Look Again—What Do You Really See?

Useful Tips for Avoiding Misdiagnosis

A N D

Compliance, Quality, and MPL—The Intersection
PIAA

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Amsterdam, the Netherlands

Medical Liability:
The Good – Reducing Risk
The Bad – New Losses
The Ugly – The Unknown

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The process of determining a valid diagnosis can be nearly as complex as the human body itself. There is a reason why the irascible physician in the television series “House” attracted such a huge following week after week: teasing out the correct diagnosis amid a bewildering array of findings and symptoms was a mystery that made a Sherlock Holmes tale seem simplistic in comparison.

The most common allegations within the PIAA Data Sharing Project’s more than 265,000 closed claims relate to diagnostic error. This type of error afflicts physicians, nurses, and every other type of healthcare professional as well as hospitals and healthcare systems. Diagnostic errors can stem from an intimidatingly long list of possible missteps: a test not ordered, a lab value not flagged, a pattern of metabolic problems not sufficiently stitched together to discern a pattern. These claims have an obvious impact on medical professional liability (MPL) entities and those they insure.

In the U.S. and around the world, medical training has continually improved, and it produces the most knowledgeable and best-trained physicians and nurses in history. Yet diagnostic errors remain endemic. Trying to quantify a valid number for the incidence of these errors has proved elusive, but recent studies using simulated patients indicate that diagnostic errors likely occur in 10% to 15% of all cases. Of course, the ideal goal would be a reduction of diagnostic errors to zero.

Value-based medicine is the new paradigm in healthcare delivery and is being woven into the changing system. To assess how we can increase value for every dollar spent on healthcare, we need to better ascertain the true prevalence of diagnostic error, and specify when and how it occurs. Over time, our changing and increasingly sophisticated health system will sort the professionals and healthcare systems that are providing value from those that don’t satisfy established metrics.

There are new significant resources focused on ferreting out the causes of diagnostic errors, such as organizations like the Society to Improve Diagnosis in Medicine. These and other researchers are striving for systematic approaches to reduce and hopefully eliminate the various blinders and biases that make misdiagnosis more likely. It may take many years before this work is completed. In the meantime, our cover story, “Minimizing Diagnostic Error: 10 Things You Could Do Tomorrow,” provides specific tips for physicians, patients, and healthcare organizations.

Quality-of-care investigations have culminated in scores of MPL lawsuits filed against individual professionals and health systems. In this issue of Inside Medical Liability, we are pleased to feature D. Scott Jones’s, “Federal Investigative Audits, Healthcare Compliance, and Quality Reporting: The MPL Connection.” Jones’s article surveys the full scope of the increasingly important link between quality-of-care issues and MPL. Jones provides the sort of pragmatic guidance that can be applied to minimize these risks.

Also in this issue you will find a poignant essay from a young physician on the insights into patient safety she gained after discovering what actually happened when her own father received poor-quality care. The essay is a reminder of the important work PIAA members do every day in promoting the safe practice of medicine.

It may seem at times as if the MPL community is beset with perils from virtually all sides. And some, like diagnostic error, are very hard to measure and even harder to know how to fix. But everyone working on behalf of PIAA is right along with you in overcoming these obstacles. We have a deep commitment to finding essential answers and sharing them with you.
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“Notably, the cases of diagnostic error in MPL claim series involve missed or delayed diagnosis of cancer or cardiovascular conditions.”
—Cover story
Changes in the insurance industry making your job feel like the wild, wild West?

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Strengthening Your Organization Through Diversified Leadership

Speakers:
Pina Albo, President, Reinsurance Division, Munich Reinsurance America, Inc.
Ana Pujols-McKee, MD, Executive Vice President, Chief Medical Officer, The Joint Commission

Moderator:
Rebecca Patchin, MD, Director, NORCAL Mutual Insurance Company

The evidence is in, and it’s compelling. Companies that place a high value on workforce diversity—particularly in senior management and executive positions—consistently outperform their competitors on a range of metrics, including overall returns on sales and investment capital.

This presentation will feature two exceptional leaders from the insurance (Albo) and healthcare (Dr. Pujols-McKee) industries. They will tell you how and why organizations with diverse leadership are positioned for success. Drawing on their own professional rise through the ranks, the speakers will share a business perspective on the operational and financial benefits for organizations with women in positions of authority and responsibility. They will also tell you how you can maximize the mentoring and fostering opportunities in your company.

Pina Albo was a young lawyer working in Toronto, when the travel bug took her to Germany. There, she found work with Munich Reinsurance, first in claims and later in underwriting. Her current position as president of the Reinsurance Division at Munich Reinsurance America brought her to Princeton, New Jersey, where she began work on a diversity initiative. In 2010, Ms. Albo sponsored the launch of the company’s women’s network.

Prior to her current position, Ana Pujols-McKee served as chief medical officer and associate executive director at Penn Presbyterian Medical Center, University of Pennsylvania Health System, and clinical associate professor of medicine at the University of Pennsylvania School of Medicine. She also served as medical director for the Philadelphia Health Department’s freestanding health centers.

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Events & Calendar

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Location</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO/COO Meeting</td>
<td>March 12-15, 2014</td>
<td>Hyatt Regency at Gainey Ranch Scottsdale, AZ</td>
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<tr>
<td>Board Governance Roundtable</td>
<td>March 13-16, 2014</td>
<td>Hyatt Regency at Gainey Ranch Scottsdale, AZ</td>
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<td>Marketing Workshop</td>
<td>April 9-11, 2014</td>
<td>The Peninsula Chicago, IL</td>
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<tr>
<td>Dental Workshop</td>
<td>April 9-11, 2014</td>
<td>The Peninsula Chicago, IL</td>
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<td>Leadership Camp</td>
<td>May 14, 2014</td>
<td>Fairmont Royal York Toronto, Canada</td>
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<tr>
<td>Medical Liability Conference</td>
<td>May 14-16, 2014</td>
<td>Fairmont Royal York, Toronto, Canada</td>
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<td>THRF Workshop</td>
<td>September 10-12, 2014</td>
<td>Fairmont Olympic Hotel Seattle, WA</td>
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<td>Introduction to MPLI Workshop</td>
<td>September 30-October 1, 2014</td>
<td>Omni San Diego Hotel San Diego, CA</td>
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<td>Underwriting Workshop</td>
<td>October 1-3, 2014</td>
<td>Omni San Diego Hotel San Diego, CA</td>
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<td>International Conference</td>
<td>October 8-10, 2014</td>
<td>Renaissance Hotel Amsterdam Amsterdam, the Netherlands</td>
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<td>Tyco/COO Meeting</td>
<td>November 5-7, 2014</td>
<td>Caesars Palace Las Vegas, NV</td>
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<td>Corporate Counsel Workshop</td>
<td>October 16-17, 2014</td>
<td>Fairmont Hotel Vancouver Vancouver, Canada</td>
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<tr>
<td>Claims/Risk Management Workshop</td>
<td>November 5-7, 2014</td>
<td>Omni San Diego Hotel San Diego, CA</td>
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<td>Underwriting Workshop</td>
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Over the course of more than 35 years as a health professional, Dr. Tuckson has worked in nearly every sector of health and medical care. In prior years, he has served as the Commissioner of Public Health for the District of Columbia; the Senior Vice President for Programs of the March of Dimes Foundation; the President of the Charles R. Drew University of Medicine and Science; the Senior Vice President for Professional Standards of the AMA; the Executive Vice President and Chief of Medical Affairs for UnitedHealth Group, a Fortune 25 Health and Wellbeing Company. Now, he is Managing Partner of his own company, Tuckson Health Connections.

His vision of comprehensive, multi-disciplinary, and integrated healthcare is reinforced by his active service on the Advisory Committee to the Director of the National Institutes of Health; the Robert Wood Johnson Foundation’s 2013 Commission to Build a Healthier America; the Institute of Medicine’s Roundtable on Value & Science-Driven Health Care; the Board of Directors of the American Telemedicine Association; and the Board of Directors of Cell Therapeutics Inc., among many other activities.

As the keynote speaker at the 2014 PIAA Medical Liability Conference in Toronto, Canada, Dr. Tuckson will offer fresh perspectives on recent developments in U.S. healthcare, and on what we’ve seen so far as the rollout of the Affordable Care Act proceeds. He will also consider what reform might really mean to healthcare professionals, their patients, and the medical professional liability insurance community.
In the final months of 2013, Frost & Sullivan conducted a survey titled "Search for Growth," which solicited opinions from 1,835 executives in more than 40 countries, worldwide. The scores are in, and the important new areas of growth are mHealth, the cloud in healthcare, and regulatory environments.

mHealth expansion has been fueled by the unprecedented spread of mobile technologies, as well as advancements in their innovative application in addressing health priorities. mHealth is expected to proliferate, especially for wireless monitoring of vital signs, location-aware telemonitoring systems, and Bluetooth wireless technology-enabled health trackers. This will offer new solutions for healthcare professionals and patients alike, across the healthcare spectrum.

Cloud computing is considered a key enabler for enterprise-wide computing. Implementing cloud computing technologies appropriately will help healthcare professionals improve the quality of medical services and the efficiency of operations, share information across geographic locations, and manage expenditures.

As for the regulatory environment, recent healthcare reforms and policy initiatives across many countries have emphasized the importance of quality rather than quantity. In the absence of sufficient proof of clinical benefit, reimbursements may pose a major hurdle.

The paragraphs above summarize a press release Inside Medical Liability received on December 14, 2013. We ask: Do you believe any of it? Some of it may prove true, as the months of 2014 proceed. But much of it is hard to parse, and even harder to imagine how it will actually work out—in specific, actual space and time. Looking back, it would seem that there are periods where some blithely projected future becomes a nearly ubiquitous presence. In the 1950s, it was (for example) heliports on the roof. And robots. Then, in the 1980s, it was rocket packs. And robots. Now, it’s m-everything and the cloud. And robots. And yet, a person still cannot get a proper cup of tea from a robot.

Perhaps there are cycles, not unlike the property/casualty cycles, when people either need to think, or perhaps even do think, that a future notably better than the times they now live in will likely come to pass. Let’s see what year-end 2014 serves up.

Source: PR Newswire, December 14, 2013

Dr. Philip Leggett encountered a nasty surprise. He discovered that his patient, Vector Thorn, obviously with some sort of deep grudge, had purchased the domain name philiplegget.com.

On his fake website, Thorn used the surgeon’s logo and detailed his professional experience. He then added fictional patient comments and responses. Here’s a sampling: “Not so sudden death.” “Not my problem.” “Deal with it, Junkie.” “Kicked to the curb.” In the About Us section, the site text said: “We recognize this may be a stressful time for you, so we will do everything possible to make sure we maximize your pain and suffering.”

The website had been live for several months before Dr. Leggett learned of it, from another of his patients. Leggett contacted authorities, who then tracked the evidence to a patient, Mr. Thorn. Thorn was arrested and freed on $5,000 bail. He was charged with felony online impersonation.

But wait a minute. Doesn’t the name “Vector Thorn” itself sound just a little a bit suspicious? However, in addition to sites offering free vector files of pictures of thorns, we did indeed find one Vector Thorn, a self-proclaimed “web information systems developer.”

Source: Medical Justice blog, September 6, 2013

Patient Posts Bogus Website of His Doctor
It’s Here! The 2013/14 ‘Judicial Hellholes’ Roster

The American Tort Reform Association’s “Judicial Hellholes” list, formally speaking, documents the malfeasance in places where “judges in civil cases systematically apply laws and court procedures in an unfair and unbalanced manner, generally against defendants.”

Under this criterion, California once again leads the pack. Recent targets of lawsuits there include the food industry, besieged with suits filed under the state’s plaintiff-friendly consumer-protection laws. There’s also been a heavy barrage of disability-access suits, and asbestos litigation has been steadily migrating from states with statutes limiting such litigation to California’s friendlier courtrooms.

Louisiana is currently holding the number two spot. Among other developments, despite its efforts to be a good corporate citizen in the wake of the Deepwater Horizon oil spill, BP is being fleeced by “fictitious” claims.

And now, the best of the rest:
- New York City
- West Virginia
- Madison County, Illinois (of course)
- South Florida.

“Hellhole”-related developments in South Florida have more specific relevance to MPL. There, a dysfunctional bad-faith law incentivizes plaintiffs’ lawyers to delay or obstruct settlement offers by insurers in order to pursue a large payday by alleging that the insurer failed to settle claims in good faith. Also, South Florida’s personal injury attorneys have come up with dubious formulas that inflate damages for medical expenses, by hiding actual costs or seeking recovery for unnecessary procedures.

The lengthy list of jurisdictions on the ATRA’s Watch List, which include the City of Baltimore and Cook County, Illinois, is in fact encouraging, the group reasons: “As the public and policy-makers learn more about the negative economic effects of poorly balanced civil courts, they are more likely to undertake reforms before their jurisdictions warrant designation among the Judicial Hellholes.”


Grading the Graders on Hospital Quality
It’s about time, isn’t it?

Exed by the proliferation of report cards that purportedly offer objective assessments of hospital quality, a New York state hospital association has turned the tables on the graders. They’ve created their own report card on them.

“HANYS’ Report on Report Cards,” from the Healthcare Association of New York State, assessed report cards according to key criteria like these: Did the report card use measures based on scientific evidence? Were the data used recent? Did the hospitals have a chance to review the findings before publication to check for errors?

In the resulting scores, U.S. News & World Report fared the worst, earning only a bleak half star for its hospital rankings, which incorporate surveys of the opinions of doctors around the country. “A subjective perception of hospital reputation is not a scientifically proven measure to evaluate hospitals’ processes of care,” HANYS wrote.

Other report cards received just one star: the Leapfrog Hospital Safety Score, because it relies “heavily on unvalidated survey data” collected directly from hospitals, and Consumer Reports’ Hospital Safety Ratings, for rolling up data derived from different sources and spanning disparate time frames. Also, some of the Consumer Reports data comes from insurance billing records, which HANYS considers inferior to data taken from medical charts.

The top grades?
- Three stars were awarded to The Joint Commission Quality Check and Medicare’s Hospital Compare.

