form and continued as issues for our insureds. From a Risk Man-

agement Department viewpoint, this shows us that we must continue to educate and remain in partnership with our insureds.

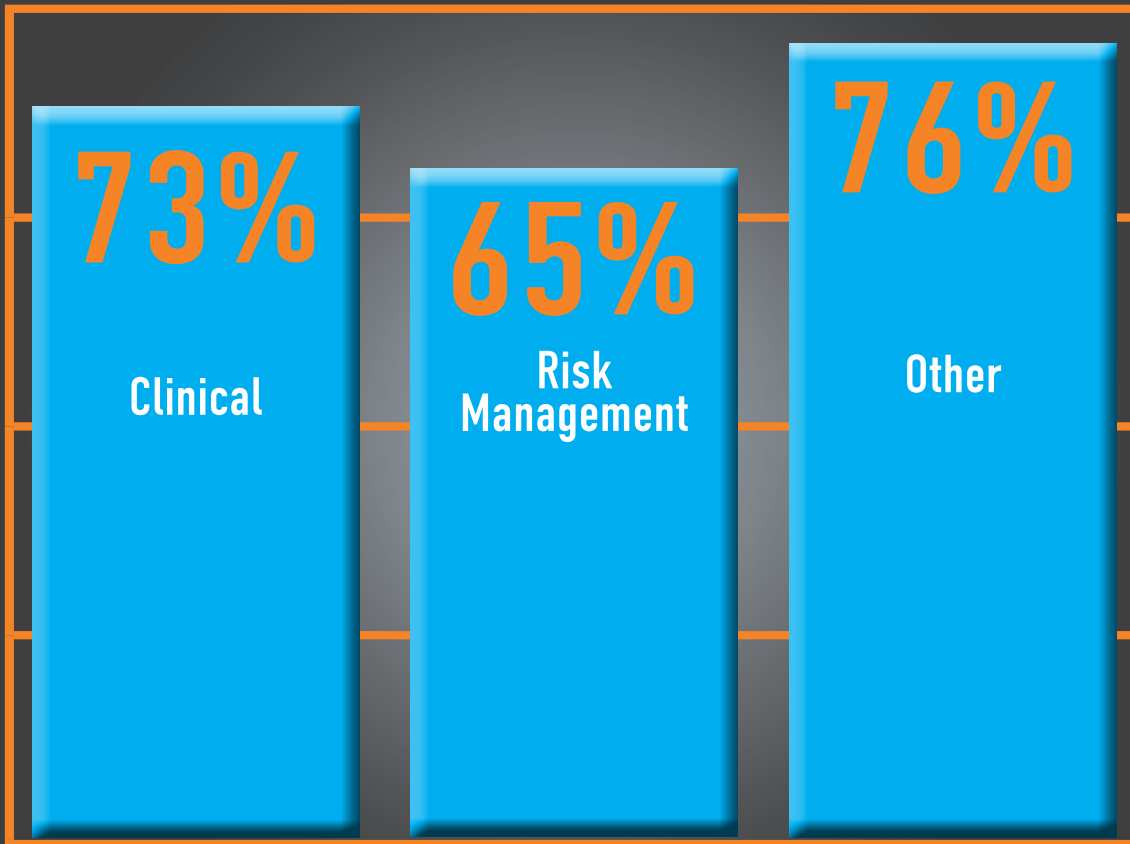
While gender and age fluctuate from year-to-year as one might expect, in 2012, the majority of claimants (59 percent) have been female and the average age of the claimant is 47 years old. The principal payment source of a claimant continues to be private insurance with 43 percent of the claims in 2012 coming from this source. Again, this follows a trend from year-to-year that a private pay, female patient is more likely to sue her physician. Following private insurance, patients paying by Medicare and then Medicaid are the next most likely to sue a physician.

## LOCATION OF INCIDENT

Most of our claims still develop in the hospital setting. In 2012, 51 percent of the claims analyzed occurred in patients who were in the hospital for more than one day as an in-patient. Those patients who had an out-patient procedure were 35 percent of our claims in 2012 and office visits to a physician's clinic made up the remaining 14 percent.



