MLMIC
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a Berkshire Hathaway company

THE SCOPE

MEDICAL EDITION

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INSIDE

IN LOVING MEMORY OF MLMIC INSURANCE COMPANY FOUNDER AND MSSNY FRIEND

Donald J. Fager

Dear Colleagues:

It is with great sadness that I write to tell you of the passing of Donald J. Fager, Esq., the founder of what is now MLMIC Insurance Company, on March 6 of this year. Simply put, Don was a man among men, and he will be sorely missed by all who knew and loved him.

Don's accomplishments in this life are far too lengthy and varied to list. He began his career as a malpractice defense lawyer, defending "his doctors" with passion and brilliance in the courtroom. He believed fervently in the honorable calling that we, as healthcare practicioners, have, and he understood that we need to be protected from the slings and arrows of our current legal system.

In 1975, working with the Medical Society of the State of New York, Don helped found MLMIC Insurance Company (then Medical Liability Mutual Insurance Company). This was a time when all other malpractice carriers had left the state, leaving doctors potentially uninsured and facing possible financial disaster. He guided the company for decades with a combination of brilliance and kindness, and his leadership no doubt encouraged Berkshire Hathaway's interest in voluntarily acquiring MLMIC, which further strengthened us financially and allowed us to be of even greater help to our insureds.

When asked to define Don, the word that came up most frequently was "kind." No one ever heard him have a harsh word for anyone, and he was genuinely interested in the welfare of others. He was that rare person, ever the gentleman, who, simply put, made everyone around him better and instilled in all of us at MLMIC a desire to be like him.

Our MLMIC insureds should know that, at all times, Don's highest priority was the welfare of our doctors, dentists, and their practices. The brother of a neurosurgeon, Don fully understood the sacredness of our profession and the wonderful things we do for our patients on a daily basis. He was determined to protect us at all costs.

You, my colleagues, should also know that Don's passion for defending our profession, at all times and with all our might, continues today at MLMIC. His mission is our mission, and we believe in it passionately. We will never forget it. We will never forget him. We will never forget you.

John W. Lombardo, MD, FACS
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Engage at Any Age:

Providing Safe Medical Care for the Aging Population

By 2030, one in six people in the world will be over the age of 60, and the demand for healthcare services in this population is increasing exponentially, as the elderly population experiences more chronic conditions and comorbidities when compared to the rest of the population.[1] According to the National Council on Aging (NCOA), approximately 95% have at least one chronic condition, and 80% have at least two chronic conditions.[2] How can healthcare providers be prepared amidst the lingering effects of the pandemic coupled with the increased demand for care?

Elderly patients, especially those with chronic health conditions, require extra precautions when receiving their care. One way to be prepared is by improving access to comprehensive and safe primary care. This is an important first step toward quality and safety outcomes in this growing patient population.

Providing a safe environment and remaining sensitive to the needs of this patient population will enhance patient care, improve patient satisfaction, and minimize exposure to claims of negligence and professional liability.

Starting with the physical aspects of the office setting, it is important to assess all the following:

- There is adequate and comfortable seating for the elderly.
- Office waiting rooms and examination rooms are clean, welcoming, and comfortable.
- There is adequate space in waiting rooms to accommodate those in wheelchairs.
- Sufficient lighting is maintained throughout the office.
- Floors and carpeted areas are in good condition.
- Hallways and waiting rooms are free of obstacles and trip hazards and allow space for those with walkers to ambulate.
- Hallway safety rails and bathroom grab bars are regularly evaluated and inspected.
- The building/office is evaluated for handicap accessibility and to ensure sufficient parking is available.
- Wheelchairs are readily available for patients.

It is then crucial to perform a comprehensive geriatric assessment that includes:

- a thorough and complete client/family interview
- a full history and physical examination
- a detailed fall assessment
- a health literacy assessment for the patient and/or caregiver
- a review of the patient's medication history and usage and the patient's understanding of their medications
- a comprehensive medication education program, including written materials utilizing a clear, large font.

In addition:

- Consider a review of the patient's cognition, support systems, and finances, as well as the patient's willingness to accept help.
- Consider a visit to the patient's home. As part of that engagement, you should provide resources when English is the second language, use everyday language, and avoid technical terms.
- Be sure to document all materials given to the patient and/or caregiver. Written or typed materials should in a 12-point font or larger.
- Give caregivers their own credentials to sign on to the patient portal in order to allow the practice to track who is accessing the patient's information. Portal access can increase compliance with the treatment plan.

