Be Prepared: Advice for a Smarter Defense
Providing expertise and resources to support strategic decision making beyond the reinsurance transaction
There is strength in numbers. "That's more than just a catchphrase. It is literally true, not just in scientific research, but also in almost every area that impacts the medical professional liability (MPL) community. It is critical in exploring new and emerging risks in healthcare—and finding ways to enhance the safe delivery of medical care. The same can be said for navigating the complexities of public-policy issues whether in state capitals in the U.S. or Ottawa, London, Paris, Canberra, or elsewhere. So it is vital that we in the MPL community achieve maximum impact by working in a coordinated manner.

When we work together, our common interests are protected and advanced. Of course, there are many differences among the PIAA members in the U.S. and around the world. The individuality of each member—what makes it unique and different—contributes to the Association's ongoing success. The challenges that MPL organizations are confronting are much the same, even though each PIAA member may address them a bit differently. For example, how do we as a community ensure the delivery of safe medical care and at the same time guard against unintended consequences? This is just one of many questions that we can work to solve together.

It is in each member's self-interest to be aligned with its colleagues' similar concerns. PIAA is positioned as the entity that aligns the MPL community to share, grow, and advance together. This is what makes the organization relevant and uniquely valuable.

PIAA members and the evolving healthcare industry are leading us into the future. And as we approach the future, it is essential to respect the past—our core principles, and the unflinching collaboration of physicians and insurance professionals who, together, launched PIAA. We hold closely the important lessons learned from the past and the important contributions of our founders who built their companies and PIAA to reflect their values.

The PIAA Board of Directors embraces this ethos as it establishes the direction of the organization, and makes key decisions to guide the organization—and they always have the best interests of all the members and their needs in mind.

This issue of Inside Medical Liability illustrates just some of the key issues we are all facing together. The cover story, "Five Strategies for Improving Medical Professional Liability Defense," offers MPL entities of every sort some clear and concise guidance for how to optimize outcomes in the event that an MPL claim culminates in a trial. There is also an article on the liability issues associated with the growing use of advanced practice clinicians to help counter the shortage of doctors in some areas.

The focus of PIAA is not just on the individual MPL organizations, but rather on the PIAA members and on all those who work to advance and defend their insureds providing care.

Rest assured that we will continue to represent your interests and needs, and provide support to the dedicated professionals who make up the MPL community.

As PIAA moves into the future, we welcome your thoughts, comments, questions, and suggestions. I can always be contacted at batchinson@piaa.us.

PIAA members and the evolving healthcare industry are leading us into the future."
Inside Medical Liability

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2018 SECOND QUARTER
Our deep specialist knowledge and extensive experience of both the reinsurance market and the medical professional liability industry enables us to ask smarter questions. We deliver outcomes to you that support your priorities and exceed your expectations.
The challenges facing healthcare, in both costs and services, are neither secret, nor new. What is different is the rate of change sweeping through the entire system. The fee-for-service model is under legislative and competitive assault. Outcome variability previously accepted as biological is no longer assumed to be immutable. Medical care has traditionally been individual physicians advocating for the best interest of their patients and shepherding them through the system. Today, the focus is on the organization of the system itself combined with demand for greater patient autonomy. Yet, above all, the meta-theme is consolidation. This is occurring throughout every segment of the economy and is a global phenomenon with economic drivers. This tide is unlikely to recede. The question is whether we can succeed in transformation as well. This means preserving the soul of medicine, of the healing arts, even as the organizational structure and healthcare financing changes.

In our professional liability community—and that is what our organization is—we seek to advance and protect good medical care. Our members are changing because their members are changing. Although we will always continue to advocate for what is right, the status quo is not an option because embracing change is better than accepting irrelevance. Simultaneously, clinical science is developing rapidly from predictive analysis of the human genome to adoptive cellular immunotherapy for cancer and bioabsorbable stents for coronary artery disease. While many of these advances are dramatic, all of them lead to greater complexity in diagnostic and therapeutic options.

As the world becomes smaller, our organization is growing. Our international members provide professional liability coverage to more than 1.3 million healthcare professionals and 2,000 hospitals and medical facilities. There is enormous value in the exchange of insights on healthcare financing, litigation, and regulation.

The 2017 International Conference in London is an excellent example. Nearly 300 attendees, from more than 24 countries, came together to discuss their challenges and learn from one another.

We will become stronger by more closely integrating our international members, even as the diversity of our domestic membership increases. We have new and expanded programs for health systems, Chief Medical Officers, defense counsel, and specialized subsections facilitating affinity grouping of companies.

As I complete my service as Chair and member of the Board, I share the goal of each of my predecessors: to leave the organization even stronger than I found it. I am grateful for the opportunity to work alongside so many great leaders from member companies and our outstanding management team.

I am proud of the strategic plan developed by the Board of Directors and the course charts to position our Association to facilitate the work of our members and the profession of medicine.

We want this organization to represent the full breadth of our membership—and to remain able to respond to the membership’s changing needs today and into the future. To achieve this, the Association must be able to adapt and adjust.

As communicated to you in recent months, this week in Orlando will bring a new chapter to this extraordinary organization as you consider the Board of Director’s recommendation to rename the Association in a way that corresponds to our expanding diversity—as the Medical Professional Liability Association. Under this new moniker, the MPL Association will deliver value through analysis, insight, and advocacy.

As evidenced by this landmark recommendation, this Association will remain relevant as your organizations, healthcare, and MPL continue to evolve.
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COMING ATTRACTIONS

EVENTS & CALENDAR

2018 Underwriting Workshop

Emerging Trends in the Practice of Medicine—and Their Impact on MPL Underwriting
July 27, 2018, 9:00–10:00 a.m.

Ann Lambrecht, Senior Risk Specialist, Coverys
Hayes V. Whiteside, MD, Chief Medical Officer, Senior Vice President, ProAssurance Corporation

Today’s healthcare professionals face a range of challenges, including a greater regulatory burden, escalating overhead costs, and reduced reimbursements for traditional services, all while trying to remain independent and make a living. To survive, physicians are reaching beyond the traditional practice of medicine to increase their revenue streams. This session will focus on the key emerging trends in physician practice—and what they may hold for MPL underwriters. The presenters will discuss some examples of this phenomenon including stem cell therapies, practicing outside of one's specialty, utilizing alternative medicine, telemedicine, and other new and unusual practice models that are currently trending.

2018 Technology, Human Resources, and Finance (THRF) Workshop

Grand Hyatt Washington, Washington, D.C.
September 26-28, 2018

Information technology, human resources, and finance are constantly evolving—so it is vital to keep up with the latest trends in these fast-paced fields. If you are involved in any of these areas, there is one event in 2018 that you can’t afford to miss: The PIAA Technology, Human Resources, and Finance (THRF) Workshop!

This event features general sessions encompassing important information for all MPL professionals, breakout sessions focused on each discipline, and always-popular roundtable discussions that examine issues—large and small—where you will have a chance to exchange information and share experiences with professionals who best relate to and understand your daily challenges. The program is designed specifically with your needs in mind and gives you the tools, resources, innovations, and solutions you need to move your IT, HR, and finance strategies to the next level.
Confidence

With the dynamic changes in the United States healthcare insurance market occurring at unprecedented speed, the only “certainty” we know is continued uncertainty. As the recognized industry leader in casualty reinsurance products and other risk transfer solutions, Guy Carpenter provides clients with the medical professional liability market intelligence and analytical expertise to help them face these times of uncertainty with confidence.

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How Common Are Lawyer-Themed Birthday Parties for Toddlers, Anyway?

There were a bunch of kids all dressed up, the boys wearing power ties.” Are toddler birthday parties themed after personal injury lawyers becoming a thing? The latest case, from South Carolina, like one noted in 2015 from Louisiana, seems to have come about because the kids see and listen to injury lawyers’ ads and jingles on TV again and again (and again) and start to fixate on them. “The report on the party includes plenty of party pics as well as a three-minute highlight video, all provided by the office of George Sink, PA, Injury Lawyers. Is it a marketing piece? Sure. But hey—the family asked him to come to the party, and he was a good sport about it. He’s entitled to a little credit for that, I think,” says reporter Kevin Underhill.

