Risks in the Office Setting: Enhancing Patient Safety

AND

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What’s in a name? Many literary giants, throughout history, have contemplated this question, the most famous being William Shakespeare, whose Juliet, in “Romeo and Juliet,” pondered precisely this question. The leadership of this association has spent the better part of the last five years considering this question, too. In the end, after exhaustive research and significant input from you, the decision of the Board of Directors and membership was that the time was right for renaming the organization.

The membership spoke clearly on this issue on May 18, during the Annual Meeting of Members in Orlando, and voted overwhelmingly to change the name of the organization to the Medical Professional Liability Association (MPL Association). We understand this was not a decision taken lightly by the Board of Directors, nor the many members of the Association who spoke with me and members of the Board in the months since the topic was raised in the new Strategic Plan adopted last year. The level of thoughtful consideration by so many of you about this organization that you value highly has been impressive.

This is an exciting development for the Association, of historic significance. But breaking new ground is nothing new for the MPL Association. The founders of this organization made history in 1977 when it was first formed. Since then, the organization and its members have been leading the way in many areas, as we, individually and collectively, strive to protect healthcare professionals, mitigate risk, and enhance patient safety.

In today’s connected society, branding has become essential. And it starts with something as simple as a name. For an association, the name should reflect what the organization stands for. This organization was formerly identified as an association of physicians insuring physicians—an image that clearly distinguished us and remained an important element in our heritage. But over the years, the association has grown in a broad diversity of ways, becoming so much more than what that prior name conveyed. Today, our members insure more than 2 million healthcare professionals around the world and more than 8,000 hospitals and medical facilities. Our new brand reflects who we have become, through maturation, over the years.

In fact, today, the Association’s membership consists of a singular mix of U.S.-based and international insurance organizations, risk retention groups, hospital/health system captives, trusts, and other entities that insure or indemnify physicians, hospitals, clinics, dentists, and other healthcare professionals for medical liability. This change will hopefully serve to support the Association’s continued evolution, as well as its acknowledged leadership role within the healthcare community. It also better positions the Association to keep pace with the changes occurring in healthcare delivery and within its own membership.

As well, you will find that our programs and services will continue to evolve, as we strive to stay in sync with the important developments in the MPL community. We now have new or expanded programs for health systems, chief medical officers, and defense counsel firms, as well as specialized subsections that facilitate the affinity grouping of companies. Our distance learning now supplements and enhances the in-person education and training.

Ultimately, our goal for the Association is to make all of the necessary preparations for a strong, vibrant, and inclusive future. Given the focus of our recent strategic plan, a name change for the organization was deemed an essential element in this evolution. We have faced the simple and inarguable truth that those that comprise this Association now are considerably different than the group that founded it some 40 years ago. Our membership in 2018 is built on the foundation of the PIAA and is strong because of it. The principles that established the PIAA and our members for the initial 41 years will hopefully continue to guide the Association for the next 41 years.

As you read through this issue of Inside Medical Liability, I encourage you to reflect on the wide variety of topics, issues, and challenges covered here that impact the MPL community. This organization was founded to provide a forum for exchanging information and solving problems, and even though the name has changed, the core philosophy of this Association remains unchanged.
Inside Medical Liability

Contents

Features

22 Cover story: Are These Risks on the Office Practice’s Patient Safety Radar Screen?
By Deborah E. Ballantyne, Christine M. Callahan, and Cynthia Wallace

27 Feature: Social Media as Nonfiction: Using Social Media in Litigation
By David Jones

30 Feature: Medical Professional Liability Risks and Telemedicine
By Ronald Sterling

33 Feature: The Evolution of MPL Reinsurance: And What Does That Mean for You, Today?
By Lindsay Ginter and Michael Nori

“Physician practices cannot simply apply the patient safety strategies used in hospitals to outpatient care. Not all hospital safety practices transfer to outpatient settings.”
—Cover story

Departments

10 Tech Talk
Artificial Intelligence and the Chatbot
By Martin Lippiett

15 Legislative Update

19 Case and Comment
Tales from the Legal Trenches:
“I should have put it in the record…”
By Paul B. Hlad

44 International Perspective
Medical Scribes: An Increasing Reality
By The Canadian Medical Protective Association

49 Books

53 By the Numbers
Déjà vu All Over Again?
By Stephen J. Koca and Richard B. Lord

57 The Asset Side
The Tide Is Heading Out
By Peter Cramer, CFA

60 Last Word

Special Section

39 2018 Medical Liability Conference

Up Front

1 Perspective

4 Events & Calendar

6 Observer

9 PI A A DSP Data Snapshot

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# Events & Calendar

## Technology, Human Resources, and Finance Workshop

### Keynote Session

**Cyber Security: Insights Beyond the Headlines**

In this presentation, noted security expert Tom Patterson, Author, *Mapping Security*, will draw upon the decades-long work in combating cyber criminals and foreign spies, to take attendees on an insider’s tour through the multiple cyber threats against the financial industry. In this highly interactive session, Mr. Patterson tells insiders' stories about the current real-world attacks attendees have read about, and dispels the myths and misperceptions that have grown up around them. He will encourage active discussions as to the how, why, and what of cyber events, and relate who is really behind it all. At the close of the session, he will offer three specific keys to a successful defense in this era of highly disruptive cyber attacks.

---

## 2018 Corporate Counsel Workshop

### Bias, Discrimination, and Sexism: An HR Perspective

Bias, discrimination, sexism, and the “me too” and “time’s up” movements are all launching points for an essential discussion for in-house counsel. Join Mary Dohner Smith and Kimberly F. Seten, both partners with Constangy, Brooks, Smith & Prophete, to learn what you, and your company, need to know about these topics. They will discuss the human resources minefields to avoid, as well as how to lead the conversation in your company to make sure your workforce is compliant with the law, but most important, how to ensure that your organization is an equitable place in which to work.

---

### Upcoming Events

- **September 26-28, 2018**
  Technology, Human Resources, and Finance (THRF) Workshop
  Grand Hyatt Washington
  Washington, D.C.

- **October 11-12, 2018**
  Corporate Counsel Workshop
  Portland Regency Hotel
  Portland, ME

- **February 13, 2019**
  Webinar

- **March 13-16, 2019**
  CEO/COO Meeting
  Hyatt Regency at Gainey Ranch
  Scottsdale, AZ

- **March 14-16, 2019**
  Board Governance Roundtable
  Hyatt Regency at Gainey Ranch
  Scottsdale, AZ

- **April 3-5, 2019**
  Marketing Workshop
  Kimpton EPIC Hotel
  Miami, FL

- **April 3-5, 2019**
  Dental Workshop
  Kimpton EPIC Hotel
  Miami, FL

- **May 14, 2019**
  Chief Medical Officer Roundtable (by invitation)
  Marriott Portland Waterfront
  Portland, OR

- **May 15, 2019**
  Leadership Forum
  Marriott Portland Waterfront
  Portland, OR

- **May 15-17, 2019**
  MPL Association Conference
  Marriott Portland Waterfront
  Portland, OR

- **June 26, 2019**
  Webinar

- **May 6-8, 2020**
  MPL Association International Conference
  Omni Shoreham Hotel
  Washington, D.C.

- **October 7-9, 2020**
  MPL Association International Conference
  Ottawa, Canada
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The segments of a sizzling new serial, “Golpo Holeo Sotti” (“A Story but True”) has recently begun on Indian television, starting on July 2. The show explores what are described by the *Times of India* as “hard-hitting subjects like medical negligence and malpractice by medical institutions.”

The show has its share of popular actors, including Ashmita Mukherjee, Dron Mukherjee, and Krishna Kishore Mukherjee. Its director, Arindam Bose, has been working on the project for a good while. According to him, the story will be based on real-life experiences that have been shared by the viewers themselves.

The show, described as a “mega-serial,” will be aired for six months.

“We have been successfully portraying the daily life of human beings through stories pertaining to the society or family. What we felt in the current scenario, the immediate matter of concern, is the healthcare departments that are actually taking a toll of human life,” said Eshita Surana, director of the channel that airs the program.

*Source: Times of India, June 27, 2018*

By now, the Joint Underwriting Association (JUA) of Pennsylvania has sued the state twice over attempts to take its surplus. The JUA contends that its funds are totally separate from the Commonwealth; its employees don’t receive state benefits, and it’s not housed in a state building.

In the most recent battle, a middle district judge sided with the JUA, and in May declared that it is indeed a private entity.

But now the lawmakers are trying something new. A bill passed within the state’s budget package would make the JUA part of the administration. It would get a brand-new board, to be appointed by the legislature and governor.

The specific legal reasoning underlying the state’s new move remains murky at best. The state asserts that there has been “a decrease in the number of claim payments and the decline in the need in this Commonwealth for the type of medical professional liability insurance policies issued by the association.”

In other words, it seems: you don’t need the money. We do.

*Source: WITF, public television station, June 28, 2018*

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And then?

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*Source: Times of India, June 27, 2018*
Finding a Common Language: Australia

It is difficult to understand why such antiquated and unreliable means of communication persists at all,” notes Australian coroner Rosemary Carlin. The impetus for the statement had been the death of a patient that was the direct consequence of a failure in fax communication. The results of this patient’s latest PET scan never made it to his hematologist, and as a result he had received a fatally toxic dose of chemotherapy.

The scan results, it turned out, had been sent to the wrong fax number.

Australia has encountered the usual problems with interoperability in attempting to find a secure messaging system to replace the fax, though. Medical practitioners realize they need a replacement that allows for secure messaging of records and results that work on a wide range of clinical software.

In June, government agencies, the medical profession, and industry met to determine standards for messaging. The meeting was hosted by the Medical Software Industry Association, the Australian Digital Health Association, and the Royal Australian College of General Practitioners.

They agreed to support two messaging formats, HL7v2 and CDA messaging formats, through the medium term and also to focus efforts on improving message payloads to improve compatibility with clinical work flows. You can find more than you wanted to know about HL7 at www.ringholm.com/docs/04300_en.htm, and about CDA at www.hl7.org/implement/standards/product_brief.cfm?product_id=7.

Source: Computer World Australia, June 21, 2018

Highest Personal Injury Compensation Amounts: U.K. vs. U.S.

"It was presumed that the U.K. had begun to replicate results in the U.S., and "joined the compensation culture prominent in the U.S." Not so, it turns out. The annual number of compensation claims in the U.K. hasn’t budged since 1989.

And more specifically, examining MPL claims, legalexpert.co.uk calls it like it is: "The U.S. wipes the floor with the U.K. for the highest medical malpractice compensation claim. A U.S. claimant received $172 million in damages for medical malpractice after suffering brain damage," after an ambulance crew gave the wrong medication, sending her into anaphylactic shock.

Meanwhile, over in the U.K., the biggest award "only reached £24 million." The claimant was supposed to receive glue treatments to block off bleeding vessels. Instead, the glue was injected into her brain by mistake, leaving her brain damaged.

Finally, the legal experts at the website want to be helpful. Even if you don’t have what promises to be a gigantic claim, you can avail yourself of their "free, no obligation, legal consultation with one of our experts." And, "From there, we can provide the help and advice you need."
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74% Of claims and lawsuits resolved with no monetary award

$52,050 Average cost to defend

90% Of lawsuits that went to a verdict were in favor of the defendant

$3.3B Total Indemnity paid

$357,199 Average Indemnity paid

11% Indemnity Payments ≥ $1M

Contact for more information:
P. Divya Parikh, Vice President of Research & Risk Management
dparikh@mplassociation.org

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The term has been in common use in the computer world since the 1950s, but what does it really mean? Outside of the rarified world of IT (and often within it), the term tends to be used vaguely and imprecisely.

A discussion of something as new and as complex deserves to start with an authoritative definition. Here are two from Webster:

1. A branch of computer science dealing with the simulation of intelligent behavior in computers.
2. The capability of a machine to imitate intelligent human behavior.