[1] who.int/news-room/fact-sheets/detail/ageing-and-health
[2] ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults

Care Models to Consider for Effective Patient Engagement

In 2017, the John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) partnered with the American Hospital Association (AHA) and Catholic Health Association of the United States to develop a social movement so that all older adult care is age friendly. The 4Ms, an age-friendly health system, utilizes a patient-centered approach to make care of older adults more manageable.[3] The 4Ms identify issues that can drive decision making in the care of older adults.

The 4Ms framework includes:

- **What Matters —** Know and align care with each older adult's specific goals and preferences.
- **Medications —** If a medication is necessary, use one that is age-friendly and won't interfere with what matters, mentation, and mobility.
- **Mentation —** Prevent, identify, and manage dementia, depression, and delirium.
- **Mobility —** Ensure older adults move safely every day and do what matters.

A 4Ms approach to care can transcend disciplines, specialties, and disease states and can have equal importance with providers in all settings.[4]

Additionally, IHI's Ask Me 3 educational program encourages patients and their caregivers to ask these three specific questions of their providers to better understand their health conditions and what they need to do to stay healthy:

1. **What is my main problem?**
2. **What do I need to do?**
3. **Why is it important for me to do this?**

Designed by health literacy experts, Ask Me 3 is intended to help patients become more active members of their healthcare team and improve communications between patients, families, and healthcare professionals.[5] Consider placing signage about Ask Me 3 in exam rooms, as this will empower patients and family members to begin the conversation with their provider.

Develop Effective Engagement Strategies

When documenting in the electronic health record, remember the importance of face-to-face time. Be cognizant of external noises while speaking to the patient. Providers should speak slowly, clearly, and loudly when talking with older patients to enhance hearing and understanding, without sounding condescending. Repeating words and phrases verbatim can particularly help those older adults with dementia.[6] If current infection control protocols allow, consider removing your mask when communicating instructions to your elderly patients.

Encouraging patients to set goals and actively participate in their plan of care can increase compliance. Effective communication can help build a rapport with older patients to appropriately manage their care, and strengthening the provider–patient relationship can lead to improved health outcomes and make the most of limited interaction time.[7]