Source: Kaiser Health News, November 6, 2013
PIAA is pleased to provide additional information to complement this quarter’s cover story, “Minimizing Diagnostic Error: 10 Things You Could Do Tomorrow,” by Mark Graber. A special query was conducted to capture data specific to diagnostic errors in MPL claims.

**DIAGNOSTIC ERRORS—AVERAGE INDEMNITY FOR TOP RESULTING MEDICAL CONDITIONS**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Average Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac or cardiorespiratory arrest</td>
<td>$600,000</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>$500,000</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>$400,000</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>$300,000</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>$200,000</td>
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</tbody>
</table>

A review of claims closed in the last five years (2008-2012) show cardiac or cardiorespiratory arrest as the most prevalent resulting medical condition linked with diagnostic errors. However, conditions resulting in cancer dominated the incidence of diagnostic error.

**DIAGNOSTIC ERRORS—TOP RESULTING MEDICAL CONDITIONS BY AGE GROUP**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Condition</th>
<th>21 and Under</th>
<th>22-29</th>
<th>30s</th>
<th>40s</th>
<th>50s</th>
<th>60s</th>
<th>70 and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 and Under</td>
<td>Cardiac or cardiorespiratory arrest</td>
<td>Cardiac or cardiorespiratory arrest</td>
<td>Breast cancer</td>
<td>Breast cancer</td>
<td>Breast cancer</td>
<td>Cardiac or cardiorespiratory arrest</td>
<td>Cardiac or cardiorespiratory arrest</td>
<td></td>
</tr>
<tr>
<td>Appendicitis</td>
<td>Emotional distress only</td>
<td>Cardiac or cardiorespiratory arrest</td>
<td>Cardiac or cardiorespiratory arrest</td>
<td>Cardiac or cardiorespiratory arrest</td>
<td>Lung cancer</td>
<td>Lung cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td>Breast cancer</td>
<td>Emotional distress only</td>
<td>Myocardial infarction, acute</td>
<td>Lung cancer</td>
<td>Colorectal cancer</td>
<td>Liver/gallbladder/biliary cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalopathy, not further defined</td>
<td>Ectopic pregnancy</td>
<td>Colorectal cancer</td>
<td>Lung cancer</td>
<td>Acute myocardial infarction</td>
<td>Breast cancer</td>
<td>Breast cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorder of male genital organs</td>
<td>Appendicitis</td>
<td>Pulmonary embolism</td>
<td>Colorectal cancer</td>
<td>Colorectal cancer</td>
<td>Acute myocardial infarction</td>
<td>Occlusion and stenosis of cerebral arteries</td>
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Dissecting the claims further identified other outcomes associated with different age groups that were linked with diagnostic errors. Breast cancer topped the list among claimants aged between 30 and 59 compared to cardiac or cardiorespiratory arrest as the most prevalent outcome among the other age groups. 

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Media Training: Its Importance and How It Transcends Your Career

Many businesspeople like to assume publicity is equal to free advertising. While media coverage is indeed one of the least expensive marketing tools, your company needs to offer timely, relevant news if you want to be included in media coverage. With so many news outlets operating at varying speeds, 24 hours a day, knowing how to interact with the media is an invaluable tool.

To connect with the media, you'll need a spokesperson who can serve as a thought leader and represent your company. An effective spokesperson is not born, but rather made, through hard work and dedicated coaching. He listens carefully to his colleagues' critiques and is eager to enhance his skills for future media appearances. The best spokesperson knows the subject matter inside and out, and will confidently communicate the most essential points in simple, short sentences.

The goal for any spokesperson is to communicate a company's key messages in the course of fielding specific questions from a reporter. A spokesperson also gives his organization a human face the audience can identify with. Through practice, anyone can become an expert in using a company's key messaging to answer questions from the media.

Media interviews are high-risk, high-reward opportunities. One phrase or answer to a reporter's question can alter the reputation of an organization. But instead of worrying you will say something wrong, or choosing not to participate, embrace the challenge and focus on the positive. Use the interview to spread awareness about what you do, and build a positive brand image by sticking to key messages.

Eric M. Morgenstern, APR, Fellow PRSA, is President and CEO of Morningstar Communications, Overland Park, Kansas. This is Eric's last column for Inside Medical Liability, and we wish to thank him for his excellent contributions to this publication.
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Lawyers tell clients to answer only what the question asks, but as a media spokesperson, you need to remember to deliver the key messages you want to say.

**Establish your credentials**

To get some good practice for becoming a spokesperson, you can speak to industry or community groups, and publish bylined articles or blogs. Raise your hand at meetings and say, “Hey, I want to talk,” and let everyone know what you think. Being recognized in these sorts of venues, and earning third-party endorsements, will position you as an ongoing expert source and a thought leader.

The spotlight: It is essential you feel prepared and confident about it. You never know when you might be thrust into it. Remember that when you speak, you are the face of your organization from the audience's point of view, and you need to serve as an effective brand ambassador.

The best way to control the conversation during an interview, regardless of the questions asked, is to master the technique of “blocking and bridging.” After proper coaching, this method will enable you to avoid any reporters’ questions you may not want to answer, or need to think through, and then bridge back to the message you want to deliver or have found sufficient clarity to be able to answer.

**What will you say?**

The media are very fast-paced and largely unpredictable. We have all seen a dog chasing a car, but we have never seen a dog with a bumper in its mouth. You may work hard to gain the attention of the reporter, but just like the dog that exerts so much effort in catching up with the car, what are you going to do when a reporter calls you?

Even the best-laid plans can change. Never go into an interview cold turkey. Feeling prepared and equipped to handle the change will help you avoid some of the pitfalls of poor media relations.

Know your reporter; do your homework and build rapport.

Remember, when everything is said and done, the overall image you present is key to your company’s success. Think about how you read or see the news. Skimmers (most of us, these days) do not consume news in detail. The average person won’t remember your name or even what you said, but he will come away with either a positive or negative impression of you and your company. Next time you find yourself in the midst of a media interview, make sure the impression you give is a positive one.

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The practice of emergency medicine is one of the more challenging specialties in medicine, in its technical difficulty as well as its legal risk. The goal is to provide prompt and competent emergency medical services to any patient who arrives via ambulance or walks through the door. The stakes are high: physicians are called on to diagnose and treat the full spectrum of medical conditions. Frequently, they must act with imperfect, incomplete, or inaccurate information, make split-second diagnoses, and provide life-saving treatment for complex and varied medical problems, all within a compressed timeframe. The judgment calls made in the midst of this chaotic environment can mean life or death. So it is hardly surprising that even the best ER doctors occasionally make mistakes.

In recognition of the unique challenges facing ER personnel, a handful of states have enacted legislation designed to protect ER doctors and nurses from civil liability. Generally, the statutes make it harder for plaintiffs to win cases against ER physicians and nurses by raising the plaintiff’s evidentiary burden, lowering the physician’s standard of care, or both.

In states with these statutes, the sufficiency and type of evidence that a plaintiff must bring to survive summary judgment or to recover against an ER physician will vary, depending on a number of factors. As discussed here, the Georgia Supreme Court recently provided guidance on the quantity and quality of evidence needed for a plaintiff’s action to survive the summary judgment phase, based on the Georgia ER Statute. The court’s ruling, which reversed the grant of summary judgment to an ER doctor, sug-
suggests that the ER Statute will not often prove sufficient to terminate cases at the motion stage of litigation, although it will continue to provide greater protection to ER defendants at trial.

Georgia’s approach to emergency MPL
As part of a sweeping package of tort reforms passed in 2005, the Georgia legislature enacted a law addressing medical care and treatment administered in a hospital ER setting. Under this provision, termed the “ER Statute,” no healthcare professional can be held liable for emergency care provided in a hospital ER, unless that professional is shown by “clear and convincing evidence” to have committed an act of “gross negligence.”

This statute was designed to protect ER personnel from liability, in two principal ways. First, it mandates a higher evidentiary standard. In most civil cases, a plaintiff’s burden at trial is to prove culpability by a “preponderance of the evidence,” defined as “the greater weight of the evidence” or “more likely than not.” But with the ER Statute, a plaintiff must put forth “clear and convincing evidence” of a defendant’s wrongdoing in a case involving emergency medical services. This heightened evidentiary burden is more stringent and requires both a greater quantum and a higher quality of proof.

The ER Statute also protects ER personnel by redefining the type of behavior for which a defendant can be liable, from ordinary negligence to gross negligence. The Georgia Supreme Court has defined “gross negligence” as “the absence of even slight diligence” or “the failure to exercise even a slight degree of care.” This standard requires that a plaintiff demonstrate that the defendant in a medical professional liability (MPL) case not only deviated from the standard of care, but also displayed a “lack of diligence that even careless men are accustomed to exercise.”

Application of the ER Statute
While the ER Statute was clearly intended to give ER physicians and nurses a legal advantage that offsets the higher risk of providing emergency medical care, until recently, it was not clear how that advantage would play out at the summary-judgment phase of litigation. Then, in 2012, the Georgia Court of Appeals heard two cases, Johnson v. Omondi and Daily v. Abdul-Samad, specifically addressing whether a healthcare professional who provides some care—regardless of whether that care meets established medical standards—is entitled to summary judgment under the ER Statute, on the grounds that there must be “clear and convincing evidence” of “gross negligence.” The Georgia Court of Appeals issued plurality opinions in both cases, meaning that no single opinion had enough support to become binding.

The Georgia Supreme Court granted certiorari to review these cases and recently issued an opinion in Johnson. The court’s ruling, which reversed summary judgment for the ER doctor, evidences a trend by the courts to allow such cases to go to a jury, instead of terminating them before trial. This is somewhat disappointing, for obvious reasons.

The Johnson case stems from the death of a 15-year-old boy (Johnson) who was treated at Phoebe Putney Memorial Hospital in Albany, Georgia. He had come to the ER eight days after arthroscopic knee surgery, complaining of pains on the left side of his chest. In the ER, Dr. Omondi ordered a chest x-ray and an electrocardiogram. Ruling out heart-related conditions, Dr. Omondi diagnosed Johnson’s pain as pleurisy, treated him with medication, and discharged him with instructions to return if the pain worsened. Two weeks later, Johnson returned to the ER via ambulance, and died from bilateral pulmonary embolisms. Johnson’s family filed suit, contending that Dr. Omondi had failed to recognize that Johnson presented with the “classic” signs of a pulmonary embolism and failed to order appropriate testing, which would have revealed the condition.

Before the trial court, Dr. Omondi filed a motion for summary judgment, arguing that there was no clear and convincing evidence that his conduct had been grossly negligent, because he had provided some care, even if that care was flawed. The court agreed with Dr. Omondi’s argument and entered a summary judgment in his favor.

On appeal, the justices’ opinions were split as to how to apply the heightened evidentiary standards in the ER Statute to the facts before the court. Some justices contended that the new law authorized summary judgment, unless the plaintiff could produce irrefutable evidence that Dr. Omondi had provided no care at all. Other justices feared that this interpretation would eliminate civil recourse for injured parties in all but the most extreme cases. Those justices argued that juries, not judges, should be allowed to make the qualitative evaluation of the provider’s care and determine whether the care amounted to gross negligence.

In a unanimous opinion, the Georgia Supreme Court concurred with the second interpretation, and reversed the trial court’s decision. Justice Harris Hines, who authored the opinion for the court, acknowledged that the “General Assembly has placed a higher evidentiary burden on the plaintiffs,” but noted that this requirement will not necessarily lead to more summary judgments for emergency medical providers. The court
emphasized that Dr. Omondi had recognized the potential for pulmonary embolism by including it in his differential diagnosis, but then failed to take the necessary steps to rule it out. Given that evidence, the court rationalized that a jury could potentially find, by clear and convincing evidence, that Dr. Omondi acted with gross negligence.

What does this mean for insurers who write policies for emergency medicine professionals?

All things considered, the Georgia ER Statute is undeniably beneficial for ER professionals and the entities that provide them with liability insurance. If your state does not have a similar statute, you should consider lobbying your legislature to secure one. At the very least, an ER statute like the one in Georgia will provide significant protection at trial and result in fewer verdicts against ER personnel. Plaintiffs will still face a daunting evidentiary burden at trial.

If you live in a state that does have an ER statute, you should anticipate a longer battle through trial (as opposed to the motion phase), and plan your budgeting and reserves accordingly. The lesson from Johnson is that courts are reluctant to take the analysis of liability out of a jury’s hands (except in very clear cases), even where the statute calls for “clear and convincing evidence” of “gross negligence.” These new standards may not always provide a meaningful benefit at the motion stage, but they will give doctors and nurses more protection at trial, which should result in more defense verdicts. While this result is not the “home run” that defense attorneys in Georgia had hoped for back in 2005 when the ER Statute was enacted, we are still optimistic that it will diminish the risk of trying emergency medicine cases and, ultimately, reduce MPL liability for the men and women who practice emergency medicine.

References
3. O.C.G.A. § 51-1-29.5 (requiring “clear and convincing evidence” of gross negligence).
4. O.C.G.A. § 51-1-29.5.
7. Id. at 794.
9. As Justice Keith Blackwell explained in a concurring opinion, “The statute essentially tells a jury to put one thumb on the scale for the defendant as to ‘gross negligence’ and to put the other thumb as well on the scale for the defendant as to ‘clear and convincing’ proof. Unlike at summary judgment, these thumbs on the scale may produce far more defense verdicts at trial than in ordinary malpractice claims.” 7 Id.

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With 2014 now well underway, the political season inside and outside the Washington, D.C., Beltway is in full gear. Ignore the incessant talk about the 2016 presidential race—2014 is here and now, and control of the government effectively rests on the outcome of a handful of this year’s races for the U.S. Senate. As a result, even more than usual, politics and policy will be intertwined, on Capitol Hill and at 1600 Pennsylvania Avenue.

**Policy**

Irrespective of the political environment, though, PIAA remains focused on government policies that affect the medical professional liability (MPL) insurance community. Presently, on Capitol Hill, we continue to concentrate on passage of the Standard of Care Protection Act—legislation that will ensure that federal healthcare standards are not used inappropriately to create new standards of care in MPL lawsuits. Having successfully shepherded the bill through two House committees, without so much as one dissenting vote, we are now focusing on the Senate. Procedural hurdles have impeded our progress, but there are reasonable grounds for optimism.

