Avoiding Liability In the Ambulatory Setting: How To Avoid Getting Sued...Sometimes!

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I have no relevant financial relationships or conflicts of interest to disclose

Larry Veltman
Have you ever...
Arizona Cardiac Surgeons Pay $100,000 To Settle HIPAA Violations

An Arizona cardiac surgery group has agreed to pay $100,000 to resolve an investigation into potential violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In the agreement the surgical group did not offer an admission of liability but did agree to implement a corrective action plan in addition to the payment.
Why You Should Care

11 Billion Visits (35M Hospitalizations)

NPDB 2009: 10,739 paid claims

• 47.6% - inpatient
• 43.1% - ambulatory
• 9.4% - both

(JAMA. 2011;305(23):2427-2431)
The Office: The “Wild West” of Patient Safety

Kaushal, et.al www.webmm.ahrq.gov)
What Are The Issues?

• The physician-patient relationship
• Consent
• Abandonment
• Documentation: EMR, paper
• Follow-up and tracking systems
• Diagnostic errors (failure or delay)
• Telephone advice
• Medication and sample safety
• Office procedures
• Allied Healthcare practitioners
• Interprofessional communication
The Physician-Patient Relationship: Personal Risk Management

Communication
Consent
Termination / Abandonment
Documentation
The Doctor Patient Relationship: When Does It Begin?  
Oregon Court of Appeals, 2009.  Mead v. Adler

– “In the absence of an express agreement by the physician to treat a patient, a physician's assent to a physician-patient relationship can be inferred when the physician takes affirmative action with regard to care of the patient.”

– “We also conclude that an on-call physician who affirmatively undertakes to diagnose or treat an emergency room patient over the telephone has impliedly consented to a physician-patient relationship for purposes of negligence.”
The Perception of Quality

- How do patients judge quality?
- Patients use *personal interaction*
- They want to *connect* with their physicians on a personal level
- May have nothing to do with competency, skill, or training
"How far can you trust a doctor whose plants have all died?"
Communication Skills

• How is your “bedside manner?”
• How would you want a patient to describe an encounter with you?
• “They were all __________, they_________, and the doctor was __________. He/she is was really__________.”
DO YOU HAVE ANY LONG-TERM INVESTMENTS?

YES, I DO

CANCEL THEM

HE GOT AN F IN BEDSIDE MANNER
“There is no cure, Mrs. Handler. That’s because there’s nothing wrong with you.”
Physicians with more claims & higher severity:
• Patients felt rushed
• Patients felt ignored
• Received inadequate explanations
• Spent less time in routine visits

Review of plaintiff depositions:
• Feelings of desertion
• Devalued views and beliefs
• Delivered information poorly
• Failed to understand the patient’s perspective
“No Claims” Physicians
(JAMA.1997;277(7):553-559)

• More statements of orientation
  – Education about what to expect
  – Education about the flow of the visit
• Laughed and used more humor
• More facilitation during visits
  – Soliciting patient’s opinions
  – Checking understanding
  – Encouraging patients to talk
LEVEL: Working with the Computer

1. LET the patient LOOK on
2. EYE Contact with the patient
3. VALUE the computer as a tool
4. EXPLAIN what you’re doing
5. LOG OFF and say that you are doing so