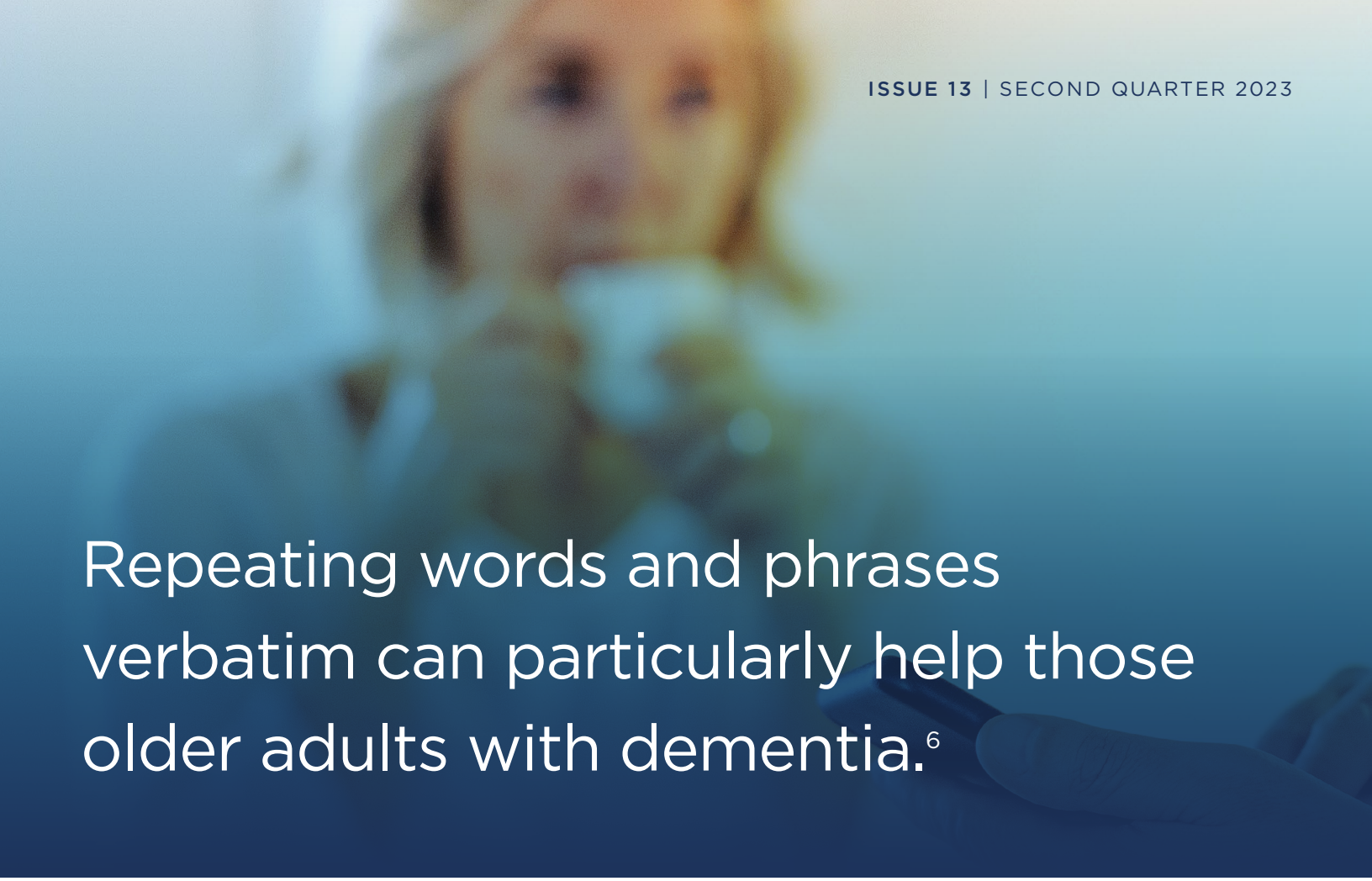
Educate Your Staff

The office staff should be aware of mobility issues and be trained for safely assisting, contact guarding, and transferring elderly patients. Consider older adult sensitivity training as part of annual staff competencies.

Additionally, staff should be aware of any vision, hearing, and transportation limitations when scheduling office visits or telehealth consultations.

Educating your staff about the needs of elderly patients will enhance their ability to demonstrate understanding, patience, respect, and compassion. Interactions between older adults and healthcare professionals are influenced by the expectations and stereotypes that each party brings to the encounter.[8]

[3] johnahartford.org/grants-strategy/current-strategies/age-friendly/age-friendly-health-systems-initiative
[4] K., Fulmer, T., Pelton, L., Berman, A., Bonner, A., Huang, W., & Zhang, J. (2021). Evidence for the 4Ms: Interactions and Outcomes across the Care Continuum. Journal of Aging and Health, 33(7–8), 469–481. doi.org/10.1177/0898264321991658
[5] ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx
[6] ncbi.nlm.nih.gov/pmc/articles/PMC5426314/
[7] ncbi.nlm.nih.gov/pmc/articles/PMC9299469/
[8] Gerontological Society of America, 2012



Repeating words and phrases verbatim can particularly help those older adults with dementia.[6]

Medication Management in Eldercare

A high liability area in this population revolves around medication. It is important to educate patients/caregivers about each medication, including its name, appearance, purpose, and effect. Include any potential side effects and/or interactions associated with the medication regimen. To ensure the patient understands, ask them to repeat what the medication is and what they are taking it for. Be sure to stress the importance of contacting a healthcare provider should any reactions, questions, or concerns arise.

Some other points to keep in mind:

1. Query patients regarding any underlying issues with medication selection to resolve any concerns.
2. The importance of using only one pharmacy to obtain all medications should be emphasized to patients and/or their representatives. Collaborative team efforts may be necessary to address the need for the consistency of one pharmacy. Suggest to family members that they request pharmacy history printouts to cross-reference what meds are being refilled and when. Emphasize to patients how compliance with the prescribed medication regimen will help keep them at home and limit admissions to the hospital.
3. Patients should also be advised to:
   - keep an accurate list of all medications, dosages, dosing frequency, and the reasons for taking the medication. This list should include generic and brand names, over-the-counter medications, and herbal supplements
   - bring a list of all medications that they are taking to each and every appointment
   - maintain a complete list of medical providers and their contact information
   - post the name and telephone number of their physician and local pharmacy in a prominent location in their home. These should be posted

near the patient's POC (plan of care) and MOLST (Medical Orders for Life-Sustaining Treatment) form so that they are readily available in case of a hospital transfer.

