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wyoming MEDICINE

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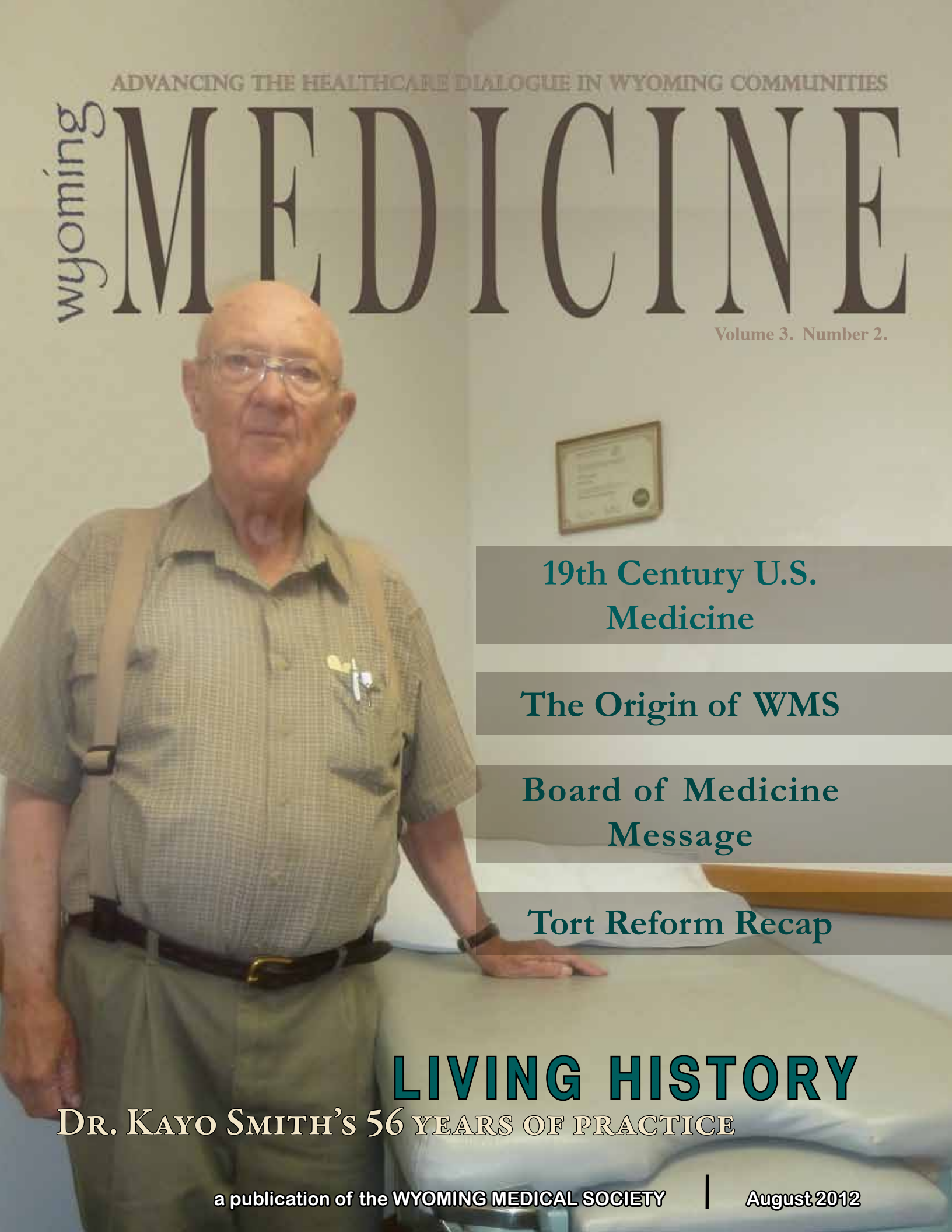

LIVING HISTORY

Dr. Kayo Smith's 56 years of practice

a publication of the WYOMING MEDICAL SOCIETY | August 2012

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Cover Photo: Dr. Kayo Smith, MD, of Torrington
Credit: Christy Chadwick, for Wyoming Medicine

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August 2012 Editor's Page

By Robert Monger, MD
Chief Editor

As many of you who read this magazine have heard by now, Denny Curran passed away on April 8, 2012, Easter Sunday, from complications related to diabetes.

Denny had a lifelong interest in organized medicine, and at the time of his passing he was serving as an Assistant Editor for Wyoming Medicine Magazine. His wife, Wendy, worked for the Wyoming Medical Society for almost 15 years including 7 years as the WMS Executive Director. She left WMS in 2005 to become Governor Freudenthal's Health Care Advisor.

Denny was born and raised in Madison, Wisconsin where his father was the Editor of the Wisconsin State Journal. After graduating from the University of Wisconsin Denny followed in this father's footsteps and went into journalism. He moved to Montana to become a "cub" reporter in Missoula and then later became the State Capitol Reporter in Helena.

In 1977, Denny took a job as the Associated Press Bureau Chief for Wyoming and moved to Cheyenne. He later left the AP to become the Press Secretary for Governor Sullivan, a position he held for eight years, and then in 2001 he became the Founding Editor of the Wyoming Business Report.

When Sheila Bush and I realized a few years ago that we needed editorial help with Wyoming Medicine Magazine we turned to Denny and he was more than generous in volunteering his time and expertise. For the past two years Denny helped edit this magazine, and Wyoming Medicine has become a much more professional publication because of his work.

Denny's standard for journalistic ethics was unparalleled. He believed in fairness and accuracy and he always strived to be fair and balanced in his writing. I learned a great deal about journalism from Denny and I'm sure over the years many others have, too.

He will be remembered for his sense of humor, for the many lifelong friendships he made, and for always being late. At his well-attended funeral in Cheyenne we were well into the service when his son Tim came walking down the center isle of the church carrying an urn with Denny's ashes. As he placed the urn on a table at the front of the church the speaker, Susan Anderson, said, "Denny was known for always being late, and now he's late for his own funeral!" As they say on T.V., it was an instant classic.

Denny will also be remembered for his fantastic family. Denny and Wendy's two children, Laura and Tim, are fine young adults and they are a living tribute to their wonderful parents.

Denny Curran will be remembered and greatly missed for a very long time.

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In this edition of WM we present several stories about the history of medicine, including articles written by Dr. Mike Jording and by Dr. Eric Wedell, and in our cover story we feature an interview with the amazing Dr. Kayo Smith.

Dr. Smith has practiced medicine in Torrington for more than 50 years and he continues to see patients several days each week. He has seen a tremendous amount of change in his career, both in the practice of medicine and in the town of Torrington. He is living history, and it is an honor for this magazine to publish an interview with him and to feature him on our cover.

Thank you Dr. Smith for serving the residents of Torrington for more than five decades. Your dedication to the practice of medicine is an inspiration to all.

On the last day of the 2012 WMS Annual Meeting there was a fascinating panel of experts who debated the merits of tort reform in Wyoming. While the State of Wyoming continues to have one of the most difficult malpractice climates in the United States, the panel members presented a number of potential solutions to this difficult problem, and Nick Healey presents a recap of the discussion in his legal article.

Thanks to Kevin Bohnenblust, the Executive Director of the Wyoming Board of Medicine for his article. We hope to impose on Kevin to write more articles for us in the future.

We welcome any feedback that you may have about Wyoming Medicine Magazine. Please feel free to contact our editorial staff with any comments at info@wyomed.org.

Thank you for reading Wyoming Medicine! **WM**

2012 Community service award winner

John Lunt, MD of Saratoga is this year's recipient of the 2012 Community Service Award. This award is presented each year to Wyoming's top physician in recognition of their contributions to Wyoming communities, honoring the physician for time and personal sacrifice for the benefit of the community.

Dr. Lunt has served the Saratoga community as a family physician since 1977 where he retired 21 years later. It was always a dream of his to practice family medicine in the wide-open spaces of Wyoming, from the time that his parents purchased a ranch in Wheatland, in 1946.

After completing college in 1950 at Cornell University in New York, Dr. Lunt attended Columbia University, College of Physicians and Surgeons, and graduated in 1954. He continued to practice in Denver, CO with a private practice in general surgery for 17 years before practicing in Saratoga.