And next, Encyclopedia Britannica:

...the ability of a digital computer or computer-controlled robot to perform tasks commonly associated with intelligent beings. The term is frequently applied to the project of developing systems endowed with the intellectual processes characteristic of humans, such as the ability to reason, discover meaning, generalize, or learn from past experience.

Another way to define AI is by what it is not. AI is not just the improved and faster processing of large sets of data, or the use of thousands of rules that are applied in a rigid and structured fashion. AI inherently involves two new technologies, machine learning and natural language. AI can take in ambiguous inputs and make inferences...and, as Britannica says, “discover meaning, generalize or learn from past experience.” The key point is that AI can improve its performance without someone having to program it. And it can find patterns in data that would be impossible for a human to detect; it will be able to draw insights that would otherwise be undiscovered.

As with near-self-drive automobiles, the state of the art of AI today doesn’t allow it to completely displace human beings. But it can augment what they do, thereby allowing them to be more efficient and to perform calculations that would be totally impossible without AI technology. Again, as with automobiles, this is a fast-changing area of technology and greater autonomy will come with time.

The most we hear of, and experience, AI is with products like Amazon Alexa, and with some of the autonomous driving aids that are built into new cars. There has been little or no adoption of AI in the insurance sector to date, probably because it is an emerging technology that is still in its infancy and there may be little expertise with it available in most insurers’ IT departments. Finally, there may be concerns about some of the customer-facing opportunities that AI can offer being poorly received and perhaps even an embarrassment.

So where does AI fit in with insurance companies, more specifically, with medical professional liability (MPL) insurers? MPL, as a specialty and complex line of insurance, is not as amenable to the introduction of AI as other lines of business. In contrast, auto insurers are already gathering driving data in real time using plug-in devices to price the risk; on the claims side as well, AI is helping with fraud detection and with claim interactions, on some of the simpler claims. MPL insurance doesn’t appear to offer as many opportunities—but there are some.

In fact, there are three areas where AI will likely be used in your company in the near future: policy generation, chatbots, and analytics. It will affect your employees, as well as policyholders and agents.

Let’s look at one of these—the chatbot—the chat robot (or “bot”).

A chatbot is software that is able to communicate with humans using AI—to the extent that humans don’t realize they’re talking...
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to a computer program. The most commonly encountered chatbots are applied in customer service interactions. If the insurer has a website, a chatbot can pop up on the screen and assist a user looking to change coverage, apply for a new policy, ask a question about a claim or billing—in fact, anything that a human can do. Most companies even give their chatbot a human name: Allianz’s is called Allie.

**Why has the bot’s time arrived?**

- A survey indicates that more than 70% of callers hang up when they hit a “phone tree,” but most customers don’t have an issue with interacting with a bot; 74% of consumers would be happy to get computer-generated insurance information.
- People already text a lot. Billions of messages are sent every hour. Humans have substituted verbal communication (human to human) with written communication (human to machine to human).
- There are too many apps. Research shows that we use only about five apps on our phones with any regularity. In an age of app overload, bots are welcome—they don’t need an app to engage with customers.
- E-mail is great for sharing information, but not so good at conveying understanding. People are more engaged with a digital chat experience than they are with an analogue e-mail exchange.

**Why, then, do chatbots fail? Here are three reasons:**

- First-generation bots focused on understanding what you say, but they “responded” with scripted responses. Even if they understand your question, they may not have an answer available because they can’t actually compose one. But this is changing. There is a demand for bots to respond with easy-to-read text that they can compose themselves—and that they can improve upon as they “learn.”
- Bots have had difficulty understanding accents, and their responses have been limited to a single language. But newer technology has improved on this: bots have been developed that can understand and respond in multiple languages.
- The simple truth is that chatbots, to date, have over-promised and under-delivered—mostly due to the two problems noted above—and that has delayed their adoption. But the technology is available to address these issues; now bots can ask intelligent questions, offer personalized responses, and provide a satisfactory online customer experience.

A well-designed bot can be a great benefit to a company, by saving on the staff costs needed to answer phone calls, by offering the insured a 24/7 service that would not otherwise be viable, and by, on a nonstop basis, teaching itself how to do a better job.

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START LEARNING:

When most people think about the Medical Professional Liability Association’s government relations work, they focus on our interactions with the U.S. Congress. That has changed in recent years, however, as the Association increased its outreach efforts to federal agencies, such as the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research & Quality, and also expanded its activities in support of member companies in their state legislative and regulatory advocacy.

Earlier this year, we stretched our wings even further. We had the opportunity to break new ground by venturing into the international arena, when the MPL Association was invited to speak at the Organisation for Economic Co-operation and Development (OECD). The OECD comprises 36 nations from around the world, and it provides a forum where governments can work together to share experiences, identify best practices, and seek solutions to common problems. Working primarily with national governments, but also with business organizations and labor, the OECD collects and analyzes data from many aspects of economic development to recommend policies whose intent is to “improve the quality of people’s lives.” The goal of the OECD is to use “cooperation, dialogue, consensus and peer review” to help develop policies that will allow countries to improve conditions for their citizens.

In June, I represented the MPL Association as a member of a panel appearing before the OECD’s Insurance and Private Pensions Committee. The process of getting to the meeting, however, had started long before.

Developing a plan
Several years ago, the OECD produced a report on medical liability insurance, but had remained largely silent on the issue in the interim. With that in mind, the MPL Association proffered the idea of the OECD looking at the issue again, but this time from the perspective of how defensive medicine may be a significant factor in healthcare costs. Working with our colleagues at the U.S. Department of Commerce, which leads the U.S. delegation at the OECD, we engaged the organization and they demonstrated interest in the topic, but sought more information regarding the impact on the international community. The MPL Association then helped the OECD review the information on this topic that was available.

It didn’t take long to discover that defensive medicine really was an international issue. We found studies from Italy, China, Turkey, Norway, Belgium, Israel, Canada, South Africa, Austria, Brazil, and the U.S., all of which discussed the implications of defensive medicine in their countries. They clearly shared a common concern, but identifying the root causes of that concern would be a more complex task. These nations have very different healthcare-financing systems, and divergent systems for addressing suboptimal medical outcomes. What they shared, though, was a common desire to reduce costs, so they could provide better healthcare at less expense. With this in mind, the MPL Association put together a plan.

We suggested that the OECD consider studying the drivers of defensive medicine, while also taking into account the numerous variables that can affect its frequency. Our idea was to search for common factors among these unique nations that would make it possible to identify approaches to reducing defensive medicine that might appeal to countries across the globe. If the OECD could
learn why defensive medicine occurred, we suggested, it might be able to find solutions that transcended any individual healthcare-financing system or litigation environment. The OECD liked the concept and invited the MPL Association to present it to its Insurance and Private Pensions Committee (IPPC).

Presentation
While many have defined defensive medicine narrowly as the provision of unnecessary health services simply to avoid liability claims, the MPL Association’s presentation adopted a much broader perspective. We defined defensive medicine as “adapting the provision of healthcare services for factors other than the medical needs of the patient,” in order to encompass the many reasons why a healthcare professional may practice defensively. We also noted that defensive medicine can range from the over-provision of services (providing services or treatments that are relevant, but not always necessary, to address a given diagnosis) to under-treating, via the avoidance of high-risk patients or procedures.

With defensive medicine thus defined, we then considered its many causes. Studies and surveys of physicians have shown that it goes well beyond the “fear of litigation” that is frequently cited as its base. Concerns about possible licensure actions should not be discounted as another cause. Increasing media scrutiny of suboptimal outcomes has been suggested as a growing reason for practicing defensive medicine, as has concerns about one’s standing before his medical peers.

Another, sometimes overlooked, motive for defensive medicine is the increasing use of patient satisfaction surveys. These surveys can encourage healthcare providers to offer treatments that are not completely unnecessary (which doctor is more likely to get the positive review from a patient, the doctor who tells a patient with a bad cold to go home and ride it out, or the one who prescribes the antibiotics that the patient mistakenly insists he needs?), but which are offered for non-medical reasons. The last, but not least, rationale for defensive medicine is simple caution. Some healthcare professionals undoubtedly over-test or over-prescribe simply as a way to make sure that no possible medical condition is overlooked, even if some of them are extremely unlikely.

The Association’s presentation concluded with a review of studies from across the globe showing high rates of defensive medicine, including 98% of gastroenterologists in Japan and 78% of hospitalists in the U.K. Interestingly, while many studies indicated that the over-zealous ordering of tests or procedures was the overwhelmingly prominent defensive medicine practice, some studies indicated that unnecessary referral to specialists was the most common of these practices in those nations.

Next steps
The MPL Association’s presentation was designed as a first step, meant to educate and inform, rather than persuade. While we believe the evidence of a global epidemic of defensive medicine is eminently obvious, it will likely take years to find out what steps, if any, the OECD may be willing to take to address this issue. In the meantime, the MPL Association will continue to reach out to the OECD to share information and encourage additional study of this topic, which clearly has implications not just for the U.S., but for countries around the world.
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That is what my dentist client had to tell the jury in a recent medical professional liability (MPL) trial in Virginia. The trial centered on informed consent for the removal of tooth #14 and what risks the patient had been informed about. The suing patient suffered an intrusion into the sinus cavity, a fractured buccal bone, and possible neurologic problems stemming from the surgical extraction. Right now, you are probably thinking, “Hey, those are recognized risks of the procedure.” You are right if that is what you’ve been thinking, but unfortunately, we had no documentation that informed consent was given, were working with a signed informed consent document that was four years old (at the time of the extraction), and failed to list some of the key recognized risks of a tooth extraction. Obviously, my client did not remember the specifics of an informed consent conversation that took place years earlier, but he was able to state he verbally gave informed consent “because he always does it.”

With that background, let’s look at what the law in North Carolina and Virginia requires for informed consent. I only practice in those two venues, but something tells me the situation in other states is likely very similar. Once we look at the law, we will come back to our trial story for some practice pointers and to find out how things turn out for my client, who we will call “Dr. N.”

**North Carolina**

Informed consent is governed by statute in North Carolina. The requirements are found at N.C.G.S. § 90-21.13. Paraphrasing (to keep you interested and reading…) the statute states that (a)

1. Informed consent must be obtained in accordance with the standards of practice among members of the same healthcare profession with similar training and experience in similar communities. This simply means in North Carolina a general dentist practicing in (insert name of any city) must obtain informed consent in a similar manner to a general dentist practicing in a similar community. This means an expert will be required on both sides to establish what the standard of practice is concerning informed consent.

2. A reasonable person would have a general understanding of the procedure or treatments at issue once given the “most frequent risks and hazards” inherent in the proposed procedure and treatment. Obviously, folks can differ concerning the “most frequent risks and hazards” of a procedure, but the intent of the statute is clear: that the medical provider has to tell a patient the treatment options available and the key risks presented by each.

3. A reasonable person would have undergone the treatment or procedure if advised of the risks. Practically, this means a person facing a life-threatening illness will not be able to argue they would not have undergone the potentially lifesaving procedure if only they had known of the risks. This section is also important when performing experimental procedures where the risks are not yet established. Finally, (3) is disjunctive of parts (1) and (2), as...
a provider would have difficulty showing all three in the instance of an elective- or cosmetic-type surgery. See 

The North Carolina statute also notes that informed consent in writing, meeting the foregoing standards, is presumed to be a valid consent. This means that the burden is on the patient to demonstrate they did not understand the information given to them; with a written document, the provider does not have to prove validity.

Virginia

Virginia does not have a statute governing informed consent. Informed consent requirements are basically folded into the general requirements the law holds for any healthcare provider in satisfying (or violating) the standard of care. Virginia law imposes a duty on a dentist to exercise ordinary care to inform a patient of the negative consequences of and alternatives to a proposed medical treatment or procedure. See 

In order to recover an award, the patient has to show through expert testimony what information should have been disclosed, essentially arguing the provider did not meet the standard of care for informed consent. 