There have been no substantive objections to this legislation, and the strategy of adding it to the pending bill that will permanently fix the Medicare Sustainable Growth Rate (SGR) formula has effectively linked the two issues, to our great benefit. As we move closer to an anticipated meeting of the conference committee—which will reconcile the differences between the House and Senate versions of the SGR fix, our primary objective is to solidify support for addressing the standard-of-care issue. And, while we have strong policy-based arguments in support of our view, accomplishing our goal will require an effective political strategy as well.

Another legislative priority for PIAA is the Good Samaritan Health Professionals Act, which will protect volunteer healthcare professionals from lawsuits when they are helping victims of any federally declared disaster. Opposition from the trial bar has rendered this bill a heavier lift than the Standard of Care Protection Act, but passage of it is still an achievable goal.

Before the 2012 elections, the bill passed the House on a bipartisan vote. Since that time, we’ve increased support for the proposal in the U.S. Senate, and we will stay focused on getting it introduced there before the end of the year. Raising awareness of the bill, and the important role it will play in ensuring adequate medical help in the event of large-scale disaster, is the next big hurdle for PIAA and, again, political strategy will need to play a substantial role.

PIAA’s interests do not reside solely on Capitol Hill, however. The Obama Administration is undertaking regulatory activities that will directly impact MPL insurers, in several ways, and PIAA is monitoring...
them closely. Only recently, the Centers for Medicare & Medicaid Services (CMS) released several new regulations that alter the way MPL insurers will interact with the agency when dealing with MPL claims from Medicare beneficiaries. In another new program, the Agency for Healthcare Research and Quality (AHRQ) has announced its plans for a new “toolkit” designed to encourage healthcare institutions to adopt “early communications and resolutions” programs meant to obviate potential MPL claims before they become lawsuits.

Late last year, the National Practitioner Data Bank (NPDB) released a new version of its “Guidebook,” for the first time in 13 years, and the U.S. Department of the Treasury’s Federal Insurance Office unveiled its widely anticipated report on the insurance regulatory environment, hinting strongly that it will support an increased federal role in this arena.

These are just a handful of the many federal initiatives that could materially impact the operations of your company in the months ahead.

**Politics**

Will any of these policy issues actually be affected by the 2014 elections? That is certainly possible. All politically focused eyes are on the U.S. Senate, where 35 senators face reelection this year (see map, below). Most pundits agree that control of the Senate is definitely up for grabs: Democrats are contesting seven more seats than Republicans (21-14) and have, coincidentally, seven incumbents who are seeking reelection in states that were won by GOP presidential nominee Mitt Romney (compared with the sole Republican incumbent running in a state won by President Obama). Republican pickup opportunities range from three to seven; six are needed to secure GOP control of that chamber. Partisan affiliation doesn’t always align with support for issues favored by the MPL industry, however (which is why our map tracks incumbents’ positions on MPL reform rather than party affiliation), and so additional factors will also play into the topography of the policy environment, going forward.

With President Obama well into his second term, and strong odds indicating that Republicans will keep control of the House, though, the Senate contests will determine which party has the upper hand in governing, going into the 114th Congress. This could

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**U.S. Senate 2014 Elections**

- **Pro-MPL Reform Incumbent**
- **Open Seat/Incumbent with No Record**
- **Anti-MPL Reform Incumbent**

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*While we can’t donate to every incumbent, we can focus on those on key committees or in other positions where they can influence their fellow lawmakers.*

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determine not only the legislative agenda for 2015 and beyond, but also the particular administrative actions that the Obama Administration is willing to embark on at the same time. As a result, we can expect that many policy decisions in 2014 will be made with an eye to the November elections. So, the actual bills that get passed, and the particular regulations that are promulgated this year, may well depend on the political advantages gained by achieving success on either front.

PIAAPAC

So, what can PIAA do in light of the political situation, to improve our prospects for favorable policy, both now and down the road? This is where PIAAPAC comes into play. By engaging politically, via campaign contributions to key incumbents, we can significantly improve the odds of getting our message across to important legislators. It may sound crass, but it’s an unfortunate reality that campaign contributions are a basic requirement for gaining access to members of Congress. The so-called “ethics reforms” enacted in 2009 actually made things more difficult for PIAA; they placed an outright ban on legitimate lobbying strategies that had created a level playing field between smaller organizations and the political powerhouses. Today, there is a greater reward for those entities able to make top-dollar campaign contributions.

Even within the political system, PIAA faces more hurdles than many other organizations. As a trade association made up of companies (rather than an individual-member association), we cannot reach out directly to individuals to ask for their support. Instead, we must contact each of our member companies to get their permission before we can ask for contributions from the few individuals that the law does allow us to solicit (essentially, salaried executives—including board—and the administrative personnel of the member company). After we get permission, we then have to contact the companies again, to get the names and contact information for each individual we are allowed to solicit.

It is illegal for us to ask for a contribution from anyone until both of these conditions have been met. Clearly, this process is time-consuming and cumbersome for our companies, just as it is for PIAA, but the law provides no other alternative. To make matters worse, the American Association for Justice (AAJ), as an individual-member association, does not have to contend with this tortuous solicitation process. As a result, the AAJ annually outraises PIAAPAC by a margin of more than 300 to 1. Clearly, these are onerous requirements, but the political picture is not all bleak. By selectively targeting our political contributions, we have a greater impact than some might assume. While we can’t donate to every incumbent, we can focus on those on key committees or in other positions where they can influence their fellow lawmakers. Getting the ear of certain specific members may be all we need to get our message across, and thereby dramatically increase our likelihood of success. Without PIAAPAC, however, our opportunities to achieve success would be significantly diminished.

Conclusion

With the right combination of policy and political strategy, we can accomplish our goals in Washington, D.C. The goal may be passage of a new piece of legislation or reducing the burden of a pending regulatory regime. In either case, the combined efforts of PIAA and its PAC can substantially influence the impact of the federal government on the MPL insurance community. Neither entity, however, can accomplish this objective alone.

An MPL Issue for ACOs

“Many of the plans offered through health insurance exchanges include high deductibles, which will result in patients taking more responsibility for their healthcare costs. As the practice steps up its patient payment collection efforts, patient relations could become strained, which could increase the likelihood of a malpractice lawsuit.”

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Mark L. Graber, MD, FACP, is a Senior Fellow, RTI International; Professor Emeritus, SUNY Stony Brook School of Medicine; and Founder and President, Society to Improve Diagnosis in Medicine; mgraber@rti.org.
Diagnostic error gets short shrift

In a recent article, I and two of my colleagues noted the dearth of attention paid to delayed, missed, and incorrect diagnosis: “Diagnosis apparently gets overlooked in most efforts to ensure quality and safety.” Tellingly, in the 1998 Institute of Medicine report, To Err Is Human, the term “medication error” was mentioned 70 times, while “diagnostic error” appeared only twice. Yet, in 2002 Lucien Leape et al. estimated from autopsy data that diagnostic errors were responsible for some 40,000 to 80,000 deaths every year. More recently, estimates of the diagnostic error rate in ambulatory practice suggest that one out of every 1,000 diagnostic encounters results in harm from a diagnostic error. Applying these figures to the average-sized hospital suggests that diagnostic error will harm one patient every day in ambulatory care, and be responsible for five to ten patient deaths per year.

Despite these figures, and the voluminous data on the promi-
nence of diagnostic error in medical professional liability (MPL) claims, physicians seem somehow to think that such errors are in fact the problem for the other fellow, physicians less careful or less well trained. How can we explain this yawning discrepancy between the estimated rate of diagnostic error (10% of diagnoses are wrong, according to best estimates), and the physician's perception that the quality of their care is excellent? First, the vast majority of diagnostic errors, fortunately for all concerned, don't result in harm. The error is inconsequential, or is caught, or harm is mitigated. Secondly, diagnosis plays out over time and over different healthcare settings. A diagnostic error might not be appreciated until later on, further on down the line. Third, the culture of medicine is such that physicians are reluctant to notify upstream colleagues that the diagnosis changed. And finally, the odds of a truly catastrophic outcome are rare—using the figures provided above, the average busy physician might be involved in just one or two cases of fatal error over a lifetime of practice, and may never learn about these cases even if they occur.

Let's also acknowledge that physicians actually do a remarkable job with diagnosis, given the fact that there are more than 10,000 diseases, and that the presentations of these diseases are typically nonspecific.

Solid numbers on prevalence

Determining the actual incidence of diagnostic error has proved to be a daunting task. And yet this information is essential for any studies that seek to understand it. The current estimates of the diagnostic error rate derive from several different types of research approaches, each with its advantages and its corresponding limitations as well.

Data from autopsies are considered the “gold standard”; they furnish precise information on the discrepancy between inpatient diagnosis and postmortem findings. However, autopsies are increasingly rare in the U.S. Other researchers have used surveys, of both patients and doctors, to elicit information on errors in diagnosis. Roughly half of physicians, in such surveys, have said that they encounter diagnostic errors nearly once a month. The use of standardized patients—real or simulated patients assuming the classical symptoms of diseases commonly encountered—makes it possible, because so many elements are controlled, for researchers to delve into the cognitive and other factors that may hinder the process of achieving a correct diagnosis. Diagnostic error rates in such studies are in the range of 10% – 15%.

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Data from closed claims are important resources for learning about misdiagnosis. PIAA's Data Sharing Project (DSP) currently holds more than 260,000 claims, and problems related to diagnostic error are the most common
allegation cited in lawsuits, just as in every other large medical professional liability claims database in the U.S. In these claims, both the final diagnosis and the diagnosis made by the treating physician are explicitly identified. (See page 24 for more detailed information about what is revealed via the DSP, in regard to diagnostic error.)

Some promising new approaches to measuring the incidence of diagnostic error include “trigger tools” (EHRs provide alerts on cases at high risk of diagnostic error) and asking physicians and patients to report any errors they see, voluntarily.2,4

When do errors occur?
In one such study, researchers investigated 190 unique instances of diagnostic errors that were picked up via two trigger queries: one linked with a hospital stay that happened within 14 days after a primary care visit, and the other specifying an emergency department, urgent care, or second primary care visit, again 14 days or less after the original visit.2 Most of the diagnoses missed were of common conditions, like asthma, pneumonia, and anemia. Several other studies have confirmed this finding—it’s not rare diseases causing most problems, it’s the common ones.1 Of particular interest are the chief presenting symptoms implicated in cases of diagnostic error, and again it’s the common complaints that top the list: cough, abdominal pain, shortness of breath, and back and chest pain. The authors comment that of the conditions linked with diagnostic errors, “these conditions were highly variable and sometimes did not bear any obvious direct relationship to the condition that was missed.” Notably, the cases of diagnostic error in MPL claim series involve missed or delayed diagnosis of cancer or cardiovascular conditions.

Most diagnostic errors involve a breakdown in the sequential diagnostic processes involving a patient and the physician. In the series just quoted by Singh et al., errors were linked with taking a patient history (56.3%), examination (47.4%), and/or the ordering of tests for making a diagnosis. Similar findings are reported by Gordon Schiff and colleagues.4 Using a different analytical framework, in the cases I’ve studied, the “synthesis” phase of diagnosis seemed to be the most problematic, putting all the information together to arrive at the most likely diagnosis.5

Cognitive and system errors
The various errors in cognitive thinking that may arise in the process of diagnosis have been fairly well studied by now. Hindsight bias was the subject of a recent article in Inside Medical Liability (Dr. Pierre Campbell, “I Knew It All Along,” Third Quarter 2013, page 46). Along with framing effects, context errors, and premature closure, this is one of the common cognitive shortcomings that can lead to diagnostic error. There is obviously much work left to be done in figuring out the mental habits, possible prejudices, predilections, and processes involved in the clinical reasoning process. System-related flaws are equally likely to contribute to diagnostic error. The leading factors in this category include suboptimal communication or care coordination, access issues (including access to appropriate expertise on a timely basis), trainee supervision, and a host of “human factor” issues that detract from diagnostic time pressures, excess workload, distractions, clumsy EMRs, etc.

What can be done?
Although a host of interventions have been proposed that might improve diagnostic reliability, research in this area is just beginning. Promising approaches include better use of electronic medical records and diagnosis-related decision support systems, reflective practice, and taking advantage of second opinions. Patients can also play an important role in improving diagnostic reliability, and should be encouraged to play an active role in this process. Finally, our healthcare practices and organizations set the stage that influences our ability to diagnose reliably. Suggestions for each of these parties are included the following page.
DIAGNOSTIC ERRORS

Steps physicians can take to avoid diagnostic errors

1. Be reflective. Take a diagnostic “time out.”
2. Listen, really listen, to your patients and their caregivers.
3. Learn the causes of cognitive error and how to avoid pitfalls.
4. Don’t trust your intuition. Always construct a differential diagnosis.
5. Take advantage of second opinions.
6. Use diagnosis-specific decision support resources: DXplain, Isabel, VisualDx, checklists.
7. Make the patient your partner in diagnosis: Ensure they know how to get back to you if symptoms change or persist.
8. Ensure all ordered diagnostic tests and consults are completed and that you know the results. Designate a surrogate to review test results if you aplan to be away.
9. Speak directly with the staff providing you with diagnostic test results: radiologists, pathologists, clinical pathologists. If you aren’t sure of the most appropriate diagnostic strategy, ask, or use online test-ordering advice.
10. Empower your colleagues to let you know if they become aware that a diagnosis you made has changed.