<table>
<thead>
<tr>
<th>Skills</th>
<th>Actions</th>
<th>What to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Let the patient look on</td>
<td>• Move the screen for patient to see.</td>
<td>“Let’s look at the lab results to see how your cholesterol is doing.”</td>
</tr>
<tr>
<td></td>
<td>• Invite the patient to move closer to the screen to view information.</td>
<td>“Let me show you the part of the medical record so we can confirm some information together.”</td>
</tr>
<tr>
<td></td>
<td>• Ask the patient to verify information as you type.</td>
<td>“Here are the injections we have in our records. Have you had other injections outside KP that we need to add?”</td>
</tr>
<tr>
<td></td>
<td>(This builds trust, actively involves the patient, and demonstrates “we know you.”)</td>
<td></td>
</tr>
<tr>
<td>Eye contact with the patient</td>
<td>• Greet the patient. Make a personal connection away from the computer</td>
<td>“Good morning, Mr. Jones. I see you hurt your ankle.”</td>
</tr>
<tr>
<td></td>
<td>• Keep that connection throughout the visit by:</td>
<td>“Let’s spend a few minutes discussing your options.”</td>
</tr>
<tr>
<td></td>
<td>• Maintaining eye contact with the patient.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Turning toward the patient when the patient speaks or engaging in conversation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Maintaining eye contact promotes active involvement.)</td>
<td></td>
</tr>
<tr>
<td>Value the computer as a tool</td>
<td>• Acknowledge the computer.</td>
<td>“The computer makes getting and sharing information with other health care team members so easy and efficient.”</td>
</tr>
<tr>
<td></td>
<td>• Let the patient know how the computer improves care.</td>
<td>“This computer is great. I have all your background information at my fingertips—medications, prior visit notes, and lab results from all KP visits.”</td>
</tr>
<tr>
<td></td>
<td>• Stay positive when faced with computer challenges.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(from the patient’s perspective, great medical technology is equated with great medical care.)</td>
<td></td>
</tr>
<tr>
<td>Explain what you are doing</td>
<td>• Keep the patient informed about your thought process and actions.</td>
<td>“I am printing some instructions, which we can go over together in a moment.”</td>
</tr>
<tr>
<td></td>
<td>• As you are documenting, let the patient know what you are doing—entering information you have just discussed, entering lab tests/medicines, accessing patient information.</td>
<td>“I am recording the details of your sore throat so our records will be complete. I’ll order the medication we just discussed, so it will be available at the pharmacy.”</td>
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<tr>
<td></td>
<td>(Patients who receive no explanation about what you are doing may think you are working on unrelated business.)</td>
<td>“I’ll add the leg swelling to your problem list, so we can keep it in mind for future visits.”</td>
</tr>
<tr>
<td>Log off and say you are doing</td>
<td>• Tell the patient that you are “logging off the computer” to safeguard their information.</td>
<td>“I’m logging off the computer now to keep your information private.”</td>
</tr>
<tr>
<td></td>
<td>(Some members are concerned about privacy and confidentiality. If their concerns are not addressed, satisfaction may decrease.)</td>
<td></td>
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</table>
Communication Skills: The Link to Quality

The Totality of the Encounter
- front office
- nurses
- physician
- billing
- lab
- pharmacy

Patient’s Perceptions of Quality
- caring
- time
- attitude
- valuing
- explaining
- “connecting”

Inferences
- good quality - bad quality
- good doctor - bad doctor
The Cascade to an Attorney

Negative Inferences
(“we’ve had bad care given by a bad doctor.”)

Bad Result, Unexpected Injury, Adverse Outcome

Surprise, Anger, Betrayal

“You should call a lawyer.”
Why Patients Go To An Attorney
“Was It Bad Luck Or Bad Medicine?”

- They are disappointed with the outcome of care.
- They want to know what happened and why.
  - It is free.
  - They can get their records reviewed by an expert.
  - They can get an opinion if there was any wrongdoing.
- They worry about where they are going to get the money to manage. “If someone did something wrong, they should pay.”
- They are angry or want revenge.
The Informed Consent Process

- It is a process – not a list of possible complications
- It is non-delegable
- Helps the patient develop realistic expectations
- Each state’s laws are different; Know your state’s law
  - Most: explanation, risks, benefits, alternatives
- Document the process (PAR, PARQ)
“Lawsuits are not about bad outcomes. They are not about bad relationships. They are about (failed) expectations.”

(Linda Crawford, JD, Ann. Surgery, April, 2003)

• Reduce the chance for negative surprises
• You want to be able to say, “I’m sorry that one of the complications we discussed has occurred.”
• You hope that a patient will never say, “Oh my God, I never expected that to happen.”
“Do I have to Mention All the Risks?”
“Do I Have To Use A Form?”