Tashman v. Gibbs, 263 Va. 65, 73, 556 S.E.2d 772, 777 (2002). The standard of care in Virginia is equated with that degree of skill and diligence exercised by a reasonably prudent practitioner in the same field or specialty. Id. at 73, 777 quoting 
Bryan v. Burt, 254 Va. 28, 34, 486 S.E.2d 536, 539 (1997). Ultimately, an expert is required to testify for both sides at trial as to what risks and options the standard of care requires a dentist to provide to a patient. The patient may then testify factually as to what risks and options were not presented. There is then a requirement that the patient demonstrate to the jury that he would not have had the procedure done if he had known the risks (proximate cause—but that is another article in and of itself).

Analysis

As noted previously, the law in North Carolina and Virginia is essentially the same.

Additionally, verbal informed consent can satisfy the standard-of-care requirement in both states. However, how do you as the provider prove informed consent was given verbally if there is no documentation? In essence, this presents a classic “he said, she said;” and it is left to the jury to ultimately decide which party they believe.

That is what happened in our trial. Dr. N and his office staff all testified to the jury that informed consent is always given verbally to a patient as part of the habit, custom, and practice of the office. The opposing attorney tried to make the entire case a referendum on the sloppiness and lack of documentation in the dental record. The plaintiff’s expert, a professor from UNC Chapel Hill, claimed the standard of care requires a general dentist to have the equivalent of subjective, objective, assessment, and plan (SOAP) notes for every patient visit, which would also include a separate informed consent document for procedures as well as notation in the note that it was given. Dr. N did not have anything close to SOAP notes and, again, had no documentation that informed consent had been given or a specific informed consent document signed by the patient stating the risks of tooth extraction.

Before I reveal the outcome, this is a good place to pause and determine the practical takeaways. The first and most obvious is this: always document the key parts of your treatment in a patient’s record. This includes the informed-consent process. You should have a separate informed-consent document signed by the patient for every dental procedure, but at a bare minimum, at least write in your chart entry that “informed consent given to patient.”

In addition, check the code or statutes governing dental care in your state to determine what has to be included in your dental charting. Unbeknownst to my client, the Virginia code now required documentation of procedures offered, treatment options, and cost estimates (among other things). See 18 VAC 60-21-90 Patient Information and Records.

As the judge in our case said in chambers, no matter how much continuing education you get, we all become set in our ways after practicing for a number of years. So take time with your office manager and look through your forms to make sure they are up to date. Dr. N was working with an informed consent form that was more than 20 years old from a prior place of employment.

You can ask my client which is better: spending a few hours updating your documentation or shutting down your practice for a week to attend a trial with all the worry that comes with it. That old saying, “An ounce of prevention is worth a pound of cure” is very appropriate here. If you are looking for a place to start, there are a number of good resources you can check to make sure your forms are adequate, to include:

http://www.nnoha.org/resources/dental-program-management/dental-forms-library/


Back at trial, we were able to clearly demonstrate Dr. N’s habit, practice, and custom, which his very credible and likable office staff confirmed on the stand. We were also able to show the jury that the plaintiff had a number of prior and subsequent tooth removals, helping to demonstrate that she would have gotten #14 removed regardless of informed consent. Ultimately, we won and the jury said that was in large part due to the credibility of Dr. N when on the stand. They believed that he warned the patient and had thus satisfied the standard of care. One juror came to talk with Dr. N after the trial and relayed what the jury thought about him and his practice, all good, before telling him she was making an appointment with him the next day. She then paused and looked at us while asking if she could give some advice. Dr. N of course said yes, to which she replied, “You should have put it in the record. . . .” All we could do is smile and agree. This trial story on informed consent had a happy ending. However, a trial win is never guaranteed, so review your forms and documents, so you can stay away from the courthouse!
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Patient safety in the outpatient setting is increasingly under the microscope. For nearly two decades, policymakers, payers, accrediting organizations, and others have scrutinized safety practices in hospitals. Until recently, however, their attention to issues of safety in physician offices has been limited.

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Every year, physician practices vaccinate millions of children and adults in the U.S. to prevent the sickness, disability, and death that can result from infectious diseases and illnesses, such as influenza, polio, measles, mumps, and rubella. Unfortunately, errors can occur, particularly during vaccine administration. Errors include the following:

- The wrong vaccine is given.
- The wrong dose is administered.
- An expired vaccine is given.
- A recommended vaccine is missed or omitted.

Although adherence to an organization’s medication-safety practices can prevent many vaccine errors, some errors are the result of issues specific to vaccines, such as confusion about adult- and child-specific presentations and mix-ups involving similar vaccine names and packaging. For example, mix-ups are particularly common for the diphtheria, tetanus, and pertussis vaccines, abbreviated as DTaP and Tdap. These vaccines have similar abbreviations but very different uses; DTaP is used to immunize patients six weeks through six years of age, while Tdap is used as a booster shot for older children and adults.

The safe administration of vaccines depends on professional staff who are trained and educated in the proper storage and handling of vaccines, correct techniques for vaccine reconstitution, and appropriate timing of vaccine administration according to evidence-based vaccine schedules issued by the Centers for Disease Control and Prevention. In addition to providing staff with education about vaccines, practices can help staff avoid errors during vaccine administration by using standard-
Some practices reportedly do not have important safeguards in place for the use of medication samples. For example, one spot check of drug samples kept by a group of family-practice and general internal-medicine offices found that 14% of the samples had expired. Another analysis of 17 urban and rural primary care practices found that no office was following all of the recommended practices for dispensing samples to patients, such as communicating precautions for use.

Physicians could be at risk of litigation if a medication sample is given to a patient by mistake and causes harm.

Short of eliminating medication samples from the practice altogether, important measures for handling samples to ensure patient safety include the following:

- Educate pharmaceutical company representatives regarding the practice's policy on sample medications, and have representatives sign in and out upon each visit.
- Remove samples from examination rooms, and store them in a secure location that is in sight of office staff and locked during non-patient hours.
- Keep a log of medication samples that lists the drug name, lot numbers, quantity, and expiration date. Providers and office staff who distribute samples should sign the medications out using the same log.
- Provide written information about the medication to the patient (reason for the medication, dose, special precautions, and side effects, including allergic reactions).
- Track sample medications to their final disposition. Be alert to recalls. In the event of a recall of medications dispensed from the office, the practice must notify the patients to whom the medications were dispensed.
- Separate and clearly identify medications of different strengths. For high-alert medications with the potential to cause serious harm if administered incorrectly, limit the number of doses and forms available.
- Store medications according to class or in some other easily understood order that prevents mix-up of similarly packaged products. Do not store medications in alphabetical order.

- Stock medications with look-alike or sound-alike product names in separate areas. Attach brightly colored warning labels to packages of drugs that might be easily confused.
- Routinely inspect medication samples, promptly removing recalled or expired drugs from the inventory. Discard expired medication samples in accordance with federal, state, and local laws.
- Limit the amounts and types of samples available to medications most often prescribed by the practice’s providers.

Many physicians provide medication samples to patients, despite safety concerns and ethical issues regarding their use. Frequently cited reasons for handing out samples are to help a patient initiate medication therapy and to reduce prescription costs for low-income patients, although some studies dispute the effectiveness of such efforts. As of 2009, an estimated two-thirds of physicians accepted medication samples from pharmaceutical sales representatives, but that percentage has been declining, with the public increasingly aware that conflicts of interest can influence physician prescribing.
Patient triage, either in person or by phone, enables a practice to direct a patient to appropriate services in a safe and timely manner. Triage services are typically offered during regular work hours within a range of practice settings, including general practices, primary care, pediatric practices, and managed care environments.

Triage is not the same as message taking. It is grounded in a clinical skill set sometimes required of licensed medical professionals that involves the safe, appropriate, and timely evaluation of patient symptoms.

Failure to set protocols in place to guide triage can create confusion and frustration for both staff and patients. ECRI Institute recommends that practices periodically evaluate their triage system, to identify opportunities to tune up their procedures and formalize their protocols. They should start by assembling a team of clinical and administrative staff to discuss the current approach and suggest improvements.

The qualifications of triage staff are an issue that often arises. Most important is to check state scope-of-practice regulations. Many states have clear guidelines related to who is qualified to make an assessment over the phone or in person. Usually, telephone triage is performed by a registered nurse, advanced-practice professional (such as a nurse practitioner), physician assistant, or, in some cases, a physician. Licensure alone is not enough. Triage staff should complete a standardized education program that includes an orientation with a preceptor prior to starting triage duties.

Also, practices need to consider the qualifications of staff performing triage on site. The person who is assigned to do triage may be the first person to encounter a patient experiencing a cardiopulmonary event. Therefore, completion of both basic and advanced cardiac life support courses may be necessary. Depending on the practice’s patient population, triage staff may need additional training in areas such as maternal and child health, behavioral health, or geriatrics.

If the office offers telephone triage, staff will need additional training to underscore the responsibilities—and challenges—inherent in taking telephone calls, as opposed to seeing patients face to face. When a practice takes a call, it is liable for any advice given—as well as any advice that is appropriate, based on the patient’s chief complaint, but is not given. Essential principles of telephone triage include the following:

- Know the “red flag” complaints that should prompt an urgent response.
- Get enough information to give informed advice.
- Give advice based on the worst-case scenario.
- Follow standard written protocols for triage of patient symptoms. Protocols are used to explore patients’ symptoms with a preestablished set of questions and then recommend a course of action.
- Resist being dismissive of a caller’s concerns or overinvesting in the patient’s self-assessment of his or her condition without asking more questions.
- If the call is about a previous or unresolved problem, revisit the problem until it is resolved.
- Document the history taken and advice given by telephone.

Staff should also be aware of common pitfalls in triage, especially on the telephone. For example, be careful with the use of voicemail. Check messages regularly, to be sure staff return calls promptly.

To identify gaps, the office should periodically assess its triage practices. Sample questions might include the following:

- Is a system in place to monitor triage staff compliance with triage protocols?
- Do nurses and other licensed professionals who give telephone advice have specific training, experience, and documented competence in telephone assessment techniques?
- Are the standard triage protocols reviewed and updated at least every two years to ensure consistency with current standards of care?
- Are triage staff instructed to consult a physician whenever they have doubts about proper instructions or advice?
- Are physicians assigned to back up triage staff to answer questions? Are physicians receptive to questions from triage staff regarding patient calls?

Delivering safe, high-quality care to patients depends on employing a staff of competent healthcare professionals of all levels.

Assessing the competence of unlicensed staff, particularly medical assistants, is another area that requires close study. In one incident, a medical assistant administered an influenza vac-
The adoption of a comprehensive approach to patient safety in physician offices has been highlighted in recent times, with the emphasis shifting from the patient-centric approach to a more safety-focused one that includes both licensed and unlicensed clinical staff. This approach is essential in maintaining patient safety, given the critical nature of healthcare settings.

**Practices should develop a step-by-step approach to assess and reassess staff members’ competence throughout their periods of employment.** Staff should be evaluated at periodic intervals to determine whether their competency meets the standards expected of their position. While the following checklist for assessing a staff member’s basic competencies can apply to both licensed and unlicensed clinical staff, its focus is assessment of unlicensed staff members, such as medical assistants.