When Dr. Lunt moved to Saratoga, he founded the Highline Ranch. Dr. Lunt began his practice in Saratoga, which had been without a family doctor for 6 months. His dedication to the citizens of Saratoga was noticed in his house calls and extra attention to each patient.

Dr. Lunt was quoted saying, "every surgeon should have to do some years in family practice, because that's where you really find out how to care for your patients."

Dr. Lunt's love for ranching and the land brought him to found the Wyoming Stock Growers Agricultural Land Trust, WYSGALT, in 2001 with the help of several like minded ranchers. He has since sold his ranch with a conservation easement in place and held by WYSGALT and moved to Wilson, WY to be closer to his family.

Dr. Lunt shares his joy with his wife Susannah and their five children John of Danbury, CT, Alex of Douglasville, GA, Sam of Sante Fe, NM, Bil of Colorado Springs, CO, and Susie of Wilson, WY and 13 grandchildren.

Dr. Dean Bartholomew, MD, the current physician in Saratoga, presented Dr. Lunt with his award at this year's WMS Annual Meeting at the Jackson Lake Lodge. **WM**

Dr. Lunt with family and Dr. Bartholomew's family

Starting them early

Rock Springs high school contributes to medical industry

By Tom Lacock

While the need for health care providers is very real in Wyoming, the Rock Springs High School's Health Occupation Career Academy is doing its part to expose its students to the opportunities of the profession. The academy graduated its first cohort of 50 students in May with estimates of 40 of those bound for further training in health related fields.

The academy idea is described as a school-within-a-school. Except for time spent job shadowing, all classes take place at the high school and students leave high school with the same diploma as their classmates.

Groups of 27-30 Rock Springs High School students who interview for the program are put into cohorts where they will spend the next three years in traditional high school classes as well as academy classes which have concentration in the health sciences field. The classes are supplemented with courses that have a "real world," element to them, such as phlebotomy or, next year, EMT basic offerings.

"Here they are just a high school kid," said Health Occupations Academy Director Bruce Metz. "But they put that Health Care Occupations Academy shirt on, then they are representing something bigger and they bring that into the building."

Building a program

Rock Springs High School Principal Darrin Peppard credited former Rock Springs teacher Ted Schroeder for bringing the idea to Rock Springs. In 2008 the school spent the year researching the academy concept and in 2010, took in its first cohort. In generations past, Career and Technical Education (CTE) courses were known as hands-on courses like wood shop or home economics. The current model of CTE instruction in Wyoming involves coupling traditional courses such as math and science with offerings that show relevance to job fields. In turn, the "hands-on," classes show the students how the knowledge taught in upper level courses such as geometry is used on the job. Successful academies exist in Jackson for engineering, as well as manufacturing in Sheridan.

Peppard said because the school can show relevance for upper-level math and science, there has been a dramatic increase in students at Rock Springs High taking Advanced Placement courses. He said he also sees students who maybe didn't think they could achieve in the upper level math and science courses be willing to take them due to the increased level of understanding provided by the CTE approach.

"We had three keys when we were planning this," Peppard said. "We wanted to build relationships with students and staff; we wanted to make the curriculum relevant for our students and we wanted to increase the rigor."

Selling the faculty on the change included searching for teachers who wanted to offer a more project-based effort or different approach to the "sit-and-git," found in traditional classrooms.

While few curriculums for projects such as the Health Occupation Career Academy exist, Peppard said for ideas, the school went to the medical field.

"In the fall of 08 or 09, we brought the professionals from the community together in the evening," Peppard said. "We sent a mailer to everyone associated with health care to our school and laid it out. We said, 'will this work' and second, 'what can we do to help you in your practice, your hospital, your therapy clinic to help you.' What we have gotten is tremendous numbers of medical professionals coming to us and say, what can we do to help?

"They have helped us put together our curriculum."

Peppard pointed out the school has had some partners in this effort. He lifted up the Wyoming Department of Education for a demonstration grant. The Area Health Education Center (which has an affiliate in Laramie) also helped out with funding for the Phlebotomy course. Memorial Hospital of Rock Springs also kicked in a $3,000 scholarship for a student in the program.

The health occupations classes themselves include offerings in everything from nutrition, anatomy, chemistry to technical writing. Those courses are supplemented with a focus on soft skills like resume writing, how to greet and prepare for job interviews and public speaking.

This year the school offered a senior-level course in phlebotomy. Students were prepared for a national certification through a joint effort between the school and Western Wyoming Community College and Rock Springs High. To pass the class, students had to manage 50 successful finger sticks as well as blood draws from the arm.

Next year, Metz said, the seniors will also be able to take an EMT basic course.

Finding a career tract

Somnem Papel spent part of the month of May feeling like a pin cushion thanks to her classes' effort to get finger and arm sticks.

"I have a couple pokes that I am pretty sure are going to be there for a long time," she said. "I actually passed phlebotomy with an 'A,' and I am proud of that because I was the only one. The national test we are supposed to do that on our own. I am filling that application out right now."

Papel - 2012 program graduate - was in Salt Lake City at orientation this month for the University of Utah's biology program.

Papel said she plans to become a pediatrician, thanks in part, to her time job shadowing.

Juniors job shadow someone in the medical field every week for two hours-a-week. That time is doubled for seniors. Metz said the kids in the program have followed doctors in the emergency department as well as nurses, veterinarians and even the hospital's central supply. The idea is to let them get a picture for what they may want to do - or - what they don't want to do.

"The first time I stepped into the academy, I wanted to be a general physician," Papel said. "We got to job shadow and I got the opportunity to shadow a physician. When I saw what they did, I said this wasn't bad, but it wasn't for me. I also got to shadow a pediatrician and I saw the way they worked with kids and I thought it was what I wanted to do."

"I think with the parents, one of the big pitches there is a lot of students go to college and change their major once, twice three times," said Metz. "Career academies allow their students to know if the health or energy industries are what they want to do."

Keeping kids in school

While the state's high school graduation rate hovers at 79 percent, the health occupations academy graduation rate is about as good as it gets. Three years ago Rock Springs welcomed in 54 students to its Health Occupations Academy and the Energy Academy (which prepares students for jobs in the energy field) and this spring watched 49 graduate, including one student who was the first

in their family to receive a diploma. One more will graduate this summer and two others

m o v e d

from the district.

Metz said his academy students run the gambit from honor roll students to at-risk kids.

"We've saved several students from not graduating," Metz said. "We had five or six kids in just my academy that would not have graduated had they not had the academy support they had," said Metz. "I had five teenage mothers this year. All five graduated. One graduated with a 4.0." Peppard is quick to say the academies are not a dropout prevention program, but points out the academy model allows students consistency in their daily routine as well as a support from students and teachers that is uncommon in a large high school. He said the academy also offers a link between real world and academic experiences.

"These are kids who school didn't make any sense to them because they didn't see the connection between school and where they were going to go down the road," Peppard said. "Being able to focus the classes you don't find interesting in a way that you do feel interesting - that is what keeps kids in school."

Metz said he had one teenage mother this year who struggled until finding the relevance in a phlebotomy career and the opportunities it could offer her baby.

"One of the teenage moms had her baby as a junior and we struggled a lot with getting her to finish school," Metz said. "She wanted to be home with her baby. When we started the phlebotomy class, this student saw the relevancy in this class and she realized if she worked hard in this class, she could have a job she would be

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proud of, she would have benefits for she and her baby."

Papel said the graduation rate has something to do with the fact the academies offer support not common to 1,300-student high schools.

"We are in groups together since our sophomore year," she said. "As you are traveling to your senior year, you get to know your peers in the group. You have a good support system in school, which you don't get in the regular high school. "The transition we made from sophomores to seniors was really great and I have never been as close with a group of people as I was this one." **WM**

Living history

The life of Kayo Smith, MD

By Christy Chadwick

Dr. Kayo Smith, MD, began practicing medicine 56 years ago, in 1957, when an acquaintance informed him of a job opening in Torrington, Wyoming. After growing up in a small town in Nebraska and completing medical school in Omaha, he lived in California for a year as an intern and spent a few months in Hawaii. He then decided it was time to return to a small town, close to home, with his wife. He stayed because the people continue to be nice and the livestock market has grown as well as the town itself. He enjoys seeing all the changes and development.

