

WSMA

# REPORTS

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### NEWSMAKERS

*When medical practices reach a point where there is too much paper—charts, faxes, prescriptions, billings—to manage efficiently, they turn to electronic health records.*

## Clinics find satisfying efficiencies as they roll out electronic health records

By JEAN COLLEY

If you are wondering if your medical practice should commit to buying and installing an electronic health record (EHR), the experience of clinics that have already gone down that road can be helpful.

**C**LINICS WITH CERTIFIED EHRs in “meaningful use” will be eligible for bonuses of \$44,000 from Medicare beginning in 2011. In this article, we feature three clinics with EHRs—two installed recently and the third, an early adopter with more than a decade’s experience.

### THE DOCTORS CLINIC, KITSAP COUNTY

The Doctors Clinic made its decision to switch to EHRs in February 2007.

“We knew going forward that it was going to be the best way to take care of patients,” said Brian Wicks, MD, president of the clinic and past president of WSMA. “We were getting too big, we had too many charts. It was becoming inefficient having to fax back and forth. Frustration was building for both physicians and patients.” Too, the federal and state governments have been pushing physicians to adopt EHRs. Clinic leaders also believed that it would be better for them to collect data on patient encounters rather than insurers. EHRs were the only way to do that efficiently.

“It was a fairly natural decision,” said Dr. Wicks. “Everything pointed in that direction. There was no way to justify continuing with the paper records.” The clinic implemented the practice management system first and then began to slowly introduce physicians to the EHR.

The clinic of 75 physicians at nine clinical sites in Kitsap County is rolling out Intergy, an EHR and medical practice management system from

*continued on page 3*

### Another twist: personal health records

**E**VEN AS ELECTRONIC health records (EHRs) proliferate, interest in personal health records (PHRs) is also growing. EHRs typically are installed and maintained by a hospital or medical practice. PHRs are usually initiated and maintained by an individual.

In March the Washington State Health Care Authority launched PHR pilot projects, called “consumer-managed health records banks,” at these sites: **St. Joseph Hospital** and the **Critical Junctures Institute**, Bellingham; **Community Choice Healthcare Network**, Cashmere; and **Inland Northwest Health Services**, Spokane.

Each site will encourage individuals to create their own free PHRs, using the secure Web-based tools Microsoft HealthVault and Google Health.

*continued on page 2*

## Spokane Health District fills top post –

After a two-year search, the Spokane Regional Health District board has hired Joel McCullough, MD as health officer for Spokane County. Dr. McCullough formerly was an assistant commissioner of the Chicago Department of Public Health and earlier he served as an epidemiologist at the National Center for Environmental Health in Atlanta.

For more news,  
go to  
[www.wsma.org](http://www.wsma.org)

## Physicians Insurance retains A.M.

**Best's excellent rating** – A. M. Best, the insurance company rating agency, has given Physicians Insurance an A- (excellent) rating for a second year.

Best assesses an insurance company's financial strength and the credit quality of its obligations. In a news release on April 21, the agency noted Physicians Insurance's "conservative reserving and investment philosophy as well as the company's growth and solidity in a time of uncertainty in global financial service sectors."

Physicians Insurance, founded in 1981 by the WSMA, covers more than 6,000 physicians and clinics in Washington, Idaho and Oregon. The firm has grown to be the largest insurer of physicians in Washington state.

## Health Volunteers Overseas seeking physicians –

Volunteer physicians are needed for the following:

- Orthopedists with sub-specialty training for two-week assignments training physicians, residents and medical students this fall at the State University of Medicine and Pharmacy in Chisinau, Moldova.
- Volunteers with specialty training in trauma, sports medicine, spine, foot and ankle, pediatric orthopedics and upper extremity and adult reconstruction for 3-4 week assignments this fall at the Second Affiliated Hospital in Wenzhou, China.
- Orthopedic surgeons in Nicaragua for two to four-week assignments from September through November. Both generalists and sub-specialists are sought.

For more information, email [a.moody@hvousa.org](mailto:a.moody@hvousa.org) or visit [www.hvousa.org](http://www.hvousa.org)

(under Program Areas). The website also lists volunteer opportunities in a variety of other specialties.

## Sign up today to receive drug alerts

**online** – The WSMA encourages its members to enroll in the Health Care Notification Network (HCNN). The HCNN sends drug and medical device recalls and safety alerts to physicians online, replacing the current paper process.

The FDA has worked with the AMA, state medical societies and liability carriers to bring you this free service.

HCNN is:

- Free for physicians and used only for patient safety notices—no advertising.
- Governed by the iHealth Alliance. Your email addresses will not be disclosed.
- Faster and more efficient than paper patient safety alerts. Delays in delivery of alerts can increase liability risk.

If you have already enrolled in the HCNN, thank you. Learn more by visiting [www.hcnn.net](http://www.hcnn.net) or calling (866) 925-5155.

## UWSOM pediatric program achieves

**national recognition** – The Department of Pediatrics at Seattle Children's Hospital and the University of Washington has been ranked sixth among pediatric programs at medical schools in the U.S.

according to annual rankings of graduate and professional programs generated by *U.S. News & World Report*. The department was ranked seventh in 2008.

The Department of Pediatrics comprises 300 physicians, researchers and others holding academic appointments at the UW School of Medicine. ♣

Another twist • *continued from page 1*

The PHRs will automatically contain prescription medications, medication allergies, labs and immunizations from participating "data holder" sources like labs, pharmacies and clinics.

When enrollees go to their physicians, they print out a copy of their PHR for the physician. Part of the experiment is to determine if the information is of value to clinicians.

For more, go to [www.hca.wa.gov/hit/press/online-health-record-projects.html](http://www.hca.wa.gov/hit/press/online-health-record-projects.html). ♣

## REPORTS

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Sage. About 60% of their physicians are using Intergy exclusively, and the rest will join by fall.

The clinic paid about \$25,000 per physician to install Intergy and expects to have ongoing maintenance costs of about \$5,000 per year per physician. “We’ve also spent quite a bit on creating a very strong fiberoptic system,” said Dr. Wicks. “You have to factor in the ‘backbone’—the IT department, the maintenance of connectivity.”

Despite those expenses, Dr. Wicks expects the system to improve profitability. Besides the gains in efficiency and productivity, the EHR will eliminate the tendency of physicians to down-code. Explained Dr. Wicks, “The computer system has a function which recognizes the data that has been entered and lets you know the level of service you delivered. We’ll increase revenue because of more accurate coding.”

For Dr. Wicks, one of the more satisfying outcomes of using an electronic health record is less paper. His medical group is not completely paperless, but the volume of paper charts, paper faxes, paper prescription pads and paper bills has diminished remarkably.

Dr. Wicks said that The Doctors Clinic used to spend \$180,000 annually just on paper charts.