Steps healthcare organizations can take to avoid diagnostic errors

1. Identify diagnostic errors: follow up with patients recently seen in the ER. Encourage inpatient attendings to report errors.
2. Provide clinicians with diagnosis-specific decision-support tools: DXplain, Isabel, VisualDx, Up-to-Date.
3. Identify physician volunteers interested in providing second opinions and advertise their services to patients and their physician peers.
4. Insist that results are acted upon within 30 days.
5. Close the loop on diagnostic test results. Send results to patients. Monitor how many critical test results are send to patients. Monitor how many critical test results are acted upon within 30 days.
6. Ensure that providers on vacation have designated a surrogate to review test results.
7. Encourage accurate problem lists, and a differential diagnosis.
8. Establish ways for providers to receive feedback on their diagnoses.
9. Encourage autopsies or virtopsy.
10. Ensure senior clinicians review all new cases with trainees in real time.
11. Encourage and facilitate communication between frontline clinicians and physician staff in radiology and the clinical laboratory.
12. Use root cause analysis to identify remediable system-related contributions to diagnostic error; host “Morbidity and Mortality” conferences with staff to review these cases.
13. Empower nurses to become involved in improving diagnosis. Monitor for new or resolving symptoms, ensure tests get done, facilitate communication between patients and providers.
14. Empower patients to be proactive in their care, to take advantage of second opinions, and to provide feedback on diagnostic errors.

Steps patients can take to avoid diagnostic errors

1. Be a good historian. Keep records of your symptoms, when they started, and how they have responded (or not) to treatment.
2. Take advantage of cancer screening.
3. Make sure you know your test results and keep accurate records of these results. Don’t assume no news is good news. Follow up if you don’t receive copies or the results of tests and consults.
4. SPEAK UP! Ask:
   a. What else could it be?
   b. What should I expect?
   c. When and how should I follow up if symptoms persist or worsen?
   d. What resources can I use to learn more?
   e. Is this test worthwhile? Can we wait? (More testing does not always mean better care!)
   f. Don’t assume the healthcare system will adequately coordinate your care. Keep your own records, and help coordinate your own care.
6. Provide feedback about diagnostic errors to providers and organizations.
7. Understand that diagnosis always involves some element of uncertainty.
8. Get a second opinion regarding serious diagnoses or unresolved symptoms.
9. Take advantage of help and support: Support groups, patient safety staff, patient advocates.

References

Note that some of the material in this article may be published simultaneously by the National Patient Safety Foundation in recognition of Patient Safety Awareness Week, 2014.
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In recent legislative proposals in Florida and Georgia, lawmakers have sought to establish a patient compensation system (PCS) as an alternative to litigation for compensating patients with injuries that could have been avoided under alternative healthcare (referred to as “medical injuries” within the legislation).

Based on the system used for workers compensation claims in the U.S.—and modeled on similar medical professional liability (MPL) compensation schemes in Denmark, Sweden, Norway, and New Zealand—PCSs have been characterized—somewhat misleadingly—as similar to “no-fault” administrative systems, because they permit compensation irrespective of whether there was alleged negligence on the part of the provider, unlike the current U.S. tort system.

Under these systems, as put forward by the legislative proposals in both states, claims for medical injuries could be filed by patients themselves, or their families, without an attorney. Claimants would then have their cases reviewed, in a hearing, by independent panels of medical experts, comprising doctors, nurses, and healthcare administration professionals. Proponents argue that these hearings would be less contentious than a lawsuit. Since negligence is not the basis for an award of damages, the goal of the panels would (purportedly) be to examine the facts surrounding the claim and decide on compensation if a medical injury has occurred, regardless of whether the standard of care was or was not breached.

Proponents say offering a PCS as an alternative to litigation could lead to faster outcomes with
claims, as it has in New Zealand, which instituted a no-fault system in 1974. According to a 2004 article in the peer-reviewed journal Health Affairs, medical claims in New Zealand are resolved within nine months, as opposed to the two to five years that is common in the U.S.

Faster resolution and less involvement by attorneys, advocates say, would ultimately reduce overall costs, while providing access to compensation for more patients. They also argue that this system would benefit claimants with minor injuries, who are frequently excluded under the current system, because their claims generally do not result in the kind of large monetary awards that make taking an MPL case cost-effective for plaintiff attorneys.

Too good to be true?
But can PCSs really provide the many benefits, in cost savings, fairness, greater access, and efficiencies, that their proponents claim?

Despite the fact that they predict a sharp increase in frequency coupled with the same compensation per claim under PCSs as in the current system, advocates argue that such systems will be more cost-effective than litigation in the long run, because they should dramatically lower—not just the defense costs that would otherwise be required for healthcare providers in liability suits—but also the state's overall cost for "defensive medicine," estimated by proponents to be approximately $30 billion annually in Florida.

At the request of a client with an interest in the MPL sector, we took a close look at the PCS legislation that was proposed during the last legislative session in Florida.

What we found is that the proposed law—while admittedly a serious response to genuine deficiencies in the tort system—probably would not, as now written, reduce MPL costs at all, let alone nearly as much as proponents claim. In fact, the proposed law could result in significant cost increases for physicians and other healthcare providers.

In fact, the proposed law raises more questions than it answers, and there may be unintended consequences, which could lead to both higher costs and a more Byzantine compensation system—one that retains the worst features of both litigation and administrative bureaucracy.

Although Florida's PCS bill—HB 897—died in committee last May, its proponents say they are determined to introduce it once again, and lobby even more aggressively on its behalf in the next legislative session.

Georgia's proposed PCS law, SB 141, which is very similar to the Florida bill, has been referred to committee for review, as of this writing.

The PCS—how it might work
Under the proposed PCS scheme (Figure 1), if a patient sustains an injury that is allegedly the result of medical care, the patient or the patient's family can file a claim and be assigned a Patient Advocate, who will help the claimant navigate the system.

Initially, the claim is forwarded to a Medical Review Department, which determines quickly whether the claim is genuine, on its face. If the claim meets this standard, it is passed on to an Independent Medical Review Panel, comprising doctors, nurses, hospital administrators, and other healthcare professionals.

This group does the bulk of the work: examining the claim, assessing its merit, interviewing witnesses, and otherwise procuring testimony. If the panel decides the claim merits some level of compensation, it is forwarded to the Compensation Department, which keeps a schedule of preestablished dollar figures for payment, based on the level of harm incurred.

If either patient or provider disputes the end result, either or both can appeal, sending the claim to an Administrative Law Judge. Note that this option to some extent undermines one of the major goals of a PCS—obviating the tort system. But it does provide an additional, independent review of what has transpired so far, ensuring that the procedures of the PCS were followed according to protocol.

If compensation is paid, the claim goes to the Quality Improvement Department, which attempts to find out what went wrong in the underlying event, to assist the medical profession in learning from its mistakes.

With a PCS, there is no such thing as a doctor who "did something wrong," only that the doctor—or any doctor, for that matter—"could have done it better." In other words, the burden is on the claimant, not to prove negligence, but rather "avoidability." Applying this criterion will increase the number of claims compensated, and the associated costs are likely to be considerable as well.

Pros and cons of the proposed PCS
One of the primary objectives of the bill, as stated by the proponents, is to provide injured patients with recourse to fair compensation, without the need for lengthy and costly litigation.

Florida State Representative Jason Brodeur (R-Sanford), who sponsored his state's PCS bill, said, "This is not a no-fault system, it's a no-blame system," adding that it would, "revolutionize the practice of medicine," by removing a major cost driver in the current system—litigation and the threat of litigation.

But not everyone agrees. The bill may not necessarily provide easier access for everyone who believes they were in some way injured by a healthcare provider. In fact, the system as proposed is complex, and appeals are likely.

Opponents of Florida's PCS proposal include The Doctors Company (TDC), the largest writer of MPL in Florida, Associated Industries of Florida, and the Florida Chamber of Commerce.

Robert White, head of TDC's Florida company, has said the PCS approach "to reforming the medical malpractice system is a misguided attempt, likely unconstitutional, that would result in an increase in costs, claims against physicians, and fraud—all in the name of curing the symptoms of a 'sick system' that appears to be getting healthier."
Rebecca O’Hara, vice-president for Government Affairs of the Florida Medical Association (until May 2012), told Health News Florida that the proposal had sparked a fierce debate at her organization, with some board members supporting the new system and others opposing it just as vehemently. She had suggested further study.

The only supporters beyond the bill’s sponsors, according to Health News Florida, were “a few researchers,” and the advocacy group that is the main driver of the proposals in Florida and Georgia, and which helped to craft the legislation in both states, Patients for Fair Compensation (PFC).

PFC has spent between $100,000 and $190,000 lobbying on behalf of the proposal in Florida, and also funded a study claiming that the PCS would increase the direct costs associated with MPL only moderately, by about $100 million, as compared with current costs of close to $800 million.

PFC also claims that implementing the PCS would dramatically lower indirect costs, principally by saving Florida more than $16 billion a year in defensive medicine costs after three years following its enactment. It is unlikely, given the flaws in the proposed legislation discussed elsewhere in this article, that the PCS would materially impact the practice of defensive medicine.

Issues with the proposed legislation

Our review of HB 897 revealed several important concerns about this bill, not previously part of the public discourse, plus some inconsistencies in the language of the bill itself, that could lead to outcomes that are very different from what the proponents have suggested.

1. “Exclusive remedy” or “alternative to litigation”? HB 897 states that the proposed PCS would serve as the “exclusive remedy” for personal injury or wrongful death in Florida. However, within the body of the bill itself, the system is called an “alternative” to litigation.

So: will the proposed PCS be an option, or a requirement? The most recent version of the bill states that a provider can choose whether or not to participate in the PCS, and that patients, for their part, have the option to resort to litigation if the PCS process is not to their liking or does not provide the restitution they seek. That argues that Florida’s PCS will be merely an option for claimants and providers—one that need not be taken. With this degree of ambiguity in the system, the legislation cannot be expected to lessen costs, only increase them—perhaps significantly.

2. Reporting to the National Practitioner Bank (NPDB) One inadequacy in the legislation, in our view, is its position that compensation made under Florida’s PCS will not have to be reported to the NPDB.

The NPDB is an electronic repository of all payments made on behalf of individual healthcare providers in connection with MPL settlements or judgments, in addition to adverse actions, via peer review, against licenses, clinical privileges, and professional society memberships of physicians and other healthcare practitioners.

Under federal law, information on all MPL claim payments must be reported to the NPDB.

The Florida bill asserts that any payment made under a PCS does not constitute a claim and will therefore not have to be reported to the NPDB. However, it is unlikely that the federal government will agree, or allow an exception for any state law, for that matter, so this requirement would undermine the “no-fault/no blame” aspect of the PCS proposal.

3. Compensation schedule

Proponents claim that the tort system and the PCS will have equal costs; in fact, this requirement is built into the proposed legislation.

They also state that claim costs will not change, despite the fact that they assume a sharp increase in frequency, since it will be easier to file a PCS claim than a lawsuit, and also easier to prove avoidability rather than negligence.

However, the PCS will use data on severity from the PIAA Data Sharing Project to develop a compensation schedule.* But PIAA data is collected on a per-claim basis rather than a per-injury basis. We’ve found that this distinction makes quite a bit of difference.

On average, there are approximately two claims filed per injury. More important, we estimate that there are approximately 10% more paid claims than paid injuries. In short, patients will receive a smaller payment if claim data are applied than they would if injury data are applied. Finally, PIAAs published severities are based on physicians’ claim data. And physicians have smaller pockets than hospitals.

Although the stated intent of the bill is not to decrease severity (the amount paid for any individual claim) for any particular type of injury, by using PIAA data to establish the dollar amounts for payouts, the proponents of the PCS are, in fact, reducing it.

*Editor’s Note: PIAA is opposed to the Patient Compensation System (PCS) proposed by Patients for Fair Compensation (PFC). PIAA has not communicated with PFC and has no plans to support the efforts of this group in any way.

4. Medical review of applications

The Medical Review Panel procedure would replace the process of “discovery” that is used in the tort system. The bill imposes strict guidelines

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Figure 1 How Would It Work?

Patients for Fair Compensation: Goal of the PCS

- **Quality Improvement Department**
- **Medical Review Department**
- **Independent Medical Review Panel**
- **Compensation Department**
- **Administrative Law Judge**
- **Patient Advocate**

Source: PIAA document, distributed to House subcommittee on April 1, 2013.
for how long each section of the review can take: 10 days are allotted for determining whether a medical injury actually took place; 30 days to determine the “validity” of the claim; and 60 days to complete a “thorough” investigation in the event that the provider opposes the claim.

But is it feasible that a panel like this, made up of busy professionals, could replicate all that happens in discovery—interviewing witnesses and otherwise procuring testimony, reading thick case files and documents—for each of potentially thousands of injuries—and accomplish all of this within 100 days?

But the Medical Review Panel is indeed charged with this extent of fact gathering, including securing responses from lawyers and medical experts if either side in the case wishes to use them. There’s nothing in the bill stating that the panels need to give lawyers time to present during a hearing, but if lawyers are allowed into the process—as they are in the current bill—not allowing them to present could form the basis for an appeal.

5. Attorney and outside medical expert involvement

Despite the fact that the primary purpose of the PCS is to avoid litigation, the proposed legislation does not prevent either claimants or providers from obtaining legal representation. Since all parties are guaranteed access to records, and since the stakes are going to be just as high as they are with litigation (with similar claim payments mandated), it seems logical that both claimants and providers would want attorneys to peruse those records for them. In addition, no precedent as yet exists that would define an avoidability standard, as precedents have been established for negligence.

It seems likely that this unfamiliar and complex system will need to involve a fair amount of time with lawyers and medical experts, and perhaps, at the outset, even more per claim than under the current tort system. If precedent is held to be relevant under the proposed PCS, all parties will have a strong financial interest in arguing their positions on behalf of the first claims heard by the panels, even for claims stemming from less severe injuries.

Will there be savings . . . or costs?

As demonstrated in Figure 2, we compared filed claims for injuries in the U.S. and Florida to what is happening with the PCSs now in place in other countries, based on articles relating U.S. tort law to other systems. These suggest that there could be an increase of as much as 840% in the number of filed claims alone (these estimates consider the practice of filing claims against multiple healthcare providers involved in the same occurrence to constitute a single “claim”—this definition corresponds to our understanding that under the PCS a single compensation amount would be paid per occurrence). The associated increase in costs could be substantial, depending largely on the characteristics of filed claims and associated defense costs.

Conclusion

There are many reasons to be critical of the current tort system as a mechanism for determining MPL, but the current PCS scheme—at least, as put forward by legislators in Florida and Georgia—will not address those problems, and could, in fact, make them worse. Exclusivity of the PCS could serve to limit costs, but would possibly raise constitutionality issues with the legislation.

