Summer 2009 | Volume 005

Insured Colleague

A Medical Liability Insurance Company

APPLIED MEDICO-LEGAL SOLUTIONS RISK RETENTION GROUP, INC.

AMS RRG President's Message

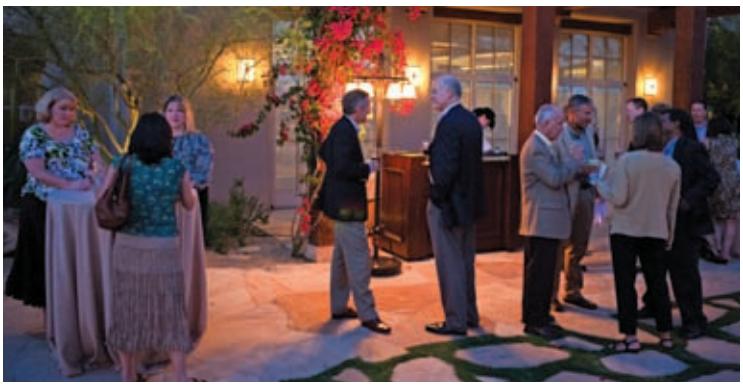
by Richard B. Welch

Richard B. Welch

Board Meeting

In April, we hosted our Board of Directors and Specialty Medical Directors at our annual meeting in Scottsdale, Arizona. Over two days, we discussed the company's growth strategy, received valuable feedback on our risk management initiatives and examined ways to enhance our relationships with members. I would like to extend special thanks to our Specialty Medical Directors for joining us and look forward to our expansion of the Insured Colleague Program™ throughout 2009.

At the meeting, we also heard a presentation from Barry Connell, managing director at our investment manager, Brown Brothers Harriman. Barry gave us an overview of our portfolio's performance over the past year and we are very pleased at the bank's management of our assets as we continue to focus on capital preservation.



AMS RRG annual meeting in Scottsdale, Arizona

Q1 Results

In the first quarter of 2009, we added Hawaii, Tennessee, Kansas and Idaho and now write in 41 states. Our premium revenue reached $6,626,728 and we are on target to meet our year-end goals.

As we enter the second quarter with an unprecedented 99 percent retention rate, we view our growing number of satisfied members as a testament

continued on page six

In This Issue

AMS RRG at a Glance:

First Quarter Results

New groups: 7

Total number of risks: 1950

Premium: $6,626,728

The ED Handoff

by Steven Shapiro, MD, AMS RRG Chief Medical Officer

Steven Shapiro, MD

"An essential element in maintaining safe operations in high risk environments with this 'on-call' organizational architecture is to understand how to bring called-in practitioners up to speed quickly during escalating situations."[1]

While these cautionary words are from an article about Space Shuttle Mission Control, shift changes in virtually every field – including medicine – can have potentially disastrous consequences. Handoffs in the Emergency Department ("ED") between physicians who are on-duty and those coming to replace them are particularly risky because of the following characteristics common to EDs throughout the country:

- The ED is composed of many interconnected stakeholders who are all constantly in motion.
- The event-driven care of acutely ill patients competes with the care of those that are less ill but may have some significant, potential long-term consequences.
- Care is increasingly time-pressured as EDs face growing patient volume.
- Resources are constrained.
- There are high consequences of system failure.
- Work is distributed across multiple people in dedicated roles with specialized knowledge and expertise.
- Computerized tools support all personnel, to varying degrees.
- There is no "at a glance" historical display or overview status available, requiring more information to be conveyed during updates.
- Numerous types of handoffs exist in the ER.

A smooth and efficient handoff of care in the ED can be challenging, for many reasons. Whether you are dealing with high patient volume or patients of high acuity that require ongoing hands-on care, multiple issues can delay the effective handoff of care from one physician to another.