Source: Overlawyered, February 28, 2017

Surprise: Paper Records and Films Are Most Common Type of Healthcare Breach

It’s easy to assume that it’s the high-tech systems that are hit hardest by security breaches. To investigate the validity of this assumption, two institutions collaborated on research to elucidate the characteristics of places where these breaches occur. The two research institutions that worked on this investigation were the College of Health and Public Affairs, University of Central Florida, and the United States Joint Base in Charleston, South Carolina.

The findings indicated that, of all types of healthcare providers, hospitals accounted for approximately one-third of all data breaches, and hospital breaches affected the greatest number of individuals. But, despite the high percentage of hospitals with electronic health records and the federal incentives that have been pushing them, here’s the bottom line: paper and film were the most frequent locations of breached data, occurring in 65 hospitals during the study period (2009 to 2016).

The researchers note that although hospitals have made major investments in technology to meet Meaningful Use and other federal requirements, protecting digitized patient data has not been a central focus.

So: “modest proposal.” Perhaps it is high time for some brand-new RRMU, that is, Really, Really Meaningful Use regulations, with instructions for how best to safeguard paper items. But these new rules will not be distributed on paper. Lest they be breached.

Source: Health Informatics, February 22, 2018
Despite its relatively lackluster showings in the Winter Olympics, the U.S. still leads the pack in sheer magnitude of medical liability claims. According to ABC Money (U.K.), “again, the U.S. wipes the floor with the U.K. for the highest medical malpractice compensation claim—the U.S.’s claimant received $172 million in damages after suffering from brain damage whilst waiting for an ambulance to arrive and being given the wrong medication, sending the claimant into anaphylactic shock.”

In the U.K.? The highest medical malpractice compensation claim was a fairly meager 24 million GBP. The injury had happened when the patient was 10 years old. The treatment involved injecting glue into her, to block off bleeding in blood vessels. Unfortunately, the glue was injected by accident into her brain, and she was left brain damaged.

The head-to-head U.S. versus U.K. comparisons (auto insurance payouts were compared too) were compiled by the website Legal Expert to see if the U.K. had joined the “compensation culture” prominent in the U.S.

But, Legal Expert concludes, “This is in fact not the case.” But, ready to buck the underdog status of claim size in the U.K., the firm asserts that it is “fully prepared to offer unparalleled claim advice.”

In the First Quarter issue of this magazine, Observer introduced you to a technological breakthrough: Palarum “smart” socks. Well, if those socks were smart, this next item is positively brilliant. It’s the Ultimate Safety Sleep Vest, intended for patients who may tend to wander: it will prevent falls from bed, avoid accidents, and prevent the patient from leaving the bed (though not necessarily in that order, one would presume).

This particular breakthrough is still in development. Which means that you can get in on the ground floor, via Kickstarter. For your contribution to the campaign, you get the complete vest kit. This includes, in addition to the vest itself, a special bed sheet, safety straps, special opening key, padded back protector, instruction leaflet, and “a USB with movie plus other files, etc.”

It would seem as if the patient is pretty much placed in custody, once all of these items are in use. The Kickstarter goal for this project is EUR 26,650. Step up and give your fair share.

Highest Personal Injury Amounts: U.S. Still in the Lead

Despite its relatively lackluster showings in the Winter Olympics, the U.S. still leads the pack in sheer magnitude of medical liability claims. According to ABC Money (U.K.), “again, the U.S. wipes the floor with the U.K. for the highest medical malpractice compensation claim—the U.S.’s claimant received $172 million in damages after suffering from brain damage whilst waiting for an ambulance to arrive and being given the wrong medication, sending the claimant into anaphylactic shock.”

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Source: ABC Money (U.K.)

Come and Grab Your Share of the Loot

First, the article cites the by-now-standard, though in fact dubious, factoids about medical professional liability (MPL). For example, that it causes more than 250,000 deaths every year.

And then, it notes that many more nonlethal effects of MPL are long-lasting and often permanent.

Fortunately, there are law firms standing by, even when an injury is causing an exorbitant amount “of physical and financial pain.” You can ask Thomas J. Henry of Dallas for a free consultation. All you need to do is answer yes to one of four easy questions.

The first one is a slam dunk: Did a doctor-patient relationship exist? If you can say yes to that, well, Lawyer Henry will put you on his “proven track record” to Big Money. The firm has had a knack for winning big cases, it seems, for more than 25 years. Recent payouts, says Henry, fall between $10.9 million and $12.7 million.

Overall, in 2017, there were a tantalizing $3.8 billion in payouts, Henry notes. And adds this last smidgen of encouragement, “Don’t let your compensation pass you by!”

Source: News 4 San Antonio February 26, 2018

Source: Digital Journal, March 1, 2018
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A review of closed claim data from the PIAA Data Sharing Project shows the percentage of claims paid with indemnity decreased from 44% to 27% between 1985 and 2015; however, the average indemnity paid and the average defense costs increased throughout these five-year intervals.

For more detailed information, see the PIAA MPL Specialty Specific Series for Anesthesiology or contact P. Divya Parikh at dparikh@piaa.us.

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Is it true that the most profitable insurance companies have the best management information (reporting) systems? Having good reports will not necessarily lead to profits—but the opposite may well be true. Whether there is a causative link between profitability and the quality of the management information that is available can be debated, but without question, the MIS can have a significant influence on the ability of a company to achieve its objectives.

The definition from Wikipedia quoted above references three categories of MIS:

- **Transaction processing systems.** These produce regularly scheduled reports, based on data extracted and summarized from the operational data to identify and inform decisions. These reports are used by department and middle managers. There will be some control over the format and selection criteria when the reports are requested, but in general, the format is fixed. Examples of these reports would be a “Loss Reserve Register,” “Aged Open Item Receivables,” or an “Unearned Premium Report.”

- **Decision support systems (DSS).** These systems are software applications used by middle and higher management to compile information from a wide range of sources, to support problem-solving and decision-making. A DSS—often called an ad hoc reporting tool—is used mostly for semi-structured and unstructured decision problems.

- **Executive information systems (EIS).** This is a type of MIS, a reporting tool that provides quick access to summarized reports coming from all levels and departments of a company, such as accounting, human resources, and operations. The content from EIS is generally used by senior management to get a snapshot of the performance of the company. It is often referred to as a “dashboard” with key performance indicators highlighted, and including drill-down capabilities so that users can obtain supporting details.
Traditionally, most MISs have concentrated on the financial performance of the company. However, it is also important to monitor as well the nonfinancial aspects of a company’s operation, such as customer satisfaction, to get a more complete picture of a company’s current and likely future performance. This can be achieved by the “balanced scorecard” technique, which is designed to give managers a balanced presentation of both the financial and operational measures.

It is informative to consider the possible criteria that we can use to judge whether a particular piece of management information is “effective” for those who may request it. Possible examples of suitable criteria are:

- Presentation of it must aid interpretation
- Linked in some way to the decision-making process
- Can be interpreted quickly
- Breadth should be primary, followed by depth
- Regularly updated at appropriate times
- Sufficiently accurate for its purpose
- Cost-effective.

We have attempted to structure our thinking by considering the various users of executive management information (EMI) within a company, followed by the various key functions that each user carries out, and finally to consider the types of EMI that might assist the user with each function he performs. The users within a company that we consider in this article, with their key functions (for which EMI has a role to play), are summarized here:

1. **Board and Senior Management**
- Ensuring that they obtain adequate return on capital for the level of risk accepted
- Ensuring that the level of risk accepted is in line with shareholder’s expectations
- Protecting the capital of the company
- Raising of additional capital
- Authorizing and monitoring expenditure.

2. **Underwriting**
- Pricing and selection of risks
- Monitoring accumulations
- Monitoring growth/profitability
- Assessment of expenses
- Purchasing of reinsurance.

3. **Claims Manager**
- Control overall cost of claims
- Satisfying needs of customers
- Apply appropriate claims management practices.

4. **Reserving Manager**
- Recommend “best” estimates of reserves
- Recommending and payment of dividends
- Ensuring compliance with the relevant legislation and regulations
- Setting of guidelines for, and monitoring of, the executive.