Proponents of these bills are assuming that claimants will not retain legal counsel—that they will just enter the PCS process and take their chances, without any representation. We believe that this assumption is wrong, especially if a PCS decision is appealed.

In other words, with this version of a PCS, claimants are just as likely to find themselves back in court, and practitioners just as likely to keep on playing defense when it comes to prescribing “defensive medicine.”

References

7. Correspondence provided by Robert White.
Medical professional liability (MPL) insurance has been enjoying a period of notable profitability over the past 10 years. Returns on equity (ROEs) for the entire sector were as high as 18% when they peaked in 2006-2008; we estimate that the ROE for the sector was 9% in 2012, and we expect a similar level in 2013, when the year closes and final reserves are set. Statutory surplus has grown from $12 billion in 2005 to more than $24 billion in 2012, even as premiums declined by more than 20%.

Stephan L. Christiansen is Managing Director, Insurance Research & Publications, Conning.
Premium growth has been negative since 2007, stemming from a combination of price competition and market leakage to alternative risk transfer mechanisms. Losses have been relatively flat since 2007, but incurred losses have been increasing since they bottomed out in 2010. We estimate they will be modestly increasing in the next two years, from an uptick in claims frequency and severity, combined with a potential decline in reserve releases. Consequently, our outlook for the line of business is that this recent level of profitability will likely weaken over the next couple of years, with returns on capital falling to levels approximately equal to those of the broader insurance industry, at closer to 6%. While this is still profitable, it is trending downward.

On one level, this is a classic underwriting cycle in a long-tail line. Companies must be able to predict ultimate claims costs several years into the future on every policy they write, often in the context of either tail winds or head winds from prior conditions. When a change in the trend takes place, it can take several years to become apparent—until the outstanding claims are settled. With companies going through periods of underestimating claims trends, this leads to underwriting losses. This may be followed by the withdrawal of some companies from the MPL market, and sharp price increases from the remaining players, potentially leading to strong operating profitability (especially if the growth in losses slows). This, in turn, may evolve into competitive excesses in chasing this suddenly profitable business, until pricing is driven down too far or until claims once again trend upward.

Is a return to overall operating losses inevitable? And, if the industry trends this way, what proactive steps can companies take? In fact, the current situation in the MPL market may exceed this traditional cycle (Figure 1). While it shows the classic effects, in terms of claims volatility as well as in pricing and other competitive responses, there are actually four forces that may exacerbate the outcome this time, and these forces may make predicting costs over the next few years even more perilous and uncertain.

The first force: uncertainty in investment income

The first of these forces is uncertainty in trends of investment yields and investment income. The overall profitability of the MPL line is highly dependent on investment income from assets, primarily as these relate to loss reserves. Total invested assets for MPL writers are roughly six times annual premium. This compares to just under three times annual premium for the property/casualty industry overall.

Thus, in the 1980s, the income produced by invested assets represented more than 40% of premium. A company could begin making an operating profit with a combined ratio of 140% (Figure 2-3). In 2013, it would require a minimum combined ratio of 123% to recognize an operating profit, assuming average leverage ratios.

Yields on invested assets have declined over the past 30 years, and this trend has accelerated during the past five years. In the 1980s the average book yield on investments for property/casualty insurers was 7%-8%, and the 10-year Treasury spiked into the 14%-16% range. By 2008, the 10-Year Treasury had dropped to 3.5%-4%, and the average book yield for insurers was slightly more than 4%. Interest rates bottomed in May 2013, with the 10-year Treasury at 1.63%, and have since risen more than 125 basis points (1.25%).
We now believe that the contribution of investment income to operating performance may well be flat in 2013, based on a continued decline in overall book yields and a modest increase in invested assets. Why are book yields continuing to decline, if rates have begun to rise? Insurers are still rolling over their maturing bonds from earlier periods—bonds that were yielding much higher rates than current levels. If current interest rates are sustained into 2014, and then rise slightly (the consensus estimates of economic forecasters), then total investment income should begin to rise in 2014 or 2015, with overall portfolio yields recovering to levels seen in 2010 and 2011. However, these yields will still be 50 to 80 basis points below levels in 2006.

On the other hand, rates may decline once again, with extended Fed quantitative easing and a persistently sluggish economic recovery. This uncertainty in investment yields may compound the uncertainty of premiums and loss trends, in terms of impact on overall operating performance.

Second force: provider migration
A second key force in the emerging competitive landscape is the change in how providers operate: consolidation of physicians into physician groups, coupled with employment by hospitals, hospital systems, and integrated healthcare systems. At the same time, we are seeing new (or more) kinds of medical providers, physician assistants, nurse practitioners, retail clinics, and others.

This represents a massive restructuring of healthcare delivery and accountabilities, with major—and potentially surprising—consequences. The larger institutional buyers of MPL tend to make greater use of risk retention, captives, and self-insurance mechanisms. This changing marketplace brings with it a degree of uncertainty about the size of the market for traditional MPL companies, and also in regard to the kinds of claims that may emerge from the new providers and structures. The products and services of MPL insurers will need to change, and the profitability and risk characteristics of the resulting products may be even more volatile.

Third force: continuing change, competitive insurance landscape
The market in liability coverage for healthcare providers is made up of the highly fragmented and highly specialized participants within the MPL insurance segment. The segment includes both large and smaller specialist companies, risk retention groups, and specialty operations within multiline companies. In 2001, specialist companies made up about 65% of the market, while multiline companies made up most of the difference. In 2012, specialists made up 70% of the market, while multiline companies made up 22% and risk retention groups accounted for 8%.

At the same time, captives and self-insurance programs might make up as much as 50% of the exposure equivalents, not reflected in the insurance industry statistics. These participants all have different approaches to accessing the marketplace; they respond to competitive changes differently and access and employ capital differently to support underwriting. While there is adequate capital in aggregate in the sector, this capital is fragmented among these different companies and will drive different responses to changing market conditions.

The final force: regulatory, legislative uncertainty
Unknowns about new laws and regulations, headed up by the Affordable Care Act (ACA) but also including changes at the state level, will lead to uncertainty about the number and types of MPL claims and in how these claims are pursued and defended. These will compound the impact of the structural changes in the marketplace. The environment for MPL insurers has been, and for the most part remains, a volatile, state-by-state experience, with some states enacting measures to control the expansion of lawsuits and others overturning or weakening past reforms. The most effective reforms have been those limiting non-economic damages and establishing limits on expert testimony.

Within the ACA and its accompanying regulations, massive changes to the healthcare provider system are being accelerated in all states, in the payment and incentive structure of medical services driving the growth in accountable care organizations (ACOs), and in encouragement of the adoption of electronic health records. The number of insureds in the system will likely increase, while the shortfall of supply relative to demand for physicians will likely increase as well.

Figure 1 The Market Cycle as Pricing Cycle, but Driven by Claims Volatility

<table>
<thead>
<tr>
<th>Peak Profits</th>
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<tbody>
<tr>
<td>Reserve releases</td>
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<tr>
<td>Strong cash flow</td>
</tr>
<tr>
<td>Low combined ratio</td>
</tr>
<tr>
<td>Capital is attracted</td>
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</tbody>
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<table>
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<tr>
<th>Hard Market</th>
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<tbody>
<tr>
<td>Rate increases</td>
</tr>
<tr>
<td>Improved cash flow</td>
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<tr>
<td>Claims cost more controlled</td>
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<tr>
<td>Combined ratio begins to improve</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Peak Losses</th>
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<tbody>
<tr>
<td>Additions to reserves</td>
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<tr>
<td>Weak cash flow</td>
</tr>
<tr>
<td>High combined ratio</td>
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<tr>
<td>Insurers need to raise rates</td>
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<tr>
<td>Capital withdraws</td>
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<table>
<thead>
<tr>
<th>Soft Market</th>
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</thead>
<tbody>
<tr>
<td>Rate competition intensifies</td>
</tr>
<tr>
<td>Claims cost may increase</td>
</tr>
<tr>
<td>Cash flow weakens</td>
</tr>
<tr>
<td>Combined ratio deteriorates</td>
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<tr>
<td>Coverage available</td>
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Significant uncertainties surround the liability of ACOs and the application of standards of care to physician assistants and nurse practitioners—these may also evolve on a state-by-state basis.

**MPL insurers can respond**

MPL companies are rethinking their strategies and operations to anticipate these changing conditions. What forms will this take?

- **Investment decisions** may be one of the more controllable elements that companies can modify. In a recent review of the investment performance of larger specialist MPL insurers (more than $100 million in premiums), we observed that the range of tax-equivalent book yields achieved by these specialists extended from a high of more than 5% to a low of about 2%. In a stochastic analysis of risk and return characteristics that combined investments and liability performance, we concluded that a typical MPL insurer could increase its expected economic return by approximately 2% by modestly adjusting its investment strategies within traditional core strategies, with no measurable increase in economic risk—and could increase return even further if prepared to take on additional risk.

- Companies need to develop mechanisms to better understand the changing conditions, before they show up in claims experience. These include understanding the emerging causes of claims, both in frequency and in worsening severity—adverse incidents, changes in types of providers of services, influence of hospital structure and ACOs, and regulatory/legislative/judicial changes. These changes may mean that historical patterns of claims may not be as instructive for predicting future experience, and companies will need to dig deeper to get ahead of trends.

- Pricing may become more competitive, as the primary market shrinks and companies look for opportunities in adjacent markets or geographic territories. Competition, at least initially, may become more intense. Monitoring the competitive environment at ground level will also be important to recognize competitive changes that might adversely impact a company’s in-force policy base.

- Companies may want to invest in deployment of risk-management support potent enough to motivate change in the behavior of providers, including better documentation of adverse events and better selection of alternative treatment protocols. This approach goes beyond merely furnishing information, training, and system support, to a level that achieves a measurable impact that is customized for specific clinical circumstances and provider environment.

These potential changes may also lead to a competitive opportunity for the prepared. Specialist companies in an environment of increasing competition and change may initially focus on retention of business, being generally strongly capitalized and less sensitive to return-on-capital metrics. This capital can be deployed in several ways, including retention incentives and business expansion when the opportunity presents. Multiline players, including excess and surplus lines writers, may attempt to hold the line on pricing, but failing that, may choose to withdraw or focus in more tightly, as they deploy capital in more attractive lines or segments. The same may be true for the reinsurers supporting this line. Risk retention groups and smaller specialists may identify opportunities similar to those of the larger specialists, but they may find their capital resources strained and reinsurance support tightening or becoming more expensive; they will need to decide whether to seek additional capital (perhaps from assessments of their existing base) or find ways to limit exposure.

All of this would speak to the potential for increased opportunities for consolidation and further shifting of the competitive landscape in the periods following 2015.
In a recent issue of this magazine, Dwight Golann examined the issue of abandoned medical professional liability (MPL) claims. According to data from PIAA, 64% of MPL claims were dropped or abandoned over a 27-year period, a finding supported by Golann’s own five-year study in Massachusetts. In his analysis, major reasons why claims are dropped or abandoned included:

- Plaintiff’s frustration with the length of the process
- Unforeseeable events occurring while the case is pending
- Tactical claim filing to facilitate discovery or avoid the “empty chair” defense
- Weakening of the plaintiff’s case during discovery.

Radiology represents the sixth most frequently sued specialty and the sixth highest in terms of dollars paid in claims. Any changes in procedure that reduce the expenses associated with these claims should therefore be welcome. The primary mechanism of adjudicating radiology claims involves the testimony of expert witnesses who opine that the defendant radiologist did, or did not, meet the standard of care when performing his duties. While a few cases are clearly meritorious and a few clearly frivolous, most cases involve arguable interpretations of findings and actions. In these cases, the persuasiveness of the expert carries as much or more weight than the actual evidence from the imaging studies in determining the outcome of the case. Ethical practitioners on both sides of the bar should welcome a process that relies more on reproducible decisions, unbiased by circumstance like the current one.

Expert bias: causes

Expert biases take many forms. "Framing bias" occurs when the circumstances around an event shape the observer's perception of the event. When an attorney approaches a radiologist with a CD of patient images, the radiologist knows ahead of his examination of it that there is something wrong with the studies on the disk, or the attorney would not have passed it along to the radiologist. This heightened level of scrutiny far exceeds what any practitioner would bring to his tasks in day-to-day practice. "Hindsight bias" and "outcome bias" share in shaping the reviewer's perception of the significance of a finding, once it is made. Finally, because of the way our brain learns, once a reviewer (or any other observer) discerns an abnormal finding, there is simply no way to "un-see" it. The abnormality will be forever obvious to one who knows that it is there.

To address these issues, we need a better review process—one where the expert would not know that the exam he is reviewing is the focus of a liability claim, and would therefore treat it just like any other exam in daily practice. In an ideal world, such a contentious case would be renamed and dated, to make it look like just another current case from the reader's institution. The patient's prior exams would have to be similarly altered, as well as the names of any referring providers or facilities noted in any of the reports. Also, if the contentious case could possibly be interpreted as having a significant abnormal finding, there would need to be some mechanism for contacting a "pseudo-provider." The un-blinding could occur at the time of the call (e.g., "Thank you, Dr. Smith, but that hemorrhage was a Quality Assurance case.").

In a more practical, but slightly less stringent scenario, a reviewer is given a stack of exams to over-read, knowing that that one or more of the exams is the subject of litigation, and is asked to review the entire group. At its simplest, this method can simply reveal that the expert reviewer did or did not identify the case in question as the subject of the litigation.

**Fleshing out the scheme**

There are several considerations in fleshing out this scheme. In the first place, since the reviewer is asked to review many more exams than he otherwise would in current practice, there has to be some way to make the process more time-efficient. The current format of CD-ROM and paper (or disk-based) reports is simply too cumbersome to scale. In addition, the toolset available on the clinical viewers is not comparable to that of the diagnostic workstation. The review set must be available on a true PACS, along with the reports, in a "production" environment that is as close to regular practice as possible.