ED Operations

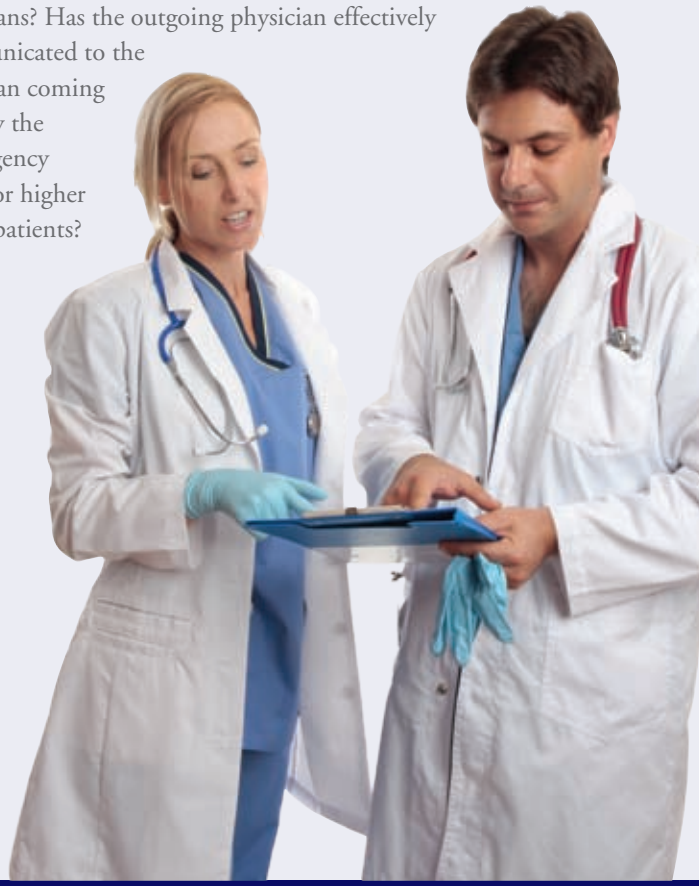
Is there a board where physicians can document current issues? How chaotic is the environment at the time of handoff? Do either the nurses or the physicians overlap their shifts to allow the departing staff to care for the "older" patients and the oncoming staff to become familiar with the new ones? Is their enough time between the oncoming physician's arrival and when the physician leaving has to go?

Resources

Was there enough staff on the old shift? If not, departing shift members may be fatigued, limiting the effectiveness of the handoff. How many physicians are signing out to the new one coming on? Has the new physician been overwhelmed?

Communication

What is the mode of communication between those leaving and those coming on duty? Is there a formal, reproducible methodology to the sign-out process? During the transfer of care, are the physicians repeatedly interrupted by nursing or other staff questions? Has the physician leaving updated the patients and their families on their current status as well as the upcoming changeover in physicians? Has the outgoing physician effectively communicated to the physician coming on duty the contingency plans for higher acuity patients?



[1] Shift Changes, Updates and the On-call Architecture in Space Shuttle Mission Control

Nurses
Is the nursing to patient ratio appropriate? Are shifts for the nurses staggered, not only with other nursing shifts, but with those of the physicians? Have they been given enough time to complete their handoff procedures? Is the physician cognizant of their time for handoff, limiting the orders placed during that time to those that are urgent or emergent? Has the new physician taken the time to round with the charge nurse, reviewing the care of each patient?

Clinical Decision Making Process Up to the Time of Transfer
Are there clear and accurate instructions regarding the current workup and proposed dispositions of the current ED patients? Are there too many loose ends? Have the results that were available to the physician leaving the ED been appropriately followed up upon?

A systematic handoff procedure can play a vital role in helping to improve patient safety and decrease malpractice risk. Included below are some strategies that should be considered when developing a protocol for the effective and efficient handoff of care.

- A face-to-face verbal update with interactive questioning is the most effective way to hand off the patient to the physician coming on duty and can provide fresh insight into a patient's course of care.
- In addition to the sign-out received from the outgoing physician, the incoming physician should review the patient's status with nursing.
- During the handoff, physicians should do their best to limit the number of interruptions.
- During the handoff, limit the patient care responsibilities of both physicians.
- The outgoing physician should primarily "pick up" the urgent care patients near the time of the handoff, providing the higher acuity patients with necessary triage while allowing the oncoming physician to "pick up" these patients.
- It is important that the team coming on duty understand the outgoing team's stance towards possible changes in patient conditions and the associated potential contingency plans.
- As a way of verifying the data being presented, the oncoming physician should read it back to ensure that the information was accurately received, particularly when it does not appear to fit the rest of the story or the patient's perceived status.
- The physician leaving the ED should write a summary, or a note of care completed, before handing over care. The chart should then reflect the handoff in care to the oncoming physician with a note that is timed and signed.
- The physician coming on duty should re-assess and refine the treatment plans on the patients in the ED. To facilitate this process, each patient, other than those awaiting a simple lab result, should be considered to be the patient of the incoming physician. Any patient that requires additional workup based upon new lab results should also be considered the patient of the oncoming physician.
- Physicians should update information in the same order every time.
- The incoming physician should scan the patient records prior to the handoff to facilitate the interaction between the two physicians.
- The incoming physician should review automatically captured changes to sensor-derived data before the handoff, including the central monitoring station where blood pressure, pulse, cardiac rhythm and pulse oximetry are captured.
- The oncoming physician should receive the most up-to-date information available, including any changes in status, lab or x-ray results.