For related information, see www.Delphi-Tech.com.
Prime Advisors, Inc., a Sun Life Investment Management company, is a federally registered investment advisor specializing in asset management for insurance companies. We offer liability-driven investors customized portfolios utilizing a comprehensive suite of investment vehicles including: fixed income, municipals, equities, cash management, commercial mortgage loans and core real estate solutions. Prime also offers dynamic financial analysis, enterprise risk management, tax and accounting assistance, ratings alignment, and friendly, dependable service, coast to coast.
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In 1978, the New York Court of Appeals first recognized a cause of action that permitted parents to recover extraordinary expenses incurred to care for a disabled infant who, but for a physician’s negligent failure to detect or advise on the risks of impairment, would not have been born. Becker v. Schwartz, 46 N.Y.2d 401 (1978).

More recently, the Court of Appeals addressed the specific issue of when the statute of limitations begins to run on these wrongful-birth claims for extraordinary expenses. In B.F. v. Reproductive Medicine Associates of New York, LLP, 30 N.Y.3d 608 (2017), the court held that the limitation period for an extraordinary-expenses claim begins to run from the date of birth of the child, rather than the date of the act or omission that the plaintiff alleges was negligent.

The cases before the court involved two couples who had sought in vitro fertilization (IVF) from the defendant physician at Reproductive Medicine Associates (RMA). The physician informed the couples that RMA screened donor candidates for all known genetic conditions for which testing was available at that time, but did not state specifically which conditions were included in the screening.

The couples were matched with an anonymous egg donor, consented to the IVF procedure, and after that, each plaintiff mother was implanted with fertilized embryos. Pregnancy was confirmed in each mother, and they were discharged to the care of their obstetrician/gynecologist. The births occurred without complications. One couple, the Dennehys, had a single infant; the other couple, the Farbers, had twins.

Subsequent to the births, the defendant physician learned that the egg donor had tested positive for the Fragile X trait, a chromosomal abnormality that can result in intellectual disability and other deficits. He informed the couples within one year of the births, and testing confirmed that the Dennehys’ child, and one of the Farbers’ twins, had the full Fragile X mutation.

The lawsuits
The couples commenced separate lawsuits. As relevant to the limitations issue, the complaints alleged that the defendants failed to screen the egg donor in a timely manner for Fragile X or to notify the plaintiffs that the Fragile X trait was not screened for. The plaintiffs alleged that these negligent acts or omissions were of material significance in their consent to the IVF procedure.

The defendants moved to dismiss the actions, arguing, among other things, that the
extraordinary-expenses claim was barred by C.P.L.R. § 214-a, which provides a 2½-year statute of limitations for medical professional liability (MPL) claims, which runs from “the act, omission or failure complained of or last treatment where there is continuous treatment for the same illness, injury or condition which gave rise to the said act, omission or failure.” Defendants argued that this limitations period began on the date of the alleged malpractice, which they identified as the date when the embryo was implanted in the mother. The plaintiffs opposed the motions, alleging that the limitations period began to run at the date of birth.

The trial court denied the motions to dismiss. The appellate court affirmed and granted the defendants leave to appeal to the Court of Appeals, New York’s highest court.

In the Court of Appeals
A claim for extraordinary expenses is restricted to those instances in which a plaintiff can demonstrate “that but for the defendants’ breach of their duty to advise plaintiffs, the defendants caused the birth of the infant with a disability.” Defendants argued that this limitations period began on the date of the alleged malpractice, which they identified as the date when the embryo was implanted in the mother. The plaintiffs opposed the motions, alleging that the limitations period began to run at the date of birth.

The trial court denied the motions to dismiss. The appellate court affirmed and granted the defendants leave to appeal to the Court of Appeals, New York’s highest court.

The Value of Teamwork
A “diagnosis management team” is a group of experts who meet daily and focus on the correct selection of laboratory tests and the interpretation of complex test results in a specific clinical field. Within the DMT’s specific clinical context, an expert-driven, patient-specific interpretation of the test results in a specific clinical context is generated by the members of the DMT. This requires the knowledge of a true expert—not someone who may have a general idea about the meaning of a particular laboratory test result—and the participation of someone to help that expert search the medical record for relevant data to be included in the interpretation.

For related information, see www.thuillezford.com.
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Five Strategies for Improving Medical Professional Liability Defense

Medical professional liability (MPL) defense attorneys often think of themselves as competitive debaters. In this metaphor, the role of defense counsel is to successfully marshal one’s extensive expertise, attention to detail, and resources to defeat, by the application of logic, the threatening narrative advanced by the plaintiff’s attorneys.
named for the northeastern region of Nepal, ethnic Sherpa are famed for their skill in extreme mountaineering and serving as guides in high altitudes. In simple terms, Sherpa shepherd ordinary mortals up into the harshest environment on the planet. Like attorneys, Sherpa do this successfully not only by understanding the facts of the situation (like the weather, the ice conditions, and the typical consumption rate of oxygen canisters) but also by understanding how to read the specific climbers they are working with: their capabilities, weaknesses, and likely response to extreme and threatening stressors.

Great Sherpa recognize that the facts about the mountain are only one important predictor of success. The other key elements are the personal qualities of the climbers.

Then, the Sherpa tailor their low-altitude practice, schedule, and advice based on the unique attributes of the climber.

Like many in this field, I’ve seen cases won when the facts were terrible but the physician defendants were sympathetic, believable, and appeared exactly like the well-intentioned doctors they in fact are. Likewise, I’ve seen cases lost when the facts were supportive but the physicians were noxious, confused, or withdrawn.

Now, I offer five strategies for becoming a great Sherpa.

1. Assume your clients are agitated and behave accordingly.

I am a vice dean at a medical school. If you watch medical students on the first day in anatomy, when they are introduced to their cadavers and plastic sheets are uncovered and they see the fingernail polish, tattoos, and wedding-ring tan lines, you cannot tell which of the students are anxious. (With a few exceptions—every year, two of our 150 or so students collapse, vomit, or run outside.) The majority look composed, even though we know from surveys that about two-thirds are anxious. (With a few exceptions—every year, two of our 150 or so students collapse, vomit, or run outside.) The majority look composed, even though we know from surveys that about two-thirds are anxious. (With a few exceptions—every year, two of our 150 or so students collapse, vomit, or run outside.)

Within months, those students will saw open a human face. While our overt goal is to teach them about human anatomy and what can go amiss in its miraculous design, we have another, more covert goal. **We must teach them to hide what they feel.** The reality is, physicians must be able to calmly proceed even when their hearts are exploding because in iceberg-infested waters, no patient wants the captain of their ship trembling, crying, or throwing up.

As a result, MPL attorneys routinely underestimate how upset their physician-defendants are. And worse, they mistakenly assume that physicians’ well-being is correlated with the “winnability” of their cases. While physicians want to win, too, what they really want most often is for the case to “go away.”

Using a standard inventory, I’ve found that about 40% of physician defendants are profoundly agitated, so much so that they worry they will be unable to testify, and another 20% are deeply upset. The defending attorneys in these situations are inevitably shocked that their “calm-appearing” physicians are so distressed.

When you assume that your defending physician is deeply agitated, that informs your approach to guiding them up the mountain. These are the behaviors we turn to next.

2. Make the experience—especially what’s coming next—predictable, and tell clients exactly what they need to do to cope.

Psychological science has demonstrated the importance of making intense stressors predictable, and the myriad of stressors associated with claims are no different.

You need only imagine traversing the Khumbu Icefall with a Sherpa to understand the importance of predictability. The icefall is a series of tall towers of ice, broken by vast crevasses that climbers navigate by walking over steel ladders dropped between them. Think about the difference between having a Sherpa talk us through each step on those precarious ladders, gently guiding us along, versus trying to do the same harrowing activity with no guidance, and you can see the clear importance of predictability.

Unfortunately, too many attorneys are so transfixed by the ground game of logical whack-a-mole to notice that their clients need attention. Physicians do not understand how depositions will be used later, how motions work, the voir dire process, “as on cross,” or many of the other typical volleys in a claim. That lack of knowledge makes the process more anxiety-provoking. And more anxiety often equates to poor performance as a witness. Making each stage predictable is essential. This means explicitly telling the physician what’s coming including the specific behaviors the attorney needs from the client and what the physician can do to cope.