The reporting system that the reviewer uses can also be optimized, to increase efficiency as well as the usefulness of the resulting information. Rather than picking the litigation case out of the stack, as in a police lineup, the reviewer should be asked to provide an evaluation of each exam. A simple, reproducible validated scoring system would make the evaluation process faster, and also, a data analysis can be performed using database methods, rather than human analysis of free-form text. The reviewer's evaluations of the "foil" exams can be compared to that of a reference group of readers, to get a sense of the reviewer's actual degree of neutrality in interpretation.

Finally, with such a system in place, expert witnesses could be organized into a pool. In the event of litigation involving a radiologist, the attorney for either side could contact the organization to engage a qualified expert. That expert would not know whether he was being retained by the plaintiff or the defendant, further increasing the degree of objectivity he brings to the evaluation.

This sort of system would appeal to the defense as well as plaintiff's bar, since both are engaged in the same search for truth—what actually happened between the patient and the provider in a case. With a process that can be supported by both sides, cooperation is possible to reduce unnecessary claims, and to quickly resolve meritorious ones.  

**References**

The Challenging Task of Stemming Opioid Abuse

In the first quarter 2013 issue of *Physician Insurer*, our article, “The Opioid Abuse Epidemic—Turning the Tide” discussed what state and federal agencies have been doing to combat this epidemic, and related how physicians and medical boards have been taking action, too, through the efforts of Physicians for Responsible Opioid Prescribing (PROP) and the revocation of physicians’ licenses.

Kevin M. Bingham is a principal at Deloitte Consulting LLP in Hartford, CT and leader of Deloitte’s Claim Predictive Modeling and Medical Professional Liability practices, immediate past chairperson of the American Academy of Actuaries’ Medical Professional Liability Committee, and an official Academy spokesperson. Alix Michel and David Ward are attorneys at Michel & Ward in Chattanooga, Tennessee. Randolph Gordon, MD, is a director at Deloitte Consulting LLP in McLean, Virginia. He is the former Commissioner of Health for the Commonwealth of Virginia.
However, the call for change nonetheless continued to build. In December 2012, a Wall Street Journal article, “A Pain-Drug Champion Has Second Thoughts,” told of a prominent pain-care specialist who had strongly supported the use of opioids in pain management in the past, but who had more recently changed his mind about them. The early advocates for strong pain medication had apparently overstated the benefits of these drugs, while understating the risks of addiction. The article notes the reaction of physicians on learning more about recent findings on opioid risk: in one word, they were “shocked.”

In July 2012, PROP submitted a Citizen Petition to FDA, requesting labeling changes for all of the opioid analgesics when prescribed for non-cancer pain. The rationale for the petition was this:

Unfortunately, many clinicians are under the false impression that chronic opioid therapy (COT) is an evidence-based treatment for chronic non-cancer pain (CNCP) and that dose-related toxicities can be avoided by slow upward titration. These misperceptions lead to over-prescribing and high dose prescribing. By implementing the label changes proposed in this petition, FDA has an opportunity to reduce harm caused to chronic pain patients as well as societal harm caused by diversion of prescribed opioids. In addition, FDA will be able to reinforce adherence to dosing limits that have been recommended by the United States Centers for Disease Control, the state of Washington and the New York City Department of Health and Mental Hygiene.

The Citizen Petition was signed by clinicians, researchers, and health officials from the diverse fields involved in the prescribing of opioids.

In March 2013, the Drug Enforcement Agency (DEA) endorsed the PROP Petition, filing its own letter with the Division of Dockets Management at the FDA, which stated:

The clinical use of opioid analgesics must be accompanied by appropriate measures to minimize the adverse health impact associated with the diversion and abuse of these products. The DEA hopes that FDA will implement suitable measures, such as labeling revisions, to help mitigate the adverse impact on the public health resulting from the abuse of these products.

In May 2013, the National Association of Attorneys General asked the FDA to place a “black box warning” on the labels of medicines in the opioid category of prescription pain relievers, to alert pregnant women that the use of such drugs may harm the developing fetus.

Countering the rise in prescription pain medications
During the past decade, the U.S. has witnessed an alarming increase in the use of opioids. Today, the American Society of Interventional Pain Physicians notes that Americans, who represent just 4.6% of the world’s population, consume 80% of the global opioid supply, 99% of all the hydrocodone, and two-thirds of the world’s illegal drugs. According to the U.S. Centers for Disease Control and Prevention, deaths from overdose of opioid pain relievers (OPR) now exceed the number of deaths linked to heroin and cocaine, combined. In 2009, drug-overdose deaths actually surpassed the number of deaths from motor vehicle accidents, for the first time since the government began tracking drug-related fatalities in 1979.

To counter this rise in addiction, researchers will need to unravel the underlying causes of pain, to prevent it, rather than treating it with potentially addicting drugs. Also, we must understand how to manage pain, when necessary, with therapies that have less potential for addiction—alternative treatments. When they are necessary, we must use the opioids in a manner that minimizes the risk of addiction. Finally, we need better ways to identify those who are seeking drugs for recreational use or resale.

Reeducation of physicians
By 2009, the FDA had recognized the scope and severity of the prescription drug abuse and diversion problem. The agency had begun what had been presumed would be a relatively quick process of contacting stakeholders, including the manufacturers of extended release/long act-
Drug information on ER/LA opioid analgesics

Counseling patients and care

Information on assessing patients for treatment with these drugs

Initiating therapy, modifying dosage, and discontinuing use of

Managing therapy and monitoring patients

Counseling patients and care givers about the safe use of these drugs.

Additionally, prescribers would need to learn how to recognize evidence of, and potential for, opioid misuse, abuse, and addiction.

Some observers contend that the REMS was issued too late and without penalties for noncompliance.

Admittedly, while it does require ER/LA manufacturers to fund CE activities, the REMS has no provision for mandatory attendance at CE activities, by any healthcare provider. Also, the REMS does not deal with short-acting opioids like Vicodin. But, regardless of these criticisms, we believe strongly that any effort at education and publicizing the causes and consequences of the opioid epidemic can only help—by pushing us in the right direction.

Conclusion

We still have a long way to go in battling the opioid abuse epidemic. Yes, we need to keep up our efforts in stopping the drug seekers and the criminal activity of physicians looking to profit from the illicit use and sale of opioids. However, the real opportunity now before us lies in helping the hard-working Americans who may slowly, and unknowingly, become addicted to opioids learn up front the danger signs of incipient addiction. For them and their physicians, the real enemy is chronic pain.

Those with chronic pain need to be aware of their other options for controlling pain. Patients need to think of opioids only as a short-term remedy for pain, not a long-term solution. Instead of immediately reaching for their prescription pad, physicians should offer chronic-pain remedies for pain, not a long-term solution. Instead of immediately reaching for their prescription pad, physicians should offer chronic-pain patients non-chemical options for pain control, all the while keeping up the effort to identify and eliminate the source of pain and remaining vigilant for any signs of addiction. The vast majority of physicians want only what’s best for their patients in pain. If we work closely with them, while raising public awareness of the growing epidemic of prescription medicine addiction, surely we can find better long-term solutions than opioids for addressing the issue of chronic pain.

Editors Note: There is more information on www.piaa.us on what you can do to educate family and friends about opioids.
The connection between compliance and quality of care is a frequently misunderstood, but major, concern for medical professional liability (MPL) carriers. In the wake of quality-of-care investigations, literally hundreds of MPL lawsuits were filed against individual professionals and health systems.

D. Scott Jones, CHC, is Senior Vice President for Claims, Risk Management, and Corporate Compliance for the Healthcare Providers Insurance Exchange, sjones@hpix-ins.com; Michelle Moses Chaitt, Esq., is an attorney with Marshall, Dennehey, Warner, Goggin and Coleman in Philadelphia, MMoses@MDWGC.com; Mark L. Mattioli, Esq., is Chair of the Health Law Section at Marshall, Dennehey, MLMattioli@MDWGC.com; and Richard E. Moses, DO, JD, is a practicing gastroenterologist in Philadelphia, and adjunct faculty for the Temple University School of Law, remoses@mosesmedlaw.com.

**Federal Investigative Audits, Healthcare Compliance, and Quality Reporting:**

The MPL Connection. Part One

Compliance, quality, and MPL: the intersection

The potential for single to multiple, or "mass tort" style, claims increases with the new quality-of-care provisions included in the Affordable Care Act (ACA). Insurance risk, claims, and underwriting managers, healthcare professionals, compliance officers, and MPL defense counsel will need to keep in mind the connection between adherence to regulatory compliance, provision of high-quality care by clinicians, and the potential for MPL actions as a result of failure to deliver quality.

Ignoring the quality-of-care and MPL aspects of regulatory compliance is a fundamental error. In fact, this connection is becoming increasingly important in light of the quality-focused compliance investigations taking place today. Quality issues, as well as billing and coding problems, lead to compliance investigations—and investigations, to MPL lawsuits.
against organizations and physicians.

The Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) made quality of care central to compliance in the landmark update to a Corporate Integrity Agreement (CIA) signed by Tenet Healthcare Corporation in 2006. More than one-third of the document’s 63 pages cited quality issues. This was one of the first national CIAs that specifically required clinical quality departments, clinical audits, evidence-based medicine programs, and standards of clinical excellence and quality metrics. The Tenet CIA was issued after an investigation of unnecessary cardiac surgeries, and the OIG report specifically noted numerous MPL actions brought against Tenet hospitals and surgeons. In the agreement with federal authorities, Tenet Healthcare Corporation was forced to divest itself of multiple hospitals, significantly altering what had been the largest healthcare corporation in the United States.

The ACA establishes several quality-reporting mechanisms. Analyzing the ACA for members of Congress concerned that the regulation might establish new standards of care in MPL, the Government Accountability Office (GAO) stated:

Certainly, Medicare beneficiaries and others who receive health care from providers who adhere to the PPACA provisions, and the guidelines and standards developed under those provisions, may receive higher quality care because of the incentives that those provisions extend to providers to improve the quality of the care they provide. Conversely, those who receive care from providers who fail to do so may receive lower quality care.

The GAO quickly made the connection between the ACA’s quality-of-care provisions and improvements in overall quality; they discerned a possible change in courts’ perception of the standard of care in MPL lawsuits, postulating that “…[I]t is possible that, if these standards and guidelines become accepted medical practice, they could impact the standard of care against which provider conduct is assessed in medical malpractice litigation.”

PIAA is a leading proponent of legislation limiting the scope of any new standards of care (SOC) that might stem from mandates in the ACA. MPL carriers can learn more about the nexus of MPL, quality, and regulatory compliance by reading related articles by the authors of this feature.

Laws support compliance and quality
Moses, Chait, and Jones summarized the key provisions of laws and regulations that should be familiar to MPL companies, healthcare risk managers and compliance officers, healthcare providers, and healthcare counsel:

- The ACA and the Health Care and Education Reconciliation Act establish a broad range of quality and quality reporting measures.
- The Federal False Claims Act (FCA) and the companion criminal law provisions (18 U.S.C. §287) establish civil and criminal penalties that cover any federally funded program or contract. The FCA establishes fines of $5,500 to $11,000 per claim filed, plus three times the amount of damages sustained by the government.
- The Anti-Kickback Statute (AKS) provides that healthcare professionals may not provide “kicksbacks” to other providers, institutions, or patients in the form of fees or services. AKS stipulates criminal penalties for certain acts, as well as a penalty of up to $50,000, plus three times the total amount of remuneration involved against those held to have been in remuneration schemes.
- The physician self-referral (Stark) law prohibits physicians from referring patients to entities in which they have financial interest. The Stark law creates certain “exceptions” for designated health services (DHS), and establishes penalties of $15,000 per claim, and civil penalties up to $100,000. A failure to meet Stark reporting requirements carries an additional $10,000-per-day penalty.
- In addition, under 42 C.F.R. §411.384, the Centers for Medicare & Medicaid Services (CMS) is required to issue advisory opinions under §1877(g) (6) of the Social Security Act. An advisory opinion provides guidance to physicians on the specific referrals or specified actions that are prohibited. The opinion is specific to the case stated in the request for opinion. The advisory opinions are fact-specific and binding only on the requesting party and specific situation, but they serve as an effective learning tool for healthcare professionals.

The False Claims Act and quality of care
The federal False Claims Act (FCA) imposes liability on persons or organizations that defraud government agencies by submitting false claims or false information in support of those claims. It applies to federally funded programs and contracts, which includes Medicare, Medicaid, and the health exchanges enacted under the ACA.

Today, the FCA is commonly used to combat healthcare fraud; the government can recover monetary damages from healthcare professionals who file false claims. Individual case settlements and verdicts easily total in the millions of dollars. Under the FCA, any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to the U.S. government is liable to the government for a civil penalty of $5,500 to $11,000, plus three times the amount of damages that the government sustains.

Private citizens may assert claims on behalf of the U.S. and recover a portion of the damages (typically, 15% to 30%), plus expenses and attorney fees, depending on the circumstances. These whistleblower or qui tam provisions are designed to encourage those with knowledge of
In these so-called “quality of care” cases, the government argues that, notwithstanding the actual performance of the service, the quality of care that the patient received was insufficient; therefore, billing for that service amounts to a fraudulent claim under the FCA.

In United States v. NHC Health Care Corporation, the government alleged that a nursing home in Missouri submitted false claims in connection with two residents because the facility failed to provide the services for which it had billed. One resident suffered dehydration and pressure sores while in NHC’s care, and the other had pressure sores and weight loss and ultimately died. Evidence indicated that staffing shortages may have contributed to substandard care. The government alleged that the quality of the services provided was so poor that billing for them at all constituted a fraudulent claim under the FCA.

In denying NHC’s motion for summary judgment and allowing the government to proceed, the court noted that by billing Medicare on a per diem basis for the overall care of these patients, NHC agreed to provide a certain standard of care. The court agreed with the government that at a certain point, a healthcare professional “can cease to maintain this standard of care.” The court deemed that only claims for reimbursement for the performance of a service that is so deficient that it is the equivalent of no performance at all will be deemed fraudulent claims under the FCA. In granting the motion for summary judgment of AHS on the “quality of care” theory, the court found no evidence to support the contention that the services being billed for amounted to a worthless service or that they were grossly negligent.