When asked why he has not retired, Dr. Smith responded, "I like what I'm doing." Dr. Smith has seen many changes, but he enjoys seeing his patients grow, helping them through their illnesses, and even holding their hands as they "take the big trip."

Kayo grew up in Bayard, Nebraska where his father was a baker. His sister and brother also turned to the medical field as his brother went into orthopedics and his sister, pediatrics. He now has three children and seven grandchildren. His daughter and son are nurses and his daughter-in-law, Marion, is a doctor at the very same clinic where he practices medicine today.

WM: What was the best thing about practicing when you first started?
"The best would have to be the challenge of taking care of people and always learning something new."

WM: What was the worst?
"The worst seemed to be the hardship of lab work. The tests were harder to read and there was less available; no MRI's or CT's. We did more things by just asking questions"

WM: What was Torrington like back then?
"It was smaller, just about 2,000 people lived here and we started as just a small clinic in town."

WM: Do you have patients and families you've taken care of for 50 years and what's that like?
"Gratifying. I run into patients at the grocery store and ask how their daughter is [that I delivered] and they'll say, 'oh good, she's 45.'"

WM: What's changed the most?
"Back then, we couldn't get advice from specialists. We had a hard time talking to them. Now we all work together better."

WM: What's the best thing about practicing now?
"Having more resources available."

WM: What's the worst thing about practicing now?
"People are more liable to sue you, so we are more apt to order tests that maybe aren't necessary just as a precaution."

WM: What's the most important thing a doctor can do to help their patients?
"Depends on the patient. Sometimes it's taking out their gallbladder and other times it's just holding their hand."

WM: What's the best thing about being a doctor?
"The satisfaction of taking care of people and seeing them get well or helping them take the big trip." **WM**

Kayo Smith, MD and his daughter-in-law, Marion Smith, MD

The birth of the Wyoming Medical Soceity

By Mike Jording, MD

It is a commonly held belief today that the Wyoming Medical Society began in 1902, but the reality is that the society was established earlier than we recognize today. In 2002, the Wyoming Medical Society marked its centennial anniversary with a gala celebration at Jackson Lake Lodge and a display of memorabilia from past society members and events. During the celebration, commentary from WMS leaders who served within the previous 50 years was heard, and the Board of Trustees of the society established the Centennial Scholarship Endowment. The events were honorable and exciting as the society remembered their beginnings and planned for the future.

However, if the truth be known, the society had its beginnings in 1898, and the details are well documented in Transactions of the Wyoming State Medical Society. At the urging of two physicians, a charter group of physicians formed the Wyoming Medical Society during a meeting in Rawlins in 1898. Invited by Drs. E. Stuver, M.D. of Fort Collins, Colorado, and Thomas G. Maghee, M.D. of Rawlins and Lander, Wyoming, physicians from Wyoming were encouraged to gather for the sole purpose of organizing a State Medical Society. Maghee's history in Wyoming is well documented, and at the time of the call for organization, he was 56 years old. Having graduated from medical school in 1873 and served as an army surgeon at Camp Brown in Fremont County, he later practiced privately in Green River and Rawlins, before becoming the superintendent of the Wyoming State Training School. His vision of a medical society was obviously based on his past experience and education. He was credited with organizing the first Fremont County Medical Association, along with Dr. N.D. Nelson of Shoshoni.

OFFICIAL CALL OF WYOMING STATE MEDICAL SOCIETY.

Rawlins, Wy., April 29, 1898.

Dear Doctor: Every year more fully demonstrates the absolute necessity of a closer organization and firmer union of the medical profession in order to promote its material as well as its scientific interests. In view of the fact that nearly every state and territory of our Nation, except Wyoming, has an active medical society to look after the welfare of the medical profession, and believing that the present is a most auspicious time, and that it is the duty of the medical profession of our state to organize a State Medical Society, so that we shall be entitled to delegate representation in the American Medical Association at its coming meeting in Denver, June 7th, we, the undersigned, do hereby issue a call for a meeting of the regular physicians of Wyoming to be held in Rawlins, May 13th, at 10 o'clock, a. m., for the purpose of organizing a state medical society, or reorganizing the one which has lain dormant for so many years.

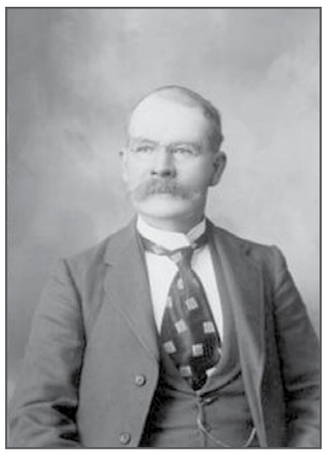
You are urgently requested, if possible, to be present at the meeting, but if you cannot be with us, send in your application for charter membership at once.

Signed: E. STUVER, M. D.
THOS. G. MAGHEE, M .D.

Stuver and Maghee recognized that "nearly every state and territory of our Nation, except Wyoming, has an active medical society to look after the welfare of the medical profession." The "absolute necessity of a closer organization and firmer union of the medical profession in order to promote its material as well as its scientific interests" was a prime goal of the early leaders. Also, by forming the society, the physicians anticipated delegate representation for Wyoming in the American Medical Association, which was only 50 years old at the time, having had its start in 1847 in Philadelphia. In a letter sent April 29, 1898 Stuver and Maghee urged physicians to be present at the meeting, and if they could not be present, to send an application for charter membership.

Wyoming physicians did heed the call and met in Rawlins at the Union Pacific Hotel. They formed the Wyoming State Medical Society, adopted a constitution and set of bylaws, and elected officers of the charter organization. Adhering to the highest professional standards, the new society's objective was the maintenance of an impeccable standard of the medical profession throughout the State, as well as "the preparing, reading and discussion of papers on medical, surgical and allied subjects, the report of cases and social advancement." In their beginning plans, they adopted the code of ethics of the American Medical Association and established that annual membership assessment was to be "not less than one nor more than five dollars." Dr. R. Harvey Reed, M.D., of Rock Springs became the first president of the society. Along with Drs. E. Stuver and J.C. Hammond, Reed was also elected as delegate to the American Medical Association.

Charter members of the new society were considered at the second regular meeting of the Wyoming State Medical Society at its meeting in Rock Springs on November 1, 1898. Amongst those members were Dr. George G. Verbryck of Cambria, , Dr. G.M. Russell of Dixon, , Dr. R. W. Hale of Otto, Dr. James Carter of Carbon, Dr. James Lane of Sweetwater, and Dr. Ernest E. Levers of Almy. The point to emphasize with those physician and town names is that many of those towns exist today only in legend, having succumbed to the movement of people away from mining towns or ranching communities of Wyoming when the mineral interests were depleted or the people moved to larger towns. Drs. Charlotte G. Hawk and Jacob W. Hawk of Green River probably were a husband and wife physician team, an unusual circumstance today and undoubtedly, even more so in 1898.



Dr. Thomas Maghee

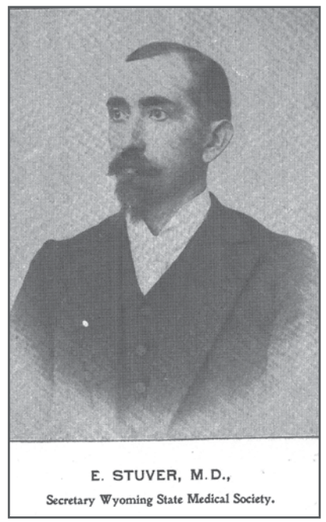
Dr. Fred Horton of Newcastle was another charter member of the society and was typical of physicians in many of Wyoming's early towns. Born in 1865 in Iowa, he graduated from Rush School of Medicine in Chicago in 1889 and immediately began his practice in Newcastle. He served as railroad surgeon for Burlington Northern for over 50 years and as Weston County Health Officer for over 40 years. His history is completely detailed in Weston County, Wyoming: The First 100 Years.