- Examine the hiring process to make sure that it includes verifying the applicant’s training, education, certifications, and experience and checking his or her references.
- Review all job descriptions at least every two years or more often, if position responsibilities or advances in technology necessitate an update. Check the state’s scope-of-practice laws before updating any job description.
- Review the staff orientation process to ensure that it includes a general office orientation as well as orientation to responsibilities specifically outlined in the individual’s job description. Use an orientation checklist to be sure that all items are covered.
- Review the available training for clinical staff, recognizing the limitations and roles of the position. Use different types of learning methods, such as written information, video, demonstration, and simulation, to ensure that the individual has a comprehensive understanding of the topic.
- Identify staff who can take on training responsibilities, and ensure that they understand their role in training new staff using current policies and best practices. Do not permit training that is based on the shadowing of staff, which can lead to the adoption of ingrained bad habits, such as workarounds and omission of necessary steps in a process.
- Assess staff competencies in all areas, but especially in high-risk or high-volume areas, such as medication administration, weights and measures, and specimen collection.
- If a staff member’s skills fall short in a particular area, institute a process to retrain and retest the individual, and document the outcome.
- Develop a performance appraisal form that is consistent with the staff person’s job description. This will provide guidance on an annual basis to help the individual perform within his or her scope of practice and effectively demonstrate competency.
- Establish an internal committee (or use an existing one) to periodically review the forms used for orientation, competence, and performance evaluations, to be sure that they are up to date and accurate.

**Adopting a comprehensive approach to patient safety**

Care provided in physician offices represents the largest and most widely used segment of the U.S. healthcare system. Even so, until recently, the physician office setting has not received the attention with regard to patient safety that, for two decades, has been directed at hospitals and other healthcare institutions. But recently, attention to safety in physician practices has been increasing, with emphasis falling on problem-prone areas, such as tracking of test results, documentation, and more. Unfortunately, other areas known to cause errors have received little attention.

Physician practices must adopt a comprehensive approach to patient safety, devoting their attention not only to the issues that appear on every office’s patient safety radar screen, but also to the risk areas that frequently go unnoticed.

**References**

Social Media as Nonfiction: Using Social Media in Litigation

BY DAVID JONES

We all love a good story. As the most social of creatures, we human beings crave the fellowship that comes with sharing details of each other’s lives. Throughout history and across cultures, we have used words and images to communicate, record, illustrate, entertain, and celebrate both the remarkable and the routine stuff of our daily experience.

The advent of smartphones and social media has stirred in our species the primal urge to spin rapt accounts about what just happened. I am a trial lawyer. My human subspecies is professionally interested in learning what happened and why, and in telling a compelling story about the facts of what occurred. Social media evidence can provide wonderful thematic content for lawyers to craft and tell a powerful, engaging story that captures the truth of events underlying a disputed case.

But long before a lawyer can present a client’s full story to a jury, a judge, a mediator, or an opponent, he needs a strategy for gathering and weaving together the elements of the tale.

Character development

Upon receipt of a new claim or lawsuit, lawyers should investigate opposing parties and witnesses (and even their own clients) using publicly available information on the internet. Increasingly, prudent lawyers engage vendors to conduct social media and Web content data captures for the social media accounts of parties and witnesses. This can help ensure the authenticity and admissibility of the evidence for an eventual trial. The more detail given to the vendor, the better one’s chances of developing a fruitful search. For example, the following basic information is useful:

- Full names of investigative targets and any aliases
- Dates of birth
- Physical descriptions (a driver’s license photo or headshot is helpful for identification purposes, especially with common names)
- Last known addresses
- Employers/occupations
- Names of spouses, close associates, and immediate family members

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Judges can be reluctant to permit counsel to access an opposing party’s

gation will receive a notification of an attempted contact. More impor-
tant, this can raise ethical problems for the lawyer and can risk com-
promising the investigation. Further, because any information gathered
will need to be properly authenticated for use at trial, the attorney or
team member who gathered the evidence may become a necessary
fact or foundational witness.

Setting the scene
For cases in which the geographic location of events is important or an
incident may have been newsworthy or witnessed by many people, it is
possible to use geofencing technology to capture social media postings
or other internet-based content from the physical area of interest or
about the subject matter of the event. Experts in forensic data gather-
ing and preservation can assist with setting up these virtual dragnets.
If done promptly, these may yield otherwise-ephemeral evidence or
otherwise-unknown witnesses.

The plot thickens
Courts across the country have begun to recognize social media as fer-
tile ground for investigation, particularly in personal injury claims. But
judges can be reluctant to permit counsel to access an opposing party’s
social media accounts, especially without limitations in time or scope.
So, written discovery tailored to fit the claims and facts of each case
 can be productive, particularly if an opposing party uses privacy set-
tings to limit public access.

Counsel should consider the timing of written discovery on social
media issues. For example, it may be beneficial to send written discovery
on foundational issues before the opposing party’s deposition.
Alternatively, it may be useful to address foundational issues during a
deposition and use written discovery after obtaining witnesses’ sworn
testimony. Either way, one should consider whether overt inquiry may
prompt a litigant to delete or modify online content. After all, it is usu-
ally preferable to invest in the gathering and preservation of key
impeachment evidence early, as opposed to seeking remedies for
perceived destruction of evidence later.

It can be wise to discover e-mail addresses and a list of all social
media or networking sites that a party created, maintained, or deleted in
the recent past. For each account, request the username, handle, or pro-
file name; when the account was created; and when the account was last
accessed. If the account was deleted, find out when and why. Counsel
may request copies of photographs, postings, videos, notes, profile infor-
mation, friend lists, instant messaging logs, sent and received messages,
and comments that the target or target’s friends or other visitors have
posted to the party’s page, “wall,” or account. Focusing the inquiry on the
party’s activities, hobbies, interests, entertainment, education, work, and
health conditions can connect the investigation to relevant information
about the party’s allegations and claimed damages.

For any responsive materials one’s opponent withholds on the

grounds of privilege, confidentiality, or any other basis, counsel should
consider requesting a privilege log identifying the withheld materials
specifically.

Conflict and dramatic tension
The arc of a lawsuit is often punctuated by taking sworn testimony of
witnesses. Attorneys thus consider whether to explore social media
topics during a deposition. The nature of the questioning may depend
on the facts of the case, the volume and nature of the witness’s social
media presence, and the inquiring lawyer’s own familiarity with vari-
ous social media platforms.

One may establish basic background information with a witness
to lay a proper foundation for the social media records sought to be
used later. Asking questions about historical or biographical informa-
tion—aliases, birthdates, prior addresses, names of family members
and close friends—early in a deposition as “background” may make
a witness less suspicious than making these inquiries along with
questions about social media. Establishing these foundational anchors
can help if the pointed inquiry about social media evidence—
particularly if it is juicy—provokes denials about the authenticity
of the information.

If counsel decides to delve into the details of a witness’s social
media use, he may explore the witness’s habits and practices with the
available social media platforms. The lawyer may wish to confirm the
user’s e-mail addresses, whether the witness uses aliases on social
media, the dates or eras of time during which the witness used partic-
ular sites (specifying the common sites listed above), and the reasons
the witness might use one account over another. Counsel should ask
whether profiles are public or private, find out if any of the witness’s e-
mail or social media accounts have ever been hacked, and explore
whether anyone other than the witness has access to the accounts or
can post to the accounts.

If early investigation has captured forensic evidence useful for
undermining the witness’s testimony, the lawyer should consider
whether it would best serve his client’s case to deploy that evidence

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during the deposition, or spring the traps later at mediation or in trial.

**Dénouement and resolution**

Social media evidence can be of great value in the performance art of a trial. Long before the courtroom drama begins, a lawyer should develop a plan for whether, how, and when to disclose social media evidence, how to deploy the evidence at trial, and how to overcome an opponent’s anticipated objections to its use. Like an old “Choose Your Own Adventure” gamebook, there are countless technical and procedural rabbit holes that a trial lawyer must be prepared for. Among the lawyer’s potential excursions are the following three.

First, as with all types of evidence, if counsel wishes to admit social media evidence into the court’s record, he must first disclose the evidence to the other side, long before trial. That will spoil the element of surprise, but it may also make it easier to ensure that jurors will get a close look at the evidence. Conversely, under limited circumstances, it is possible to impeach a witness’s testimony, challenge a witness’s credibility, or refresh a witness’s recollection using previously-undisclosed evidence. To do that, counsel will be limited in using the evidence and must first justify using it for these purposes. Doing so requires navigating a gauntlet of evidentiary conditions that restrict the use or display of “extrinsic evidence” to challenge a witness’s testimony.

Second, the lawyer should assess the relevance of each piece of social media evidence to the elements of the opposing party’s claims, and decide whether the evidence makes the important facts in the case more true or less true than they would otherwise be. This requires selectivity and judgment about what to put in, what to leave out, and what attempts the other side may make to justify or explain away the evidence.

Third, counsel should carefully consider the myriad of rules governing hearsay evidence, and know how to overcome objections properly, based on the hearsay rules. Social media postings may contain statements or images intended as communications, and the postings themselves may be communicative conduct that bears on the facts or the claims.

**Final thoughts**

Lawyers or not, we humans have always been storytellers. Our early ancestors painted cave walls to cast the narratives of their experiences. Over time, we developed traditions of oral history; and pictograms became written characters, which morphed into alphabets, written language, and the printing press. Typewriters, cameras, and computers followed. Now, with smartphones and internet access, each of us has nearly limitless ability to record and broadcast our stories to an attentive world.

When appropriately integrated into the evidence developed in a lawsuit and presented at trial, these stories told on social media help expose the truth we seek to reach in our system of justice.

**Footnotes**

1. The most popular platforms tend to include Facebook, Twitter, Instagram, LinkedIn, Flickr, Snapchat, YouTube, Reddit, Pinterest, Google Plus+, Tumblr, and Vine.

2. These names can be useful for obtaining social media evidence from others’ profiles—family members and friends are typically less diligent than parties in scrubbing their profiles before litigation.
Telemedicine offers cost-effective tools for serving patients, with more flexibility than is possible with the traditional office visit, but it entails new challenges to managing patient care, as well as medical professional liability (MPL) risk.

“Telemedicine” refers to the process of serving patients through a HIPAA-compliant video session (similar to GChat or Skype) in place of a trip to the clinic. Clinic visits may be inconvenient, difficult for patients, and/or involve a significant delay in assessing a patient’s situation. A video session that can be immediately begun (or scheduled for a specific time) may offer a cheaper, more flexible patient-service option that could mitigate the need for a visit to the clinic or hospital, as well as allow for more frequent contact with at-risk patients. For example, patients receiving wound care could be served through a telemedicine session in place of the expense of a home or clinic visit. A telemedicine session could be triggered by receipt of a secure message over a patient portal, a phone call, or receipt of information from a Web-enabled device such as a scale, glucose meter, or heart monitor.

Telemedicine presents a new kind of service competitor to healthcare organizations (HCOs). For example, some healthcare kiosks have a telemedicine feature as well as Web-enabled diagnostic tools to serve patients. Similarly, patients can use telemedicine services available over the Web from the comfort of their home or office. Such conveniences may complicate maintaining and monitoring continuity of care, since patients may more easily access a Web service than waiting for a response (or an available office visit slot) from their doctor. Serious continuity-of-service issues could emerge from patients using Web services that do not have the office-based depth of information about the patient’s health history. If a patient cannot get a timely response to his needs from his regular provider, an internet-based telemedicine option may address a short-term issue, but at the risk of failing to fully track the patient’s condition and status. Thus, more and more HCOs will probably offer telemedicine to compete with the internet-based providers.

Telemedicine can mitigate the risk of an adverse clinical event. For example, a physician or qualified clinical staff member can immediately engage the patient via a telemedicine session to review a patient’s situation and discuss an adjustment to the patient’s treatment plan, without waiting for a trip to the doctor’s office. In other cases, a trip to the hospital may be averted with timely review of the patient’s situation during a telemedicine session. Such telemedicine services are an important part...
of the overall strategy to support value-based payment models such as shared savings, performance incentives, and care management fees.

Telemedicine requires clinically driven policies and procedures to achieve success with patient service, as well as to avoid any problems that could lead to a claim of MPL. Some of the most important considerations are discussed below.