I’ve also started advising newly named defendants to take up meditation. Meditation teaches them how to acknowledge stressors, without being consumed by them. About 40% of my clients take me up on this advice, and they are almost always better, calmer, witnesses.

Setting expectations is another key process that is commonly overlooked. Many physicians are loath to lose the income they generate from seeing patients in the service of preparing for their case, attending depositions or, especially, the entire trial. To tell them the amount of their time that will be needed at the outset is essential. Some attorneys are simply too respectful of a physician’s time to demand what they know will be needed.

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Dan Shapiro is the Vice Dean for Faculty and Administrative Affairs at Penn State Health and the CEO of DES Health Consulting LLC.
3. Rehearse more than you think you need to.
In private, many attorneys have confided shock that some of their physician clients ever managed to get through medical school. In a common response, one experienced attorney said to me recently, “Honestly, I think this guy is cognitively impaired. He doesn't understand my basic questions.”
While we do encounter the occasional physician who seems to be mentally compromised facing a suit, it is more often the case that they are dramatically distracted by the possible consequences of their case.
In their heads, they are repeatedly rehearsing their fears: that they are going to lose their good reputation, financial security, referral networks, and sometimes, that they have caused unnecessary harm to their patients and have begun to wonder if they don’t deserve to be physicians anymore. Long-term implications for their families, job security, and other high-stakes worries rattle through their minds.
We should not be surprised that many physicians are deeply troubled by the claims against them. We select physicians because they are perfectionists. Then, in the course of the unfolding case, it is SOP for plaintiff’s attorneys to paint the physicians as negligent, sloppy, uncaring, and self-centered (and send letters suggesting they are at high risk for major damages).
Because of focus and retention issues, reading likely questions and preferred answers to a defending physician is not enough. Attorneys should carefully rehearse their clients, especially on the most important three to five questions, again and again. This means giving the physician a chance to answer each question completely. At key moments, when physicians may feel they cannot take another step, a simple reminder, “Hey, you always sound like a doctor to me—you’re ready?” or, “Hey, quit slouching, that’s not you!” can be the encouraging balm they need to take the next step in preparing for a trial.
4. Use praise liberally.
After watching me intervene (successfully) with a physician he had struggled with during trial-preparation sessions, an experienced attorney jokingly quipped, “What, with you, does everyone win a medal just for participating?”
Yes, he was kidding, but, he was also letting his desire to keep up the veneer of a tough-minded defense attorney eclipse his real job as a Sherpa.

I give every client a specific metaphor to guide how they speak and behave during the entire process.

The only thing I added to what he’d said to the client was copious praise whenever the physician answered the questions well. I said things like, “A jury will immediately understand what you are saying about this,” and: “Wow. That was really compelling.” The physician brightened, grew more confident, and was better focused.
There are many ways to answer a question truthfully. Some will be compelling to a jury; others will not. The successful attorney guides the physician toward developing a compelling narrative, by giving plenty of feedback, especially praise.

5. Overtly remind the defendant that he needs to look more like a health professional, and not like a defendant, during depositions and trial.
When a juror sits and wonders if the defending physician would be willing to see his sister as a patient, the case is won.
I give every client a specific metaphor to guide how they speak and behave during the entire process: “Your jury will be made up of your patients. Talk to them as if they are your patients. Teach them what you were thinking, why you thought that way, and then, even if you ultimately committed a mistake, because they see you like a doctor, they will almost always rules in your favor. That also means looking organized and confident. It is essential that you not look or behave like a criminal defendant.”
Then, the attorneys and I work together to ensure that the physician’s nonverbal communications also align with the metaphor of jurors as patients. The physician’s chin should be up and his back straight, she should speak with confidence and directly to the jury: Hand wringing, slumping, whispering, or fidgeting are all prohibited. We rehearse until this is accomplished.
At key moments, when physicians may feel they cannot take another step, a simple reminder, “Hey, you sound like a doctor to me—you’re ready!” or, “Hey, quit slouching, that’s not you!” can be the encouraging balm they need to take the next step in preparing for a trial.
I’ve never been at base camp when climbers have come back down from a successful ascent of Everest. I can only imagine the satisfaction a Sherpa feels when a once-tenuous climber strides back to safety. But I have watched from 3 feet away while defending physicians wept with relief at the end of a harrowing and unfair suit.
It’s always worth the effort.
Responding to the Opioid Crisis: New Education for Your Insured Prescribers

Several States are Now Requiring Education for Prescribers of Controlled Substances

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The fact of the matter is that data is being collected about you, every day. But what is being done with it? In general, data is used to make our lives easier. For example, internet companies use customer data to:

- Suggest movies that may appeal to users based on their prior selections
- Display ads on a viewer’s screen that correlate with his recent search history
- Share birthday reminders and tag friends in pictures
- Pre-populate addresses in map apps to make it easier to find a destination
- Track how much physical activity a person is getting with pedometers
- And so much more.

It is easy to see how several of the examples on the list are already showing up in hospitals and in the day-to-day activities of healthcare providers. From the algorithms and checklists built into electronic health record (EHR) software to informatics being leveraged by chief medical officers, the payoff from these innovations is that patients are benefiting from better diagnoses of their maladies; also, machine learning has been harnessed to augment the delivery of care.

**Our digital footprints**
The things that we do every day leave digital footprints that tell the story of our lives. What we buy, how we drive, where we eat, and how we socialize can all be used to develop a picture of who we are. These digital artifacts can be analyzed to hypothesize how healthy we are, whether we are risk takers or not, and what combination of treatments may work best for us. Every time we take our smartphone with us, drive our car, visit a doctor’s office, fill a prescription, or shop online, we are creating an information trail that is captured and compiled.

In particular, a combination of internal and external third-party data is being used by insurance companies and healthcare organizations to increase patient safety, reduce medical professional liability (MPL) risk, and increase the value of healthcare. These organizations analyze a plethora of data to identify both statistical outliers and the more common patterns that can be
used to address a patient’s needs.

As you leave more footprints, the picture of you becomes clearer. And then, healthcare providers can tailor treatments to what they believe will better serve you in a particular situation. As Larry Winget observed in his book *It’s Called Work for a Reason,* “Knowledge is not power; the implementation of knowledge is power.” Healthcare providers are getting better at implementing actions based on data-driven knowledge!

The symbiotic relationship of humans and machines

In the Deloitte Insights article titled “Tech Trends 2018—The Symphonic Enterprise,” the authors discuss how humans and machines can develop a symbiotic relationship. Figure 1 illustrates this relationship, as the array of complex interactions between humans and machines.

When there is a symbiotic relationship (i.e., artificial intelligence augments human capabilities), healthcare workers benefit: they can more effectively spend their time, improve decision-making, and increase productivity by focusing their energy on the right treatment, for the right patient at the right time. The “Tech Trend” series covers several other significant topics, such as the application of machine learning, the internet of things (IoT), augmented/virtual reality, and robotic process automation. Let’s explore some of the ways that these trends are impacting healthcare.

**Diagnosis**

According to the PIAA Data Sharing Project, errors in diagnosis constitute the largest source of medical errors and the most powerful driver of MPL costs, for radiologists in particular. Healthcare providers have made significant strides in reducing these types of diagnosis errors, by analyzing available data and adopting technological advances. The healthcare industry has invested in capturing data through EHRs. Machine learning-based models, such as iCAD and IBM Watson, can be taught using the data from EHRs, published literature, healthcare provider input, and other data sources, so that they can “think like a clinician would.”

In the area of breast cancer detection, iCAD is leveraging artificial intelligence and patented algorithms to help radiologists detect actionable missed cancers earlier than with screening or mammography alone. Sophisticated machine learning is being used to improve oncology decision-making at Memorial Sloan Kettering Cancer Center. According to a spokesman for the company, “In 15 seconds, Watson analyzes 200 million pages of clinical data, cross-references the symptoms of 1 million cancer patients, and reads millions of current medical journals to test hypotheses.”