Wyoming physicians considered scientific papers and case discussions during their November 1898 meeting. Dr. C. H. Solier, M.D. of Evanston presented "The Prophylaxis of Puerperal Infection," and Dr. John F. Leeper, M.D. of Casper presented "Cerebro-Spinal-Meningitis." Dr. R.C. Chamberlain, M.D. of Rock Springs presented "Report of a Case of Foxtail Infection."

The president of the society, Dr. R. Harvey Reed of Rock Springs discussed the changes that were taking place in medical education and lauded the fact that medical education had changed from a two year program to a four year program. Courses of study had quadrupled, and "the student of today has to delve into the mystery of bacteriology seeking the cause of disease produced by several vegetable organisms that cause typhoid fever, diphtheria, yellow fever and a score of other diseases." He encouraged physicians to seek a closer scientific and fraternal relation.

During his address, Dr. Reed also advocated for the establishment of a State Board of Health, "which shall be vested not only with the power of examining into the qualifications of every physician or surgeon who shall knock at our door for admission to the medical profession of this state, but by the same time have under their care the sanitary and hygienic condition of its citizens." So, the beginnings of medical licensure, the State Board of Medical Examiners, and the Wyoming Department of Health were first discussed at the 1898 meeting of the Wyoming State Medical Society.

It should come as no surprise that the early leaders of the society, like the society's leaders of today, had the



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democratic process at their disposal. From the November 1898 meeting, Wyoming Congressman John E. Osborne requested a resolution which was passed condemning a bill in Congress to prevent medical experimentation using live animals. "Be it therefore resolved that we, the Wyoming State Medical Society, in regular session assembled, do hereby condemn Senate Bill 1063 and strongly protest its passage and urge upon our representatives in Congress and the United States Senate, as well as all friends of progress, to use every honorable means to secure its defeat, ..."

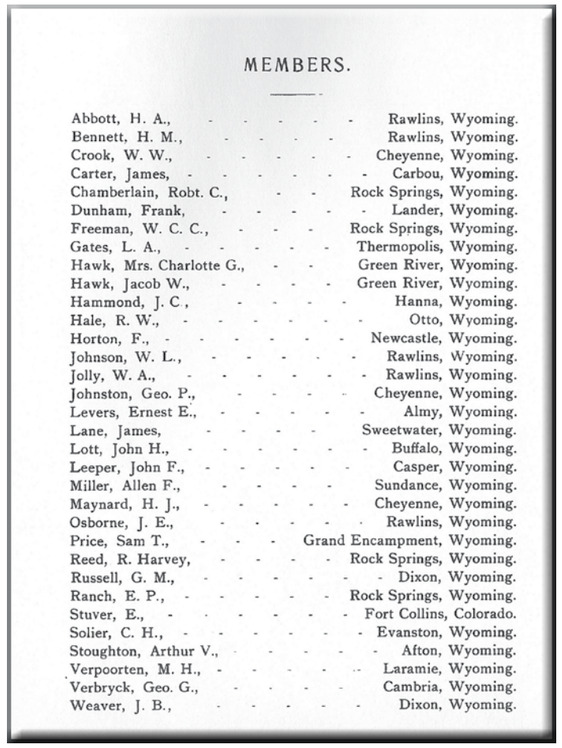
Recognizing the advances using "sanitary experts," and advocating further on a national level for better sanitary conditions, the society resolved in another statement to recommend "the establishment of a public health department under the direction and control of a medical expert, who shall be a member of the President's cabinet." In another issue dealing with foreigners obtaining patents on vaccines, the society pointed out what they thought were unfair trading policies (foreigners were taking advantage of U.S. laws) that dealt with lax patent laws. By having a presence as an organization of Wyoming physicians, the society was approached for leadership on social issues and felt compelled to advocate for improved national medical care. One hundred years have not changed that process too much.

The new society also heard from the Wyoming's delegates to the American Medical Association who had met in Denver in June 1898. Drs. Stuver and Reed reported that they presented papers and participated in discussions before several sections, and the Wyoming State Medical Society was recognized to be in full affiliation with the AMA.

Between sessions at the November 1898 meeting in Rock Springs, the members of the society were taken on a tour of the Wyoming State Hospital, "seeing many interesting cases that are being excellently cared for under the able management of Dr. Reed, with the assistance of Drs. Chamberlain and Ranch and a corps of trained nurses."

In the closing decisions from the meeting, the members elected to extend their meeting to two days and to hold their next meeting in Laramie City beginning at 2 p.m. on the second Tuesday in October 1899. One hundred years have not changed that process too much!

Records show that the Wyoming Medical Society is 114 years old and has a long and interesting history. Early Wyoming physicians dealt with issues that are still alive today, like physician and professional isolation in small towns, national medical and political issues, medical education concerns, and the need to organize as a professional organization. The society has a rich file of historical documents about physicians and meetings, political and social advocacy, and personal achievements. If you have an interest in further developing the history of the Wyoming Medical Society or have records or archives that you feel may benefit the efforts to document the history of the Wyoming Medical Society, please contact the Wyoming Medical Society (307-635-2424) in Cheyenne or contact Mike Jording, P.O. Box 594, Newcastle, Wyoming. ***WM***



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Verpoorten, M. H.,	Laramie, Wyoming.
Verbryck, Geo. G.,	Cambria, Wyoming.
Weaver, J. B.,	Dixon, Wyoming.

Wyoming Board of Medicine

Tips to protect your medical license

By Kevin Bohnenblust, Executive Director

Each summer the University of Wyoming Family Medicine Residency programs in Casper and Cheyenne welcome their incoming classes. As part of the orientation for the new residents, Board of Medicine staff meets with the students and introduces them to the basics of medical licensure. The presentation always includes a discussion of physician discipline, and the residents learn some of the "danger zones" they may encounter.

We emphasize to new residents that the overwhelming majority of Wyoming physicians are skilled, knowledgeable, compassionate and ethical in the practice of medicine. In fact, for more than 95% of the approximately 3,000 physicians licensed in Wyoming, the only contact they have with the Board of Medicine is their annual license renewal.

Each year, though, the Board receives complaints regarding about 100 physicians -- meaning just three percent of Wyoming-licensed doctors are the subject of complaints. These usually originate with a complaint from a patient, but can also result from malpractice claims, arrest reports, or other information that comes to the attention of the Board.

We explain to the residents that most of the complaints received fall into a handful of categories. We also stress that no physician – whether a first-year resident, or a seasoned, board-certified specialist – is immune to having complaints made. With some care and prudent actions, however, physicians can reduce the chances of having a complaint filed with the Board of Medicine.

So where are these "danger zones" that physicians of all experience levels want to avoid? Here are the prime suspects…

Communication and the "Likeability" Factor

About half of the complaints filed against Wyoming physicians have a common thread: A breakdown in communications. Defense attorneys will tell you that patients don't sue physicians they personally like; nor do they file complaints with the Board of Medicine. The Board almost never receives complaints from patients who feel their physician has been honest, open, and sympathetic. So why does something so simple cause so many physicians to have to answer complaints made to the Board of Medicine?

All too often a physician will be genuinely surprised when a patient complains about him or her. While the physician thinks things are just fine, the patient stews over a perceived slight, failure to share information, or lack of availability by the physician. A visit with the physician will often reveal that he or she felt they were doing well with the patient, but upon reflection the physician realizes he was distracted by scheduling problems, other patients, staff, and the myriad other things that vie for attention. It becomes a forehead slapping "Aha!" moment for the physician, who learns that patient communication isn't difficult – provided you remember to actually do it.

Of course, there will always be the patient who is just plain difficult and will never be satisfied with the physician's interpersonal skills – that's just how life is. When a physician is able to show the Board that all the right steps were taken, and "best efforts" were made to work with the patient's idiosyncrasies, these complaints are usually closed with no further action.

Care in Prescribing Controlled Substances

The promotion of "pain as the fifth vital sign," growing pressure to treat pain promptly and completely, and the burgeoning abuse of prescribed controlled substances have dramatically increased the hazards of prescribing controlled substances in recent years. All physicians – whether first-year residents or longtime practitioners – need to exercise caution when writing these prescriptions.

Lack of an objective measure of pain compounds this problem. Physicians are faced with the patient who complains of pain that is "10 of 10" with no clear cause or explanation, while another is stoic and grits his or her teeth after a major injury and says "aspirin will be enough." There are no easy answers in this arena. But there are things a physician can do to reduce the risk to patients – and him or herself.