Recording telemedicine visits. One of the more serious risk factors associated with telemedicine visits is the ability of the provider or patient to record the session. Indeed, one can record and save the session forever. The recording of the session by the provider is of questionable clinical value, since it is not likely that the doctor and staff are going to sit through a 20-minute video to derive the salient information from the telemedicine visits. Providers rely on the electronic health record (EHR) to review care issues and highlight the patient's health status. On the other hand, the patient or his caregiver may record the telemedicine visit (without informing the provider) to review later or to help him follow the provider's instructions. The patient (or HCO) recording could be saved and reviewed in the case of a claim of MPL.

Mitigation strategy. Telemedicine visits should be formally structured and documented, to assure that instructions and advice are properly and clearly conveyed to the patient and documented in the medical record. The provider should be especially careful to document the severity of the clinical situation and the recommendations made to the patient. The provider should summarize the final recommendation to the patient and solicit a positive confirmation from the patient that he understands the treatment recommendations. Thus, the practice/HCO has no need to record the telemedicine session since the substantive issues and recommendations are captured in the EHR.

Documenting telemedicine visits. Telemedicine visits require the same level of documentation as an office visit. Telemedicine documentation may include snapshots from the video session, such as a view of a wound or injury site. Telemedicine-visit documentation should be recorded in the EHR using the appropriate tools and planning features, including treatment orders and instructions to staff to follow up on any care or treatment issues. Using standard documentation tools in the EHR is especially important, since telemedicine sessions may provide critical continuity-of-care information. For example, some practices document telemedicine sessions on paper documents that are scanned into the EHR, and thereby not included in the information derived from the use of clinical checklists in the EHR.

Mitigation strategy. Physicians and staff should be trained to properly structure and manage telemedicine visits to assure proper documentation and communicate the interactions with the patient. Follow-up orders or recommendations should be clearly documented in the patient services portion of the Certified Electronic Health Record Technology (CEHRT) to assure follow-through on the provider recommendations and maintain continuity-of-care information.

Telemedicine technology. Telemedicine technology typically is not integrated with the HCO EHR. HCO staff and physicians must handle the telemedicine session through the communication software and separately document the session in the EHR. During the telemedicine session, the provider may take a snapshot of the location of the patient's injury or gather other information that is recorded in the EHR.

Mitigation strategy. HCOs should ensure that their telemedicine technology can be simultaneously used with their EHR technology. Telemedicine providers should be trained in how to capture information from the telemedicine technology for subsequent posting to the EHR record.

Managing telemedicine services. Telemedicine visits must be structured and supervised as if the service was being provided in the office. As such, HCOs need a monitoring and escalation strategy to assure that the patient's issues are addressed. For example, telemedicine services provided by physician assistants should include an escalation option to call upon a physician to join the telemedicine session. The practice/HCO should monitor telemedicine visit performance, completion of the medical record, and resulting treatment plans to assure that the patient is properly managed. The scope and framework for telemedicine services should be documented as part of the clinical standards and patient service standards, including specific procedures to assure proper supervision and monitoring.

Mitigation strategy. Telemedicine sessions should be supervised and tracked, by staff at the appropriate level of supervision—the same as would be used for similar services provided in the office, anytime telemedicine visits are offered. For example, HCOs may offer 24/7 coverage to support chronic care management services. Supervision includes reviewing documentation on telemedicine visits where appropriate, monitoring responses to requests for telemedicine sessions, and an escalation strategy for appropriately addressing more complex issues and needs. Telemedicine management may be necessary outside of standard office hours, or even overnight, according to the nature of what is being offered via telemedicine.

Telemedicine is a key component in a variety of strategic and tactical approaches to improving patient care and controlling healthcare costs. However, telemedicine visits require integrating an additional technology into the patient care strategy of HCOs, with proper clinical standards, adequate monitoring and supervision, and proper documentation. Such due diligence will assure that telemedicine improves patient service and enhances productivity, without raising the MPL risk profile of the HCO.
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The Evolution of MPL Reinsurance
And What Does That Mean for You, Today?

At this point in the year, you have likely been exposed to dozens of conversations surrounding the current medical professional liability (MPL) market and where it is headed for 2019. Boards of directors, ratings analysts, reserving actuaries, and your own leadership teams are looking internally for signs of results shifting, and externally for aggregate trends that hint at a market turn.

BY LINDSAY GINTER AND MICHAEL NORI

JLT Re’s MPL composite (companies that write 90% or more of direct written premium as MPL, resulting in 170 affiliated and unaffiliated entities as reported by A.M. Best) exhibited 14% more writers reporting a combined ratio above 100% in 2017, as compared with 2012 (see Figure 1). The dividend-to-surplus ratio was under 5% in 2017, for the first time since 2011. Fifteen entities dropped off the list entirely within the last year, due to a myriad of changes: voluntary runoff, acquisition, involuntary receivership, and expansion into other lines (thereby rendering the 90% threshold not met). Signs of market change are certainly upon us.

Survey: the mindset of MPL insurance and reinsurance executives

In a survey conducted by the JLT Re MPL team annually since 2012, both primary and reinsurance executives have consistently predicted a steady trend of price stabilization, or even decline, in the MPL reinsurance marketplace. This dramatically changed in 2018, with 94% of reinsurance executives predicting an anticipated increase to reinsurance pricing for MPL, and 62% of primary executives agreeing with that assessment. While the vast majority of executives in the market now seem to believe that the next 12 months will deliver reinsurance pricing increases, MPL companies are still largely underwritten based on their own merit: on profitability, overall financial strength, and the ability to harness relevant business data.

Lindsay Ginter is Senior Vice President, Healthcare Practice Group, and Michael Nori, FCAS, MAAA, is Executive Vice President, Global Head of Actuarial, JLT Re.
Changes in reinsurance buying habits

In the world of MPL reinsurance, the last 15 years have certainly displayed a pattern of steady change. In 2002, premium-to-surplus ratios were a significant concern for many now MPL Association member companies. Reinsurance capacity for MPL was difficult to find. Retentions on “working layers” were intentionally set low; excess layers were purchased on a cessions basis to provide cover up to the highest policy limit; and “event” coverage was virtually nonexistent. Swing rates were relatively common; they were viewed as one way to bridge a gap between the reinsurer and the cedent in regard to views on portfolio profitability. Swing rates were also used with most start-up entities, as they lacked credible historical experience data.

The evolution in MPL claims, coupled with the precedent-setting accumulation of capital by many MPL carriers, has dramatically changed reinsurance buying habits since then:

- A significant number of working layers have increased retentions, and are no longer placed at 100%, or, in many cases, have been removed entirely.
- Excluding those with national MPL portfolios, today’s MPL carriers typically buy in the range of $5 million to $20 million of “event” coverage, intended to protect against a wide array of claim scenarios: clash loss, punitive damages, per policy aggregates, systemic loss, runaway loss adjustment expense, and others (as well as to protect original per-claim limits).
- Profit-sharing components have replaced many swing rates, with the upside benefiting the cedent.
- Commutation provisions are prevalent, whereby a pre-negotiated return premium percentage and defined timeframe are set, for a company to take reserves back onto their own books.
- Exclusions, definitions, and other coverage components have expanded (beginning around 2010) to allow for a broadened primary underwriting discipline.

Not surprisingly, these buying trends have had a significant impact on the premiums ceded by specialist writers to the MPL reinsurance market (Figure 2).

For the MPL market as a whole, the same trend has occurred. In 2002, which could be viewed as a peak of reinsurance utilization by MPL insurers, the industry ceded $1.97 billion to unaffiliated companies. By 2017, this figure fell to $960 million. Also startling is the number of entities ceding MPL business to unaffiliated companies: despite the ceded premium being cut in half, the number of ceding entities grew from 92 to 138. This exhibits the trend of significant new entrants to this market in the last 15 years, as well as intense price competition (Figure 3).

Reinsurance consulting in 2019

For those with reinsurance programs renewing in the next six months, what does all this mean? The consultation for reinsurance program structuring and pricing has grown in corresponding complexity over the last two decades and, as a response, reinsurance brokers have compiled resources to aid decision makers—not only on the solution itself, but also on how to articulate the methodology they have used to boards of directors, rating analysts, reserving actuaries, and leadership teams.
Reinsurance structure modeling
Modeled loss costs for your portfolio, coupled with the “subscription placement” nature of the reinsurance market, will take you to the initial stages of pricing a particular treaty. But the decision to secure an optimal reinsurance program requires far more complex modeling and must take into account the unique nature of the breadth of risks to which each ceding company is exposed.

Dynamic financial analysis (DFA) aids your company in identifying the efficiency of your reinsurance program, as measured by the return you forecast for your portfolio (expected underwriting income) versus the risk for that portfolio (the standard deviation of the underwriting results; see Figure 4). These tools allow for a comparison of ceded margins and net effects on a company’s tail risk across various reinsurance structures. Ceded margins are the costs of the reinsurance structure. Measuring net effects on the company’s tail risk illustrates the benefits of the reinsurance, in terms of downside protection provided. The key objective is to assess the value of the risk you transfer, within the context of your own risk tolerance/appetite and the views of your respective rating agency, as applicable. In Figure 4, we see the results of a risk/return comparison and how an organization can often select a reinsurance program along that frontier that meets its corporate and regulatory risk objectives.

Alternative reinsurance options
In addition to DFA, there are certain types of insurance portfolios, specific insurance transactions, or company circumstances that call for additional strategies. Such strategies in the reinsurance community are referred to as “structured reinsurance,” and require a deeper actuarial dive in analyzing the exposure and a thorough understanding of the accounting, tax, capital, and rating implications to develop the ideal solution.

Retroactive reinsurance. A significant practice of a reinsurance broker is now dedicated to what is termed retroactive reinsurance. This segment has evolved in the last 20 years due to market demand, but also the reinsurance market’s foresight in understanding what can be done to support such transactions. The changes in the statutory accounting rules, as well as the refinements in industry capital models, make retroactive reinsurance a viable and attractive solution for a host of ceding companies, ranging from those simply managing their capital, to those exiting a line of business to those hedging inflation. Two primary forms of retroactive reinsurance are adverse development covers (ADCs) and loss portfolio transfers (LPTs).

A review of case studies for the use of LPT and ADC transactions would unearth thousands of different sets of terms, and ultimately prove that the circumstances of each are fact-specific and tailored to each individual client’s needs. However, for purposes of this discussion, the following table (Table 1) identifies buyers’ motivations for the majority of such arrangements: ADCs and LPTs may provide financial flexibility to your company by helping to put the past behind you, or unlock some of the economic value embedded in your company loss reserves and convert this into “capital” useful for a myriad of strategies.
Your reinsurance broker will have thorough and market-tested analyses for helping you identify whether a retroactive reinsurance solution is appropriate and valuable to your company.

Strategic and economic advisory. Beyond reinsurance structuring, pricing, and negotiation, brokers have developed a wealth of tools to further enhance your overall company strategy. Highly advanced teams in the areas of ratings, finance, regulation, and data analysis customize their services around clients, and these are designed to address the most important issues facing the industry today.

Portfolio management and growth consulting. One area of consulting that has impacted the MPL industry considerably in the last five years has been growth consulting. Given the challenges the MPL market faces in terms of price competition and a changing insured demographic, reinsurers have tools that can model performance and address trade-offs between return and risk for growing a portfolio in a territory or class. Such tools are also utilized to model the efficiency of your current portfolio, and possibly identify pockets of underperforming risk that can be modified so as to earn a better return.

**Venue-specific analysis.** Because MPL is significantly state-specific (arguably, more so than any other line of insurance), reinsurance brokers dedicated to the space will maintain databases of state regulations, frequency and severity trends, and rate filing information to allow proper analysis if a company is interested in entering a new territory. The aggregation of data reinsurance brokers have access to, given their unique position in the marketplace, makes possible a view of state and nationwide trends that writers with single-state or regional portfolios may not necessarily have.

**Financial planning and valuation.** Another area of newly sophisticated consulting in MPL pertains to the effective uses of capital. Broker tools can provide the objective information you need to assess the value of reinsurance structures relative to other forms of capital (as well as other strategic initiatives), with the goal of supporting your firm’s value, whether public or private.