# ISSUES IDENTIFIED



Please note each file reviewed could have multiple issues.

As is done each year, the concerns identified with the cases are categorized by clinical issues, risk management issues and other issues. One case could have an issue in more than one category and, in fact, most cases have multiple, over-lapping issues that are more fully defined and reviewed later on in this article.

For 2012, 73 percent of the 52 files had at least one clinical issue; 65 percent had at least one risk management issue; and 76 percent had at least one issue that we classify as other. A file could have had simply one or multiple instances of a clinical issue, a risk management issue, and an "other" issue. See more details of each category to follow.

## CLINICAL ISSUES

Of the clinical issues in 2012 identified by the physician members of the Claims Committees, the majority of those dealt with practice-related concerns in comparison to the diagnosis-related concerns. Please note each of the 52 files reviewed could have had multiple issues.

### Practice-Related Concerns



### Diagnosis-Related Concerns

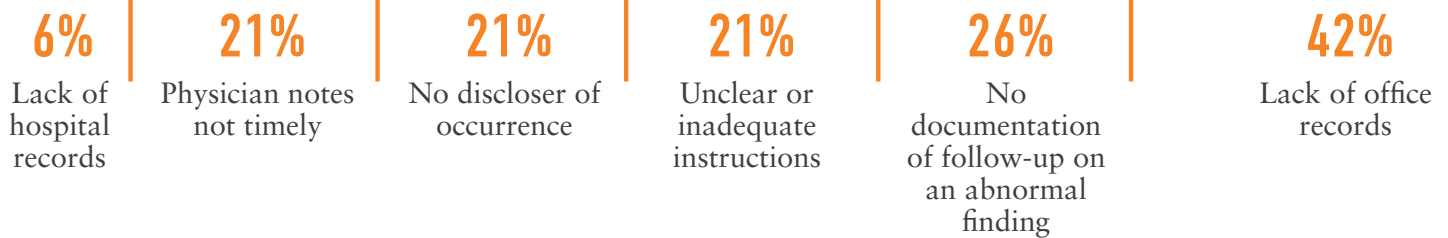


# RISK MANAGEMENT ISSUES

The more common risk management concerns deal with medical record documentation, communication issues, office system failures, and informed consent. These concerns have been a part of this report for as long as we have been reviewing cases so the numbers for 2012 were not unexpected.

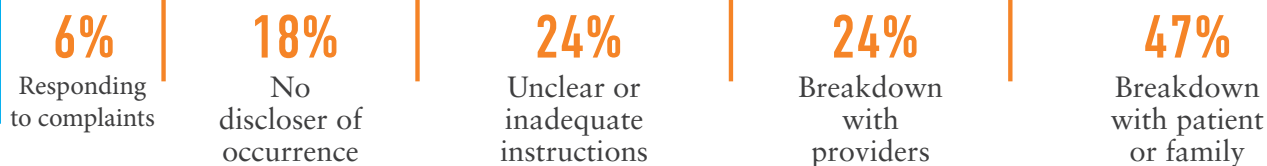
Specifically for 2012 claims, the following issues were identified within the various categories of Risk Management concerns. Please note each file reviewed could have multiple issues.

## 58% Record Documentation



Hospital system failures such as inadequate staff performance, communication break-downs, issues with medical records (whether EMR or paper), or unavailable resources were also identified.