> "Physicians have made a substantial investment in their education and career to get where they are... Skilled physicians are an asset to the community and the state."

To borrow a Cold War phrase, physicians should "trust but verify" when prescribing controlled substances. Physicians are urged to use WORx – the Board of Pharmacy's Wyoming Online Prescription Database (formerly the Prescription Drug Monitoring Program) – to get an accurate picture of the controlled substances their patients are getting from other prescribers. Many times a WORx report will show the patient has gotten opioids from other physicians, nurse practitioners, dentists and even podiatrists.

Other tools that can help (and protect) physicians include requiring patients to enter "pain contracts" prior to prescribing medications for chronic pain (and then enforcing the terms of the contract!), and mandating unscheduled urine drug tests to detect the presence of the "right" drugs and the absence of others.

Finally, a prudent physician, regardless of his specialty, experience, or any other attribute, holds the ultimate tool for properly prescribing controlled substances. It's the word, "No." The Board of Medicine has never disciplined a physician for exercising his or her professional judgment and refusing to prescribe a controlled substance for a patient. While telling a patient that you will not prescribe the medication he or she "needs" may lead to histrionics from the patient, threats to file complaints, and a stormy exit from your office, it almost certainly will not result in second-guessing by the Board of Medicine.

Maintaining Patient Boundaries

The old saying, "Good fences make good neighbors," is a guide for the physician-patient relationship. Physicians always need to remember the difference between "being friendly" and "being friends" with patients. This is especially difficult in Wyoming, where everyone knows everybody and social circles are small.

For most people, the mention of "boundaries" conjures thoughts of romance between a physician and a patient. Some physicians fall into the trap of thinking that the patient's consent excuses the breach of the professional relationship, but a careful review of the medical practice act shows that consent does not excuse the breach.

"Boundaries violations" don't just occur in matters of the heart, though. Any activity that gives the appearance the physician is taking advantage of the unequal "power differential" in the physician-patient relationship may be considered unprofessional, depending on the circumstances. Before venturing beyond a traditional physician-patient relationship, a wise physician will stop and consider whether the action blurs the line. A moment of sober reflection may avoid embarrassment and disciplinary action down the road.

Document, Document, Document!

Physicians have heard it ad nauseam, but it's true: If it isn't written down, it's like it never happened. Still, it's remarkable how often the Board's request for a physician's records related to a complaining patient results in sparse, sketchy records. Even worse, there are times when a physician is forced to admit to the Board that he or she doesn't have any records for the patient for whom they prescribed medications and more.

In virtually all cases, detailed and accurate records – even when bad things happen – are the physician's best friend when a complaint is received by the Board. The credibility gained from honest, consistent, and thorough record keeping can speak far louder than words.

Know Your Limitations

One of the most devastating things that can be said about a physician is, "He doesn't know what he doesn't know." This seemingly circular statement emphasizes that a physician is vulnerable to making mistakes when he is unable or unwilling to acknowledge that there is something he doesn't know or can't do well.

The education and training physicians receive, and the stature that society holds them in, can lead a physician to be overconfident in his/her skills and knowledge. That is why, although it seems counterintuitive, physicians are best served when they embrace the power of saying, "I don't know."

The Board encourages physicians to be open to receiving input from others. Whether it is the classic "second opinion"; the comments of nurses, P.A.s, technicians and others; the concerns raised by pharmacists filling prescriptions written by the physician; or questions posed by the patient and his or her family – all can provide valuable insight to the physician. No one is infallible, and you never know what comment or question may save your medical license.

Finally, physicians are always welcome to contact the Board office with questions. The Board wants to help physicians avoid problems before they happen.

Closing Thoughts

Physicians have made a substantial investment in their education and career to get where they are. Likewise, Wyoming communities invest tremendous amounts to recruit and retain physicians. Skilled physicians are an asset to the community and the state.

While the Wyoming Board of Medicine's first duty is to protect the public, the Board balances against that, the need for physicians in our communities. The Board has taken the position that it is far better – and often more cost-effective – to remediate physician problems than revoke licenses and take doctors out of our communities. The Board hopes that by sharing information and insight about the complaints that are received, and some of the ways physicians can avoid them, the public – and Wyoming physicians – will be even better served. ***WM***

Medical practice and education in early America

By Eric Wedell, MD

"In the 19th century the medical profession in America was weak, divided, insecure in its status and income, and unable to control entry into practice or to raise the standards of medical education." Even in the mid-19th century, illness was regarded as an imbalance of the four humors and disturbances of solid entities in the body, such as the blood vessels. The treatment was bloodletting and/or heroic therapy which often included heavy doses of the cathartic callomel (mercurious chloride) until the patient salivated.

"By 1850 there were 52 medical schools in the United States compared to three in all of France." "The schools were all self financed out of students' tuition." "They had no laboratories and only limited libraries." "Faculties were comprised of five to seven professors. The term of study for a year of medical school lasted only three to four months. Two years were required for a degree and the second year repeated the courses of the first year." Examinations were not rigorous because professors, who received compensation directly from student fees, were paid only if the student passed. Medical licenses, if they existed, were easy to acquire. The only restriction placed on the unlicensed was that they were blocked from using the courts to recover debts.

"By 1830, in Europe, there was a decisive break with the vague systems of classical medicine and the formation of modern clinical methods." The stethoscope was invented, statistics and correlation were applied to illness, and public hygiene began to be applied to public health. These advances, especially the microbial theory of infection, were slow to get to America.

By the latter half of the 19th century the growth of cities, some paved roads, and public transportation made it much easier for the patient to visit his doctor. Telephones, which became available in the late 1870s, enabled patients to see their doctor at a prearranged time. "Automobiles, more reliable after the turn of the century, further reduced time lost in travel to see the doctor. These developments widened the doctor's market geographically and increased his income." The average daily patient load increased from five to seven patients a day, to 18 to 22 patients a day by the early 1940s.

The AMA was organized in 1846 and adopted a code of professional ethics because of the widespread repeal of licensing statutes. "The AMA tried a voluntary reform of medical education that failed miserably. The medical profession was further weakened by bitter feuds and divisions that plagued doctors throughout the late 19th century." In the second half of the 19th century, besides orthodox physicians, the principal medical sects were the homeopaths and the Eclectics. Eclectics were botanic doctors who claimed to have indigenous American roots and had a very adversarial relationship with orthodox physicians. Homeopaths thought that disease could be cured by drugs which produced the same symptoms when given to a healthy person, the "law of similars", like cures like. Orthodox physicians felt that homeopaths should be expelled from the profession. But, as long as physicians were divided, any move by the orthodox physicians to bring back licensing or reform medical education seemed like a narrow maneuver on their part aimed at winning advantage over the dissenters. The homeopaths called orthodox physicians "allopaths", cure by opposites, the reverse of homeopathy.

But, as scientific knowledge advanced into the area of therapeutics, differences tended to diminish. Medical licensing was more commonly supported by the latter half of the 19th century. Licensing laws progressed from requiring only diplomas to requiring an acceptable diploma and the passing of a state examination. The legitimacy of medical licensing was finally established by an 1888 Supreme Court decision. By 1903 the AMA adopted a revised code of ethics that allowed homeopaths and Eclectics to be admitted to the organization. Notably, only after homeopaths and Eclectics won a share in the legal privileges of the profession did they lose their popularity. "The more they gained access to the privileges of regular physicians, the more their numbers declined."

Other competition came about, however. Osteopathy was founded by a rural Missouri doctor, Andrew Still, in the late 19th century. Christian science was begun in the eastern United States by Mary Baker Eddy. Chiropractic originated as a commercial enterprise in the Midwest in the 1890s.

"In 1901 the AMA revised its Constitution creating a new legislative body, the House of Delegates, with representatives drawn from state medical societies in proportion to their membership." Membership and income increased. Physicians began to achieve the unity and coherence that had so long eluded them. "From 8,000 members in 1900, AMA membership shot up to 70,000 in 1910, half the physicians in the country." By 1920 membership had reached 60%. AMA membership enabled doctors to get low malpractice insurance rates which, in turn, helped to attract more members.