The switch to an EHR has freed up enough space formerly dedicated to medical records to add an office and exam rooms for another physician in most of the clinics, he said.

#### **SWEDISH MEDICAL CENTER, KING COUNTY**

Swedish Medical Center is in the last laps of its rollout of the EHR Epic. Epic handles ambulatory and inpatient care, an important selling point for Swedish. The last of Swedish’s three hospitals went live in February; 10 of its 25 clinics in Seattle and the Eastside still remain to be converted from paper to the electronic system. Besides the 350 physicians employed by Swedish, a number of physicians who operate at Swedish use Epic to follow their Swedish patients.

Tom Wood, MD, chief medical information officer, said that Swedish looked at EHR vendors for five years before settling on Epic in 2005.

“Even in the short time we’ve been up, we’ve had anecdotal evidence that our EHR has benefitted patients,” said Dr. Wood. Vascular surgeon Swee Lian Tan, MD told of a man who came into the Swedish emergency room recently with gas gangrene of his foot. The ER staff called Dr. Tan, assuming the foot would have to be amputated. Dr. Tan logged on to the EHR from home—at 3 a.m.—to look at the X-ray of the patient’s foot, his lab results and previous vascular testing. As she left her house, she called the X-ray team to do an angiogram, and the OR team to let them know they should get ready for a popliteal artery to dorsalis pedis bypass. The upshot: “We saved the patient’s foot,” said Dr. Tan. “With patients like this, time is of the essence.”

Swedish has reconfigured clinic exam rooms in order to install computer monitors with adjustable arms so that patients and physicians can view them together. “Physicians are still learning how to use the computer monitors with the patient in the room,” he said. “They are doing well with the new system. After a few months using it, they say they would never go back.”

That’s not to say there hasn’t been any grumbling. “Some of the younger physicians who’ve grown up with games or Google, are more intolerant of a complex system,” he said. “They expect semi-magical results.”

Physicians access Epic through a secure server over the Internet.

Swedish also plans to license its Epic EHR to community physicians with privileges at Swedish, for a yet-to-be-determined fee.

Swedish does not yet have the capability to exchange information with other systems’ EHRs—called interoperability—but upgrades in Epic could make it possible within the year. The federal stimulus money for EHRs will help with that.

#### **MULTICARE HEALTH SYSTEM, PIERCE COUNTY**

MultiCare was an early adopter of electronic health records when it first installed Epic in 1998 in its now 21 clinic sites, in Pierce and South King County. Epic was added later at Tacoma General, Good Samaritan in Puyallup, Allenmore in Tacoma and Mary Bridge Children’s Hospital in Tacoma, the health system’s four hospitals.

Today, MultiCare’s 300 employed physicians use Epic in the system’s hospitals and clinics, and another 60 community physicians pay \$350 per physician per month to use Epic in their offices.

In 2004 MultiCare began offering patients a look at a portion of their medical record, using a function in Epic called MyChart. With an access code and a password, patients can log on from their own computers and view their clinic lab results, imaging studies, allergies and some diagnoses. (After considerable discussion, MultiCare decided that physicians should preview the contents of a record to protect patients from learning they have a serious illness like cancer just by logging onto their record.)

Recently, MyChart was expanded to include inpatient information as well. Next month, diabetic patients will be able to view their target hemoglobin A1c levels and their most recent test results.

Right now, patients mostly use MyChart to make appointments, said Maggie Lohnes, administrator for clinical information management at MultiCare. The organization is planning a marketing campaign to encourage wider use of MyChart. In preparation, MultiCare recently conducted focus groups of patients to ask them what additional functionality they would like. “They want more and more,” said Lohnes, citing links to information about diagnoses and more information about the meaning of lab results. ♣

*A toxic prescription for medical errors, loss of respect, and possible litigation*

## Disrespectful behavior

By RONALD L. HOFELDT, MD, Director of Physician Affairs, Physicians Insurance

YEARS AGO, I MET with a highly respected physician who earned praise from his peers and was worshipped by patients. At the same time, he was a tyrant. Dr. D., as I'll call him, was notorious for publicly berating the nursing staff, vocally challenging the hospital's management, and scolding patients for not following orders.

To avoid the hospital's disciplinary action, which included the possible revocation of his license, Dr. D. agreed to consult with me about his behavior. Like the majority of physicians who exhibit rage and ill manners, Dr. D. is a product of our inherited culture of medicine.

"My professors expected perfection in medical school," he remembered. "They treated students with disdain if we didn't perform. Plus, the attending staff screamed at us if we showed any less intelligence than theirs. I thought it was acceptable to demonstrate this behavior."

How many of us can recite stories like this—professors and residency instructors throwing clipboards at us, or yelling at us for our alleged incompetency? We have often

been credited for our cognitive abilities, not necessarily for good bedside manners.

Because disrespectful behavior is prevalent in our training programs even today, three to four percent of the physician population perpetuates it as the norm. Fortunately, the culture may be changing, though slowly, as this type of behavior is

tolerated less and less by colleagues in the workplace.

Why? It causes stress, low morale, and high job turnover. It may lead to serious mental and physical repercussions, including depression, substance dependency, and personal and professional relationship disaffection. It may incite legal action from distressed support staff and irritated patients. Most importantly, it may jeopardize patient safety.

### WHAT IGNITES OFF-PUTTING BEHAVIOR?

Most of us are overstressed on a daily basis. We're expected to be "on" all of the time—dealing with frequent-flyer patients, reductions in reimbursements, and multi-tasking.

Once in a while the most minor incident unnerves even the best of us. We raise our voices at coworkers, demand instead of ask, and throw charts. We may

become physically violent. We have a hard time admitting, "I'm running on empty and I need help!"

I attended a conference in London last fall where Elizabeth Paice, MD, professor for the London Deanery, referred to such poor behavior as "ward rage" in hospitals. In her study, physicians tended to overlook or excuse the disruptive behavior in their colleagues. She also found that junior physicians who displayed these behaviors were more likely to be reported to the administration, but the senior physicians were ignored. Confronting these behavioral problems early provided the best results in altering these behaviors.

### DISRESPECTFUL VERSUS DISRUPTIVE CONDUCT

Disrespectful behavior can be classified as rudeness, arrogance, or vocal exhibitions of superiority over others. It may incite "bypass syndrome," where coworkers skip contacting on-call physicians for fear of reprisal—often resulting in patient-care errors.

Disruptive behavior goes beyond minor displays of angry temper. It involves a pattern of shouting, inappropriate comments or gestures, and violence toward coworkers and patients.

The American Medical Association, the Joint Commission, and many state medical associations are stepping up policy formulation on disruptive behavior. (WSMA recently completed its policy: it is posted on [www.wsma.org](http://www.wsma.org) under Medical Professionalism, Medical Staff Resources). Ultimately, this is where the risk of losing one's medical license comes into play. Hospitals and medical practices will soon be required to establish workplace guidelines on disruptive behavior and ways to address it.