• Law only requires consent
• Need to prove you gave it - documentation
• Form is helpful to document process
  – In some states form is prima facie evidence of consent
  – It gives more evidence of discussion
• Choose for significant procedures and treatment regimens
• Decision aids – keep them
Informed Refusal

• The process:
  – Informed consent process goes on as usual
  – The patient refuses
  – The physician then needs to explain the risks of not following through with the recommendations to allow the patient to make an informed decision against the recommendation.
  – Material risks; dreaded risks also apply

• May use a form

• Documentation is key
Avoiding Accusations of Abandonment

• Definition: Termination of the professional relationship between the physician and patient at an unreasonable time or without affording the patient the opportunity to procure an equally qualified replacement.

• Special situations:
  – Vacations
  – Group practice
  – Third party payers change
  – Illness
  – Closing a practice
  – In the middle of treatment
If Termination is Necessary

PLEASE, DOC!
I’LL DO ANYTHING!
I’LL STICK TO THE STUPID DIET!
I’LL COME TO THE APPOINTMENTS!
I’LL EVEN BE NICE TO THE PUSHY RECEPTIONIST!!

SORRY, JOHN.
IT’S OVER!
Sample Letter of Termination

Date
Patient Address Certified Mail #_________________

Dear ___________: 

This letter is to inform you that I will no longer be your physician and will stop providing medical care to you effective 30 days from date you receive this letter.

I will continue to provide routine and emergency medical care to you for 30 days while you seek another physician.

I suggest you consult the local physician referral service, your county medical society, or the yellow pages of your telephone book as soon as possible so that you may find another physician who will assume responsibility for your care.

I will be pleased to assist the physician of your choice by sending him or her a copy of your medical records.

Sincerely,

_______________________________
(Physician Signature   (Oregon Medical Association, Medical Legal Handbook)
Documentation
What you’re Up Against

MISSED MESSAGES
Patients often don’t understand or retain what doctors say

18% to 45% of patients are unable to recall major risks of treatment.

44% of patients don’t know the nature of their operation.

60% to 68% of patients don’t read or understand information in a consent form.

80% of what doctors tell patients is forgotten as soon as they leave the office.

50% of what is recalled by patients is incorrect.

Source: Patient Safety & Quality Healthcare
Documentation: The Boy Scout Rules

• Accurate
• Legible
• Comprehensive
• Objective
• Timely
• Unaltered
Changing Medical Records: Spoliation of Evidence

• Still common
• It’s a crime (similar to perjury)
• Sophisticated ways to detect:
  – Paper analysis (watermarks, pressure analysis)
  – Ink analysis
  – Comparing original to other distributed records
  – Electronic: Audit trails, metadata
• You will lose: *Omnia praesumptur contra spoliatorem*
Thin Layer Chromatography
Of Various Blue Inks
MEDICAL CASES

When the authenticity of a medical chart and related forms comes into contest there are usually three questions that need to be answered. Have notations been added to an existing chart? Have new pages recently been added to the file? Has the entire chart been backdated or rewritten?

There are several ways to address these questions. In our laboratory we can:

- compare the contested chart to other charts from the same time frame
- intra-compare various entries in a file to assess whether they are similar or different
- refer to manufacturers technical information in our databases respecting the materials (such as paper, ink, type-fonts, etc.) used to produce the document.

A number of analyses are conducted to determine the extent and nature of any alterations or additions, including:

- infrared examination of inks and obliterated entries
- indentation and sequencing analysis of words, lines, or entire pages
- intersection analysis of overlapping writing
- inter-comparison of signatures, initials, or handwriting
- inter-comparison of the paper stock or pre-printed forms
- examination of incidental markings
- inspection of all dates
- analysis of legibility and the care taken to write the notes
- analysis of spacing and formatting characteristics, as well as layout of text.
The EMR

Legal risks of going paperless
Electronic medical records are meant to save time and money, but they also can create liability issues for doctors.