- Establish a daily routine when taking their medications.
- Make patients aware of the various medication adherence aids and devices available, such as dosing reminders, pill boxes, and refill reminder programs.
- Provide useful written information, in plain language with a large font, that clearly explains how patients can correctly manage their medications.
- Consider the "teach back method" when explaining medications. Teach the information first, and then ask patients to repeat it back in their own words.
- Advise caregivers about the importance of giving not only medication reminders but also the timing of certain medications. For example, not wanting to shower a patient when their blood pressure medication is at its peak effect.

Social Determinants of Health

As part of good patient engagement, it is vital to address the social determinants of health. These are factors that play a key role in better health outcomes and overall well-being. Factors to discuss with this patient population include accessibility of housing, food, and transportation. Internet bandwidth is another important factor to discuss as part of an assessment of whether telehealth encounters and home monitoring are viable options for your patient.

Research shows that a lack of understanding about cultural practices, along with an unwillingness to acquire such information from the patient, can result in inaccurate patient evaluation and diagnosis. It may also increase the possibility that the recommended treatment plan will not be followed due to the patient's dissatisfaction with the healthcare provider.

It is estimated that in the next several decades, the elder patient population will triple. Knowing their everyday physical and social environments will help providers better address this population's health concerns, lead to better outcomes, and minimize exposure to claims of negligence and professional liability.

Medical Society of the State of New York

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For more information or to become a member, visit mssny.org/join or contact MemberResources@mssny.org.

CASE STUDY:

When Standing Orders Are Disregarded...

A 75-year-old obese female with a history of COPD, depression, Type 2 diabetes, thyroid and breast cancer, hypertension, macular degeneration, anemia, and bilateral knee replacements required revision of the right total knee arthroplasty. She first presented to the MLMIC-insured orthopedic surgeon with a complaint of worsening pain and decreased range of motion in her right knee after suffering a fall. The surgeon's impression was aseptic loosening of the right knee prosthetic, and the plan was to perform a right total knee revision of the tibial component, though he noted that the entire knee might have to be revised.

The patient was admitted to the MLMIC-insured hospital with a diagnosis of failed right total knee replacement, on which the orthopedic surgeon performed a right total knee revision. During the surgery, it was noted that the patient had also suffered a patellar fracture, which was repaired.

The patient was deemed a "fall risk," but on the following day while brushing her teeth in the bathroom, the patient was witnessed falling to the floor, bumping her head, and sustaining an abrasion of the left middle finger. X-rays ruled out a fracture or dislocation. The patient was transferred to the hospital's Transitional Care Unit for rehabilitation.

Five days later, a MLMIC-insured orthopedic PA issued orders for an immobilizer to be kept on the right knee. Two days later, the surgeon issued orders for the patient to wear the immobilizer when ambulating. Nursing records indicated that the patient was to be transferred from her bed to the chair with the assistance of one person and with the immobilizer to be in place.

Eight days post-op, the surgeon examined the patient and found the knee to be neurovascularly intact with no infection. He advised that she was to begin physical therapy that included continuous passive motion, and the knee immobilizer was to be used when ambulating. The surgeon did not replace the immobilizer after the examination. Shortly thereafter, the patient asked to use the restroom and was assisted by the CNA, who questioned whether she required the immobilizer. The patient advised that she would not require the immobilizer for the short distance to the bathroom and enlisted the help of the nursing assistant.

After toileting and attempting to pull up her pants, the patient felt her right knee buckle and heard a "pop." Thereafter, she was seen by the MLMIC-insured hospitalist along with a first-year resident,

who noted active bleeding from the wound and complaints of pain. It was also noted that she was ambulating without the immobilizer despite orders to the contrary. As the hospitalist and resident felt she may have avulsed the patellar tendon, a plan was placed for constant use of the immobilizer. X-rays were consistent with a high riding patella due to a patellar tendon rupture.

Six days later, the patient was transferred back to the hospital, where the orthopedic surgeon repaired the right patellar tendon rupture using an allograft. A complete disruption of the patellar tendon was noted. Post-op, the patient was maintained on IV antibiotics and was noted to have some drainage and erythema of the surgical site. Blood and wound cultures were negative, though a wound infection and cellulitis was suspected. The patient was afebrile with stable vital signs throughout the entire admission; however, the knee remained swollen and red with a one-by-one inch eschar at the lower portion of the wound. Broad spectrum antibiotics were prescribed due to the infectious disease consult's suspicion of wound infection.

After 3 weeks on antibiotics, the patient received 9 days of hyperbaric oxygen treatment. Gram stain showed no organisms and no elevated white blood count, the culture did not grow anything, and the antibiotics were discontinued after 5 weeks.