"A face-to-face verbal update with interactive questioning is the most effective way to hand off the patient to the physician coming on duty and can provide fresh insight into a patient's course of care."

- The physician coming on duty should receive a written sign-out that includes annotations of various issues that are ongoing or may be of concern.
- The ED staff, the patients and their families need to be aware of the unambiguous transfer of responsibility, referred to commonly as the "bright line," and it should be documented and timed in the medical record.
- It should be made clear to others at a glance which personnel are responsible for which duties at a particular time, including which nurse, employee and staff member in the ED is assigned to each bed.
- Once the handoff is complete, it is helpful if the physician leaving the ED can assist the oncoming physician for a brief period of time.
- Delaying the transfer of responsibility when there is concern about the status/stability of the patient will also help improve patient safety, decreasing the potential for medical errors.

Ultimately, patient safety is the goal we are all trying to achieve. The added benefits of a standardized process include a decrease in the number of medical errors and, subsequently, in the potential for medical malpractice litigation.

For the full text of this article and accompanying charts and diagrams, visit www.amsrrg.com.

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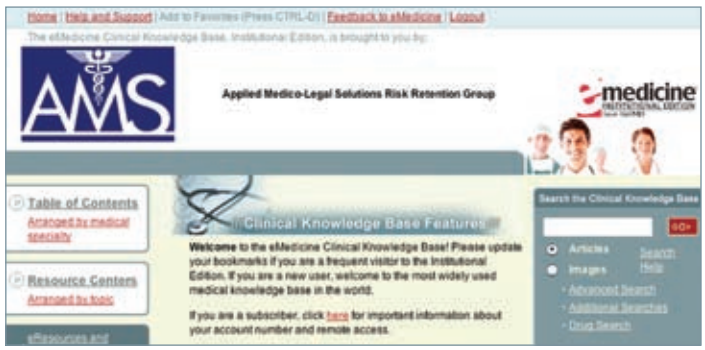

Gregory McGowan Joins AMS RRG Board

At the annual board meeting in Arizona in April, Gregory McGowan was elected to the AMS RRG board of directors. McGowan is executive vice president, director and general counsel of Templeton International, Inc., the organization responsible for the development and operation of Franklin Templeton business outside of North America, and for Templeton Worldwide, Inc., the holding company of all the Templeton subsidiaries. Prior to joining Franklin Templeton Investments, McGowan was a senior attorney for the US Securities and Exchange Commission.

"Greg's extensive experience in the financial services sector will be of tremendous value to the company," said Richard Welch, President and CEO of AMS RRG. "We look forward to his contributions as a member of our board."

The "Missed" MI Remains a Large Loss for Emergency Physicians

By Susan Martin, Esq., Executive Vice President, Litigation Management/Loss Control, and Frank Smeeks, MD, FACEP, Emergency Medicine Specialty Medical Director

Susan Martin, Esq.

Frank Smeeks, MD

A 69-year-old female arrived ambulatory to a Florida hospital Emergency Department ("ED") at 3:00 a.m. stating that she woke suddenly with numbness, tingling, and an aching sensation in her left arm. The hospital used a template charting system, and the triage nurse pulled the "Extremity Injury" one. The ED physician evaluated the patient and ordered x-rays of the arm. When the film was returned, he diagnosed the patient with arthritis, placed her on anti-inflammatory medications and sent her home with instructions. Two days later, the patient was found unresponsive and the autopsy confirmed she died of acute myocardial infarction ("AMI").

The physician in the above case had tunnel vision and proceeded down a very slippery path. He relied on the template for extremity injury, even though the patient never complained of any injury. Moreover, most patients don't want to be in the ED at 3 a.m. and someone who presents with the patient's symptoms at that time should be taken very seriously. Unfortunately, the physician never considered cardiac pathology as a cause of her symptoms and, in fact, frankly admitted that he could not give a reasonable explanation for his thought process.

Chest pain continues to be one of the most frequent presenting complaints to the ED. ED physicians are quick to recognize patients who present with chest pain, pain radiating into the arm or neck, shortness of breath, sweating and nausea, and immediately order an EKG, serial enzymes, and cardiac consultation. But some studies indicate that between 5 to 15 percent of AMI is missed in the ED because the patients present with more subtle, atypical symptoms, including a complaint of arm pain, chest wall tenderness, or mild epigastric discomfort. Female patients, the very young and the elderly frequently fall into the category of atypical presentations.