**Treatment**

In addition to helping providers in diagnosing potential pathologies, algorithms can be used to recommend potential treatments for individual patients, based on their unique characteristics and behaviors. While the person is an inpatient, the provider has greater control over the treatment. However, there are still potential hazards, such as bed sores and falls, that can hinder a patient’s recovery. The IoT makes it possible for inanimate objects to identify and react to changes in the environment around them—without human monitoring. For example, smart beds can adjust a patient’s body position to help stabilize his...
and accuracy are needed to help maintain its ability to identify and trends emerge. Periodic updates and tests of the model's precision, and performance over time may tend to decrease as new data are implemented. Similarly, a model's ability to segment risk, pre-

The problem of prescription drug abuse is also being tackled by the application of predictive analytics. Insurers use mathematical models to help them identify the patients who are more likely to take an excessive amount of opioids. For those patients who may be at risk of becoming addicted, physicians can alter their intervention, and recommend non-opioid alternatives (e.g., NSAIDs, massage therapy, acupuncture, and weight loss) or limit the supply and dosage level of the pills prescribed.

Detection of anomalies and analysis of outliers are also used by insurers and government officials to help identify the physicians who are overprescribing relative to the rest of the physician population. For example, one large health insurer performed an analysis of its top 1% of opioid “super-prescribers” by specialty (e.g., family practice, internal medicine, neurology, Ob/Gyn, rheumatology, surgery). As a result of this effort, their chief medical officer was able to send out a personal letter to almost 1,000 doctors, to help them understand just how far off the norm their prescribing habits had become.

Augmented and virtual reality

Both augmented and virtual reality are being used by physicians to live-stream patient operations, train medical students, access medical records and MRIs instantaneously while performing a surgery, consult other medical professionals while using wearable technology, and more. As this technology proliferates, it will be important to monitor how effective it actually is at improving healthcare delivery and patient safety. From training physicians to actually assisting surgeons during operations, this area will require more research, so we can better understand, and then share, the practices that have been shown to help drive better outcomes for patients.

Potential impacts on MPL

The applications of technology in the healthcare industry have the potential to improve patient outcomes and reduce medical errors. This development should be good news for MPL underwriters. However, there are some potential challenges that could lead to MPL claims.

First, there is a learning curve associated with the use of any new technology by healthcare professionals. It will take time for this effect to subside, as practice and process catch up with technology. Next, physicians may become overly reliant on predictive algorithms, once they are implemented. Similarly, a model's ability to segment risk, precision, and performance over time may tend to decrease as new data and trends emerge. Periodic updates and tests of the model's precision and accuracy are needed to help maintain its ability to identify and classify risks correctly. Diminished performance of the model may lead to false-positive results and/or unnecessary treatments, which could shake a provider's confidence in it.

So predictive models should be combined with other capacities: physician intuition, training, experience, and behavioral economics. We believe that data analytics can best serve as "eyeglasses for the healthcare provider's mind," helping physicians see more clearly which diagnosis has a greater likelihood of helping to relieve the impact of a patient's injury or underlying condition.

Conclusion

Advances in data collection, analytics, and technology are changing the way healthcare is delivered. Providers can now augment their own experience and knowledge with artificial intelligence-based algorithms and technology such as wearables and smart objects. However, at the end of the day, it's not the algorithms or technology that saves lives; it's how the physicians and hospitals leverage these tools. As artificial intelligence researcher Eliezer Yudkowsky has said, "By far the greatest danger of artificial intelligence is that people conclude too early that they understand it.”

It is important for insurers, hospitals, and healthcare providers to understand and question the tools they are using. As with any new investment, there is bound to be a learning curve. Models, just like people, aren't always perfect. From false-positives and the incorrect use of a wearable technology, to a patient diagnosis not contemplated in the original modeling dataset, ongoing human interaction is critical for proper utilization of these innovations. With that caveat in mind, we are excited about the future of these tools and the positive impact they will have on patient safety, MPL risk, and healthcare delivery.

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Unfortunately, until this report, there had been little attention paid to DE, perhaps because it is difficult to define and measure; perhaps because going into the “house of medicine” on this issue was threatening to diagnosticians in some way; or perhaps because we didn’t really understand what contributed to the problem and, therefore, didn’t know what to do about it.

Interestingly, DE was barely addressed in the oft-cited 1999 report *To Err is Human,* when in fact, DE happens with greater frequency and cost than many of the safety problems cited in that report. Thankfully, due to the efforts of a relatively small and dedicated group of multidisciplinary healthcare professionals here in the U.S. and beyond (primarily the Society to Improve Diagnosis, which includes people from the MPL industry), DE is now being recognized as being of significant personal, professional, and financial impact; and, there are great hopes that its occurrence can be reduced by further study and engagement by the many people who participate, in one way or another, in the diagnostic process, including patients and their loved ones.

Diagnostic error, as defined in the 2015 report by the National Academies of Sciences, Engineering, and Medicine, “is the failure to establish an accurate and timely explanation of the patient’s health problem and communicate that to the patient.” Contrary to most people’s beliefs about the physician playing an exclusive role in getting the diagnosis right and communicating it to the patient in a timely fashion, there are many con-
tributing factors in the diagnostic process over which the physician may have little influence, control, or awareness, despite the best of intentions.

System failures
In fact, an analysis of our claim data at MMIC shows that in 40% of our cases with DE as the primary allegation, even if the doctor has done everything "right," there occur what we call follow-up system failures, or FUSFs, that result in DE. Addressing these system failures is critical and may well prove easier than some other tactics to decrease the incidence of DE since, as a "systems fix" that is technical in nature, it doesn’t involve attempts to influence practitioners’ cognitive processes, an effort best left to educators and peer review programs.

Constellation (of which MMIC is a founding member) uses a third-party proprietary platform for classifying the contributing factors that lead to adverse outcomes. In the case of DE, we leverage a 12-step diagnostic process of care framework, which consists of three phases—Initial Diagnostic Assessment, Testing and Results Processing, and Follow-up and Coordination—to guide our analysis of claims and our tools for intervention (Figure 1). Using this framework, we map 40 different types of contributing factors in the diagnostic process to see which ones are more common, financially impactful, and amenable to change when it comes to influencing behavior and systems. This analysis of our MPL data informs our work as patient safety consultants for our clients and contributes to the national conversation and work on DE.

DE cases are our third top major allegation in occurrence across all settings of care, and our second in terms of total incurred cost (Figure 2). Five percent of U.S. adults who seek outpatient care each year will experience a DE, and DEs account for 6% to 17% of hospital adverse events. Our analysis of 2,867 MMIC claims from 2010–2015 confirms that DE cases are both common and costly.

And, although the average indemnity of diagnosis cases is higher in the inpatient setting ($529,000; Figure 3), we see DE cases four times more frequently in the outpatient setting, a fact that leads us to consider what we can do in this setting to effect change.

When we look at major allegations specifically in outpatient claims, we see that diagnosis is still number three in occurrence, but it climbs to number one in total incurred cost (Figure 4).

Figure 1.
Analyzing the Diagnostic Process

Figure 2.
Top Major Allegations Across all Settings

FIVE PERCENT OF U.S. ADULTS WHO SEEK OUTPATIENT CARE EACH YEAR WILL EXPERIENCE A DE, AND DEs ACCOUNT FOR 6% TO 17% OF HOSPITAL ADVERSE EVENTS.
setting involve a failure in the Testing and Results Processing phase, where we see problems with test performance, interpretation, and transmission of test results. We see many cases with problems in interpretation of diagnostic tests, 77% of which are radiology studies, with a disproportionate percentage of claims involving interpretations by non-radiologists (64%); this is remarkable, given that the vast majority of studies are read by radiologists.

These results have led us to recommend increased collaboration and consultation with Radiology, ideally, including a discussion and documentation of what to do with a clinically significant abnormal test result to ensure appropriate management by the ordering clinician.

Forty-five percent of our claims occur in the third phase of the
diagnostic process, Follow-up and Coordination. This is where break-downs in communication and coordination lead to DE. Errors involving physician follow-up with the patient; the referral and consulting process; patient information communicated among the care team; and the establishment of a follow-up plan are the major contributors to DE in the final phase of the diagnostic process.

**Systems-based approach**
This focused analysis leads us to a systems-based approach, which has the greatest potential for impact, and at the same time, leaves improving the cognitive part of diagnosis to the educators, the clinicians, and the clinical support systems and team. Interestingly, 45% of MMIC outpatient cases with a major diagnosis-related allegation involved an FUSF! This confirmed our hypothesis that even when appropriate clinical steps are taken to lead to the correct diagnosis, we still have DE. This is at odds with the traditional thinking that an accurate and timely diagnosis is the sole responsibility of the physician; it’s an impossible “ask,” given what the significant role that FUSFs play in DE.