However, doctors had still not been able to reform medical education. "At the turn of the century a key source of physicians' economic distress remained the continuing oversupply of doctors." By 1900 there were 160 medical schools in America. The reform of medical education began around 1870 and was led by President Charles Elliott of Harvard and President Daniel Coit Gilman of Johns Hopkins. In Germany, the laboratory sciences of physiology, chemistry, histology, pathologic anatomy, and bacteriology were revolutionizing medicine. "But in American medical schools there were no laboratories let alone a tradition of original research. By 1871 Harvard Medical School's finances were placed under the control of the Harvard Corporation and the system of dividing up fees was eliminated. The academic year was extended to nine months and the length of training needed to graduate to three years. Students would have to pass all their courses to graduate."

"The most radical departure took place at Johns Hopkins University which opened its medical school in 1893." All students were required to have college degrees. It was a four-year program of graduate study, rooted in basic science and hospital medicine. "The two major figures at the school were William Welch and William Osler."

In 1904 the AMA formed a Council on Medical Education which established a minimum standard for physician education. It began to grade medical schools. The Council on Medical Education then invited an outside group, the Carnegie Foundation for the Advancement of Teaching, to conduct a similar investigation, headed by Abraham Flexner, a young educator. Even before Flexner's report was published in 1910 the number of medical schools had begun to decline, dropping from a high of 162 in 1906 to 81 by 1922 due to factors such as rising requirements set by state licensing boards, higher tuition fees, and doctors being unable to begin practicing medicine before

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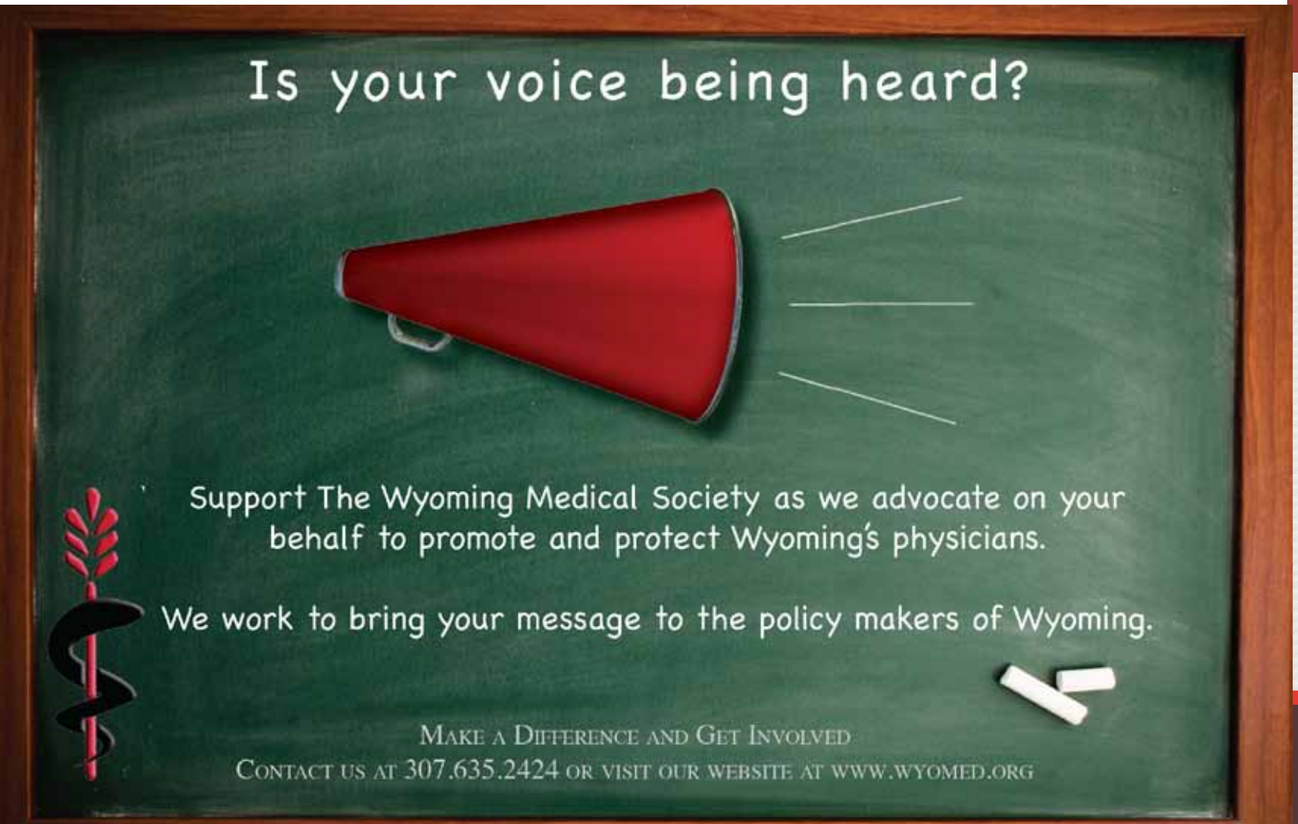
the age of 30. Flexner visited each of the nation's medical schools. He found false catalogs, nonexistent laboratories, reeking corpses, libraries without books, and faculty members busily occupied in private practice. The power of Flexner's report was that he was not an agent of the AMA and that made the weak medical schools vulnerable to public exposure and embarrassment. The AMA's decisions came to have the force of law. "This was an extraordinary achievement for the organized profession." Over the next two decades this report guided many major foundations' investments in medical care and medical education. In one short century, the American medical profession had gone from weak, divided and indecisive to strong, cohesive and decisive, and from lower economic status to a much improved and comfortable income.

In the next issue of Wyoming Medicine, look for American medicine from the 1920s to the present.

All of the above, and more, may be found in The Social Transformation of American Medicine by Paul Starr, 1982, Basic Books, winner of the 1984 Pulitzer Prize for General Non-fiction. ***WM***



Customer satisfaction in the medical practice

You won't know what you don't know – if you don't ask

By Kathleen M. Roman, M.S.

Customer satisfaction is an increasingly important component in the provision of healthcare. There are several reasons for this. First, patients increasingly see themselves as consumers of medical services. Many want to be more directly involved with the planning of their healthcare and reject as obsolete the theory that patients should passively submit to paternalistic decisions in which they have no say. This transition has been in the making for at least a decade and a number of studies have shown that patients who feel like partners in their healthcare generally have better outcomes and report higher levels of satisfaction. In spite of these studies, the transition has been slow.

Second, and perhaps more compelling, regulatory entities have stepped up the pressure for patients' inclusion in the healthcare equation. As patient populations shift into ambulatory care centers, and as the scope of clinical services increases in medical offices, health insurers and accrediting bodies such as the Joint Commission require consistency in patient safety and satisfaction protocols, regardless of the environment of care. Bodies such as the Centers for Medicare and Medicaid Services (CMS) as well as The Joint Commission, use data about customer satisfaction to compel providers to measure outcomes – from their patients' perspectives.

Taking these changes into account, more and more medical encounters include some assessment of the patient's experience of care.

Health insurers, for example, have long contended that patients' perceptions of their healthcare is a key quality indicator. Increasingly, this data is being used to determine whether or not providers may participate in some insurance panels. Depending on the doctor's locale and specialty, being "fired" by Medicare or a health plan can play havoc with a medical or dental practice's survivability. And some doctors worry about complying with patients' unreasonable or potentially dangerous requests/demands out of fear that patients will write less-than-satisfactory reviews in patient satisfaction surveys.

There's a third – and possibly more beneficial – reason why doctors should regularly seek input from their patients. The results provide two kinds of opportunities. Perhaps the easiest to assess is clients' feedback about the things that went right, the specific elements of care that pleased them. By identifying what they've "done right," doctors can build on those successes and avoid inadvertent dismantling of processes that work. The flip side of this opportunity gives doctors a chance to hear patients' perceptions of areas that need improvement. In today's busy medical offices, doctors can't be everywhere and neither can their employees. But, when asked, patients can often be quite specific about elements of their care that didn't work for them.

The request for feedback is important because a number of studies have shown that patients may switch doctors rather than complain about inadequate service. It is to the physician's advantage to learn about service lapses and be able to fix them. By doing so, they may be able to retain good business and reduce the potential for disputes that might encourage the disgruntled patient to find a sympathetic ear in an attorney's office.