(www ama-assn org/amednews/2012/03/05/prsa0305.htm)
Legal Pitfalls

• Reliance on cut and paste, templates, carry forward
• Overreliance on differential diagnosis templates
  – Including deletion of screen shots
• Lack of safeguarding electronic data – encryption
• Lack of transparency in changing the record
• Notification issues with data breaches
• Deletion of records when there is potential litigation

(www.ama-assn.org/amednews/2012/03/05/prsa0305.htm)
Cut and Paste

• January
  – “patient is a 28 year old woman in her 32\textsuperscript{nd} week…”
• February
  – “patient is a 28 year old woman in her 32\textsuperscript{nd} week…”
• March
  – “patient is a 28 year old woman in her 32\textsuperscript{nd} week…”
Cut and Paste

Physician attitudes toward copy and paste function (CPF) in electronic notes

Of 253 physicians who wrote inpatient notes electronically:

- 90% Used CPF (ever)
- 70% Used CPF frequently
- 80% Think CPF leads to mistakes in patient care
- 24% Want to continue using CPF

eDiscovery

How is the storage of information in an EMR different from a Paper Chart?
- Remember the good old days:
  - The chart;
  - The office schedule;
  - A phone message record book;
  - The billing record;
  - If it didn’t exist, than don’t create it! (Memory and custom and practice prevailed!)

Audit Trails;
- Metadata;
- Data Exchanges;
- Clinical decision support (Clinical pathways);
- Pharmacy/Prescribing;
- Remaining paper sources (i.e. handwritten sheets in radiology folders, writing on fetal monitoring strips.) (Can contradict EHR)
Lab Follow Up / Tracking Systems

• Communications with patients
  – Reason(s) for the test
  – Follow up of results
  – Notification practices
    • Is “no news is good news” enough?
    • Mail? phone call? appointment?

• Documentation
  – Should be able to follow rationale, plan for follow up based on results

• Tracking systems
Timely Follow-Up of Abnormal Outpatient Test Results: Perceived Barriers and Impact on Patient Safety

**Figure 1.** In your experience, how often do you come across the following abnormal test results that have not been acted upon in a timely manner?
Tracking Systems

1. Laboratory test log: what tests, date
2. Have a relationship with lab
3. Critical values notification
4. Log in return results – did patient actually get the test?
5. Prove the practitioner reviewed results (initials, EHR)
6. Appropriate filing system to get in correct chart
7. Notification of the patient of results in writing: all or some
8. What merits phone notification?
9. What merits office consultation?
10. What constitutes reasonable attempts to notify?
Pitfalls and Barriers: Follow-Up of Laboratory Results

- Time pressures
- High risk situations that decrease vigilance
  - After vacation
  - Fatigue
  - Large volume of results
  - Expectations of results – the “very rare abnormal”
  - The transition to EMR – difficult access to results
- “No news is good news” approach
- Not clear who is responsible
- No systems in place
Telephone Liability

• *It is critical to have a system to document carefully the information received and the advice given*

• Phone calls to the office
• Phone calls to the physician after hours
• Protocols for common problems
• Who is qualified to give advice?
  – MA, RN, Receptionist
  – What kind of training?
• Message flow
  – Paper, electronic
  – Should accompany chart
Medication and Sample Safety

- Prescription writing issues
- ePrescribing
- Samples
  - Document sample distribution
  - Check expiration dates
- Check emergency medications for expiration dates
E-prescribing

- Reduces route, strength, abbreviation, legibility, refill errors
- Study: >2000 prescriptions, 21 physicians, 1 year
  - Adopters reduced from 26 to 16 errors per 100 prescriptions
  - Non-adopters 37.3 errors per 100 prescriptions

Joint Comm J Qual pt Safety 2011 37:470
Medication Sample Hazards
Office Procedures

• Scope of in office procedures
  – Is there a community standard?

• Equipment safety
  – Electrical
  – Outdated
  – Manufacturer’s warnings
  – Regular inspections

• Management of emergencies
  – Code cart
  – Management of over sedation
  – Working equipment (e.g., pulse oxymeter)
  – In office drills, mock codes
"Because it is not always possible to predict how a specific patient will respond to sedative and analgesic medications, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended."
Checklist for Treatment of Local Anesthetic Systemic Toxicity

The Pharmacologic Treatment of Local Anesthetic Systemic Toxicity (LAST) is Different from Other Cardiac Arrest Scenarios