### SERIOUS REPERCUSSIONS

Disrespectful behavior breeds fear and contempt along with compromised patient well-being. *The New York Times* recently cited an Institute for Safe Medication Practices study that found that 40 percent of hospital staff members who were intimidated by doctors did not report their concerns about orders for medications that appeared to be incorrect. As a result, seven percent of those cases ended in medication errors.

It was also noted that some 30 percent of nurses have left their jobs because of disrespectful physicians.

According to Gerald Hickson, associate dean for clinical affairs and director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center, "Any behavior which impairs the health care team's ability to function well creates risks." Health care leaders should encourage and promote colleagues, patients, and family members to speak up when behavioral problems create unnecessary risks.

### CREATING A WORKPLACE WITH DIGNITY

Good communication is critical for establishing expectations

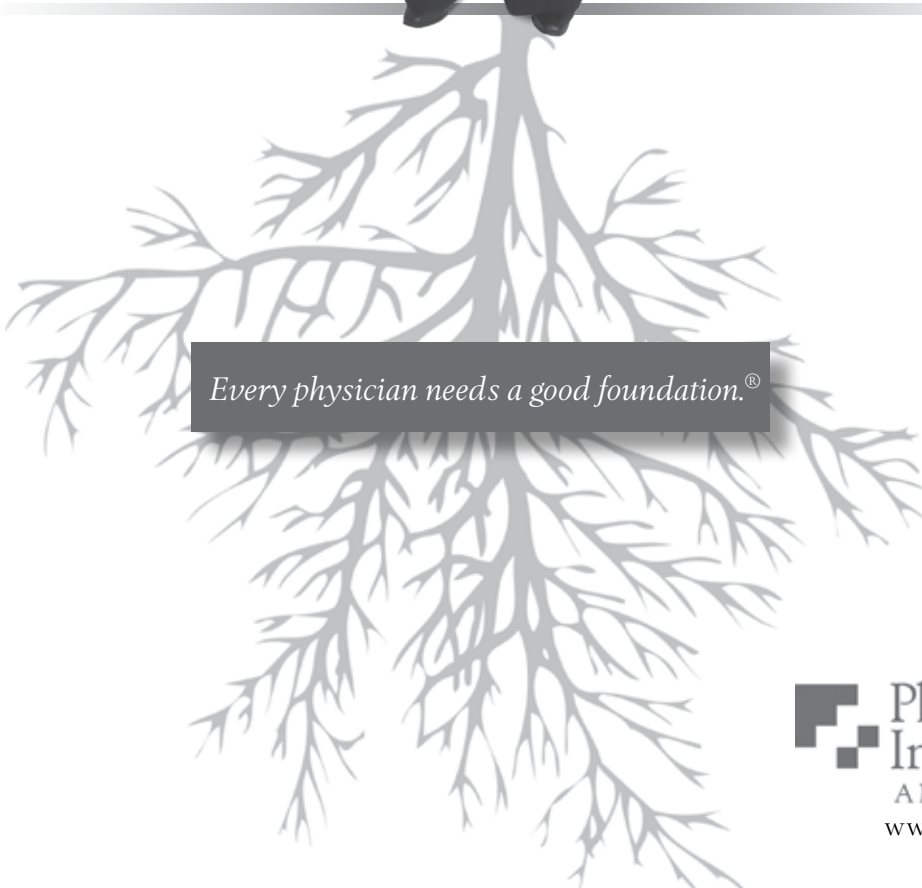
*continued on page 12*

Healthy organizations provide support for stressed-out providers, while providing safe opportunities for employees to report instances of disrespect.



**Cynthia Markus, MD, JD,  
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# HIPAA privacy changes in economic stimulus act

By STEPHEN D. ROSE, JD, MBA, Chair, Healthcare Law Section, Garvey Schubert Barer, Seattle



**T**HE AMERICAN RECOVERY and Reinvestment Act (ARRA) of 2009, signed into law on February 17, offers financial incentives to physicians to adopt electronic health records\*, but the stimulus bill also contains about 50 pages of significant changes to HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy and security rules. The following is a run-down of some of the more significant changes.

## **Business associates' privacy and security provisions now directly applicable**

Business associates under HIPAA are companies or persons hired under contract by a covered entity, such as a physician or physician group, to perform a function or activity on behalf of the covered entity other than providing treatment to the patient that requires the business associate to review or process protected health information supplied by the covered entity. When HIPAA was first established it placed on covered entities the burden of ensuring that their business associates complied with HIPAA and not disclose protected health information improperly. Today this contract is typically referred to as a "business associate agreement" or "BAA."

The ARRA fundamentally alters the current law and makes the HIPAA privacy and security requirements applicable to business associates to the same extent that they "are made applicable with respect to covered entities..." Even though the privacy and security requirements will be imposed on business associates by law, the stimulus bill also requires that the HIPAA privacy and security requirements "shall be incorporated into the business associate agreement between the business associate and the covered entity." Additionally, the civil and criminal penalties applicable to covered entities are now also directly applicable to business associates.

## **Notification of breaches**

HIPAA, as originally passed, does not mandate that a health care provider notify an individual if their health care information is improperly disclosed.

The ARRA significantly changes this. HIPAA will require later this year that individuals be notified by the physician who improperly discloses or allows access to, or

reasonably believes they disclosed or allowed access to, the individual's unsecured protected health information. If the breach is made by and discovered by a business associate, the business associate is only required to notify the covered entity.

All breach notifications must be made no later than 60 calendar days after the discovery of a breach by the physician's office or business associate. In some circumstances the covered entity must describe on its home webpage the breach and give patients information on how to determine whether their protected health information has been improperly disclosed. Depending on circumstances, the physician or the business associate must also notify the Secretary of Health and Human Services (HHS). Then, HSS may identify on its website the organization or physician allowing the breach and may require notice to prominent media outlets for publication.

## **Improved enforcement**

AARA makes a number of significant changes to the HIPAA criminal and civil penalties and how those penalties will be enforced and now requires HHS to conduct HIPAA audits.

## **HIPAA audits**

ARRA directs the Office of Civil Rights (OCR) to conduct audits looking for HIPAA violations as opposed to just relying on complaints filed. The Secretary of HHS is now required to provide for periodic audits of covered entities, such as physicians and physician offices and their business associates, to ensure compliance with HIPAA. Presumably HHS will delegate this audit function to OCR and OCR will continue with its current role of investigating HIPAA complaints.

## **Willful neglect**

Within 18 months of February 17, 2009, HHS must promulgate regulations that impose a mandatory civil penalty for any HIPAA violation due to "willful neglect." Further, HHS must formally investigate any complaint of a HIPAA violation if a preliminary investigation of the facts of the complaint indicates a possible violation of HIPAA due to willful neglect.