Further, when we compared DE cases with FUSFs to those without, we found that those with FUSFs were less about breakdowns in patient assessment and misinterpretation of diagnostic studies, and more about communication between providers and patient/family, or among providers (Figure 6). These cases were also significantly more about a failure or delay in obtaining a consultation or referral, and about reporting abnormal or revised findings. There was significantly more failure or lack of patient follow-up systems, patient noncompliance factors, and documentation mechanics.

When we look at the significant contributors to DE in the outpatient setting, we consider the many roles involved and how we might collaborate for effective change. We have combined the 12-step diagnostic process3 with AHRQ’s **Improving Your Office Testing Process** toolkit,4 into nine steps.

In each step, there is an opportunity to delve into the underlying vulnerabilities that may result in DE, using a variety of performance improvement tools.

We believe that our findings regarding the role of FUSFs in the outpatient setting, documented in 45% of our DE cases, should result in a clarion call to action to help our insured clients—clinicians and facilities—in improving the diagnostic process. The first step in addressing any problem is raising awareness, and we hope that we are contributing to that effort. Ideas around “closing the loop” on vulnerable systems (Figure 7) by using tried-and-true performance improvement methods (Figure 8) should help decrease the number of DE cases where an FUSF led to a DE.

Communication between patient/family and clinicians; communication among providers; failure/delay in obtaining consults or referrals; and reporting findings or revised findings are all areas in great need of improvement and are necessary to help our clinicians get the diagnosis right and delivered in a timely fash-
Figure 7. Modeling Closing the Loop

Figure 8. Leverage Performance Improvement Methods to Improve the Process

References

For related information, see www.ConstellationMutual.com.
The year 2017 manifested a continued decline in underwriting income for the medical professional liability (MPL) insurance industry. While on a downward trend, however, movement in the industry’s profitability continues to occur at a relatively slow pace.

In 2017 the industry’s combined ratio increased to 103%, 3 points over the prior year. Behind this increase, insurers experienced significant declines in reserve releases, compounded by lower rate levels.

At the same time, investment gains increased almost 5 points, to 24% of premium. This produced an operating ratio of 79%, well below breakeven. Despite the decline in underwriting profitability, the MPL industry again returned a substantial portion of its income as dividends to policyholders. Surplus declined slightly in 2017, the first time this has occurred since 2002. Nonetheless, the MPL industry remains in a financial position roughly consistent with where it has been for the past five years.

For most of the past decade, the favorable operating ratios in the MPL industry have had one primary cause—the release of prior-year reserves. In 2016 and 2017, reserve releases contributed an average of 17 points to the industry’s operating ratio in each year. However, this is a noticeable decline from the reserve releases of prior years. In the decade preceding 2016, reserve releases contributed an average of 27 points to the industry’s operating ratio each year. Yet despite this decline in reserve releases, without them, the industry would have remained profitable in 2017, albeit by a smaller margin.

The industry’s onetime pattern of declining frequency ended several years ago. We have since seen the reporting of claim counts stabilize for most companies, with some volatility evidenced for certain writers and increases seen in certain markets. Trends in defense costs remain in the range of 4% to 6% per annum. Indemnity severity trends remain manageable for smaller-dollar claims, but an increased frequency of larger claims has fueled overall increases in indemnity costs.

This trend towards higher indemnity payments has been driven, in part, by consolidation in healthcare. Whereas an occurrence might previously have resulted in payments on behalf of both a hospital and an independent physician, that independent physician is...
in many cases now employed by the hospital. As a result, the hospital is likely to assume the full indemnity payment—leaving overall indemnity unchanged in this example, but increasing the average indemnity per claim.

At the same time, the hospital typically carries higher limits than the physician, so there may be greater availability of coverage for indemnity payments.

Rates have continued to fall for many writers, as evidenced by the declining premium volume of the industry as a whole. Certain markets have seen a cumulative decline in rate levels in excess of 25% over the past several years. It is common for companies to see certain of their competitors writing at rates perceived to be inadequate, forcing companies to choose between losing market share and writing at levels they themselves believe are unprofitable. At the same time, this trend in declining rate levels has somewhat abated.

A trend that has not abated is healthcare consolidation, as evidenced by the acquisition of physician practices by hospitals and healthcare systems and by many newly trained physicians opting to join these larger systems rather than enter into independent practice. MPL carriers continue to face declining market share as a result of these acquisitions. Healthcare reform only served to accelerate the trend in physician employment that was already well underway. Whatever reversals to healthcare reform lie in the short-term or long-term future, it is unlikely that any such changes would completely reverse the trend in physician employment—change and uncertainty are hardly an encouragement to independent physician practices.

To get a more detailed picture of the state of the MPL industry today, we have analyzed the financial results of a composite of 35 of the largest specialty writers of MPL coverage ("the composite"). Using statutory data obtained from S&P Global Market Intelligence, we have compiled various financial metrics for the industry, categorized by:

- Written premium
- Overall operating results
- Reserve releases
- Capitalization
- Policyholder dividends.

In considering the financial results discussed below, it is important to consider that the 35 companies included here are all established MPL specialty writers. They exclude any MPL specialty writer that has become insolvent or otherwise left the market and the multiline commercial writers of MPL coverage, as well as the smaller MPL writers with less-established histories. The companies in each of these three excluded categories are generally less well capitalized than the 35 companies included here. In addition, the underwriting results of the multiline commercial writers as well as some of the smaller writers have generally been somewhat less profitable. Of course, this was also true for the writers that became insolvent. Thus, the results presented below reflect the experience of the established specialty writers, which is inherently more favorable than a view of the industry as a whole.

Written premium

Last year, 2017, marked the eleventh straight year of decreases in direct written MPL premium for our composite (Figure 1). Cumulatively, premium has decreased by over $1.1 billion since 2006—more than 25% of the premium written in that year. To put that in perspective, consider: in the close-to-40-year history of the MPL industry, no other period of decreasing premiums has lasted longer than two years, and the greatest consecutive-year premium reduction was 7%.

Premium decreases during this time frame have been driven only in part by declining rate levels. An additional factor behind the lower level of premium has been the loss of business to self-insurance mechanisms. Throughout this time frame, PIAA companies have been losing business due to healthcare system acquisitions of both hospitals and physician practices. In earlier years—through about 2008—companies also frequently lost business due to the formation of new captives.

This is a distinct difference between the current market and the previous soft market, of the mid-to late 1990s through the early 2000s. Both the current and prior soft markets have shown inadequate rate levels, but to a lesser level and in fewer locales in this current soft market, as compared with the previous soft market. During this prior time period, rate deficiencies—including those documented in rate filings—ultimately culminated in adverse financial results. The dramatic reduction in frequency since the early 2000s means that MPL rates are in a much better
position now than they were 20 years ago. However, we continue to see aggressive rate action in certain markets and have observed significant premium reductions on non-renewed, large accounts.

Overall operating results
As measured by the composite operating ratio, the industry reached its peak profitability during 2010. During that year, the composite posted an operating ratio of 57%, which has risen to about 80% since that time (Figure 2). The increase has been driven by the decline in reserve releases, beginning in 2012, and by an increase in underwriting expenses. The 2017 combined ratio for the industry was 103%, up from a low of 77% in 2008 (Figure 3). This is the second year in a row that the industry’s combined ratio has exceeded 100%, meaning that the industry would have been unprofitable during the past two years without its investment income.

The investment gain ratio of 24% in 2017 was the highest achieved by the composite since 2010. This is a noticeable increase from 2015 and 2016 in particular, in which the investment gain ratio averaged 17%. In large part, the lower investment gain ratios of these two years were due to the accounting treatment by one larger carrier of its investment in its affiliates. The industry’s capital gains ratio increased to 7% in 2017 from slightly negative amounts in both 2015 and 2016. The investment income ratio decreased from 19% in 2016 to 17% in 2017.