- Get Help
- Initial Focus
  - Airway management: ventilate with 100% oxygen
  - Seizures suppression: benzodiazepines are preferred; AVOID propofol in patients having signs of cardiovascular instability
  - Alert the nearest facility having cardiopulmonary bypass capability
- Management of Cardiac Arrhythmias
  - Basic and Advanced Cardiac Life Support (ACLS) will require adjustment of medications and perhaps prolonged effort
  - AVOID vasopressin, calcium channel blockers, beta blockers, or local anesthetic
  - REDUCE individual epinephrine doses to <1 mcg/kg
- Lipid Emulsion (20%) Therapy (values in parenthesis are for 70kg patient)
  - Bolus 1.5 mL/kg (lean body mass) intravenously over 1 minute (~100mL)
  - Continuous infusion 0.25 mL/kg/min (~18 mL/min; adjust by roller clamp)
  - Repeat bolus once or twice for persistent cardiovascular collapse
  - Double the infusion rate to 0.5 mL/kg/min if blood pressure remains low
  - Continue infusion for at least 10 minutes after attaining circulatory stability
  - Recommended upper limit: Approximately 10 mL/kg lipid emulsion over the first 30 minutes
- Post LAST events at www.lipidrescue.org and report use of lipid to www.lipidregistry.org
Office Procedures: The Scope of Care

1. Patients should receive informed consent
2. Patient evaluation, including patient history and physical examination, should be performed prior to surgery
3. Physicians should use the ASA patient selection classification system in considering patients for surgery
4. Physicians should have proper qualifications, such as board certifications and/or hospital admitting privileges
5. Facilities should be accredited
6. Necessary equipment (for procedure and emergencies) should be in place and skills in use are current
7. Emergency transfer protocols should be in place
8. A physician should remain at the facility until the patient has recovered
9. A physician should decide when the patient can be discharged.
Allied Healthcare Practitioners

• Names, roles, interface with patients
  – Introductions, identification
  – Setting expectations
  – Protocols

• Seeing post op patients
  – Timeliness
  – Scope of experience
Diagnostic Error

Any mistake or failure in the diagnostic process leading to a misdiagnosis, a missed diagnosis or a delayed diagnosis.

This includes:

• Timely access in eliciting or interpreting signs, symptoms, and/or laboratory tests and results
• Formulating and weighing of differential diagnosis
• Lack of timely follow-up and specialty referral and evaluation.

(JAMA. 2011;305(23):2427-2431)
Among malpractice claims, diagnostic errors appear to be the most common, most costly and most dangerous of medical mistakes.

More diagnostic error claims were outpatient than inpatient (68.8% vs 31.2%).

Diagnostic errors (n=100 249/350,706) were the leading type (28.6%) and accounted for the highest proportion of total payments (35.2%).
Failure To Diagnose: Cancer

Most Common Specialties:
- Family medicine
- General surgery
- Internal medicine
- Ob-gyn
- Orthopedics
- Pediatrics
- Radiology

Most Common Malignancies:
- Breast
- Colorectal
- Lung
- Prostate
Interprofessional communication

- Multiple providers – quality of hand overs
- Clear documentation of interaction
- Critical messages – be sure of delivery
- Appropriate follow up of referrals – both ways
- Personal notes
- Social media caveats
Personal Notes

• Def: any recorded “private” observations, recollections, comments on care, etc. that are written for the benefit of clarity of one’s role in a particular situation but are kept separate from the medical record.

• Often they are self-serving and self-protective and may make observations about other’s care or presumed liability.

• THEY ARE DISCOVERABLE
Online Professional Violations

Figure. Prevalence of Online Professionalism Violations Reported to State Medical Boards (N=48)

- Discriminatory language or practices online
- Online depiction of intoxication
- Online derogatory patient remarks
- Failure to reveal conflicts of interest online
- Online violations of patient confidentiality
- Use of Internet for inappropriate practice
- Online misrepresentations of credentials
- Inappropriate patient communication online
- ≥1 Violation in at least 1 of above

State Medical Boards Reporting Violations, %

JAMA, March 21, 2012—Vol 307, No. 11
How Do You Know How You’re Doing?