One week later, the patient was seen by the orthopedic surgeon, who noted that subsequent X-rays revealed a new patellar tendon rupture. He speculated that the patient had completely ruptured the tendon. The plan was to obtain a second opinion and further reconstructive surgery at another hospital.

Two days later, the orthopedic surgeon tapped the knee, and 10 CCs of blood-tinged clear fluid was obtained. The fluid revealed glucose of 126, which was normal due to the patient's diabetes. The WBC was 2,570, which was low for the indication of infection.

A wound culture the following day showed sparse budding yeast, and the culture revealed Candida albicans. The sutures were later removed and, although some drainage was noted, everything appeared to be stable. The patient was examined by a wound care physician, who found no further need for the hyperbaric treatment as her pain had improved significantly and the knee was essentially healed, with only a small scab at the wound site.

As Medicare would not approve another week in the Transitional Care Unit prior to transfer to the new hospital, the patient was transferred to the MLMIC-insured rehabilitation facility. Records and documentation accompanied the patient indicating the importance of checking the right knee for signs of infection.

A MLMIC-insured internist was the patient's attending physician during the week she was admitted to the facility, and his orders included that dry protective dressings were to be applied to the right knee each day after cleansing with normal saline, the right knee brace was to be applied, and occupational and physical therapy performed. Lab work was to be completed, and the physician was aware that the patient had been off antibiotics for 2 weeks and was to be off them for 3 weeks prior to her pending knee repair surgery. The patient's vitals were recorded three times daily.

On her second day of admission, the nurses noted the patient's skin integrity to be "intact," and her labs revealed elevated white count and platelets. On subsequent days, the patient complained of increased pain in the right lower extremity. In addition, she developed a fever, and red and yellow drainage was noted on the right knee. The internist was called, and he gave orders to elevate the leg and administer Tylenol. By the following morning, the patient's fever was subsiding, though she continued to complain of pain as she was transferred to the hospital.

At the subsequent hospital, the patient was seen by an orthopedist, who noted the right total knee arthroplasty to be infected with absent extensor mechanism and bone infection of the knee. His exam revealed lymphedema in the bilateral lower extremity. The surgeon advised the patient that the

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MLMIC Claims

Defending Good Medicine

The Scope continues to highlight the various departments of MLMIC Insurance Company and their roles in supporting the healthcare practitioners of New York.

As we all know, things change rapidly in medicine. New advances in treatment modalities coupled with new pharmaceuticals are being rolled out every day. Just as in medicine, the law is changing almost as quickly. New theories of liability are being put forth by plaintiff attorneys and, in many cases, the judiciary is allowing these to be put in front of a jury. This is why MLMIC Insurance Company partners with only the best professional liability defense attorneys from Montauk to Niagara. We all share a common goal, which is one of partnership to defend good medicine and protect MLMIC policyholders. This is evident from pre-suit activities through a trial verdict, if necessary. For example, our coverage includes a Defense Only endorsement, which, if added to the policy, allows us to assign an experienced medical professional liability (MPL) defense attorney to accompany a policyholder to governmental-type investigations by organizations such as OPMC and CMS. The information gathered throughout these conferences can be made public if you are not protected. Our attorneys safeguard your rights, since this information could be used against you in a future lawsuit.

This level of protection has become increasingly necessary since 2020 when Covid transformed the legal and medical landscapes. Across the board, 2020 was a year of upheaval and enormous change that brought appreciation and admiration from the public for all types of medical providers. However, it disappeared almost overnight as the pandemic dragged on. Telemedicine became the "doctor visit" of choice for many, and the patient/physician relationship became distant and strained. The mindset of the public toward the medical community turned negative, and this was most evident in the attitudes of juries across the country as well as in New York State.

As the judicial system tried to get back on track midway through 2021 with respect to MPL lawsuits, courtrooms were turned into battlegrounds. Jurors had to sit at least 6 feet apart, wear masks, and try to pay attention to the judge, attorneys, and witnesses alike as they spoke through face coverings. Plaintiff attorneys honed in on jurors' underlying sense of resentment, coupled with the uncomfortable environment in which they had to hear a case. The result was that these attorneys began to anchor a provider witness to an alleged missed diagnosis. Consequently, a bias started to emerge against the provider community, and medical judgment was also put on trial. This led to juries giving undue weight to monetary demands put forth by plaintiff attorneys and resulted in excessive verdicts against medical defendants. These became known as nuclear verdicts, which led to more litigation in an effort to protect provider assets and get these runaway verdicts overturned.