To date, there is very little case law to assist practitioners in understanding their obligations regarding application of the “quality of care” standard to the FCA. The two cases discussed above illustrate the threshold standard required to survive summary judgment and demonstrate that the results are fact-dependent.

Conclusion
The second part of this two-part article will explain how the federal government’s investigations of quality of care can lead to both individual and mass tort-style MPL lawsuits. We will also identify risk strategies that MPL carriers should be aware of when underwriting and managing claims brought after quality-of-care investigations.

References
3. Id.
7. Moses, supra note 1, at 2.
8. Id.
9. Id.
12. Id. at 1053-54.
13. Id. at 1054.
14. Id. at 1055-56.
15. Id. at 1056.
17. Id. at 1287.
18. 274 F.3d 687, 703 (10th Cir. 2001).
19. AHS, E.Supp. 2d at 1288.
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**International Section Conference, October 8-10, 2014, Amsterdam, the Netherlands**

“**The Good, the Bad, and the Ugly**”

How Threats Can Become Opportunities in Medical Liability

*By Ebbo van Gelderen and Harry Henschen*

**V**AA and MediRisk, together with PIAA, will host an inspiring international conference in Amsterdam, the Netherlands, on October 8-10, 2014. You will leave the conference with in-depth knowledge about innovations, and best practices, in medical professional liability (MPL), from the best thinkers in the field, from around the world.

This conference offers you an engaging program, filled with thought-provoking sessions, as you join with your colleagues from both the PIAA International Section member companies as well as those PIAA companies based in the United States. You will participate in critical dialogues with your fellow insurance professionals and company board members.

**A conference every three years**

The PIAA International Section holds a conference every three years. The Netherlands served as the host for the first International Conference, back in 1999. Since then, these conferences have provided an invaluable forum for hundreds of insurance professionals, all looking to discuss the global and the day-to-day issues confronting MPL insurers.

“**The Good, the Bad, and the Ugly**”

As the conference title suggests, the 2014 International Section conference will feature “The

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*Ebbo van Gelderen is Director of Non-Life Insurance at VvAA; Harry Henschen is a Director at VvAA insurance.*
Good, the Bad, and the Ugly” in
the MPL industry. In the context
of MPL, the “the Good” might be
the physician or other healthcare
professional, “the Bad” the claim,
and “the Ugly” new and evolving
areas of liability and exposure.
This scheme provides a useful
framework for the sessions.

In addition to general discus-
sions on shared areas of concern,
the conference will also consider
the influence of each country’s
healthcare system, and legal
and regulatory structure. After
all, nearly everything that hap-
pens in MPL in one nation has
already happened before, in
another.

All of the topics and speak-
ers, acknowledged global thought
leaders in their field, have been
selected by the 2014 Amsterdam
Program Committee. Each ses-
sion will include at least one
speaker from the various coun-
tries that comprise the PIAA
membership.

The 2014 Program

Thursday, October 9

- Human Factors in Healthcare and Patient Safety
- Serial Claims: When One Event Leads to Many Lawsuits
- Disruptive Doctors: Identifying, Measuring, and Addressing Unprofessional Behaviors
- Electronic Health Records and Other New Media in Healthcare
- Improving Diagnoses Through Cognitive Debiasing
- High-Severity Claims: Is the Sky Really the Limit?

Friday, October 10

- Social Media: Friend or Foe in 21st Century Medicine?
- Alternative Dispute Resolution: Debating the Pros and Cons
- Failure to Diagnose: The Impact on Patients, Physicians, and MPL Entities
- International Claims Trends: Is the Wind Always from the West?
- Public Pressure and Its Influence on Medical Professional Liability
- The Future of Healthcare: What Will the Patient Want in 2020?

The program also features a full social program, starting off
with a welcome reception on Wednesday evening, and a confer-
ence dinner on Thursday evening. The dinner will take place at the
Hermitage Amsterdam, the renovated (and smaller) version of the
famous Hermitage museum in St. Petersburg, Russia.

Location

The conference sessions will be
held in the seventeenth-century
Koepelkerk (Domed Church),
located in the picturesque center
of Amsterdam. This church was
built in an impressive Byzantine
architectural style, and now fea-
tures state-of-the-art, high-tech
conference rooms.

The hotel for the conference,
next door to the Domed Church,
is the Renaissance Hotel
Amsterdam. This contemporary
hotel features charming accom-
mmodations, with WiFi and flat-
screen televisions.

Hermitage Amsterdam

The building that houses the
Hermitage Amsterdam was a resi-
dence for the elderly for more
than 300 years. When, at the end
of the twentieth century, it became
apparent that the “Amstelhof Care
Facility” could not meet the cur-
rent requirements for elderly
housing, the building was repur-
posed for a new use. Since June
2009, the site has been the home
of Hermitage Amsterdam.

Destination highlights

There are few cities in the world
that combine a rich history with
a sense of modern urban flair the
way Amsterdam does. This con-
vivial city is characterized by its
encircling system of canals,
major masterpieces of art, a tra-
dition of excellence in theater,
and an atmospheric seventeenth-
century residential area.

What makes Amsterdam so
popular with visitors from around
the world? There are also all of
those cozy outdoor terraces, and
its fabulous shops and depart-
ment stores. All that, and more.

Typically Dutch

Rijksmuseum

The Rijksmuseum is perhaps the
most famous museum in the
Netherlands. At the
Rijksmuseum, art and history are
skillfully combined, thereby
appealing to a broad contem-
porary national and international
audience. As a national institute,
the Rijksmuseum offers an
overview of Dutch art and history
from the Middle Ages onward,
and of most of the major periods
of European and Asian art are
represented here.

In 2013, an entirely renovated
Rijksmuseum opened its doors to
the public. Visitors are now greet-
ed by a stunning building, with
amazing interior design, wonder-
ful exhibitions, and lively events.

Typically Dutch
Anne Frank Huis (Anne Frank House)
Anne Frank was a Jewish girl whose family was forced to go into hiding during the Second World War to escape the Nazis. While there, she wrote her world-famous diary. This museum is the actual house where they hid during those years.

Haring (Herring)
Herring is the most popular fish in the Netherlands. Eat it on a bun (with pickles and onion) or in the traditional way: holding it in the air by its tail while taking a bite. But note: Herring is to be eaten raw.

Vlaamse Friet (Flemish Chips)
The Dutch like their chips (french fries) crispy and thick, with copious amounts of mayonnaise. Do try the tasty chips from the hole-in-the-wall restaurant Vleminckx, a local favorite in the Voetboogsteeg; these chips are worth the inevitable queue.

Negen Straatjes (9 Streets)
The Negen Straatjes are tucked away between Leidsestraat and Raadhuisstraat. Here you’ll find a charming neighborhood, full of unique shops, wonderful places to eat, and a great atmosphere.

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2013 PIAA Breast Cancer Study
MPL Cancer Claims Miniseries: Volume 1
The highly anticipated PIAA Breast Cancer Study, the first in the “MPL Cancer Claims Miniseries,” is now available for purchase. This landmark report provides an overview of the critical issues in the diagnosis and treatment of breast cancer, with a particular emphasis on how they impact MPL claims. The report’s findings are based on an analysis of claims submitted to the PIAA Data Sharing Project, during the period 2002 to 2011.

MPL Closed Claim Comparative
PIAA is pleased to introduce the MPL Closed Claim Comparative. This new report replaces the Claim Trend Analysis and includes many new enhancements, including:

- Claim trends for the most recent five and ten-year intervals
- Data on the impact of damage caps
- Additional loss causation data
- Enhanced graphs

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It's a risky world. We'll help you manage it.

The attorney representing the nurse is responsible for that nurse.

The advent of ACOs will affect nurses and how they need to look out for themselves?

Brostowitz: Yes, absolutely. First and foremost, with so many more patients coming into the healthcare service area, many of whom have access to insurance coverage for the first time because of the ACA, there may be more patient visits. For a number of reasons, including potentially a shortage of physicians, nurses, nurse practitioners and physician assistants may face increased responsibility and workload. It's not just direct patient care; it's the coding and charting—all of the administrative work that goes into the delivery of medicine today.

So yes, I do see where there's the potential for more exposure for them. And, to a certain extent, they will have to deal with the level of sophistication of the employer, and the systems that they supply, for the nurse to be successful.

Electronic medical records—they're here. Your employer may have a good system. Your employer may not have a good system. That's another area where we are trying to help educate nurses. Our nurses know about electronic records; it's not news to them. What we try to do is provide gentle reminders and educational materials, and again, it's really a question of how much can they absorb, given everything else that they're dealing with.

Do you think the advent of ACOs will affect nurses and how they need to look out for themselves?

Brostowitz: Yes, absolutely. We are attempting to educate; ANA is attempting to educate. It really depends on how the nurse receives the message—they've got a lot to deal with today. It somewhat depends on how much time and energy they can afford to spend reading up on these issues.

Have nurses ever taken a role in forming their own MPL companies?

Brostowitz: I have never seen that done in my 20 plus in working in MPL. There was one instance, though, where a group of nurses partnered with a risk retention group that was focused on their occupation. And that ultimately ended up—well, it didn't work out. Those nurses are back having to find coverage through commercial carriers.

Do you think the advent of ACOs will affect nurses and how they need to look out for themselves?

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IML: Is that message being promulgated via the ANA?

Brostowitz: Yes, absolutely.

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I N S I D E  M E D I C A L  L I A B I L I T Y  5 0  F I R S T  Q U A R T E R  2 0 1 4
IML: But what about nurse practitioners?

Brostowitz: Nurse practitioners fall into a different class of risk—in general, higher exposure to loss equates to higher rates. They have had significant—well, more like meaningful—rate increases over the past decade. Rates have leveled off, for the most part. But so have rates for physicians.

They may provide a higher level of medical care, under the guidance of physicians. But they are getting named in suits more often than an RN, and the awards are much larger.

So nurse practitioners have a different level of risk, and a stronger need for professional liability coverage.

There are more than 125,000 nurse practitioners in the U.S. today.

IML: But there’s still a shortage, right?

Brostowitz: Yes, and if they are employed, their employer’s policy may or may not automatically cover them. Whereas for RNs, it’s pretty common that they are covered, as employees of the entity. But it’s not always a given for the nurse practitioner. They may need to be named on the policy. The carrier’s policy may state that certain kinds of practitioners have to be named to be insured in order to be covered, and nurse practitioner is one of those occupations where the practitioner has to be named. If the nurse practitioner is not aware of that, and nobody’s caught it, the result could mean no coverage for them.

We do have some nurse practitioners, and for that matter, some RNs and LPNs who work for healthcare entities that don’t buy professional liability insurance for the entity—and therefore there is no coverage for the entity or the healthcare practitioner.

IML: So they need to do due diligence before they take a job, right?

Brostowitz: Yes. We had an obstetrical claim come in—it’s still open so I can’t give you any detail—and the clinic named in the suit was focused more on the low-income patient population. That’s great, but the clinic could not afford to purchase insurance. So the nurse practitioners working for that clinic went out and bought their own policy. If they had blindly expected they were going to be covered, when the lawsuit came, they wouldn’t have had coverage. Who knows what would have happened to them if they hadn’t had it.

Nurse practitioners should be proactive in learning about professional liability in general, and whether or not insurance coverage will be offered in connection with a professional position. If they take a job, they have to ask about it, though it may be an uncomfortable question: Does the employer’s professional liability insurance cover me?

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- Design and Conquer: A Bootcamp for Better Design
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- Insights from Brokers: Marketing MPL in 2014 and Beyond
  How will brokers operate in the healthcare system of tomorrow? How will they need to change their relationships with both large and small accounts as healthcare reform is implemented? This session, featuring both a national broker and a regional broker, will examine healthcare reform and explain how its implementation will impact the relationship between brokers and their customers and PIAA companies.

- PIAA Customers: What Keeps Them Up At Night?
  In this session, a physician in private practice, an employed physician, and a healthcare group practice manager will share their views on the issues in healthcare and medical liability that are having the biggest impact on them—and what PIAA companies can do to help.

- Strategic Leadership for Changing Times
  Lt. Gen. John F. Sattler will speak on the importance of communication and team buy-in during an era of new directions and planning. The session will also focus on the optimal role of leaders in strategic planning during challenging times, and participants will understand the role they can play in successfully developing strategy for effecting change in their own companies.

- Dental Risk: A Corporate Risk Manager's Perspective
  How does a corporate risk manager view the evolving environment for dental liability carriers? The speaker will describe his organization's business model and compare it to other corporate practices. He will also describe how practice risk is assessed, how risk retention level is determined, and the decision process for insuring risk in a corporate practice setting.

- Avoiding Pitfalls When Defending Corporate Dentistry Claims: Lessons from the Front Lines
  Claims arising from corporate dentistry can be time-consuming and costly. This session will feature case studies, presented by a claims professional, that provide invaluable perspective on the types of claims, and scope of awards, that can occur as a result of legal actions related to corporate dentistry. In addition, the session will feature two defense attorneys who have extensive experience defending claims related to the practice of corporate dentistry. You will hear about potential pitfalls in defending these cases and learn informed recommendations for attaining positive outcomes.

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Do you want an accelerated tax deduction for something that hasn't happened yet? Alternative risk entities that qualify for insurance treatment under the provisions of the Internal Revenue Code (IRC) are allowed a significant tax deduction for unknown losses and loss adjustment expenses, in addition to those that are known and unpaid. The ability to deduct an estimate for unknown future claims, which may not materialize until several years after a policy is issued, provides a tax advantage that is not afforded to traditional corporations. This is valuable to the healthcare industry, where medical professional liability (MPL) claims tend to be long-term in nature. The policyholder is permitted a tax deduction in the tax year when the premiums are paid, and the insurance company receives a tax deferral on a significant portion of the premiums received, by deducting estimated values for future losses. Sounds like a win-win proposition, right?

Among the most common alternative risk entities are captive insurance companies (CICs) and risk retention groups (RRGs). The healthcare industry accounts for the largest portion of RRGs nationwide and the second highest percentage of Vermont-domiciled CICs. In addition to the accelerated tax benefit, there are non-tax benefits for companies that participate in one of these structures. These entities are typically owned by the policyholders or their direct affiliates, so each policyholder has more control over its operations. Control can be exerted in managing claims, in establishing the degree of risk appetite you’re comfortable with, in figuring how, and at what rate, premiums are determined, or simply filling a void by adding a line of coverage that is not available in the commercial market.