## **Distribution of civil monetary penalties**

Any monetary settlements or monetary penalties collected with respect to a violation of the HIPAA privacy or security rules will now be transferred to OCR to be used for purposes of enforcing the HIPAA provisions of the stimulus bill and the HIPAA privacy and security rules. In other words, OCR will now have a financial incentive to pursue cases until a monetary settlement or civil monetary penalties are imposed. In all likelihood this will make it more difficult to settle cases early by implementing a plan of correction without any payment.

*continued on page 15*

*Employer-sponsored insurance is becoming a casualty of the recession.*

## Collections, cash and 'retainers'

By BOB PERNA, FACMPE, WSMA Practice Resource Center

AS THE HARSH ECONOMIC environment continues to take a heavy toll, some businesses are failing outright and others paring expenses. One casualty is employer-sponsored health insurance. Employers are eliminating the benefit or increasing employees' share of their premiums to unaffordable levels. This trend is swelling the ranks of the uninsured, around 45 million Americans before the start of the recession.

Physicians' practices must be prepared to address these developments. Staff should check to make sure patients' health coverage is still in force, reinvigorate the practice's efforts to collect outstanding accounts receivable and ascertain patients' true identity.

Patients may have switched to a high-deductible policy or a health savings account. If a patient has a high-deductible policy, the insurer is unlikely to pay for services until the deductible is met. That means the practice must pursue the patient for payment. Practices can see a

drop in health insurance revenues as patients bear a greater portion of the financial responsibility for services, that is, as insurers pay less of the bill. More office labor and time will be required to pursue payments from patients rather than from health insurers. Some practices

reportedly are adjusting fees for long-time patients who have lost health insurance coverage and still need care, but for patients with insurance be careful not to violate contract provisions.

Insurers are now testing electronic "point of sale" models that provide the practice with instant information on a patient, including insurance eligibility and the patient's deductible, so that payment arrangements can begin before the patient leaves the office.

Practice staff should monitor closely the trends in all patients' insurance benefits. Keep an eye out for loss of coverage, switches to high-deductible policies and growth in self-pay accounts receivable and bad debts. Act quickly to make payment arrangements with patients to avoid

excessive write-offs. Brush up on "collections" skills. The WSMA is offering this seminar in June: Collecting Accounts Receivable. Check the WSMA's website under Practice Resource Center, Seminars for details.

Be sure to confirm patients' identity. Every practice should have an identity theft prevention program as part of its larger compliance program. For more details, see the April 2009 *WSMA Reports* and the Identity Theft section of the WSMA Practice Resource Center ([www.wsma.org](http://www.wsma.org), go to the Practice Management Operations web page).

### Cash is king?

With the continuing loss of health insurance, physicians are looking anew at cash payment and "retainer" relationships with patients. Practices are beginning to offer services on a cash basis, collecting all or part of the amount due at the time of service. Be cautious with these arrangements when dealing with patients who carry health insurance if you have a contract with that insurer. Review the contract to make sure you are not violating any provisions. Also carefully check the provider manual and any newsletters, or contact the insurer for clarification.

The WSMA advocated vigorously in the 2006 and 2007 legislative sessions to protect the "retainer" style practice model from unnecessary and unreasonable regulatory oversight. In 2007, E2SSB 5958 was passed and took effect on July 22, 2007. That legislation defined "Direct Medical Practices" and explicitly exempted these practices from the definition of "health care service contractors" (like Regence and Premera) in state insurance law.

Direct medical practices are prohibited from accepting patient's insurance payments from regulated insurance carriers (commercial, government sponsored or self-pay). Direct medical practices may accept payment of retainer fees, directly or indirectly from non-employer third parties. They are prohibited from selling direct practice agreements to employer groups.

However, in the 2009 legislative session SSB 5436 was introduced. A legislator made a last-minute amendment imposing troubling requirements on direct model practices. The bill requires that direct model practices contribute to the high risk pool, a requirement until now reserved for regulated health insurers. The bill also requires that direct medical practices submit marketing materials to the Office of the Insurance Commissioner for review. These requirements would make these independent physician practices operate more like health insurers, an approach strongly opposed by the WSMA when the 2007 protections were passed.

At this writing, SSB 5436 had been passed by the House and Senate, but not yet signed by Gov. Gregoire. In a strongly worded memo, the WSMA urged the governor to veto the onerous sections of the bill.

If you have questions or comments, please email me at [rjp@wsma.org](mailto:rjp@wsma.org). ♣

Practice staff should monitor closely the trends in all patients' insurance benefits. Keep an eye out for loss of coverage, switches to high-deductible policies and growth in self-pay accounts receivable and bad debts.

*A patient's estate successfully sued a hospital for delaying his intubation. The hospital had argued that the patient's morbid obesity was the cause of the delay.*

## **Juries' verdicts in some cases understandable, in others, questionable**

By WILLIAM O. ROBERTSON, MD

**C**ASE 1. A.A., A 20-YEAR-OLD otherwise always healthy woman, developed some nausea, vomiting and headache. She went to two different emergency rooms affiliated with Temple University's Health System in Pennsylvania on the same afternoon. In the first ER she was diagnosed as having the flu, and in the second, as being pregnant with its usual complications.

A couple of days later, she fell down the stairs at home and was taken by ambulance to a third emergency room. She was carefully examined, X-rayed and diagnosed as having a brain lesion that subsequently proved to be a tumor. Later, she became paralyzed on her left side and was confined to a wheelchair. She then became blind and died shortly thereafter.

Before her death, she sued the first two hospitals, alleging that their examinations were insufficient to detect the brain lesion, specifically that no X-rays were taken at either hospital. She added that a CT scan would have led to an earlier diagnosis and the chance for surgery to interrupt the tumor's progress.

The defendants responded that she had reported to only one of the several physicians involved that she had had

some numbness in her extremities and further that it had disappeared by the next day. Both hospitals added that their repeated neurological examinations had failed to detect any neurological findings and that her signs and symptoms were readily explained by her pregnancy. They also main-

tained that her brain lesion had nothing to do with her fall. They testified that the lesion had been quickly diagnosed as a metastatic choriocarcinoma that was surgically removed. They pointed out that she then received chemotherapy, but the lesion had not really responded to the drugs—as so

often happens. Nonetheless, the jury returned a verdict of some \$11 million for the plaintiff. No appeal is pending.