As we look to the future, we know that there will be a significant increase in the number of cases involving an alleged failure to diagnose a disease process of any type. Medical issues that have gone untreated due to the pandemic will now become life-threatening illnesses. Although New York put in place Covid immunity statutes to protect medical providers from these types of cases, plaintiff attorneys are still trying to get around these defenses by reverse engineering other deviations that have little or nothing to do with these alleged failures.

As previously stated, the law, just like medicine, is ever changing, which is why we in Claims work closely with the other departments within the company to bring together the multi-disciplinary resources necessary to help our policyholders continue to practice good medicine. In addition, our highly trained professional claims staff collaborate with assigned counsel to help guide you through the litigation process.

Upon notice to MLMIC that a lawsuit has been instituted against one of our insureds, we immediately set the "defense in motion," since timeframes within which to protect your rights are pre-set by New York law. From the beginning, and as the litigation process unfolds, we are with you. A judge will set down specific discovery schedules to keep cases moving through the court system. However, despite these efforts, most MPL cases take several years to make their way through the court system before getting to the final adjudication point. These delays can be daunting to a practitioner who has been named in a lawsuit, especially while continuing to treat patients. It can feel like it is "never going to go away." However, throughout these delays, MLMIC is here for you, and we continue to remain focused on defending our policyholders. In addition to working with the best defense attorneys in the business, we also secure highly qualified medical experts to review and comment on the care at issue to assist us with the defense of each case.

Standards of care may be adjusted from one year to the next, but MLMIC's dedication to protect your legal rights will never change. We are committed to our policyholders and remain focused on our motto:

"We Defend Good Medicine"

Helen Granich is a Regional Claims Manager with MLMIC Insurance Company.

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FROM THE BLOG

Top 2023 Patient Safety Concerns: The Pediatric Mental Health Crisis

Each year, **ECRI** and its affiliate, the **Institute for Safe Medication Practices** (ISMP), release their annual report, ***Top 10 Patient Safety Concerns.*** The report identifies serious issues that threaten the safety of patients and healthcare workers when processes and systems are not in alignment. The report provides recommendations to address these concerns and is grounded on the following four interdependent foundations provided by the **National Steering Committee for Patient Safety:**

- Culture, Leadership, and Governance
- Patient and Family Engagement
- Workforce Safety
- Learning System

The pediatric **mental health** crisis is ECRI's top concern for **patient safety** in 2023. Prior to the pandemic, the rates of depression and anxiety rose in children due to the increased use of social media, gun violence, alcohol, drugs, and socioeconomic factors. Rates of anxiety and depression in children aged 3–17 rose 29% and 27% respectively in 2020 compared to 2016, according to a study published in **JAMA Pediatrics.** While anxiety and depression are on the rise in children regardless of gender, the CDC reported that teenage girls are experiencing a record high level of violence, sadness, and suicide risk.

Emergency room visits are also on the rise. Studies have shown that while the emergency department (ED) can stabilize a child in crisis, follow-up is key. Unfortunately, due to factors such as lack of access to psychiatric care, children often wind up back in the ED or, in some instances, remain in the ED for extended periods of time, waiting for appropriate resources to become available.

A study published recently in the journal **Pediatrics** followed over 28,000 children aged 6–17 who had at least one ED visit between January 2018 and June 2019. All the children were Medicaid recipients. The study found that less than one-third of the children had a follow-up mental health visit within 7 days of discharge and that only slightly more than 55% had a follow-up visit within 1 month. According to the study, follow-up mental health visits decrease a child's risk for suicide, increase medication adherence, and decrease the risk for additional ED visits. The study also revealed that without appropriate follow-up care, more than a quarter of the children returned to the ED within 6 months.

Prior to the 2023 ECRI report, MLMIC identified the pediatric mental health crisis as a critical concern for our insureds and their patients. MLMIC has developed and shared several risk management strategies to address this issue. The following are a few procedures to implement when taking care of a minor with mental health issues:

- **Conduct an appropriate and thorough assessment.** It is important to understand the patient's complaints, concerns, and past medical history, including their family history. The practitioner should always be alert to potential high-risk diagnoses and keep an accurate, up-to-date list of concerns.
- **Always convey and coordinate clear communication.** It is imperative to provide thorough and clear instructions to the patient and their family. When speaking with patients and families, determine whether there are **health literacy** or other comprehension barriers. It is also important to set expectations with the patients and families, especially where behavioral health resources are limited. If other medical specialties participate in care, the practitioners should discuss next steps and determine who is responsible for the patient. This should all be documented in the **medical record.**
- **Documentation must be accurate, detailed, and timely.** The practitioner should describe the rationale for the inclusion/exclusion of each differential diagnosis. It is crucial to timely document thorough, objective information about the results of patient assessments and education of the patient/family about treatment plans. This should include medication regimens and any history of nonadherence.
- **Ensure your office has the appropriate policies and procedures in place.** The office practice should have policies and procedures in place that include emergency plans such as de-escalation techniques. MLMIC recommends having a process in place for tracking and follow-up on diagnostic testing, consultations/referrals, appointment setting, and managing patient nonadherence.

Additionally, practitioners must be mindful of **informed consent** when treating a minor. The consenting party must have "parental responsibility," and in many circumstances this is not a biological parent. A minor can consent to care when receiving confidential treatment in situations such as reproductive healthcare, post-sexual assault care, and emergency medical care.

As we continue to navigate our way through the pediatric mental health crisis, MLMIC Insurance Company offers a variety of educational programs on this topic, as well as risk management advice on topics such as implementing policies and procedures, vaccination compliance, informed consent, guardianship, and more.

MLMIC policyholders can reach our 24/7 emergency support services by calling (844) MMS-LAW1. You can also submit a specific question by sending an email request **here.**

Tammie Smeltz is the Content Marketing Manager for MLMIC Insurance Company.

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CASE STUDY: When Standing Orders Are Disregarded...

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options were above-the-knee amputation or an attempt to salvage the leg with a graft. He then admitted her to the ER for an infectious disease consultation, IV antibiotics, and aspiration of the knee. His plan was to wait 1 week and then resect all components.

After a 6-week admission, the surgeon performed complex reconstructive surgery and knee fusion with a long intramedullary rod. Post-op, the patient was noted to have a well-healed incision and was ambulating in rehab using a walker.

The patient subsequently complained of left knee pain after slipping off the toilet and had chronic falls due to issues with balance. The right knee remained unchanged; however, the fusion resulted in a one inch shortening of the right lower extremity.

As a result of her initial injury and cascading events thereafter, the patient brought a lawsuit and sought monetary damages from the defendant hospital for being allowed to ambulate to the bathroom without her right knee immobilizer following her total knee arthroscopy.

This case was reviewed by experts in orthopedics and internal medicine, who found a departure in the standard of care for our insured hospital as the CNA failed to follow the physician's orders to utilize the immobilizer, resulting in the patient's fall and the resultant tendon rupture. A nursing consultant agreed that the CNA deviated from following standing physician's orders and adhering to the Safe Program.

The hospital agreed to resolve this matter with a settlement of $600,000.

A Legal and Risk Management Analysis

The failure of the MLMIC-insured surgeon's CNA to put the brace back on before allowing the patient to ambulate was the precipitating cause of the negative outcome. As far as the CNA knew, the order to wear the brace at all times was still in place. When she encountered the patient without the brace, it was her obligation to ensure the patient understood and complied with the doctor's instructions. Unfortunately, the patient misunderstood the doctor's instructions, and the CNA's wrongful reliance on the patient's understanding compounded poor decision making. When a patient's failure to understand physician instructions contributes to an incident, as it did here, assessment of the communication is important.

As discussed in the previous article, elderly patients need to feel empowered and included in their care plan. An effective provider/patient relationship leads to better outcomes and fewer lawsuits. The issue in this case started with the doctor's morning examination of the patient's knee. After examining the patient's knee, the provider took off the brace and never replaced it. He then changed the order to use the knee immobilizer "when ambulating," rather than "at all times." When the provider walked out of the room, the patient had the impression that she was permitted to walk a few steps without the

brace, flex her knee while bearing weight to sit on the toilet, and extend her knee while bearing weight to stand.

Without a record, the MLMIC-insured hospital cannot recreate the interaction between the provider and the patient. However, for training purposes, the insured can ask:

1. Did the provider tell the patient about the change in plan?
2. Did the provider explain why he was changing the plan?
3. Did he explain the dos and don'ts and risks of noncompliance?
4. Before the provider left, was he confident that the patient had heard him?
   a. Did he consider noise level or distractions?
   b. Did he speak clearly, slowly, and loudly enough for this particular patient?
5. Did the provider ensure that the patient fully understood the change in plan?
   a. Did he avoid unnecessary technical medical terms?
   b. Did he ask her to repeat what he said? If she demonstrated misunderstanding, was he patient when rephrasing?
   c. Did he ask if she had questions or required clarification? Was his demeanor rushed and impatient or engaging and open?
6. Did he provide the name or title of someone who could clarify if she had questions after he left?