## 52% Communication



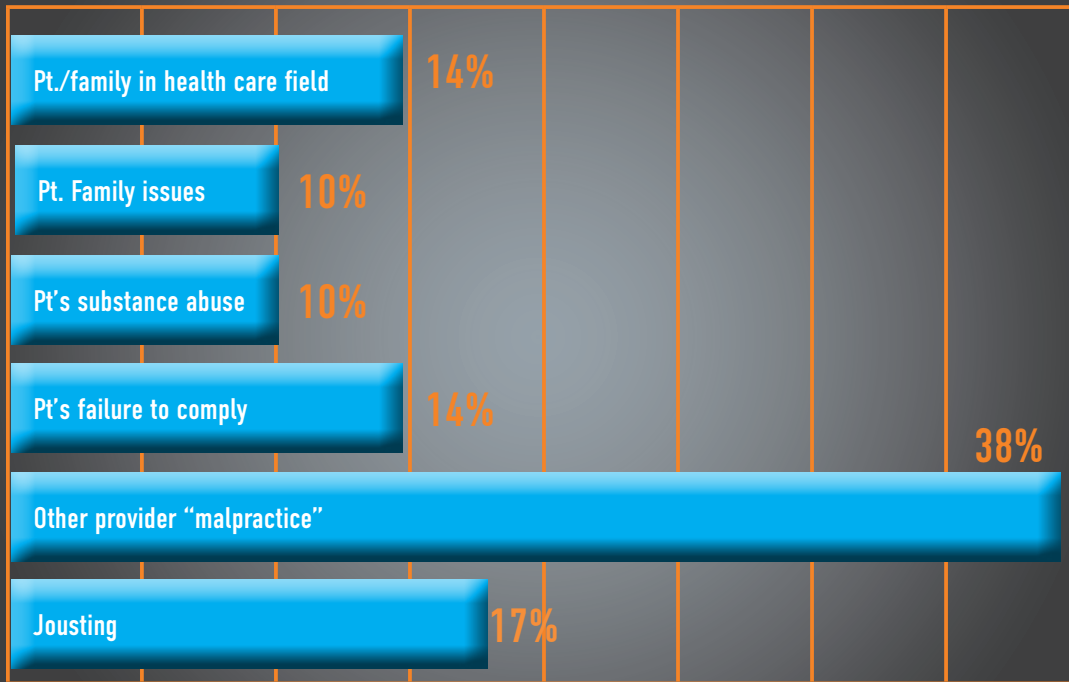
## 42% Office System Failure



## 36% Inadequate Consent

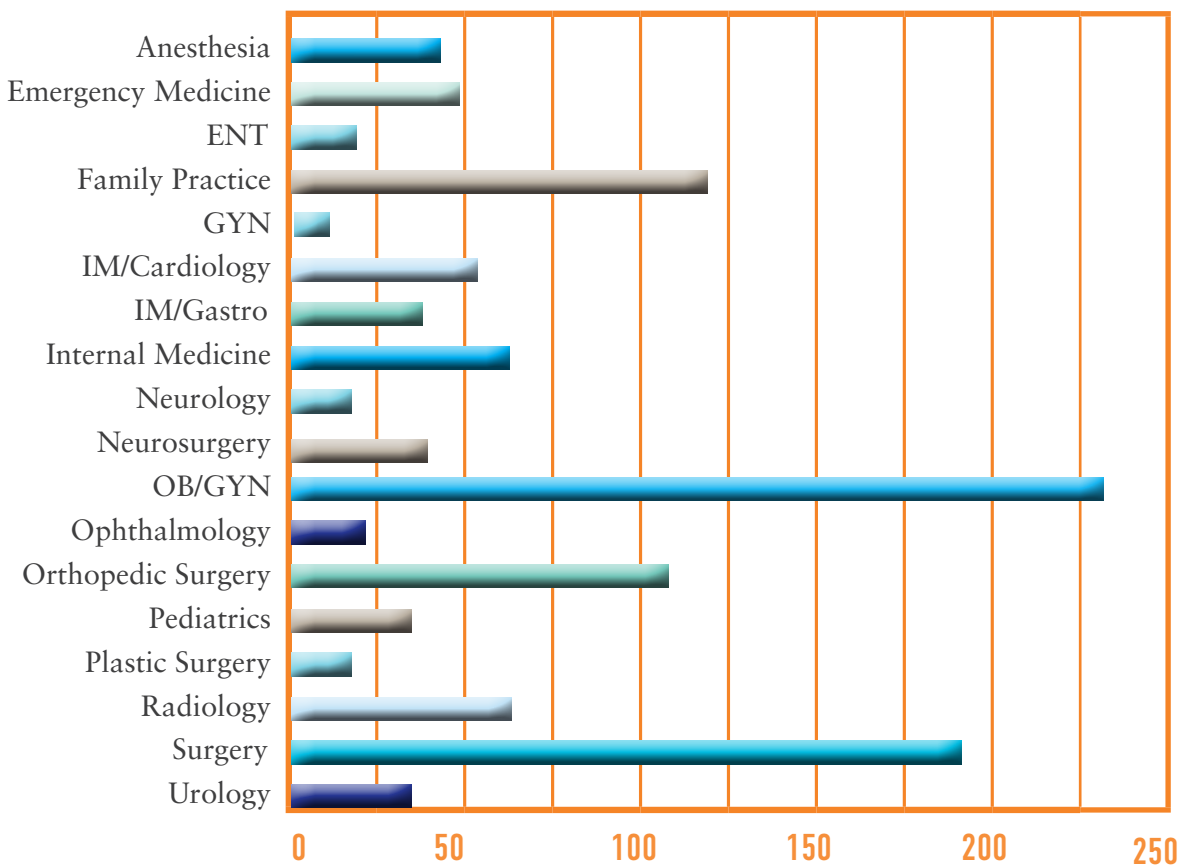


# OTHER CONTRIBUTING FACTORS



*Other* contributing factors include another provider's *malpractice*, the patient/family member working in the healthcare field, the patient's pattern of substance abuse, the patient's failure to comply with treatment, the patient has family issues, and jousting. Jousting is making offhanded or ill-informed comments verbally or in writing by one provider regarding another provider.

## Cases Reviewed by Physician Specialty since 1996 (Specialties with less than or 10 cases reviewed not included)



Of the 1,218 cases reviewed since 1996, this chart shows a breakdown by specialty. Unfortunately, OB/GYN and Surgery have the greatest number of cases that have been reviewed and have remained the top two specialties with the highest incurred losses. Those specialties with less than 10 cases reviewed since 1996 are not included.

The Risk Management Department will continue to follow and trend data retrieved from analyzing claims presented to the Claims Committees. We believe it gives areas of focus for the consultants to continue to monitor.



## EVERETT JOINS MACM AS RISK MANAGEMENT CONSULTANT

The MACM Risk Management Department welcomed a new team member on April 10, 2013, when Anne Everett, RN joined the department as a Risk Management Consultant. Through the educational services offered to insureds, she will work on issues and topics that affect the delivery of health care in Mississippi.

With the changes and new technologies coming about in health care, Everett believes her greatest responsibility will be staying up-to-date and working to help protect the physicians of MACM from litigation.