Figure 5 demonstrates the output of such a tool, which, in this particular case, models franchise value for a collection of specialist MPL writers, based on the variables of forward earnings and expected earnings volatility. Forward returns on capital and the volatility associated with those returns are closely correlated with price-to-book multiples. Utilizing both public and internal data points for estimating these variables, this model is able to depict the varying levels of franchise value, as well as forecast which future strategies (involving reinsurance or not) will decrease future volatility and increase valuation.

**Conclusion**

As you look to 2019 and beyond to the next five years, how will you face today’s shifting landscape and differentiate your company in the marketplace? Ensuring your preparedness for achieving your goals is a significant component of what a reinsurance broker can do in working with you in developing practical strategies. An experienced broking firm will proactively approach your needs for the reinsurance renewal, board meetings, and ratings review, and also arm you with the requisite detailed analytic information to support your strategic plans—certainly those pertinent to reinsurance, but also those paramount to ensuring your company’s success.

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**Table 1. Buyer Motivation for LPT or ADC**

<table>
<thead>
<tr>
<th>Position</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital position</td>
<td>Companies seeking to optimize capital position under regulatory guidelines and throughout various stages of company development (growth and retraction).</td>
</tr>
<tr>
<td>Rating situation</td>
<td>Companies seeking to earn or maintain a rating while transitioning through organizational changes, market turns, or periods of capital strain.</td>
</tr>
<tr>
<td>Exiting line of business</td>
<td>Companies seeking to protect future earnings from potentially underperforming lines of business/portfolios of risk.</td>
</tr>
<tr>
<td>Sale or purchase of company</td>
<td>Buyers and sellers seeking to protect future earnings of newly merged companies from any surprises from the past. Particularly prevalent during prolonged soft market conditions with considerable M&amp;A.</td>
</tr>
</tbody>
</table>

**Figure 5. Select MPL Carriers: Franchise Value Analysis**

Source: JLT Re Analytics, Bloomberg Finance L.P.

For related information, see www.jltre.com.
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The 2018 Medical Liability Conference (MLC) in Orlando, Florida, brought together hundreds of professionals who work in insurance and alternative risk transfer, all looking to gain key insights into the issues facing the medical professional liability (MPL) community. The meeting addressed the most important topics these professionals needed to learn more about and discuss.

Subjects covered included the role and scope of MPL in the future, strategies for promoting tort reforms, and the benefits—and corresponding risks—of using telemedicine.

Attendees left the meeting with a clearer perspective on the present and future, and with specific strategies for meeting the challenges of the evolving healthcare system, both in the U.S. and around the world.

A new name for PIAA:
Medical Professional Liability Association

At the annual meeting of members, an integral part of each year’s MLC, PIAA announced that the members had voted to change the name of the organization to the Medical Professional Liability Association (MPL Association).

The change supports the Association’s continued growth, as well as its widely acknowledged leadership role within the healthcare community. It also better positions the Association to keep pace with the changes occurring in healthcare delivery and within its membership.

“I am excited about the new brand, and where it will take the Association in the ensuing months and years,” said Mary-Lou Misrahy, newly-elected Chair of the MPL Association Board and President and CEO of Physicians Insurance A Mutual Company. “This change, and our strategic plan, will best position the Association to assist members and at the same time support the profession of medicine as a whole. I am confident that this action will help keep us on target for meeting the needs of the ever-broadening MPL community.”

Keynote address: “The Healthcare Trilemma: Access, Quality, and Innovation”

“Why are coverage expansions so difficult?” asked keynote speaker Amitabh Chandra, noting that the answer is actually fairly simple: “Because health insurance is so expensive.” Healthcare is what he terms a “low-value enterprise.” He then explained to attendees the myriad factors resulting in endlessly higher health insurance costs, and told them what needs to be done to transform U.S. healthcare to a “high-value enterprise.”

Amitabh Chandra, PhD, is Professor of Public Policy and Director of Health Policy Research at the Harvard Kennedy School of Government.

Trained as an economist, Dr. Chandra expresses the value of healthcare as an equation: value = total outcomes/total cost. According to this equation, in order to raise value, we need to increase the numerator, and decrease the denominator. Health insurance premiums have increased by roughly 200% since 1999. That would be okay, in terms of Dr. Chandra’s equation, if outcomes as well had improved by more than 200%.
There are environmental factors that play a significant role in this disparity between costs and outcome. In one example, Dr. Chandra noted the consequence of hospital mergers and acquisitions, and in particular the acquisition of physician practices: prices unambiguously increase, and quality unambiguously decreases.

Second, when physicians are vertically integrated through employment by a hospital, Dr. Chandra’s data show, they are much more likely to refer patients to hospital-based services, for example, for MRIs, and thus are linked with substantially greater costs.

The purported emphasis on population health claimed in proposals for mergers and acquisitions in hospitals and health systems, in fact increases the market power of the merged entities. At the same time, health insurance companies have been attempting mergers. These merged entities would be able to extract significant discounts from very large hospitals.

“But there is nothing in economics that suggests that I as a provider will pass that discount down to my patients,” Dr. Chandra pointed out. “And two monopolists are always worse than just one monopolist.” So, he says, the Department of Justice was right in blocking these transactions.

But now we are seeing new kinds of mergers, such as that of CVS and Aetna. “I think we need to be careful about these—but careful, as distinct from opposed,” Dr. Chandra says, “because there are some value-creating opportunities in these nontraditional mergers. We have to think carefully about whether they are good for our patients.” We don’t yet know if the new mergers will yield lower costs.

The number-one challenge, Dr. Chandra believes, why American healthcare is often low value, is not just these mergers. It’s also the impact of new technologies, and how they are frequently used by hospitals, in marketing campaigns for their new, shiny machines. But are the results with it better? Often, there are no studies proving their superior value.

The challenge with medical innovation, said Dr. Chandra, is to figure out who gets to decide which new treatments to adopt, and pay for. Economics suggests that it be physicians, because they have the most information. In one study, using pre-established bundles of care lowered spending by 32%.

The doctors in the study were in the driver’s seat, empowered to determine which surgeries were actually helping patients.

But none of the hoped-for increases in value will be achieved, Dr. Chandra concluded, without liability reform: “Doctors can’t change, unless they know they won’t be sued.”

Spotlight on a session

“MPL in the Future: Responding to the Evolution of Healthcare”

In this session, the CEOs of four MPL companies offered a singularly broad perspective on the likely future course of the MPL sector. In an interview-type format, they provided an insider’s take on what has been impacting MPL in the wake of the ongoing transformation of the healthcare industry. To thrive, MPL companies need to understand the full scope of the various forces driving this dynamic environment. They need to know how to innovate, in close coordination with the relentless pace of new complexities—in short, to stay relevant in today’s market.

What will the MPL market be like 25 years from now? That, the panelists agreed, will depend on the architecture of the healthcare system. What we do know is that patients will be demanding ever more healthcare, which will likely be delivered by larger care organizations. Will the situation with MPL parallel that of healthcare? Yes, if there is enough capital, in companies with a sufficiently large geographic footprint.

One strategy companies have found, said Mary-Lou Misrahy, President and CEO, Physicians Insurance A Mutual Company, is using partners to provide services, e.g., stop-loss coverage. These allow physician-owned networks to remain independent.

The moderator of the session, Scott C. Syphax, Chief Executive Officer, Syphax Strategic, Inc., and Director, NORCAL
Insurance Company, asked whether the panelists thought that corporate structures like mutuals can survive. W. Stancil Starnes, JD, Chairman, CEO, and President, ProAssurance Corporation, noted that, “The mutuals have done a splendid job, we’re all mission-driven. We were formed by MDs in Alabama. That’s great, but it is not sustainable.”

Gregg L. Hanson, CEO and President, Coverys, said that the MPL companies must have a capacity to diversify. Toward that end, Coverys has formed a subsidiary that provides medical education throughout the country. And Ms. Misrahy added that in the future, the emphasis in the MPL market will shift from offering the lowest price for coverage to providing services of value to physicians, to make their purchase worthwhile.

Asked by the moderator whether they will be expecting changes in the tort system, the panelists noted that in the U.S., there are 50 states, each of which has its own view of tort reform; and the plaintiff’s bar is likely to remain very aggressive. In contrast, Mandy Anderson, CEO and Managing Director, Medical Insurance Australia Pty Ltd., pointed out that in her country, tort reforms enacted have been very successful. She said that one challenge for her company is to determine how to respond to the new digital world.

▶ Focus on a Session

“The Expansion of Telemedicine: A Boon to MPL, or Just a New Set of Challenges?”

The explosion of new knowledge and information in the health sciences is creating greater disparities in the quality of health-care services, while at the same time rapidly increasing health-care costs are a major concern. This is our current situation, noted panelist Thomas Nesbitt, MD, MPH, Interim Vice Chancellor, and UC Davis Health Director, Center for Health and Technology, UC Davis.

For telemedicine, the hope is that it can help to redistribute healthcare information and expertise to where and when it is needed and thereby potentially reduce costs of care. Dr. Nesbitt sketched a brief history of telemedicine and noted the settings in which it is used today: outpatient care, hospital care, chronic disease management in the home, and community direct to consumer care.

Evidence of patient satisfaction with telemedicine, and the accuracy of its outcomes, is supported by numerous articles in the scientific literature. And yet, there are a number of liability considerations for outpatient telemedicine, as one example of a telemedicine setting: it is often a supplement rather than a substitute, there may be two health professionals’ (often MDs’) opinions involved, the image quality in asynchronous applications may be questioned, a specialist may have to rely on a primary care professional to provide an exam, and there may be issues of medication management and questions about state licensure.

For all of the settings where telemedicine is now used, Dr. Nesbitt said that the liability issues can be kept to a minimum by using evidence-based telemedicine guidelines, providing care only within the states in which the provider is licensed and covered by a carrier, ensuring credentialing where appropriate, documenting informed consent, including limitations, and assuring

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**Lifetime Achievement Award**

At the Conference, John Gray, MD, CCFP, FCFP, was recognized with an Award of Excellence for Lifetime Achievement. Dr. Gray was honored for his outstanding contributions to the Association and the international MPL community, as well as to medicine. His dedication to the medical profession is reflected by his service of more than 20 years on the executive committee of his county medical society, 10 years with the Ontario Medical Association, including one year as president; and five years on the board of directors of the Canadian Medical Association.

In addition, Dr. Gray dedicated many years of service to the Association, serving on the Board of Directors, the Audit Committee, and on the International Section, including as its Chair.

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**MPL Industry Defender Award**

This year, the Association inaugurated a special award, to recognize outstanding work by attorneys whose life work has been devoted to tirelessly defending healthcare professionals. The recipients for this first set of awards were William H. Archambault, JD, Craig Fontaine, JD; and G. Patrick Galloway.
data security—HIPAA-compliant processes. Healthcare professionals should not compromise; if they are unsure they should recommend an in-person visit. They need as well to regularly assess patient satisfaction and have in place a process for patient complaints, and maintain a professional appearance, background, attitude, and etiquette.

In conclusion, Dr. Nesbit noted that currently, telemedicine models of care, although having great promise, have limitations that have potential liability implications. Also, he advised that it is critical that regulatory bodies, healthcare organizations, physician organizations, and liability carriers and others develop consensus standards for these models of care.

Medicare Australia provides a payment to patients (or to doctors) for a range of medical services provided by doctors, for office-based consultations and in-hospital consultations, said Jane Deacon, MBBS, GradDipHL, Medico-Legal Advisor, MDA National Pty, Ltd. In addition, from 2011, telehealth consultations have been funded to enable patients who are some distance away from specialist care to have a consultation with a specialist using video conferencing. The number of such consultations has increased significantly: first quarter 2011, 1,808 services; last quarter 2016, 40,510 services.