### **Case 2**

B.B., a 66-year-old man with asthma, hypertension, type 2 diabetes, obesity and hypercholesterolemia, went to a local emergency room in Massachusetts with a complaint of light-headedness and some facial weakness. Initial lab results suggested mild insufficiency and hyperkalemia. He was given IV saline to try to decrease the serum potassium, with glucose and insulin to follow. However, the patient panicked and became very short of breath, telling the physicians that he was having an asthmatic attack. His Albuterol inhaler provided no relief, so the staff tried to intubate him. Four separate attempts were made over less than 10 minutes; all failed. An anesthesiologist arrived and was quickly successful. B.B.'s pulse returned, but he never regained consciousness. He went on to develop encephalopathy and died four days later.

His estate sued, alleging that the hospital had delayed too long in intubating him, with the hospital responding that his morbid obesity was the cause of the delay. The hospital also said that its staff had done everything it could to respond as quickly as possible. The jury returned a plaintiff verdict of \$400,000.

### **Case 3**

C.C. and D.D., a husband and wife, respectively, sought marriage counseling once in 1998 and again in 1999, when they decided to get a divorce and argued over who would get custody of the children. With the approval of both parties, the court-appointed evaluator sought the records of the joint sessions from the counselor. The counselor was still seeing the husband as a patient.

The wife sued the counselor, arguing his report inappropriately emphasized his opinion that she suffered from bipolar/manic depression and that the husband would make the better custodian.

The wife also argued that the counselor had a conflict of interest since he was still treating the husband.

The counselor responded that the wife had signed the necessary forms authorizing him to submit his opinions about her to the evaluator and that she had not availed herself of the opportunity to refuse. The husband emphasized the same point. The Illinois jury agreed and permitted the husband to become the children's custodian.

### **Case 4**

E.E., a 17-year-old California girl, went to a Kaiser health facility. A phlebotomist attempted to draw venous blood from her right antecubital fossa. When the phlebotomist inserted the needle, E.E. felt severe, acute pain. She went on to develop extreme pain and swelling of the arm, along with discoloration of the skin of the hand and uncontrollable muscle spasms in the arm.

She sought help from physical therapy but could not

**After the hospital nursing staff gave the patient more morphine than the surgeon had ordered, she suffered prolonged memory loss.**

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This column is made possible through the support of Physicians Insurance. Opinions expressed here are not necessarily those held by Physicians Insurance or WSMA.

tolerate the increase in the pain that it caused. She was then advised to seek surgery on her spinal column to try to obtain some relief. At that point she filed her suit, alleging that a significant error had been made. An arbitrator awarded her \$959,700. No appeal is pending.

#### **Case 5**

F.F., a 46-year-old Missouri housewife and mother of two children, was advised to have a vaginal hysterectomy and removal of her fallopian tubes and ovaries. All went well. During the postoperative period, she was given morphine in an IV solution and received good pain relief. A short time after the nursing shift change, she received an overdose of the morphine. Her surgeon gave her some Narcan, but F.F. continued to be light-headed with some depressed respiration. She began to have episodes of vomiting. She became confused and experienced short-term memory loss. A neurologist felt that she had somehow suffered from cerebral hypoxia. Though she seemed to be getting better, she continued to have some memory loss and was urged not to drive.

Then F.F. progressed to forgetting people's names. She had trouble managing her medications and became significantly depressed.

She sued the hospital, alleging that the nursing staff had given more morphine than the surgeon had ordered. The conflict was settled for \$850,000.

#### **Case 6**

F.F., a 33-year-old woman, had a history of repeated depressions. She was hospitalized several times, but not in mental health institutions. One summer evening, she was found unconscious at home and was brought to a California hospital where she was diagnosed as having overdosed on her medications again.

She woke up from her coma two days later. She was then transferred to a nearby psychiatric unit. Three days later she was observed by two guards as she was leaving the unit without permission. They persuaded her to return to the unit, but a few minutes later she fell and lost consciousness. She awakened rather quickly, with no signs of having had a seizure. She then claimed that she had only gone out for a smoke and that the guards had chased her and one had grabbed her and forced her to return. She also alleged that after reentering the building, the guards continued to try to restrain her and, in the process, one pushed her. She said that this was when she fell and lost consciousness.

The guards denied the allegations, but they did say she had had a seizure after she fell. As far as they were concerned, the fall led to no consequences—and that she had returned to her room on her own.

F.F. sued and a defense verdict followed.

#### **Case 7**

G.G., a 39-year-old woman, entered the hospital at term for an elective Cesarean section. She explained that she

wanted to avoid any instruments that might injure the baby. The C-section began under spinal anesthesia. After the uterine incision had been made, the obstetrician had difficulty in delivering the fetal head. He applied a vacuum instrument, despite the mother's request. In any event, there was then a very minor delay in the delivery. As the neonatal period progressed, it became obvious that some brain damage had apparently occurred.

The initial delivery record omitted the use of the vacuum extractor, but the obstetrician shortly amended it to say it had been used. The mother claimed that he had told her initially that it had not been used, but later told her that it had become critical to do so and after that he had amended the record.

G.G. sued the hospital and the physician. The hospital reached a settlement for \$3.5 million, but the suit against the physician went to trial. The jury, after hearing a range of experts testify, rendered a verdict in favor of the physician, much to the consternation of the mother, who is taking care of a severely brain-damaged infant.

Again, no appeal is pending.

#### **Discussion**

This potpourri of cases brings up a lot of controversies to try to deal with. First, do you think that each of the outcomes of the suits was justified? I suspect not.

Case 1 demonstrates a rather common occurrence in ERs across the country—a young person probably with “the flu, the pip or the grippe”—something that is going around. Time often proves to be the most valuable diagnostic tool and patients usually get well. That's not what happened here, but the matter was complicated by the fall, which made for the legal problem.

Case 2 involves yet another problem with day-to-day efforts at intubation—particularly when done by an inexperienced individual.

Case 3 summarizes a marital debate. Do you agree that the jury was correct based on what they had heard?

For Case 4, are you convinced the needle stick itself was the sole culprit?