“We offer consultations, surveys, and seminars which can help provide insured physicians with the needed resources to assist with the delivery of health care and reduce litigation,” she said. “I believe that effective risk management encompasses recognizing, identifying, and reducing risks in order to improve quality of care and, at the same time, lessen the exposure for prevention of potential claims.”

Prior to coming to MACM, Everett worked at UMMC in the Adult Emergency Department as an RN case manager. In addition, she worked for Mississippi College as an adjunct nursing instructor. She has a Bachelor of Science in Nursing from Mississippi College; a Master of Science in Nursing from Delta State University; and is currently a Graduate Student at the University of Southern Mississippi enrolled in the Research and Statistics Doctoral Program pursuing a PhD with a major in Adult/Higher Education.

“There have been many changes that have come about for medicine and the practice of risk management since I entered the field,” Everett said. “Some of these changes include an overall transformation of patient management and health care delivery; information transfer through advanced technology, equipment and the internet; research such as stem cell research; and new medical therapies such as genome therapy.”

Everett has a wide variety of experience both in bedside nursing and medical risk management. She worked for 13 years as a professional medical liability RN consultant for two nationwide providers of professional liability claims and risk management services. In addition, she is a licensed insurance adjuster in Mississippi, Alabama and Arkansas.



“I am looking forward to working with the insureds of MACM and to tackle what is coming in the world of health care,” Everett concluded.