Instructing the patient on the proper use of her immobilizing device was crucial to avoiding further injuries or complications. Had the patient fully understood, she would not have presumed it was acceptable to ambulate, squat, and extend her knee while bearing weight without the brace. This is not to assign blame to the patient or physician in this case. The CNA should have known better. However, effective patient/provider communication and patient engagement may have prevented reinjury.

This case demonstrates why open and clear communication throughout the course of care is critical, particularly with this elderly patient. Communication errors put patients at risk of injury. Hospitals that fail to have in place, enforce, and train on best practices for communication and health literacy in the elderly patient population are at risk of medical malpractice.

From a litigation perspective, it is also important to understand that the direct cause of an injury is only one factor defense counsel considers when assessing the likelihood of a defense verdict. All deviations affect defensibility. The CNA disregarded the fall prevention plan by allowing the patient to wear slippers. This disregard may not have caused the patient to reinjure her knee, but it compounded the perception of carelessness. Each deviation, whether the direct cause or not, extends the shadow across the insured's behavior, giving a jury the impression of general carelessness. In this case, an assessment of communication and engagement with the elderly patient population, in addition to refresher training on the importance of all aspects of fall prevention, would be useful.

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UNDERWRITING UPDATE

Take a moment to perform a quick policy review!

Just as you encourage your patients to have their annual wellness checks and important screening exams, MLMIC encourages its policyholders to take a few minutes to conduct a policy check-up to ensure things are in order and that you are getting all the savings you are eligible to have applied to your premium.

With July 1st fast approaching and it being the most common policy renewal date, now is a perfect time to do this. Even if you have a different renewal date, it's still worthwhile to take a look.

A few of the questions to ask include:

- Are you due to complete a risk management course so that you can continue receiving your applicable discount?
- Are you working part time and, if so, did you submit your part-time renewal application to continue your part-time premium discount?
- Do we have your current contact information for mail and email communications?
- Last, but not least, are you taking advantage of all of the possible savings that MLMIC has to offer?

UNDERWRITING UPDATE

MLMIC Preferred Savings Programs

MLMIC's Preferred Savings Programs (PSPs)* have saved New York physicians **over $16 million since 2020!** These MLMIC-exclusive programs offer significant savings to qualifying New York physicians and represent MLMIC's commitment to putting the interests of our policyholders first. Visit the **Preferred Savings Programs page** on our website for a current list of organizations we collaborate with and to view the discount amounts, which range from 10% to 15%.

Over the past few years, we've seen steady growth in MLMIC policyholders who qualify for and participate in these programs, resulting in significant savings. In 2020, our Preferred Savings Programs saved physicians $4.6 million. In 2021, total savings were $5.4 million. In 2022, savings totaled $6.4 million — resulting in more than $16 million combined over those 3 years.

MLMIC Savings

In addition to our PSPs, MLMIC policyholders may qualify for a variety of additional savings through MLMIC's portfolio of discounts. These can be combined with one PSP discount, potentially yielding savings of up to 30%!

- **5% —** Risk Management Course completion
- **5% —** No-Consent/Waiver of Consent option
- **35% or 50% —** Part time (up to 88 hours per month)
- **50% —** New doctor discount
- **7.5% to 12% —** Claims Free discount, starting at 5 years without any open, closed, or paid claims; and
- **2% —** Annual Premium Pre-Pay

If you have any questions about your policy, or if you need help using the MLMIC policyholder portal, you can call 1-800-ASK-MLMIC or speak to your MLMIC Underwriter. You can also contact **Patricia Mozzillo** or **Lori Hertz** to learn more about any of the MLMIC discount options.

We'd love to hear from you. If you have any questions or concerns, we're here to help!

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CAIPAcare

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MGMA NEW YORK

Excellus Credentialed Physician Insurance Program

VAP Voluntary Attending Physicians

**Qualifying physicians are those who have a better than average loss experience. The PSP discount amounts are reviewed annually, are subject to upward or downward adjustment (including removal altogether), pending approval by the NYS Department of Financial Services, and are based on the overall loss experience of each program's members.*

P.O. Box 1287
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New York City | Long Island | Colonie | Syracuse | Buffalo

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