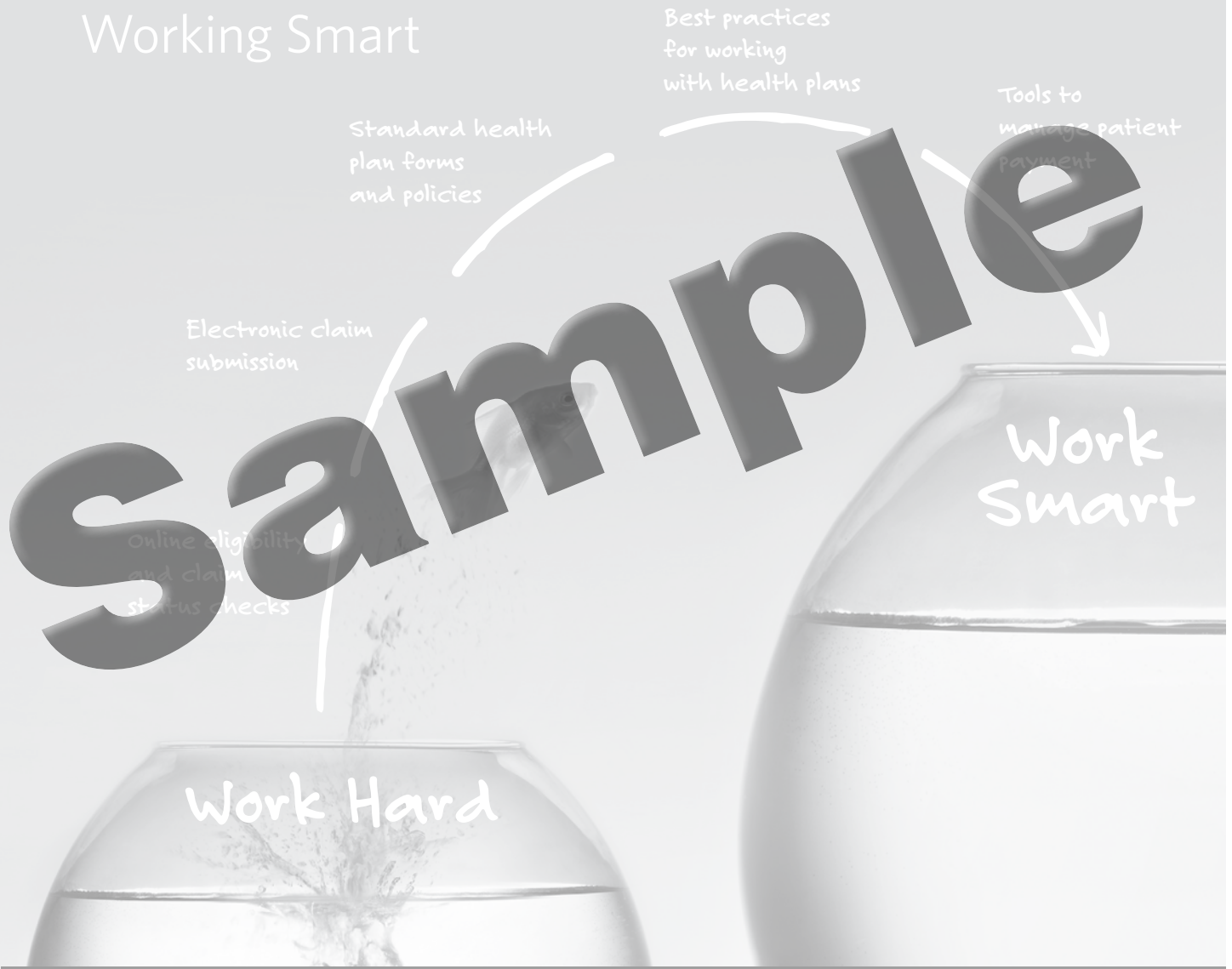
Case 5 was caused by yet another medication error, and Case 6 is an example of disputes that happen again and again.

Case 7 is the most unusual one. The physician was exonerated even though he had ignored the patient's instructions—apparently for what the jury felt was a very good reason. Even so, use of the vacuum extractor did not solve the problem.

#### **What can you do?**

Trying to cope with the issue of malpractice prevention is a lot like trying to minimize your or your patients' weight gain. But keep up your efforts. Don't be disappointed if you cannot achieve universal success. Your training and experience can usually help. ♣

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of respect in the workplace. Healthy organizations provide support for stressed-out providers, while providing safe opportunities for employees to report instances of disrespect.

Here are my recommendations for ensuring a respectful practice:

- ENCOURAGE COMMON-COURTESY SKILLS OF COMMUNICATION. Instead of tolerating shouting, expect leaders and staff members to apologize for such behavior. Expect zero tolerance for disrespectful interactions of any kind. The golden rule trumps all else.
- ESTABLISH TRANSPARENCY AND HONOR A BASIC HUMAN VALUE—RESPECT. Create a safe setting for anyone to report disrespectful behavior, and provide follow-up with physicians and staff who demonstrate stress or burnout that may be causing them to become incensed.

- PROVIDE RESOURCES TO PHYSICIANS AND OTHERS who exhibit disrespectful or disruptive behavior, including counseling or other treatment that will combat the causes of their offensive actions.
- ENCOURAGE FACE-TO-FACE APOLOGIES for any outbursts of anger. Emails and notes don't have the lasting effect that personal conversation does.
- ENCOURAGE GOOD HEALTH HABITS. There's a direct correlation between adequate R&R, proper diet, fitness, socialization, and respectful interpersonal interaction.

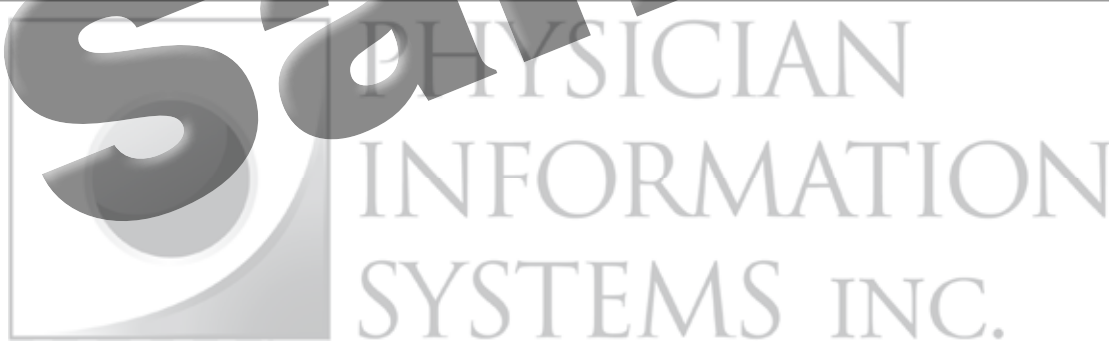
#### THE TURNAROUND

I'm pleased to report that Dr. D. is now serving in a leadership role at a teaching hospital. He has worked through personal and professional issues that triggered his disrespectful

behavior. In fact, he's now teaching residents effective communications skills that bolster their own and others' dignity. This trend is being duplicated in medical schools and residency programs around the globe.

For some, being appreciative and respectful is an ability that must be learned and constantly practiced. It can be done. The results are exciting. ♣

The information in this article is obtained from sources generally considered to be reliable; however, accuracy and completeness are not guaranteed. This document does not establish a standard of care; the information is intended as risk management advice and is intended for use as a tool to reduce malpractice risk. It does not constitute a legal opinion, nor is it a substitute for legal advice. Information presented herein is not intended to be a modification of terms or conditions of insurance policies. Legal inquiries about topics covered in this article should be directed to your attorney.