*Anne Everett reviews files prior to a Risk Management Committee meeting with Diane K. Beebe, M.D. and Vice President of Claims, Charles M. Dunn, III.*

**Were you familiar with MACM prior to coming to work for the Company? What kind of reputation does MACM have in the health care community?**

Yes. I was very familiar with MACM having worked in health care in Mississippi previously. The reputation of MACM in the health care community is one of professionalism, expertise, and commitment to insureds.

**Why do you think MACM is a good company? Why did you want to work here?**

I think the longevity of MACM employees' service to the company speaks as to why MACM is a great company. I could see from the moment I first began that the employees were team oriented, considerate of each other, and very family oriented.

**For an insured, what do you consider to be the biggest benefit of MACM?**

I think the fact that MACM is a local company organized by Mississippi physicians that serves only Mississippi physicians is the biggest benefit.



Medical Assurance Company  
of Mississippi

# *Crossing the Bridge to the Future of Healthcare*

2013 Continuing Medical Education

Registration now available at  
[www.macm.net](http://www.macm.net)

Sheraton Hotel on Canal Street  
New Orleans, Louisiana  
September 13-14, 2013



## MEDICAL ASSURANCE COMPANY OF MISSISSIPPI

404 West Parkway Place  
Ridgeland, Mississippi 39157

601.605.4882  
800.325.4172  
macm.net

PRST STD  
U.S. POSTAGE  
PAID  
Jackson, MS  
Permit No. 775

Information contained in this publication is obtained from sources considered to be reliable. However, accuracy and completeness cannot be guaranteed. Information herein should not be regarded as legal advice.

The Risk Manager is a publication of Medical Assurance Company of Mississippi.

## NEW MSBML RULES REGARDING COLLABORATION AGREEMENTS WITH APRNS

In the April 2013 issue of the *Risk Manager Alert*, an article was included about the new rules regarding collaboration agreements with advance practice nurses that were to become effective on April 24, 2013.

As an update, implementation of the new amendments adopted by the Board of Medical Licensure on March 21, 2013, has been suspended until July 31, 2013, pursuant to an Agreed Order entered on April 23, 2013, in the Chancery Court of Hinds County pending the outcome of litigation. The rules in effect PRIOR to any such amendments remain in force.

Source: Mississippi Board of Medical Licensure

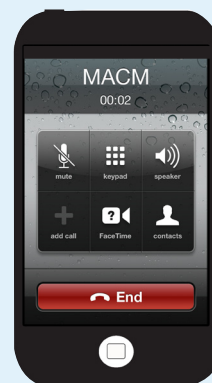
## CLARIFICATION OF NEW LICENSURE BOARD PRESCRIPTION CME REQUIREMENTS

For the past few months, we have received questions asking why we are requiring CME related to prescribing medication and believe there is some confusion. This requirement for physician CME is not a requirement of Medical Assurance Company of Mississippi. This is a result of a change that was made in September 2012 to MSBML Regulation Chapter 7 regarding "CME Requirements" and reads as such: "Five (5) hours must be related to the prescribing of medications with an emphasis on controlled substances." There has been a clarification that this applies to any physician who holds a DEA license.

Any questions regarding whether the new requirement will apply to your license, what date you will need to meet the new requirement by, and if the course you plan to take will qualify for the requirement should be directed to the Mississippi Board of Medical Licensure.

Anyone needing hours to meet this requirement should consider attending the MACM CME program in New Orleans where a panel discussion will qualify for 1.5 of the required hours. Please see our website at [www.macm.net](http://www.macm.net) to register for the MACM CME Program.

**THIS IS WHAT RISK MANAGEMENT CAN DO FOR YOU. LET US KNOW IF YOU HAVE A QUESTION OR CONCERN.**



**435**  
PHONE CALLS AND  
EMAILS DURING THE  
FIRST QUARTER OF 2013

**THE RISK MANAGEMENT  
DEPARTMENT IS FAMILIAR  
WITH**

**26**  
EMR SYSTEMS