The calendar-year loss and loss adjustment expense (LAE) ratio for 2017, 72%, is higher than in any year since 2005, and represents an increase of 18 points since 2008. The increase has been driven largely by the decline in reserve releases noted earlier, which is discussed further below. The starting loss and LAE ratio for the most recent corresponding coverage year has changed little during this time.

Information from the composite on the development of the 2017 coverage year to date, such as claim frequency, would not suggest that the 2017 coverage year will perform comparably to its predecessors. This implies that the 2017 coverage year is starting from a weaker position than other recent coverage years.

Finally, as noted previously, the industry saw a dramatic decrease in reported frequency during the 2000s. However, for most companies, frequency (on a per-physician basis) has since stabilized. Other companies have continued to see small declines in frequency, while for some writers, frequency has turned slightly upward again.

Given the rate decreases of the past decade, frequency has of course increased more relative to premium than to the number of insured physicians. Reported frequency per $1 million of direct earned premium increased significantly leading into 2012, although increases have been smaller since then. Thus, for every claim reported, fewer premium dollars have been available to defend or settle the claims than was the case at the beginning of this time frame.

Cumulatively, reported claim frequency (measured relative to premium) has increased by 30% since 2008. This increase is largely the result of rate decreases (mostly in the form of greater premium credits, as opposed to manual rate changes), although some writers have seen modest increases in “true” frequency—i.e., claims per insured physician.
Reserve releases
The composite released $540 million in reserves during 2017, an amount that has declined annually from the $1.0 to $1.2 billion released in each of the years 2008 through 2013 (Figure 4). Despite this decline, the reserve releases remain material. Yet, they should be put in the context of the reserves carried by the composite, which for net loss and LAE totaled $9.0 billion as of year-end 2016. The release of reserves was driven by a relatively benign trend in indemnity severity during the past several calendar years along with, for some companies, a less-than-expected ratio of claims closing with indemnity payment.

It is important to recognize that a history of favorable calendar-year reserve development is not necessarily indicative of redundant reserves currently. In fact, a review of calendar-year development segregated by coverage year shows that favorable calendar-year reserve development has historically continued two to three years past the point when reserves were subsequently found to be adequate. Thus, if the industry is currently at a level where reserves are theoretically exactly adequate, history would suggest that we will see favorable reserve development, on a calendar-year basis, through 2019 or 2020. This would then be followed by adverse development (at least for the older coverage years) in subsequent calendar years.

Capitalization
The composite’s surplus decreased slightly during 2017, from about $12.3 billion to $12.2 billion (Figure 5). Although relatively small, this represents the first decline in surplus for the composite since 2002. In part this decline was due to significant adjustments to surplus by two carriers in the composite. Even without these adjustments, the composite’s surplus would have grown only 2% during 2017.

Between 2012 and 2017, the composite’s surplus grew an average of 2% in each year. This represents a noticeable decline from the double-digit growth rate seen during most of the prior decade. While net income for the composite was close to $650 million, a large portion of this income was returned to policyholders in the form of dividends, discussed further below.

To put the industry’s capitalization level in a broader context, consider the risk-based capital (RBC) ratio for the industry. This metric provides a comparison of a company’s actual surplus to the minimum amount needed from a regulatory perspective (although, from a practical perspective, given market fluctuations, many would consider the practical minimum amount of capital needed to be well in excess of this regulatory minimum). The RBC ratio of our MPL composite was 1100% in 2017, approximately its same level since 2012. However, individual RBC ratios vary considerably within the composite, from a low of 250% to a high of more than 3600%.

Policyholder dividends
The stabilization of the industry’s capitalization level is in part due to the significant amount of policyholder dividends that MPL writers have continued to pay. In 2017, the composite writers paid slightly more than $200 million in policyholder dividends, representing more than 6% of net earned premium (Figure 3). Cumulatively, the composite has paid $2.7 billion in policyholder dividends since 2005.

MPL writers have sustained a steady pattern of policyholder dividend payments, despite a decline in the reserve releases that
have historically been used to fund these dividends. Since 2015, policyholder dividends have been approximately 35% of net income in each year. This represents an increase from an average of approximately 25% of net income in each of the preceding eight years.

Typically, these dividends are paid to all renewing policyholders as a percentage of premium. Thus, on a dollar basis, the dividends have provided greater benefit to those physicians who have historically paid higher premiums. We expect that policyholder dividends will continue for several more years, given their historically cyclical behavior and the composite’s strong balance sheet.

Profitability expected to continue—but so is its decline
In its most recent “Review & Preview” report, A.M. Best estimated a net total reserve redundancy of $3.3 billion for the MPL line of business as a whole. This is approximately 12% of the carried net reserves, which implies a redundancy for our composite of $1.1 billion. Thus, continued reserve releases can be expected to mask deteriorating underwriting results on current business, both prolonging the soft market and possibly increasing the risk of rate inadequacy. Insurers face other risks to the bottom line as well: possible increases in frequency and severity, including challenges to tort laws in several states; the continued impact of healthcare reform or its reversal; and a declining market share, among other factors.

We expect that further pressure will be exerted on the industry’s rate adequacy as the soft market continues, and that profitability will continue its slow erosion as a result. Yet capital remains strong, and we expect that discussion of its appropriate deployment will continue to be a common topic of conversation. Any “pleasant surprise” that comes to the industry will take the form only of declines in profitability that are less than expected, or a longer time period during which current capital levels are maintained, prior to declining.

We continue to see the soft market extending further and further into the future. The relative flatness of trends in frequency, rate levels, and capital, in particular, suggests that the current equilibrium could be maintained for some time. In the past, we have attempted to speculate on when the market might harden, but in truth we know not much more than that the market will harden only when it is done softening. In an industry that remains consistently, although decliningly, profitable, we expect that it will be at least several years before we can begin to speak of the hard market in the present tense again.

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These legal obligations are part of a general policy for improving the safety of patients, advocated by the public authorities in order to control medical risks and minimize accidents. In successive steps, the regulation has specified what is involved in these obligations.

Magali Augu is with Groupe MACSF.

Late appearance of the concept of SAE
Safety had already been a central concern for risky industries such as civil aviation and nuclear power, for several decades.1 But the concept of a safety culture within healthcare facilities (with the specific aim of developing a risk-management policy) did not appear until the late 1990s and early 2000s, under the influence of studies that highlighted the damage preventable by such a culture.2

The notion of SAE is relatively recent in French regulations. It was not until the Kouchner Act of March 4, 2002, that professionals and healthcare institutions were required to report "the occurrence of a medical accident, an iatrogenic condition, a nosocomial infection, or an event undesirable associated with a health product" (Article L.1413-14 of the Public Health Code - CSP).

And it was only with the law of August 9, 2004, on public health policy, that the generic term "adverse event" emerged on the one hand, and the criteria for its seriousness on the other, with Article L.1413-14 amended to state: "Any professional or health facility that has experienced a nosocomial infection or any other serious adverse event related to care performed during testing, treatments, or preventive actions must make the declaration to the competent administrative authority..."

Proessions that must report SAEs
This obligation to report SAEs is a requirement that applies to all health professionals, regardless of their specific profession (e.g., doctor, dental surgeon, nurse, midwife, nursing assistant, physiotherapist, etc.), their place of practice (office, hospital, health center) and their status (independent, salaried, or hospital

Obligations for Serious Adverse Events in France

Health professionals and institutions in France are required by law to report and analyze serious adverse events (SAEs).
employee), reflects a strong commitment by the public authorities to “provide the country with the structures and approach necessary to implement an ambitious policy of protection,” and “If France is considered by WHO as the country with the most efficient health system, it is nonetheless true that preventable mortality and morbidity remain among the highest in the developed world.” This situation reveals an imbalance between the resources allocated to individual curative approaches and those allocated to prevention, which makes it possible to act effectively on environmental factors and behaviors.

Indeed, if the occurrence of any level of preventable harm is considered anathema by the general public, the occurrence of an SAE is judged totally unacceptable. The focus has therefore been on this category of accidents.

The Regional Health Agency (RHA) was then positioned as the heart of the system, because it was deemed more suitable than a potentially cumbersome national system, remote from the characteristics of each local area.