Participants in an alternative risk structure also share in both the good and the bad experience of the entity. When entities have underwriting gains, they are typically shared with the participants. The exact method of sharing will depend on the entity’s specific structure and business plan; but in general, the profits are distributed among the policyholders. This approach also provides a greater incentive for policyholders to monitor their safety standards and control their loss exposures, something that is less relevant in the commercial market, with its much wider distribution of risk.

Another benefit of CICs and RRGs is that these entities, typically, are not required to participate in a state’s guaranty fund. State insurance regulators are responsible for monitoring the financial health of the insurance companies licensed in their respective states. When a large commercial carrier goes belly up, state regulators step in to protect the policyholders, under state guaranty fund regulations. You could say this is similar to the Federal Deposit Insurance Corporation (FDIC); however, unlike the FDIC, insurance companies don’t pay into a fund every year like banks. Instead, when an insurance

Matt T. Gravelin, CPA, is a Senior Manager with Johnson Lambert, LLP.
company becomes insolvent, the state guaranty fund divvies up the losses, and passes them on to the other state-licensed insurance companies that are writing the same type of coverage, in proportion to their in-state market share.

It isn’t too difficult to predict the impact this might have for a physician who is renewing his policy. Looking to one of the remaining carriers for coverage, the physician will find that these surviving carriers have likely increased their rates to cover the losses of the bankrupt carrier, which have been pushed on them by state regulation. This exemption for CICs and RRGs provides an extra level of stability to policyholders that participate in an alternative risk entity, as they are not subject to this regulation. However, the policyholders would not have access to this guaranteed protection if their CIC or RRG became insolvent.

What’s required?
Next, let’s discuss the basic requirements that must be considered in order to qualify for insurance tax treatment. There is no formal definition of “insurance” within the IRC or Treasury regulations that exists today. As such, insurance is generally defined by judicial precedent, which can be summarized by the following three-prong framework.

■ The presence of insurance risk
Insurance risk is generally the result of an unplanned event, such as a fire or accident that causes an economic loss. Insurance risk must account for more than 50% of an entity’s revenue; investment risks and business risks cannot be counted as insurance risk.

■ Risk shifting and distribution
It’s important that insurance contracts transfer a risk of economic loss from the policyholder to the insurance company and that these risks be distributed widely enough among unrelated parties that the statistical phenomenon known as the law of large numbers can work. If there is only one of these present, without the other, the IRS would disqualify an entity from insurance tax treatment. An entity could fail in the test for adequate risk shifting if it has insufficient capital, excessive guarantees to its parent company, or is indemnified by another entity.

■ Commonly accepted notions of insurance
This is best summarized by the analogy: “If it looks like a duck, quacks like a duck, walks like a duck, and smells like a duck, it proba-
bly is a duck.” The same is true for an insurance company. You need to consider all of the facts and circumstances relevant to the entity to make a determination. Important elements to examine include corporate structure, the substance of its transactions, the entity’s operations and whether they are “in the spirit of insurance,” whether the entity is regulated as an insurance company by its domicile state, if there is adequate capital for the risk assumed, and whether there are valid binding contracts, with premiums established at arm’s length.

Now, let’s dive deeper into the major tax benefit afforded to insurance companies. Assuming an entity meets the requirements described above, the policyholder can reduce their taxable income for premiums paid to the insurance company during the tax year. The insurance company would report the premium receipts as taxable income, but would reduce this income for its estimate of known but unpaid, and unknown future claim costs, that would be covered under the contracts. Unlike most corporations, the discounted present value of this accrual for both indemnity and claim expenses would reduce the

<table>
<thead>
<tr>
<th>Table 1 Tax Treatment, Insurance vs. Non-Insurance</th>
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</thead>
<tbody>
<tr>
<td><strong>Individual Policyholder</strong></td>
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<tr>
<td>Taxable income, excluding premium deduction</td>
</tr>
<tr>
<td>Insurance expense</td>
</tr>
<tr>
<td>Taxable income</td>
</tr>
<tr>
<td>Tax rate</td>
</tr>
<tr>
<td>Current tax expense</td>
</tr>
<tr>
<td><strong>ABC Insurance Company</strong></td>
</tr>
<tr>
<td>Premium income</td>
</tr>
<tr>
<td>Investment income</td>
</tr>
<tr>
<td>Total revenue</td>
</tr>
<tr>
<td>Losses paid</td>
</tr>
<tr>
<td>Accrual for future losses</td>
</tr>
<tr>
<td>Discount for time value of money</td>
</tr>
<tr>
<td>Total loss deduction</td>
</tr>
<tr>
<td>Underwriting &amp; operating costs</td>
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<tr>
<td>Taxable income</td>
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<tr>
<td>Tax rate</td>
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<tr>
<td>Current tax expense</td>
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insurance company’s taxable income immediately, irrespective of when these losses are actually paid. Regular corporations are not allowed to deduct accruals unless all events-test and economic-performance rules are satisfied.

Simply put, they can only deduct accruals if the actions generating the expense have occurred, and they will be paid within a short period of time after the tax year. This is a unique benefit only afforded to insurance companies, and it lets them use more cash for investments, instead of paying taxes. Income generated from the investments can then be used to offset general operating expenses.

Let’s highlight this with an example: ABC Insurance Company (ABC) is an RRG that writes MPL insurance on an occurrence basis and qualifies for insurance treatment for income tax purposes. ABC has 100 policyholders, individual physicians who each own a private practice and pay $10,000 in annual premiums (Table 1). ABC estimates its loss ratio at 75%; underwriting and general operating expenses amount to $50,000 annually. All premium terms coincide with the calendar year, and ABC earned $200,000 in investment income.

At a tax rate of 35%, ABC saves $204,750 in current tax [(650,000 - 65,000) x 35%] by taking advantage of the unique provisions in the tax code. All parties in this example save $519,750, collectively, in current taxes, as highlighted in Table 2.

### Table 2  Savings in Taxes

<table>
<thead>
<tr>
<th>Insureds</th>
<th>Insurence</th>
<th>Non-Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC</td>
<td>162,750</td>
<td>17,500</td>
</tr>
<tr>
<td>Total tax</td>
<td>187,250</td>
<td>332,500</td>
</tr>
</tbody>
</table>

Among the most common alternative risk entities are captive insurance companies (CICs) and risk retention groups (RRGs).

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In partnership with the Lucian Leape Institute of the National Patient Safety Foundation, The Doctors Company recognized six young physicians for their essays on their deep personal insights into the significance of patient safety work. There were five winning essays for 2013. Here, we feature the full text of one of these.

Last year, I admitted a patient with severe dementia. My attending asked if I had checked for ulcers. I hadn’t. Even after this oversight, pressure ulcers still weren’t at the forefront of my mind—until my dad developed his own.

My dad
My dad’s final stroke was in May 2012. He died in October. His course was wrought with patient safety errors, including mismanagement of his blood pressure immediately after his stroke and five days without dialysis prior to his death. But the problem that will forever haunt me is his sacral ulcer.

After the acute hospitalization, he was discharged to a long-term acute care facility (LTAC). On the facility tour, we were told the standard of care to prevent decubitus ulcers included repositioning patients every two hours. Our guide handed us a brochure advertising the facility’s wound care management program.

Upon transfer, my dad’s sacrum had a 1-cm shallow erosion. Though disappointed, we had high hopes the LTAC would reverse it. In two weeks, the erosion progressed to a 2 x 5 cm smooth eschar framed on by 3 cm of shallow ulceration. The ulceration extended further down his buttocks; everything was surrounded by purpura.

At the LTAC, sign-in sheets recording patient care (position changes, dressing changes, etc.) would be empty from 9:00 a.m. to 4:00 p.m. Magically, at 4:30 p.m. they were filled, despite the fact that I had only seen the nursing staff once or twice. Polite reminders that my father had not been repositioned in several hours were brushed off: the staff “was busy with other patients.” Annoyed reactions when we requested his soiled diaper be changed made us question whether we were over-advocating. My mother became concerned that if she was perceived as the “irritating” family member, my father would receive worse care. Not all the staff was terrible, but all an ulcer needs to flourish is a few minutes of ischemia, and we couldn’t choose our nurse/techs. Despite formal complaints, the care remained steadily poor. Eventually, removal of the bandage revealed more than ulceration. First muscle. Then bone.

Who is to blame?
My interest in patient safety started with a research project I participated in a few years ago. We evaluated the misdiagnosis rate of cellulitis, an intervention to improve diagnosis and hoped to reduce unnecessary hospitalizations and antibiotic administration. A lesson learned was that sometimes it is our system of learning and decision-making that is flawed, not the individual. Similarly, while I was angry at my dad’s hospital(s) and staff, the truth is, the problem was bigger than the individuals themselves. I’ve spent a lot of time mulling over these problems, and I see three systemic areas for improvement: (1) increasing accountability, (2) changing how we view ulcers and (3) improving incentives surrounding ulcer prevention. One potential tool to address the issues could be a mobile application (App).
Solutions

(1) Accountability. My proposed App starts with a simple alert system that reminds caretakers to reposition their patients. Then caretakers take a photo of the repositioned patient. Photos are electronically time-stamped, making it impossible to falsely record actions not performed. Electronic data can be compiled and reviewed by management. Furthermore, knowledge that actions are monitored increases accountability among nursing staff and managing physicians. Drawbacks include protection of patient privacy. However, I feel most patients would consent to photography if they knew it was to improve outcomes. Furthermore, many App developers are familiar with HIPAA regulations, and photos can be stored in a “cloud” rather than on phones. The App also includes a section to photograph wounds. Having immediate access to this picture series can be powerful. Improvements in wounds motivate providers to do more, while evidence of further deterioration can trigger reassessment of management. The process adds time, but the few extra minutes may improve quality of life and potentially reduce healthcare costs.

(2) Changing how we view ulcers. Providers must believe they can prevent ulcers. My father’s first stroke was in Istanbul. He was transferred to Zurich for the remainder of his care. Though he was comatose for two months, it was ingrained in the nursing culture that decubitus ulcers were preventable. Because of their attention, he did not develop a single bedsore.

In the United States, the Centers for Medicare & Medicaid Services thinks decubitus ulcers are preventable (denying reimbursement for ulcers developed during hospitalization). But the belief doesn’t seem to be pervasive. At the acute hospital and LTAC there seemed to be an unconscious assumption that ulcers were inevitable, not preventable. We need to empower providers with proof that their efforts can make a difference. A nice example is a 48-month initiative performed by the New Jersey Health Association that resulted in a 78% decrease in the incidence of new pressure ulcers through collaborative multidisciplinary efforts.

I hypothesize that the inability to make personal connections with patients contributes to apathy. As with care of babies, a large part of the nursing care for patients with ulcers includes jobs like cleaning. Unlike infants, who reward caretakers with sweet wide-eyed gazes or the grasp of a tiny palm, many adult patients, like my father cannot communicate. Consequently, relationships are not formed, and nursing feels like a burden.

(3) Changing incentives: Rewards over penalties. It’s important to create positive associations: reward success with gift certificates for providers who turn their patients on time, parties for teams that reduce ulcer incidence, public acknowledgement within the hospital. The App itself can be “gamified” by including random scenes, like seeing a herd of sheep run across the phone screen after User A has turned a patient 10 times. Similar, funny screen scenes can occur at varied time intervals. Lastly, an underappreciated incentive is the opinion of peers. Free access to the performance of peers encourages low performers to improve, and rewards high performers with pride.

Conclusion
Pressure ulcers occur daily throughout the world. I now have a personal understanding of their impact on the individual (pain, suffering, indignity) and society (cost, time). Knowing this, there would be no better way to honor my father than by making even the smallest contribution toward the extinction of this problem.

The rapid expansion in the use of social media and online networking has altered the way we communicate, quite possibly forever. Twitter and Facebook have become entwined in all that we do—even on occasions when their use is really not appropriate.

For example: during a trial. The explosion in social media has had a notable impact in the courtroom, particularly for jurors. Inappropriate use of social media activity during trials has triggered mistrials, and new trials. According to a Reuters Legal article published in 2010, at least 90 verdicts have been challenged since 1999, with allegations that jurors had been using social media during the court proceedings. More than half of these challenges happened after 2008—so, clearly, this trend is on the rise—and there were new trials, or overturned verdicts, in nearly one-third of these cases.

Jurors have even been charged with contempt of court for their posts and activities on Facebook or Twitter during trials.

So, what are jurors tweeting about? Just about anything you can imagine…and then some. You name it, they are tweeting it. Boredom appears to be a main motivation. A Reuters Legal study of Twitter, over a three-week period, revealed that tweets from people describing themselves as prospective or sitting jurors flew at a staggering rate of one every three minutes.

According to the same Reuters study, many of the messages were in fact complaints about having been called for jury duty, or noting how tedious it is to be compelled to sit through a trial. To most of us who are familiar with the court system and the typical attitude of jurors, this finding is probably not too surprising. More disturbing, the study found that a substantial percentage of communications included blatant statements about the defendant’s innocence or guilt—before some, or all, of the evidence had even been presented. Here are two examples: “Looking forward to a not guilty verdict regardless of evidence,” said one message. Another message read: “Jury duty is a blow. I’ve already made up my mind. He’s guilty. LOL.”

In the defense of courts—pardon the pun—some of them are trying to take steps to combat this problem. In some cases, judges have ordered that jurors surrender their computers and phones upon entry into the court. But for many jurors, social media is part of their daily routine, so it may be unrealistic to think that they will really keep their opinions about courtroom proceedings off of Facebook and Twitter.

Despite the best efforts of PIAA members to defend their policyholders in a court of law, the social media factor adds just one more variable to what is already a challenging environment for defending MPL claims.

The problem may stem from a gap in understanding between court officials and the public about the responsibilities of a jury member, or perhaps relate to the ubiquitous presence of social media as an immovable anchor in our society. Regardless of its actual cause, our judicial system will need to find a way to deal with this issue. Given the current state of our legal system, however, I'm not holding my breath.
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