Telemedicine is automatically included in the cover (provided via internet, video, or phone) provided by MDA. Both doctor and patient must be in Australia, and practice must be in accordance with guidelines of the Medical Board, relevant college, and Medicare.

Ms. Deacon noted the advantages of telemedicine, including access to care for remote and rural patients, and efficiency and cost, for both patient and doctor. But she also cited several disadvantages, such as the inability to touch and physically examine the patient and issues with follow-up.

The Association recognized Paul C. McNabb, II, MD, as the recipient of the 2018 Award of Excellence in honor of Peter Sweetland. Dr. McNabb was honored for his singular contributions and longtime dedication to the MPL insurance community, the MPL Association, and healthcare professionals. Dr. McNabb, an internal medicine physician and infectious disease specialist in Tennessee, has represented the interests of the medical community through his decades of work in the MPL industry as well as teaching medical students at the Mayo Graduate School of Medicine and the University of Tennessee College of Medicine. He is Chairman Emeritus at State Volunteer Mutual Insurance Company (SVMIC). “Paul has served the needs of thousands of patients through his distinguished career as a physician while at the same time making significant contributions to the success of the Association,” said Richard E. Anderson, MD, Chairman and Chief Executive Officer of The Doctors Company and outgoing Chair of the Association’s Board. “He has maintained a lifelong interest in patient safety and we are honored to present him with our highest award in recognition of his dedication and commitment to the Association and those who provide healthcare.”

Brian K. Atchinson, President and CEO of the MPL Association, stated, “We are extremely pleased to present this honor to Dr. McNabb. He embodies the tenets of the award through his steadfast and long-time support of the Association and the medical liability community. We are truly grateful for his service.”

The Award of Excellence in Honor of Peter Sweetland, established in 1993 by the Association’s Board of Directors, was created in honor of the late Peter Sweetland, one of the Association’s chief architects and most fervent supporters. The award recognizes an individual who has provided exemplary service to the industry and to the Association, and who epitomizes the high ideals and ethics for which Peter Sweetland stood.

The Association recognized member company SIMED, the largest provider of MPL insurance for physicians in Puerto Rico, with the Humanitarian Award. SIMED was honored for its relief efforts and support of the medical community in Puerto Rico, in the wake of Hurricane Maria. “SIMED supported not only its policyholders, but in addition the greater medical community and the citizens of Puerto Rico in response to the devastation of Hurricane Maria,” said Richard E. Anderson, MD. “SIMED and its employees truly epitomize the spirit of the Humanitarian Award, and we are proud to recognize them for their selfless acts.”
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Medical scribes sit in on patient consultations and enter the data into the record for physicians. The goal is to reduce the time that physicians spend in documenting, so they can focus instead on delivering patient care.

Physicians who are considering adding a scribe to their practice should plan for what they need to do in order to meet their legal and professional obligations, including acting as an employer, delegating and supervising, documenting, and obtaining patient consent.

Well established in the U.S., medical scribes have only recently been introduced to Canadian healthcare, and physicians here are wondering about the benefits and risks of using them. Studies have shown that the benefits include increasing the productivity of busy specialists, and improving clinical satisfaction and patient-clinical interactions.

However, from a medical-legal perspective, to date, the CMPA has had little experience with scribes; it is unaware of any regulatory authority (College) complaints, and no civil actions have been brought.

“As we assess the role of medical scribes and the associated risks, we can use many of the lessons we’ve learned from other physician extenders, such as physician assistants,” says Dr. Tod Watkins, the CMPA’s Managing Director of Physician Services. “The most important message is that, when any new provider comes into the system, we need to continue to fulfill our role as physicians and meet the standards of care.”

**Determine who is the scribe’s employer**

When a hospital suggests the use of medical scribes, or a physician is thinking about hiring one for his hospital practice, the first
question is: Who is the employer? For example, is the hiring of medical scribes a decision made by a group of physicians? Or, are the medical scribes to be employees of the hospital where the physicians work?

The answer is important, because employers have many broad obligations. They need to make certain that there is an appropriate written agreement in place that defines the conditions of employment, states the minimum requirements for education and training, and sets forth the various potential business issues and liabilities. Physicians who hire a medical scribe must meet the obligations of an employer. So the CMPA encourages physicians to get professional advice on these agreements and other obligations.

**Delegate and supervise**

Medical scribes are neither independent nor regulated professionals. This means that the physicians who delegate the task of clinical documentation to scribes are themselves responsible for ensuring that it is appropriate to delegate the task to that individual. They are also responsible for supervising scribes while they are carrying out the task.

Supervising physicians need to ascertain that their scribes are qualified and have been properly trained, and that they adhere to the physician’s professional and ethical obligations for record-keeping.

For their part, scribes need to abide by their conditions of employment, including the clinic or hospital’s professional protocols, and to any pertinent privacy legislation. Like any staff member who can view personal health information, medical scribes should sign a confidentiality agreement as a condition of employment.

Medical scribes generally require monitoring and regular evaluation of their work, like any other staff member.

**Establish clear rules for documentation**

The supervising physicians are the ones who are responsible for instructing the scribe on how to document correctly and ensuring the scribe is adhering to the statutory and professional obligations of physicians. In addition to the legislative requirements for keeping records, Colleges have policies and guidelines for medical records, and physicians need to make sure that scribes follow these.

While there is little specific guidance on how to use a scribe, it is generally expected that the record should clearly identify the name of the medical scribe who made the original entry and indicate whether the physician has reviewed the note.

**Get patients’ consent**

Physicians also need to obtain their patients’ consent before a medical scribe can sit in on a clinical encounter.

Physicians need to introduce...
the scribe to patients and explain why the scribe is there. And they need to reassure the patients that the scribe has to follow the same expectations of confidentiality as the physician. But if patients object to the presence of the scribe, physicians must honor their wishes and ask the scribe to leave.

The bottom line

The role of medical scribes in the Canadian healthcare system continues to evolve. Physicians who are thinking about using scribes in their practice should keep in mind that they need to continue to fulfill their role as physicians and meet the usual standards of care. They should think about these points:

- Clarify who is responsible for meeting the obligations of the scribe’s employer, and for delegating tasks and supervising the scribe.
- Ensure the scribe adheres to the conditions of employment, and to the professional and legal expectations for record keeping that apply to physicians.
- Be sure to obtain patient consent for a scribe to sit in on a patient consultation.

Additional reading


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1. American College of Medical Scribes [Internet]. Montville (US); American College of Medical Scribes; [cited 2018 Jan 4]. Available from: https://theacmss.org/about-us/.
Some risks are simply more complex

The ever-evolving world of insurance, coupled with the high volume of data available today, creates a unique set of challenges for Medical Professional Liability carriers.

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NEW SECOND EDITION OF CAP’S MEDICINE ON TRIAL

A compilation of more than 80 real-life cases


The responses printed here are from Gordon Ownby, General Counsel, CAP.

Q: How does the book enhance risk management?
A: By using closed litigated claims, readers can view risk management lessons through the prism of the legal system. No healthcare provider wants to be embroiled in a legal dispute, but the reality is that, regardless of their commitment to employing best practices, most physicians will be sued at least once during their lifetime. CAP’s compilation of more than 80 litigated real-world case studies provides our member physicians with the insight to build on those practices that can improve medical outcomes and minimize risk in their own practice.

What we look for in these cases are not lessons in medicine, but lessons in risk management, the kinds of things that physicians don’t necessarily learn in medical school, but will have to acquire as they continue with their practices.

In our industry, we firmly believe that the risk management education that we promote to our physicians has been a major factor in reducing the number of injuries, increasing patient safety, and avoiding the need for lawsuits.

Q: What sorts of guidance does it provide on communication in different practice settings?
A: The cases attempt to address communications in various settings: Between physicians and patients in the office, among referring physicians and specialists outside the hospital setting, when handing off care from one physician to another, and among the entire care team at the hospital. The case studies address the risk management techniques that physicians can employ to avoid the errors and the risks to the patient.

What physicians can keep in mind to avoid lawsuits on a day-to-day basis falls into several categories: Be mindful of your patient and physician communications, know what’s happening in your office, and be aware of how your actions can affect the reaction of a patient to an adverse event. Adverse events happen all the time. They’re part of medicine, but the way the physician deals with that and communicates with the patient is very important to maintaining the trust in the physician-patient relationship and not having it break down into an adversarial relationship.

Q: How does the book address the issue of challenging patients?
A: The book dedicates a chapter to challenging patients. In every practice, there are probably a few patients who are more difficult to manage than others. While there is only so much a physician can do to safeguard the health of these patients, protecting against a lawsuit requires diligence and proper documentation.
Q: Are there potential issues with end-of-life conversations, and are there cases in the book that illustrate these issues?
A: The book contains two cases involving end-of-life care, both located in the “Hospital-Based Risk” chapter. Both cases present scenarios on how the healthcare team can seek out and confirm the patient’s or family’s wishes when dealing with a hospitalization that involves complex, incapacitating medical issues.

Q: Can providers who are not with CAP purchase the book?

Q: What is new and different about the second edition—is it just the compilation of new cases? Or is there a different emphasis on what readers can learn from the cases and your comments on them?
A: In addition to increasing the number of case studies by some 25%, the second edition is organized into chapters to help readers better reference and absorb the nature of the lessons presented.

In *Medicine on Trial*, we go through the major categories such as physician and patient communications, following through, watching to see what’s happening in the office, and self-inflicted wounds. We address these on a chapter by chapter basis so that physicians can see several examples of the same phenomenon. By seeing those examples, we hope that physicians can adopt risk management principles to help them avoid similar situations.

Q: Do you envision a third volume at this point?
A: While there are no current plans for a third edition, CAP continues to share new “Case of the Month” write-ups in its membership newsletter called “CAPsules.” CAP also offers an extensive repository of support services and other educational resources to physicians.

**The book contains two cases involving end-of-life care, both located in the “Hospital-Based Risk” chapter.**

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Déjà vu All Over Again?

Financial undercurrents continue to trouble the waters in the MPL market

BY STEPHEN J. Koca AND RICHARD B. LORD

For traditional physician-based medical professional liability (MPL) insurers, the past 10 years have been unlike any stretch of time in quite a while.

With the MPL market prone to short-lived jolts of hardening rates, followed by a handful or so years of waning rates, MPL insurers are perhaps more accustomed to a roller-coaster market cycle than the relative calm and financial stability of the past 10 years. And while their recent good fortune could change, it would take an unexpected turn of events to cloud the bright outlook of the MPL market, which still looks profitable—at least as far as the near horizon.

In 2017, the MPL market extended its run in profitable years, as net income increased, largely the result of a considerable jump in investment income. At 11% of premium, investment income more than offset insurers' underwriting loss, which also narrowed somewhat last year.

In fact, MPL insurers didn't quite break even on underwriting results in 2017. Their 102% combined ratio, although four percentage points better than the previous year (see Figure 1), does not appear to be a significant turnaround from the largely steady and gradual deterioration of underwriting results over the past decade. The increase in combined ratio from 79% to 102% over the past 10 years indicates that insurer net income (prior to investments) has decreased 23 cents for every dollar of premium collected. And while the trend, no matter how uneven, is undeniably a sign of worsening underwriting results, the deterioration has been tolerable and, to some degree, expected.

The reserve release effect

For the past dozen years or so, MPL insurers have released prior-year reserves—what can be considered as income typically associated with a re-evaluation of losses on prior policy years—which have buoyed insurers' profitability and are largely responsible for the rise and fall in the combined ratio over the past 10 years.

Reserve releases, which started as a trickle in the mid-2000s, grew to a flood by 2013, when they swelled to $2 billion and were responsible for offsetting some 25 points in the then-current policy-year loss ratio. The combined ratio moderated to 90% that year. Since then, reserve releases have waned, hovering around the $1 billion mark for several years before easing to $0.9 billion in 2016. This pullback caused the combined ratio to rise to 106% that year. In 2017, however, reserve releases reversed the trend and increased by $200 million, and allowed the combined ratio to improve by 4 points.