Increasingly, healthcare providers are being pressured to switch to electronic health records (EHRs). Regardless of whether they have a fully-integrated

EHR or are still committed to a paper-based system, there are numerous ways in which physicians can seek patient feedback. These can be as simple as:

- The sign hanging in a Texas pediatrician's office: "If we treated you great today, please tell your friends. If we didn't, please tell us about it right now."
- End-of-appointment systems include small surveys that can be completed and deposited in an office mailbox; Or postcards that can be turned in at the end of a visit or mailed at a later date; Or email addresses or practice website addresses where patients can complete surveys or share their feedback.
- Verbal requests for feedback – from clinical staff and from office employees who interact with patients after the clinical portion of the visit is complete.
- Computerized surveys that allow the patient to enter survey responses directly into the practice's quality management files, while still in the office.
- Lists of contact names and phone numbers so that patients can speak directly with providers, practice administrators, or technical managers, e.g., billing or reception. This option may be especially useful if the patient has a complaint that may take some time to explain or that involves more than one employee of the practice. This option presumes that staff will understand the value of this approach and actually respond to the patient, e.g., pick up the phone and not let the caller be dumped into voice mail.
- Third party survey and feedback programs, typically contracted with vendors who specialize in gathering and analyzing the feedback data. Some of these vendors also provide benchmarking services that help providers compare their results with de-identified results of other similar

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providers.

Ideally, everyone associated with a medical practice should feel a sense of ownership for customer satisfaction. The structure should include:

- Job description details that specify customer service accountabilities.
- Written policies and procedures should ensure that the customer service plan is comprehensive enough – and that its various elements are consistently implemented by all doctors, staff, and employees.
- This should include timeframes, formats, document templates, e.g., surveys, response letters, etc., training programs, and disciplinary actions for non-compliant staff. Periodic review and update should be a part of any quality initiative.

A well-designed customer service program will have a positive effect on the culture of a medical practice. It will help doctors and staff alike develop a mindset that focuses on ways to provide outstanding service – and on seeking patients' input and feedback relative to that service. It shows a willingness to acknowledge that there is room for improvement and the determination to make it happen. **WM**

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WMS is now on Social Networking Sites:

Twitter and Facebook

www.facebook.com/
WyoMedSociety

W
M
S

www.twitter.com/
WyoMedSociety

Statistics and Findings:

Social Media is now gaining more influence than both television and newspaper. Seventy-four percent of people are making decisions based on social media outlets and their socializers as surveyed by immoderate.com. In terms of membership organization, as the older population retires, they are being replaced by those who have become accustomed to social media as a trusted information source, using it to guide many of their decisions to join. The average age of a Facebook and Twitter user is 38 and 39, respectively. According to Google Ad Planner, forty-three percent of social media users are between ages 25 and 44, making it a responsive audience to target. A few interesting statistics about social media:

- In 2005, 8% of all adults online had a profile on a social network site – today, 35% do
- In December 2008, 54.5 million people visited Facebook - a 57% increase from the previous year
- In December 2008, 4.5 million people visited Twitter – a 753% increase fromthe previous year
- 5-10 thousand new Twitter accounts are created daily
- In August 2008, 23.7 million people visited YouTube
- 1 out of 3 videos viewed online is on YouTube
- 73% of active online users have read a blog

After much deliberation, WMS has decided to branch out into the world of Social Media. Both Twitter and Facebook can be used in conjunction with an already created website for an organization, making it easier and faster to spread news and events throughout the state. It is a great way for physicians, physician assistants, nurses, students, retired physicians, and others to network. When WMS has updates on legislation or reminders of the current events, they will be posted to both Twitter and Facebook. To become a part, you must first have a profile page of your own, then "like" Wyoming Medical Society on Facebook and "follow" on Twitter. Complete instructions on how to find WMS as well as brief Guidelines and Terms of Use can be found on the website: www.wyomed.org and click the SocialMedia-strategies.pdf under the Annual Meeting Page.

WMS' 2012 tort reform panel discussion:

Setting a place for patient safety at the tort reform table

By Nick Healey, JD, Dray, Dyekman, Reed & Healey, P.C.

How do you win an argument when everyone is right?

The 2012 Tort Reform Panel Discussion at the Wyoming Medical Society's 2012 Annual Meeting at Jackson Lake Lodge seemed poised to answer that question. Both the traditional perspectives were represented: pro-(traditional) tort reform and con-(traditional) tort reform. Notwithstanding the convincing arguments on each side, the legislative perspective (like the one ring that rules them all) was simple and equally compelling: the political will does not exist to implement a change to the current tort reform system, so irrespective of the merits, its not going to happen in the near future. So, essentially pro- and con- came to a stalemate, cemented by a realpolitik acknowledgement that there is no present governmental stomach to break the tie.

A potential solution was presented by a fourth perspective, one that has been underrepresented to date in the tort-reform debate: patient safety. Like many good solutions to intractable problems, the patient safety perspective neatly side-steps the difficult question of whether caps on non-economic damages are appropriate. Instead, proposes the patient-safety perspective, what if we (physicians) simply injured less patients, told patients when we injured them and then agreed to fairly compensate the ones that were injured before they sought relief through the court system? That question, and the myriad possible ways that could be accomplished, became the focus of the panel discussion and fired the imaginations of all on the panel and many in the audience.

Pro-(traditional) tort reform

Scott Ortiz, a seasoned Wyoming trial lawyer with Williams, Porter, Day & Neville, P.C. in Casper, Wyoming, argued convincingly (to a highly receptive audience) that capping non-economic damages on medical malpractice plaintiffs was the right approach. This, he argued, would have two beneficial effects; first, it would reduce the rising trend of huge awards in Wyoming medical malpractice cases that are leading to higher premiums and driving physicians out of Wyoming. Second, it would cull the ranks of potential plaintiffs (and their attorneys) that may or may not have been injured, but make huge non-economic claims in hopes of a huge payday. This, he asserted, would stabilize premiums because insurers would no longer fear these huge payouts, and physicians would not fear being harassed or even ruined by lawsuits.

And Scott was right. There have been several recent high-profile, medical malpractice cases in Wyoming against hospitals and physicians that have resulted in huge (by anyone's standards, not just Wyoming's) awards. Wyoming already suffers in many areas from a physician shortage, and at least anecdotal evidence shows that physicians are both leaving the state and declining to relocate to Wyoming because the American Medical Association (AMA)'s "medical liability crisis" map shows that Wyoming is in "crisis". Also, the AMA has published several reports indicating that capping non-economic damages has lowered the expense of contesting medical malpractice lawsuits and the ultimate awards paid out, and stabilized medical malpractice premiums. Logic dictates that this cannot help but improve the Wyoming practice climate for physicians, thus keeping physicians in Wyoming and encouraging relocation, ultimately helping Wyoming's citizens get necessary healthcare.

Con-(traditional) tort reform

But, countered G. Bryan Ulmer, III, an equally seasoned trial lawyer with the Spence Law Firm in Jackson, Wyoming, the lawsuits we bring on behalf of injured patients aren't frivolous, they are real people who have really been hurt by a provider's negligence. In some part, Bryan argued, these people's injuries aren't simply economic, and artificially capping compensation for those injuries tells those people, "you haven't really been hurt." Bryan asserted that the best safeguard against unjustifiably large awards is the common sense of Wyoming juries, who are the friends and neighbors not just of the plaintiffs in these cases but also the providers that are the defendants. Bryan also rightly questioned whether capping non-economic damages would lead to reduced premiums for providers, and whether those savings (if they materialized) would ever be realized by providers and not retained by insurers as profit.

And Bryan is also right. In 2006, the New England Journal of Medicine published a study of medical malpractice claims that indicated that most frivolous medical malpractice claimants don't receive compensation. Moreover, the same study showed that a surprisingly large percentage of patients injured by clear provider negligence aren't compensated either. In addition, the AMA's position is that while medical malpractice premiums have stabilized, they have stabilized at what has been described as an "obscene" level, thus supporting Bryan's premise: there is no guarantee that premium savings, even if they materialize, would ever be passed onto providers. Likewise, whether Wyoming's possibly higher premiums are offset by other more favorable economic conditions in Wyoming (such as a lack of state income tax) may not have been adequately explored.