To address the missed MI cases, there has been an increased focus from ACEP and other medical specialties in the community to more rapidly assess a patient with chest pain; reduce the diagnosis time in the ED; and, ultimately, improve patient outcomes. Hospitals and other ancillary services have developed rapid cardiac assessment (such as CODE STEMI and other similar "heart acronyms") teams to get patients into the hospital and to the cardiac cath lab as soon as possible. In many jurisdictions, the EMS providers take a history in the field, send the EKG to the hospital, and, if the patient meets the criteria, bypass the ED altogether and take the patient directly to the cath lab where a cardiology interventionist has been alerted about the arrival.

ED physicians also need to always consider a person's age and risk factors to avoid missing an MI. A young person who uses cocaine is more at risk and should have a cardiac work-up in the ED when presenting with symptoms, even if it is an atypical presentation. Many experts also believe that anyone over the age of 40 who presents with chest pain, epigastric pain or an associated symptom should have serial EKGs and cardiac enzymes in the ED.

"If an MI is missed, the case can result in potentially huge damages."

Missed MIs can also arise when the patient's symptoms are totally resolved prior to presentation. If the symptoms have subsided, can the patient be safely followed as an outpatient with their own internal medicine physician or cardiologist? Although many physicians will argue that the patient can be discharged with appropriate follow up, it is always safe to *consider* the alternatives. Does the patient have a cardiologist or primary care physician who will see them in the office within the next few days? Does the patient have the necessary resources to get to the physician? Does the patient live alone without family to observe and assist if the symptoms return? Does the patient know to call 911 or get immediate assistance if the symptoms return? If the answers to these questions cause the emergency physician to have any doubt that the patient should be sent home, then the patient should be admitted to the hospital for observation.

If an MI is missed, the case can result in potentially huge damages. Those patients who survive may suffer from a range of health issues, including arrhythmias and heart failure. Patients with a very low ejection fraction will likely be on a heart transplant list. These cases result in extremely high-dollar settlements due to the large medical and economic expenses, including life-long commitment to keeping heart

continued on page six

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A Medical Liability Insurance Company

Upcoming Conferences and Meetings

WVSMA 2009 Healthcare Summit
August 28-30
White Sulphur Springs, WV

ACEP
October 3-5
Boston, MA

President's Message

continued from front page

to our superior service, clinical expertise and hands-on approach to reducing risk. Our insureds are our greatest advocates and we appreciate your commitment to AMS RRG and the philosophy that drives our success. After just seven years, we are now the nation's largest multi-specialty RRG.

"Our insureds are our greatest advocates and we appreciate your commitment to AMS RRG and the philosophy that drives our success."

PIAA Membership

In February, AMS RRG became a member of the Physician Insurers Association of America (PIAA) by unanimous vote. The PIAA is a consortium of companies that provide affordable and dependable professional liability insurance free from the uncertainties of the commercial market. Membership in the PIAA is available to physician-directed healthcare professional liability insurers, and comes after a lengthy application and interview process.

As members of PIAA, AMS RRG will benefit from access to board and staff technical training, industry news, data sharing, and best practices and benchmarking information. We are honored to join this prestigious organization and will maximize the advantages our memberships affords both AMS RRG and our insureds.

"Missed" MI

continued from page five

transplant patients healthy and active. Another big problem in the litigation of missed MI cases is the jury factor. There is so much education in the community about heart attacks – what to do, when to go to the hospital, etc. – that jurors will not be too empathetic unless the physician can give very reasonable answers about his/her decision-making process and why the diagnosis was **ruled out** in the ED. If the ED physician didn't consider MI, and the jurors believe that even they, as laymen, would have based on the patient's presenting symptoms, the physician will likely lose credibility – and the case.

Chest pain continues to be one of the most common complaints for patients presenting to the ED, and resources may be over-utilized in the ED to rule out AMI. However, the downside of not diagnosing AMI is much worse for the patient, and much more costly for emergency physicians. As a former ED patient who experienced chest pressure several years ago (radiating into the neck region), I was grateful that the physicians "considered" the possibility of AMI and put me through a battery of tests. Although my diagnosis was ultimately something else that was much less severe, and despite a "pricey" hospital bill, I could reassure myself and my family that the worst possibility was considered and ruled out. AMI needs to be part of your differential diagnosis the next time you see a patient with epigastric pain, arm pain, jaw pain, or other atypical symptoms of AMI. Call the cardiologist if you believe the patient needs admission, and if the patient's ultimate diagnosis is a benign problem that is not cardiac in nature, the patient will still be grateful you cared enough to rule out AMI.

If you have any questions or concerns about the contents of this article, please call one of us at the following numbers.

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