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– The Madigan Army Medical Center has exceptional opportunities in the beautiful Tacoma, Washington area for civilian board certified internal medicine and family practice physicians to join a first-class internal medicine & family practice clinic team. Five day a week full-service clinic; no ward work, night calls or weekends. Affiliated with a top-notch internal medicine and family practice residency program, the medical center is a beautiful, state-of-the-art facility. At least one year of experience preferred. At Madigan you will find an atmosphere driven by our commitment to service, excellence, trust, accountability and respect.

Madigan Army Medical Center is a Joint Commission-accredited, 205-bed, level II trauma academic military medical center with 21 residency programs and 7 fellowship, serving thousands of beneficiaries throughout the Pacific Northwest with a combined military and civilian staff of 4,000.

We offer a competitive compensation package which may include a recruitment incentive and relocation expense reimbursement. Excellent benefits are available including competitive salary, malpractice coverage, health, life and disability coverage, dual retirement plan including the civil service variation of a 403b, and CME allowance. An active, unrestricted license in any state is required, as well as US citizenship.

To learn more about this excellent opportunity contact Medical Provider Recruiter at (253) 968-4994 or send CV to henry.laguatan@us.army.mil.

## Family practice available for purchase, Sequim

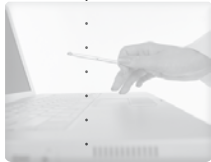
– This turn-key operation is now available for the small purchase price of existing equipment. This is a well established and busy family practice, with approximately 4,000 active patients. Clinic staff currently includes 1 MD, 2 PA-Cs. We have 6,000 square feet of leased space with 12 fully equipped exam rooms wired for EMR. Relatively light evening call, shared call group for weekends.

Nestled between the Olympic Mountains and the Strait of Juan de Fuca on the Olympic Peninsula in northwest Washington, Sequim is a friendly community offering a wonderful lifestyle with mountains for skiing and hiking, salt water for fishing and boating and local farms for fresh organic choices. Located midway between the Pacific Ocean and Puget Sound, Seattle

and Victoria, B.C. are easily accessible. Enjoy vacation scenery every day in the sunbelt of western Washington. No state income tax.

Physicians appreciate our supportive medical community and progressive community hospital. Olympic Medical Center is a 126-bed, level III trauma designated hospital that combines state-of-the-art medicine with hometown care in a semi-rural setting.

Email or send CV to Catherine Van Os, Practice Manager, Sherwood Medical Center, 540 West Hendrickson Road, Sequim, WA 98382, (360) 683-5215, Catherine@HomeTownDoc.com. EOE



## Pediatrician wanted, full or part time, Arlington

– Our pediatric group is seeking to add a general pediatrician (full time or part time). This is a great opportunity to develop a successful practice in a growing community with a service population of 50,000+. We are the only pediatric group in the area.

Arlington is in the foothills of the Cascade Mountains where one can find outdoor activities such as hiking, boating, skiing and fishing. The advantages of the urban culture of cosmopolitan Seattle are an hour away.

You will be able to treat a wide variety of pediatric issues in a friendly clinic with staff motivated to support our providers. Please contact Ralph Hill, (360) 618-7807, ralphhill@cascadevalley.org.

**Revenue cycle manager wanted** – Healthcare facility needs revenue cycle manager to oversee all aspects of patient accounts for 16 locations. Manager will ensure efficient operations in billing, cash applications, insurance follow-up, collections, training and evaluation of staff. Requirements: 5 years in management; bachelor's degree and knowledge of relevant federal and state laws. Email gaden@guidanceinternational.com.

## Family practice primary care physicians wanted, Lacey

– Established family practice clinic needs two providers for non-obstetric general practice in rapid growth area. Immediate MD/DO and mid-level provider openings. Great medical community with excellent hospitals nearby including all specialties. Initial contractual association as employee may lead to partnership. Relatively light call schedule with neither obstetrics nor hospital coverage. Salary or wage

package to include malpractice, PTO, retirement and medical/dental benefits available per negotiable total compensation package.

If interested please email CV to rmlacymed@reachone.com.

## Primary care physician with obstetrics wanted, Tacoma

– Tacoma, WA: Community Health Care, a leading non-profit organization, is currently seeking an experienced primary care physician, with OB, to join our family practice clinic. Must possess or be eligible for a Washington State medical license to practice and have a current, unrestricted DEA certificate with prescriptive authority and must be BC or BE in FP. CHC offers competitive benefits and compensation, including medical and dental plans; pre-tax retirement investment plans; paid vacation, sick time and holidays; loan repayment, CME allowance; 1:17 call coverage; and employer paid license and malpractice insurance. Loan repayment may be available to those who qualify! Send CV via email to abryant@commhealth.org or by fax to (253) 722-1546. More information is available at our website www.comhealth.org. CHC is EOE/AEE.

## Family practice/urgent care/emergency medicine physicians wanted, Puyallup

– Woodcreek Healthcare in Puyallup has positions open in family practice, urgent care or emergency medicine in its Convenience Care Clinics. Full or part-time, day, evening, or weekend shifts available. Contact Karen Merritt at (253) 446-3202 or kmerritt@woodcreekhealthcare.com.

## Physician opportunities throughout the West!

– Providence Health & Services, the Northwest's premier health system, has more than 300 primary care and specialist opportunities in desirable communities throughout the West. We're in Washington (Everett/Snohomish County, Olympia, Centralia, Vancouver, Walla Walla, Spokane, Chewelah and Colville) as well as Alaska, California, Montana and Oregon. Find details on more than 300 employed and private practice opportunities at www.providence.org/physicianopportunities or contact Meg Linza, RN, Meg.Linza@providence.org, 1 (866) 504-8178.

## Orthopaedic surgeon wanted, Pullman/Moscow

– Inland Orthopaedic Surgery and Sports Medicine Clinic, located in Pullman, WA/Moscow, ID, is a well-established, physician-owned, single specialty practice. We are seeking a BE/BC orthopaedic surgeon to add to our 3-physician group. We

are adding to meet the growing needs of the community and fellowship training is encouraged. In the Palouse region with its beautiful rolling hills, the area provides 4 seasons and is home to 2 universities. The area is a wonderful place to raise a family. Competitive compensation package offered and position will remain open until filled.

Please send cover letter, curriculum vitae and inquiries to Inland Orthopaedic Surgery, care of Barbara Cochran, 825 SE Bishop Blvd., Suite 120, Pullman, WA 99163 or email [bcochran@inlandortho.net](mailto:bcochran@inlandortho.net) or fax (208) 882-2179. See [www.inlandortho.net](http://www.inlandortho.net).

**Medical space available, Kittitas County –**

1500 square feet of medical space adjacent to the only hospital in Kittitas County. Available immediately. Sale, lease or month-to-month tenancy. Contact [jwalters@paceime.com](mailto:jwalters@paceime.com).