Reserve releases have been a mainstay of insurers' profitability since 2005, contributing between 20 points and 25 points of relief to the current policy-year combined ratio for a large part of the time. And while for the past three years, they have been approximately half the level of the largest releases, they are likely to continue to contribute to insurers' profitability for some time to come.

Reserve releases by cohort

It would be a mistake, however, to view the average reserve release, which, during 2017, accounted for around 14 percentage points of underwriting relief, as a broad-based move among MPL insurers. As Figure 2 shows, there are significant deviations from the average, some

Stephen J. Koca, FCAS, MAAA, is a Principal and Consulting Actuary, and Richard B. Lord, FCAS, MAAA, is a Principal and Consulting Actuary, both with Milliman.
of which reflect a change in the direction of underwriting results. A good case in point is the cohort of insurers in the “less than -20%” band (or those insurers releasing the largest amount of reserves). At the height of reserve releases, they accounted for between 40% and 45% of insurers. But since 2013, their numbers have faltered. The year 2014 had the first noticeable decrease, as the percent fell from 47% to 39%. That year, the combined ratio jumped 6 percentage points, to 95%. In 2016, the number of insurers in the “less than -20%” band dropped to 31%, its lowest point in years. This falloff in reserve releases caused most of the deterioration in combined ratio that year.

Last year, the percentage of insurers that released reserves (those in the “less than -20%” and “0% to 20%” bands) accounted for approximately 62% of total insurers, a figure that is nearly dead even with results from 2016, but the number of insurers that released the largest amount of reserves (those in the “less than -20%” band) increased. This spurred an improvement in the combined ratio, which eased to 102%.

No help from premiums

Premiums declined in 2017, easing from $8.15 billion in 2016 to $8.0 billion last year. This less than 2% decline, while not significant in itself, continues an 11-year trend of falloff in premium, the result of price competition and a dwindling market of traditional physician-based exposures. Moreover, it affirms suspicions that pricing, if not soft, hasn’t yet hardened.

To the untrained eye, the annual declines in premium that have occurred since 2006 may not seem all that troubling. From Figure 3, it’s easy to see that 2017 premiums still greatly exceed the pre-hard market levels of the late 1990s. Moreover, claims frequency unexpectedly improved, dropping approximately 40% from the early 2000s. This dramatic drop in frequency had greatly reduced the claims costs. So is all the hand wringing over premium declines somewhat overblown?

Probably not, when medical inflation, which is a significant driver of MPL costs, is factored into the equation. Trending at around 4% long-term, medical inflation over the past 20 years indicates that costs have increased by approximately 220%. This would mean that 1998 premium of around $5 billion would have had to increase to $11 billion to keep pace with 1998 claim levels. Insurers—even with their ample reserves—would likely be in dire straits if not for the drop in claims frequency.

On the bright side, the hefty increase in investment income and moderating underwriting losses allowed MPL insurers to post a healthy profit and increase surplus, which will most likely forestall any upward movement on pricing. For as long as insurers can maintain their surplus positions, the possibility of a...
turn in the market is moot. But as soon as a loss in surplus occurs, price hardening is a near possibility, as it has been historically.

For now, however, MPL writers may not have sufficient motivation to move prices up. Prior-year reserves still seem ample and are likely to provide insurers a cushion against current-year losses for several years to come. Interest rates are rising, which helps to bolster insurers’ investment income. And concerns about increasing claims from an influx of patients, the Patient Protection and Affordable Care Act, telemedicine, liberal courts and an increase in large losses, rollback on tort reforms, more aggressive coverage options in the market, and a raft of other potential issues have not yet materialized to a significant effect.

So perhaps MPL insurers’ biggest challenge is complacency. Because a turn in the market will happen sooner or later and, when it does, those insurers that have failed to develop a differentiating product, embracing new data technologies, and/or geographic strategy could well be left behind.

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As we have commented in prior publications (“The Shifting Sands of Central Bank Monetary Policy,” Inside Medical Liability, Fourth Quarter 2017, page 61), the magnitude of this reversal of currents is hard to underestimate. The U.S. Federal Reserve’s balance sheet increased from just under $1 trillion in 2007, to a peak of $4.5 trillion, or from 6% of GDP to 23%. With quantitative easing now being wound down, this amount has slowly started to fall. This retreating tide has exposed several cracks in the investment landscape that have been developing below the surface, but are just now coming to light. The first of these cracks was the equity market sell-off in early February, which saw the S&P 500 fall 10%, and the VIX volatility index increase by 150%, over the course of nine trading days. The rationale given was a surprisingly vibrant wage inflation upsurge, and some wrong-footed volatility traders. In March came concerns of a global trade war after tariffs on steel and aluminum were announced. Next, the emerging markets started to crack, with the Argentine peso falling almost 25%, from April through the end of May, and the Turkish lira falling 18.5% (against the U.S. dollar). And most recently, concerns about the newly elected Italian populist government drove the yield on two-year Italian government bonds from a low of -0.7 basis points (bps) on May 15 to as high as +250 bps on May 29.

Each of these events has its own unique causes; one could reasonably conclude that each represents nothing more than an isolated incident. However, the combination of these events, and more importantly the timing of their occurrence, which overlaps with the winding down of the Federal Reserve’s balance sheet, indicates that these are not merely isolated incidents. They are, instead, the result of the removal of easy monetary policy, which had functioned as the shock absorber to stabilize the market in the wake of the Great Recession.

To understand why this is happening, it is helpful to break down this concept of removing easy monetary policy into three related, yet distinct, areas of impact: the reversal of the movement of investors along the risk spectrum, the slowing of the global liquidity flow, and the impact of a higher dollar.

Movement along the risk spectrum
Let’s start with the movement of investors along the risk spectrum. The basic premise here is that a prolonged period of low interest rates across the globe forced investors into increasingly risky assets in their quest to achieve targeted (and often mandated) yield hurdles. This dynamic has now been thrown into reverse. The U.S. Federal Reserve has raised its overnight lending rate seven times, most recently to 2.00%, pushing up the yield available on two-year Treasury debt to 2.50%. This means that the relative appeal of investing further out on the risk spectrum has been reduced. A junk-rated bond yielding 5.75% was very attractive in 2013, with a risk-free, two-year Treasury reference rate of 0.3%, as it offered a pickup of almost 550 bps. However, that same risk premium today has shrunk to around 400 bps. At the same time, the opportunity cost of being invested in a risk-free asset has also been reduced, since that asset is now offering 215 bps more in yield than it was five years ago (Figure 1). Buying risk-free assets is no longer akin to stuffing your money under your mattress. This has caused investors to reexamine the merits of investing in riskier asset classes.

Global flow of liquidity
The next dynamic is the global flow of liquidity, which has been greatly reduced as the tide

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of central bank stimulus heads out. In this case, we are focusing on the cost of liquidity, which we can broadly think of as the cost of funds required to finance an investment position. Just as we observed that the opportunity cost of holding cash (or a risk-free asset) has been reduced, we can also observe that the cost of borrowing cash has increased. It is, therefore, more expensive to use leverage when investing, a phenomenon that makes it more difficult for large market participants to step in and stabilize falling markets, or arbitrage away the market inefficiencies created by sudden and dramatic changes.

As liquidity costs have increased, capital flows have been consistently weaker, resulting in a much smaller buffer to absorb shocks. In this environment, negative catalysts get magnified, driving periodic stress in funding markets, which then exacerbates fundamentals for the weakest links. Figure 2 highlights how the LIBOR-OIS spread, which is often used as a barometer for funding market stress, has coincided with the runoff of the Federal Reserve’s balance sheet. This is one reason why the “risk off” periods we highlighted earlier have been so extreme and violent in nature.

**Resurgence of the dollar**

The third dynamic is the resurgence of the U.S. dollar, which has caused investors to reconsider their positions in international stocks, bonds, and currencies. This is most apparent in the case of emerging-market positions, which for years had offered higher returns for commensurate levels of risk. But the recent rally in the dollar has increased the cost for countries to service dollar-denominated debt. This causes stress in countries that have large amounts of debt that they must service, and ultimately repay, in the increasingly expensive U.S. currency. The combination of these factors has caused emerging-market assets to look less attractive. This is particularly true for U.S. investors, whose returns become watered down when converted back into U.S. dollars.

Argentina is the best example of this phenomenon. As recently as June of 2017, Argentina was riding a wave of investor optimism, having just issued $2.75 billion worth of 100-year bonds at a yield of 7.9%. However, high inflation and underdeveloped capital markets meant Argentina was unable to find the financing it needed locally, and, importantly, in its own currency. In fact, according to the Institute of International Finance, almost 64% of Argentina’s combined government and corporate debt is denominated in U.S. dollars and other foreign currencies, making them unusually vulnerable to the status of the dollar. The only other country that is close among the big emerging markets is Turkey, with 56%, while most other countries are in the 10% to 20% range. Both countries experienced significant selloffs in their currencies and local equity markets in April and May as a result.

Understanding each of these individual dynamics helps paint a detailed picture of the impact that the removal of easy monetary policy is having on global markets. And just as the rising tide of these policies helped bring about the second-longest period of economic expansion in the U.S. on record, so should their withdrawal give us pause. We should expect an increase in both the frequency and magnitude of disruptive market events, as the tide continues to ebb.

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IML 3Q 2018  BACK _Layout 1  8/27/18  12:49 PM  Page 16
COMMUNICATION AND THE PHYSICIAN–PATIENT RELATIONSHIP

BY ERIC R. ANDERSON

In this age of astonishing technological advances and wonderfully successful treatments and cures, why do we find that patients can nevertheless be so dissatisfied with their healthcare that they feel compelled to file a lawsuit?

It’s easy to point the finger at personal injury lawyers. Their assaults on the healthcare profession and their marketing tactics have probably contributed to the abundance of lawsuits.

But maybe it would be helpful to analyze the practices of the healthcare professionals we defend, too. Then, we can ask ourselves what might change patients’ minds about their decision to sue doctors, hospitals, and other healthcare professionals.

Researchers have done studies to answer this question, using different methods to probe the perceptions of the patient. But regardless of the method employed, there has been a recurring theme: some sort of failure in physician–patient communication. Everyone well versed in risk management has likely heard about these communication roadblocks before: “He just wouldn’t listen,” “She wouldn’t talk openly,” “He was unavailable—I felt abandoned,” “She delivered information poorly,” or “He just wouldn’t try and see it as I see it.”

According to the American Association of Orthopaedic Surgeons (AAOS), there is an “art” to the communication that occurs in everyday patient encounters—the delicate balance that must be observed when facing an unhappy, upset, or angry patient or the critical discussion that is an essential element in the process of informed consent. Good patient-focused communication is “open, honest dialogue, that builds trust and promotes healing,” says the AAOS.

With this in mind, it seems, then, that this is the seminal question: Do healthcare professionals have any influence over the circumstances that cause patients to file lawsuits? While it is unreasonable to think that healthcare professionals can control all of the reasons that drive patients to undertake a legal action, they are surely in a position to influence the quality of their relationships with patients.

It seems undeniable that effective communication is the foundation of the patient–physician relationship. Furthermore, the findings of studies on the subject reveal that patients may be relatively less likely to sue a physician whom they have come to respect and trust.

What should we do with this information? It is our role, as advocates and steadfast supporters of the professionals who work so hard to deliver healthcare, to help them help themselves. We should tell them yet again about the art of patient communication and the important role it plays in their daily interactions.

Communication is something that, at times, we all take for granted. That’s why we’re not thinking about our behaviors and habits incessantly. Yet, it is one of the unnoticed things that we do every day that, if we were to focus on it a bit more, could make such a great difference in our lives. And, in the case of healthcare professionals, it might prevent a lawsuit.

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