The legislative perspective

It fell to the legislative perspective, provided by 30 year legislative veteran Senator Charlie Scott of Casper, to break the stalemate. Right or wrong, Senator Scott argued, the argument is essentially moot. The political will does not exist at the state level to enact substantive tort reform, whether by capping non-economic damages or otherwise. Legislative energies are simply focused elsewhere, with the struggling national economy and volatile energy prices affecting Wyoming's economy. The make-up of the Wyoming Legislature (heavily populated by lawyers, in Senator Scott's opinion) is not friendly to the tort-reform issue, and people looking for a solution to the problem should look elsewhere.

Enter the patient-safety perspective

"Elsewhere" was represented by Timothy McDonald, M.D., J.D., a patient safety pioneer and advocate from the University of Illinois College of Medicine. Appealing to both sides of the debate, Dr. McDonald is both an anesthesiologist and a licensed attorney. Using these powers for undeniable good, Dr. McDonald described how the University of Illinois hospital system has abandoned the traditional "deny and defend" mentality that has dominated medical malpractice risk management for providers, and instead has focused on improving patient safety, drastically reducing the number of potential claims could be brought. Equally as important, Dr. McDonald described the University of Illinois hospital system's efforts to fully disclose medical errors to patients as soon as possible after they happen, whether or not the patient is injured and whether or not the result of a provider's negligence. If the patient is injured, the patient is compensated fairly, not just with follow-up care but also potentially by waiving charges and prospective payment. This has, as Dr. McDonald described, reduced the number and severity of malpractice claims experienced by the University of Illinois hospital system; but more importantly, it helps restore the patient's trust in the provider.

Of all the perspectives represented, Dr. McDonald's may be the "most right". Physicians and other providers view themselves, first and foremost, as advocates for patients. However, the most effective argument against conventional tort reform is the suspicion that the benefits to patients are (at best) indirect, and that capping non-economic damages is primarily intended to economically benefit physicians. Focusing on patient safety, and early medical error disclosure and fair compensation systems, effectively shift the focus directly back to the patient, while serving many of the same goals as capping non-economic damages. A growing body of evidence, both academic and anecdotal, also supports Dr. McDonald's approach. Other large institutional providers, including the University of Michigan hospital system and the Veteran's Administration hospital system, have implemented similar programs with glowing results. Even medical malpractice insurers, such as Colorado's COPIC, have instituted early disclosure and compensation systems with similarly great results. Likewise, no major legislative changes (if any) are required to implement these programs. In most cases, the legal tools are already there, they just need to be picked up and put to work.

There is no question that each of the patient safety programs described above benefits from particular conditions that may be hard to replicate in Wyoming. In the university examples, the physicians and hospitals are typically part of the same larger institution with the same insurer, providing a unity of purpose and solidarity that may not exist between hospitals and physicians in the traditional hospital-medical staff relationship still prevalent in Wyoming. Likewise, Colorado's 'medical error disclosure and apology law' is unusually broad, preventing even expressions of fault from being used against providers in subsequent lawsuits. Wyoming's medical apology law is not so broad. But in an era where legislative fixes are not on the horizon, and the familiar pro-and-con tort reform argument has stalemated, Dr. McDonald's patient-safety focused perspective breathes much-needed new life into the debate, and deserves attention. **WM**

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Securing and protecting electronic medical records

By Lizabeth F. Brott, J.D., Regional Vice President of Risk Management, ProAssurance

Use of electronic medical records (EMRs) is steadily increasing. The National Center for Health Statistics estimates that in 2011, fifty-seven percent of office-based physicians were using some type of medical record system that was all or partially electronic (excluding billing systems). This estimate shows a significant increase in usage from only eighteen percent in 2001. Estimated 2011 EMR usage by state ranged from forty percent to eighty-four percent, with Wyoming at fifty-one percent.1

If your office has adopted or is considering an EMR, it's important to address the privacy and cyber liability risks associated with this technology. Network security, internet viruses, and electronic data breaches are relatively new issues for many medical practices. Failure to safeguard against these risks can result in dire consequences for medical practices and patients alike.

Concerns regarding EMRs and patient privacy are not unfounded. A 2011 study of large healthcare organizations found ninety-six percent of respondents had experienced at least one data breach in the preceding 24-month period. The top three causes of breaches were: lost or stolen computing devices, third-party error (e.g., by a business associate), or unintentional employee action.2

To reduce the likelihood of a data breach, you must have an effective security policy in place and be proactive in the use of that policy3. Consider including:

- an initial risk assessment with periodic follow-up assessments (consider using external experts);
- regular system testing and security updates;
- comprehensive clinician and staff training on your security policies and procedures and the importance of protecting patient data;
- specific policies for use of personal devices including laptops, home computers, mobile devices and social media;
- use of passwords and encryption for personal devices;
- agreements with business associates outlining data privacy and security requirements;
- an incident response plan;
- varying levels of access for employees on a need-to-know basis;
- complex passwords and frequent required password changes;
- physical placement of computer screens with special attention to visibility of social security numbers; and
- root cause analyses of major data breaches.

In addition, interactions with your EMR should take place over a secure, encrypted network.

Taking proactive steps to secure your EMR will go a long way toward protecting patient data; however, even the best managed system can be vulnerable to data breaches. Cyber liability insurance will help cover expenses associated with this risk. **Most cyber liability policies include protection for:**

- **Network and security privacy breaches**—virus attacks, patient identity theft, online and offline data breaches;
- **Regulatory fines and penalties**—defense costs for governmental investigations (including HIPAA), and payment of regulatory fines and penalties;
- **Patient notification and credit monitoring costs**—payment of legal and other expenses incurred to notify patients of an information breach, and payment of credit monitoring costs for persons affected by a breach; and
- **Data recovery costs**—payment for costs of recovering or replacing data that is lost, erased, stolen, or corrupted.

Physicians who choose ProAssurance for medical professional liability insurance automatically have baseline cyber liability protection as outlined in the insurance policy. This coverage helps begin to address the above risks; higher limits for these risks are also available. **WM**

ProAssurance is a national provider of medical professional liability insurance and risk management services. For more information about the company, visit ProAssurance.com.

1. Hsiao CJ, Hing E, Socey TC, Cai B. Electronic health record systems and intent to apply for meaningful use incentives among office-based physician practices: United States, 2001-2011. NCHS Data Brief. November 2011; No. 79. National Center for Health Statistics, Centers for Disease Control and Prevention.

2. Ponemon Institute. Second annual benchmark study on patient privacy & data security. Ponemon Institute Research Report. December 2011.

3. PricewaterhouseCoopers International Limited. Eye of the Storm—Key Findings from the 2012 Global State of Information Security Survey®. PricewaterhouseCoopers International Limited. New York; September 2011.

This article is not intended to provide legal advice and no attempt is made to suggest more or less appropriate medical conduct.

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Wyoming Patient Safety Summit

November 1-2, 2012 ✪ Casper, WY

Please join us to present and exchange ideas on how we, as participants of all kinds in Wyoming's health care system, can get involved and improve patient safety and ultimately improve the quality of life for all Wyomingites.

Save the Date!

Join the Wyoming Medical Society and
the Wyoming Hospital Association for the first statewide

Patient Safety Summit

November 2, 2012 ~ 8am - 5 pm
Casper, WY ~ Ramada Riverside Plaza

Summit information will be distributed electronically.
If you are interested in receiving further information, please visit www.wyomed.org/patientsafety to ensure we have your email address.

First, do no harm" is the first principle of medicine and the first thought in every health care provider's mind when treating patients. Increasingly, we are coming to learn that our health care system does not always meet patients' needs in that respect. In Wyoming, this hits even more close to home, because our patients are not anonymous statistics; they are our neighbors, friends, and co-workers. Patient safety is receiving increased attention as the result of federal health care reform and a growing movement among health care professionals, patients and others to improve patient safety, both as a way of reducing cost and simply because it's the right thing to do.

Wyoming Medical Society • P.O. Box 4009 • www.wyomed.org • 307.635.2424

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