**Partnership opportunity in Puyallup –** Long-term, stable, established practice seeks family practitioner/internist. Excellent compensation, growth potential, benefits and colleagues. EMR system is in place, lab services on site, career oriented staff. Please contact email [CyndyJ@PuyallupClinic.com](mailto:CyndyJ@PuyallupClinic.com) or fax CV to (253) 770-2295. ✦

In addition to the above, HHS is commanded to implement a methodology under which an individual who is harmed by a HIPAA privacy or security breach may receive a percentage of any civil monetary penalty or monetary settlement collected with respect to such HIPAA violation.

**Tiered increase in amount of civil monetary penalties**

The new statutory scheme creates four “tiers of penalties.” from \$25,000 per year up to \$1.5 million per year.

**Enforcement through state attorneys general**

The attorneys general of the various states are now empowered to bring a civil action in federal court on behalf of the residents of their states who have been or who are adversely affected by any person who violates HIPAA. The attorneys general are empowered to seek injunctions to enjoin any further violations or to seek damages limited to

\$100 per violation with a cap of \$25,000 per year. If the prosecution is successful, the court may award the attorney general the costs of the action plus a reasonable attorney’s fee.


**Starting dates**

The provisions of the ARRA that affect HIPAA have a number of different starting dates.

Physicians should monitor HIPAA to determine when each set of changes becomes effective. During the next two years you will have to modify your “Notice of Privacy Practices” to reflect some of these changes and educate your work force about these changes. ✦

Stephen Rose has been one of the HIPAA educators for WSMA since the privacy rules were first issued. He can be reached at [srose@gsblaw.com](mailto:srose@gsblaw.com) or (206) 816-1375.

The information in this article is intended solely for educational and informational purposes only and should not be regarded as legal advice.



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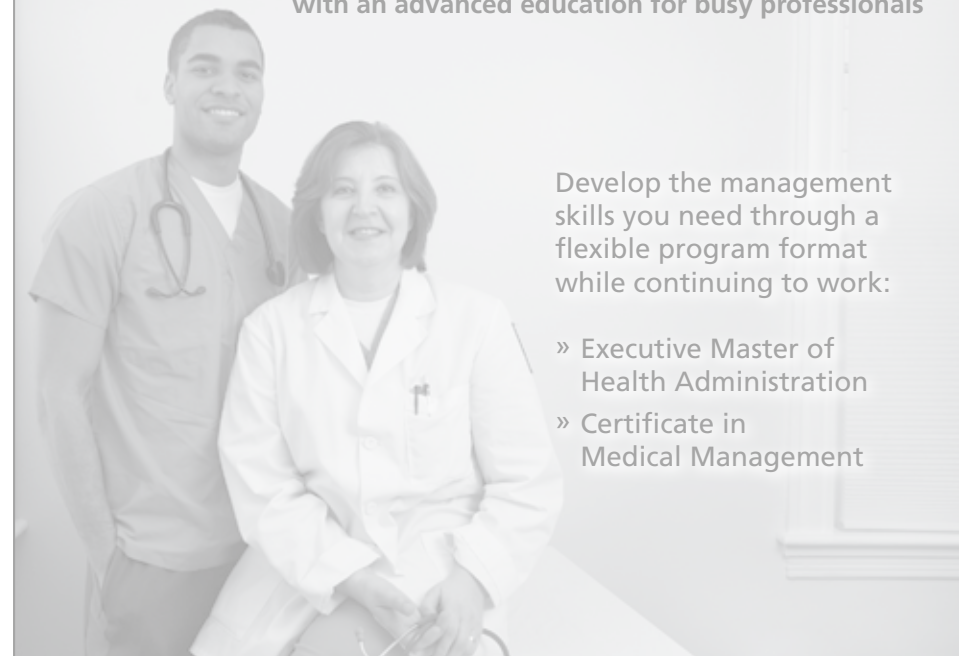
If you are interested in being part of this dynamic team, please contact:

**Colleen Mooney**  
Physician Recruiter  
1-800-776-4048  
[practice@rockwoodclinic.com](mailto:practice@rockwoodclinic.com)

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## Newsmakers

**I**N APRIL, WSMA member **John McCarthy, MD** of Spokane was appointed University of Washington assistant dean/WWAMI clinical coordinator for Eastern and Central Washington. Dr. McCarthy will serve half time in this role and half time as a preceptor for the UW family medicine residency program. Dr. McCarthy is president of the Washington Academy of Family Physicians.



Dr. McCarthy

DaVita Inc., a provider of kidney care services, recently selected WSMA member **J. Hamilton Licht, MD** of Yakima as its Outstanding Physician

Citizen and has awarded the Yakima and Sunnyside doctor its Doctor PEPPER Award. He was given the award for outstanding patient service. Dr. Licht is a nephrologist.

The Spokane County Medical Society recently honored WSMA member **J. William Peters, MD** of Spokane with the 2008 Physician/Citizen of the Year Award. Dr. Peters is a family practice physician at the Rockwood Clinic in Spokane.

At a recent surprise award ceremony at Grays Harbor Community Hospital, WSMA member **Hany Bashandy, MD** of Aberdeen was presented with the 2009 Physician of the Year Award. The hospital honors a local physician each year, recognizing exceptional professionalism, focus and staff respect. Dr. Bashandy is an internist.

At the annual Brewster Chamber of Commerce banquet on March 16, retired physician and WSMA member **Fred Schnibbe, MD** and his wife Verona were presented

with the Citizen of the Year award. Dr. Schnibbe, a general practitioner, helped form the Community Medical Center in Brewster in 1958. He and his wife live in Walla Walla.

WSMA member **Cliff Robertson, MD** of Tacoma was recently promoted to chief operating officer of the Franciscan Health System. Based in Tacoma, the Franciscan Health System is a 6,500-employee organization with five South Sound hospitals, a network of medical clinics, and the largest hospice service in the state. Dr. Robertson is a family practice physician.

WSMA member **Hal Quinn, MD** of Mercer Island recently received the Richard A. Molteni 2009 Medical Staff Award for excellent and personal medical care. The award is named after a former medical director at Seattle Children's Hospital. Dr. Quinn is the chief of pediatrics at Overlake Medical Center in Bellevue.



Dr. Quinn

WSMA member **Kevin Sanders, MD** of Tacoma recently received a three-year appointment as cancer liaison physician at Good Samaritan Hospital in Puyallup. As liaison, Dr. Sanders will provide leadership and

support to the cancer program.

WSMA member **R. Dale McClure, MD** of Seattle was named president of the American Society for Reproductive Medicine at the society's 64th annual meeting in November in San Francisco. Dr. McClure is director of male infertility and the microsurgical unit at the Virginia Mason Clinic in Seattle. ♣