Checking Yourself and Your Practice
Safety Attitudes Questionnaire: Ambulatory Version

• Patient safety is everyone’s job:
  – Describe quality of communication and collaboration
  – Describes the culture
  – What are your top three recommendations for improving patient safety?
  – 63 questions about patient safety
  – www.uth.tmc.edu

• Gives a snapshot of overall safety culture and risk potential for an ambulatory practice
Safety Attitudes Questionnaire (Ambulatory Version)

With respect to your experiences at this site, use the scale to describe the quality of collaboration and communication that you have experienced with:

1. Physicians
2. Registered Nurses
3. Nurse Managers
4. Residents
5. LVN
6. Radiologists
7. Medical Assistants
8. Referral Coordinators
9. Physician Office Administrator
10. Office Nurses
11. Business Office Manager
12. Receptionist
13. Radiology Technicians
14. Nutritionists

Please answer the following with respect to your clinical area here. Mark your answers using the following scale:

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree Slightly</td>
<td>Agree Slightly</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly</td>
</tr>
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</tr>
</tbody>
</table>

MARKING INSTRUCTIONS
- Use number 2 pencil only.
- Erase clearly any mark you wish to change.

1. High levels of workload are common in this office.
2. I like my job.
3. Nurse input is well received in this office.
4. I would feel safe being treated here as a patient.
5. Medical errors are handled appropriately in this office.
6. This office does a good job of training new personnel.
7. All the necessary information for diagnostic and therapeutic decisions is routinely available to me.
8. Working in this office is seen as being part of a large family.
9. Senior management in this office is doing a good job.
10. The management of this office supports my daily efforts.
11. I receive appropriate feedback about my performance.
12. In this office, it is difficult to discuss errors.
13. Briefing other personnel before a procedure (e.g., biopsy) is important for patient safety.
14. Briefings are common in this office.
15. The office is a good place to work.
16. Communication breakdowns which lead to delays in delivery of care are common.
17. Office management does not knowingly compromise the safety of patients.
18. The levels of staffing in this office are sufficient to handle the number of patients.
19. Decision making in this office utilizes input from relevant personnel.
20. I am encouraged by my colleagues to report any patient safety concerns I may have.
21. The culture in this office makes it easy to learn from the errors of others.
22. This office deals constructively with problem personnel.
23. The medical equipment in this office is adequate.
24. In this office, it is difficult to speak up if I perceive a problem with patient care.
25. When my workload becomes excessive, my performance is impaired.
26. I am provided with adequate timely information about events in the office that might affect my work.
27. I have seen others make errors that had the potential to harm patients.
28. I know the proper channels to direct questions regarding patient safety in this office.
29. I am proud to work at this office.
30. Disagreements in this office are resolved appropriately (i.e., not who is right but what is best for the patient).
31. I am less effective at work when fatigued.
32. I am more likely to make errors in tense or hostile situations.
33. Stress from personal problems adversely affects my performance.
34. I have the support I need from other personnel to care for patients.

*Medical error is defined as any mistake in the delivery of care, by any healthcare professional, regardless of outcome.
One Clinic’s Template

Number of complaints by reporting period

Number of complaints per clinic

Complaints by category

Complaints by scale

Complaints by domain

Legend:
0  No breakdown of service; No quality of care issue
1  Potential service breakdown; Quality of care issue
2  Service breakdown; Quality of care issue
3  Potential for significant adverse outcome
4  Adverse outcome

Complaints requiring financial adjustment
1 of 24 (4%)

Average of financial adjustment
$58

Range of financial adjustment
--

3/4/2008
First SCOPE Certified Offices Announced

The Safety Certification in Outpatient Practice Excellence (SCOPE) for Women’s Health Program is proud to announce its first ten SCOPE Certified offices. Please join us in congratulating them! If you are interested in learning more about the program or having your office achieve SCOPE Certification please visit the SCOPE website at www.scopeforwomenshealth.org, contact us at scope@acog.org, or call 1-800-266-8043.
“Unsafe acts are...like mosquitoes. You can try to swat them one at a time, but there will always be others to take their place”

“The only effective remedy is to drain the swamps......”

James T. Reason
We All Have Our Swamps