New kinds of practices included
In the Law of January 26, 2016, whose intent was to modernize our health system, the legislature extended the obligation to report SAEs to medico-social establishments to those who do aesthetic medical procedures, and what was to be reported was expanded to any infections associated with care (rather than just nosocomial infections, as stated in the prior text). It also charged providers with a new obligation, to analyze the SAEs and reported infections; in this way, the culture of safety became a national priority.

Thus, through these several legislative developments, a method of declaring broad-spectrum ISGs has been developed. It should be noted, however, that this is a nonpunitive system, as noncompliance with these legal obligations is not subject to any sanction.

New obligation to analyze SAEs
“The health professionals involved are analyzing the causes of these infections and adverse events” (Article L.1413-14 paragraph 2).

We have thus moved from a purely declarative (passive) system, inexpensive in terms of human resources, but with many flaws—an underreporting of SAEs for fear of punishment and because of a misunderstanding of the usefulness and purpose of the system, reinforced by insufficient feedback—to an active system more expensive in human resources but more efficient, where professionals and health institutions become active players in the reporting system, looking for both the immediate and underlying causes of the occurrence of the accident. They are thus more involved and aware of the management of medical risks; this promotes an improvement in safety (Article L.1413-14 paragraph 2).

Definition of the SAE and modalities of the analysis
But what does “SAE” actually mean? How can its significance be measured? How should the data on these be collected?

According to which method and in what form should the analysis...
be conducted? All these questions were, until very recently, still under discussion.

Then, a decree of November 25, 2016 was adopted. It introduced the new article R.1413-67 of the Code of Public Health, which defines the SAE as “an unexpected event with regard to the state of health and the pathology of the person and whose consequences are death, a life-threatening condition, or the probable occurrence of a permanent functional deficit including an abnormality or a congenital malformation.” It therefore seems to be a broad definition for the concept of seriousness: the finding of a permanent functional deficit is sufficient to meet the definition.

The text also specifies the terms of what must be reported, in two stages. Immediately, the reporting entity must send to the AMS director information as to the nature of the event and the circumstances of its occurrence, as well as the first measures taken internally to remedy it. In this report, all the protagonists are anonymous except the individual who reports it. Then, within three months, the legal representative of the health facility completes the declaration, providing a description of the management of the event, the in-depth analysis of the causes of the event, and the corrective action plan in place.

The whole document is then completely anonymized and transmitted by the ARS to the High Authority of Health (HAS), in order to draw up an annual report of the declarations and to elaborate recommendations that will be included in a general policy for improvement of patients’ safety.

In support of patients and health facilities in this process of analysis, regional structures to support the quality of care and the safety of independent and certified patients bring their technical and methodological skills. They will have previously responded to a call for proposals and signed a contract, renewable after five years, with the ARS.

They develop an annual work program and also draw up an annual report for the LRA and the HAS. A ministerial decree specifies the complete details for these entities.

Footnotes
1. A safety culture was adopted in the nuclear field as early as 1955.
5. Decree No. 2016-1606, November 25, 2016 on the reporting of serious
Delay in Diagnosis of Breast Cancer: Genetic Testing as a Risk-Mitigation Strategy

Learning Objectives:
1. Minimize the risk of incurring a “delay in diagnosis” lawsuit related to breast or ovarian cancer
2. Properly identify patients who meet criteria for genetic testing
3. Recognize and manage the risk associated with the absence of FDA regulation of genetic testing

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Use of Advanced Practice Clinicians Helps Counter Doctor Shortage, but Raises Liability Issues

To manage the rising cost of care and contend with a growing shortage of physicians, healthcare entities are increasingly relying on advanced practice clinicians (APCs) to perform medical tasks.

By Bridget Zaremba

Handled properly, this increased use poses a viable solution to an emerging crisis. A study funded by the Association of American Medical Colleges notes that by 2020 there will be a shortage of 91,500 physicians. In a 2012 study by the Physicians Foundation, physicians reported they were “at capacity” and were “overworked and overextended.” These physicians face multiple liability challenges posed by errors due to exhaustion, longer patient wait times, the inability to quickly address worsening medical conditions, and the lack of time to provide preventative medical care.

In response, APCs are growing in number and now make up nearly 20% of today’s healthcare workforce. APCs include both nurse practitioners (NPs) and physician assistants (PAs). NPs practice under their own licensure and can practice independently in some venues. PAs practice medicine only under the direction of a licensed physician. Both professions require a master’s-level degree, and both require passage of a state licensing exam.

While the rising use of APCs helps address the cost of care and the physician shortage, it also brings liability risks. For example, in one lawsuit, a jury awarded $217 million to a man who became paraplegic due to the alleged misdiagnosis of a stroke in a Florida emergency department. Based on an examination and tests performed by a mid-level employee, the supervising doctor prescribed a pain reliever for sinusitis and ordered the patient to be discharged instead of treating the patient for a stroke. The next day, the man returned with irreversible brain damage. A deposition revealed that the mid-level employee was an unlicensed PA. The lawsuit named not only the assistant, but the doctor and hospital as well.

Lawsuits involving APCs are likely to grow, as their numbers increase and their scope of practice expands. Since the 1980s, the role of APCs has evolved in response to increasing primary healthcare. Many APC practices are trending toward specialization.
such as neonatology and cardiovascular and palliative care, among others. By specializing, APCs avoid the long hours and lower pay typical for primary-care positions. However, such specialization places APCs in high-risk treatment environments, a consideration when evaluating professional liability exposure.

To successfully address liability issues, healthcare entities need to ascertain the required level of supervision and prescriptive authority applicable in a state's statute and regulations, as they differ, sometimes dramatically, from state to state. The lion's share of liability for the acts of an APC lies with the supervising physician. Relevant legal theories include both direct and vicarious liability. Lawsuits rarely target an APC alone, but usually focus on the care rendered by an APC under a physician’s supervision. Frequent allegations against the APC include failure to diagnose, failure to refer to a supervising physician, practicing beyond the accepted scope of practice, and failure to abide by the elements of a collaborative or standard-of-care agreement. Moreover, these allegations are almost always accompanied by the allegation of a failure to supervise directed against the physician or healthcare entity.

To guard against these risks, healthcare entities can benefit by working with insurance brokers and carriers with specialized expertise in the healthcare sector. These specialists will most likely be aware of the latest regulatory changes and best practices for ensuring solid credentialing and supervision policies of APCs. Coverage applications should identify all APCs by name and specify at what capacity they are expected to practice and what procedures fall into the expected scope of work. Policies that include APCs need to limit the coverage to the scope of work specified by the insured, as many APCs engage in healthcare activities outside their employment.

The increased use of APCs will likely continue, as healthcare entities seek to satisfy America’s need to provide affordable healthcare to more and more people despite a shortage of physicians. But this increased use must consider the safety and liability risks inherent in today’s evolving healthcare models. Fortunately, healthcare entities can improve their ability to mitigate the liability exposure associated with APCs if they work with the right experts to help them recognize the limitations and the ever-changing regulations governing the APC practice.

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A CASE FOR A GATEKEEPING STRATEGY

Preventative Actions
Minimize Risk

By John P. Benson, JD

The procedures used in underwriting have gone through many transformations over the years. The most influential transformation has been the evolution from manual underwriting to underwriting that, first, uses large data sets that include longitudinal data and third-party content from major data aggregators and, then, uses multiple data sources to build risk-scoring algorithms that are highly predictive.

A gatekeeping practice requires two fundamental steps:

1. Thorough screening and verification at the issuance of a policy, and
2. Continuous monitoring throughout the life of a policy.

This step-by-step approach will impact loss ratios in a significant way. Technology has only recently reached a level where it can deliver reliable analytics and intelligence in the use of data. But not all data is created equal. Outdated or incomplete data, even when aggregated, cannot produce accurate results that correctly inform the underwriting process.

The industry offers data sets that can bring the general picture of the applicant into focus, but they are not complete data systems, because they are only contributory.

MIB, Medical Information Bureau, Inc. (MIB), is a contributory data set of application content from health and disability carriers used in underwriting private policies.

Under an agreement with the Federal Trade Commission in 1995, the MIB, and all insurance companies that are members of the MIB, agreed to abide by the Fair Credit Reporting Act. Similar agreements were entered into with ChoicePoint, the predecessor company to LexisNexis.

The NPDB, National Practitioner Data Bank, was established by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Reporting of medical professional liability (MPL) claims to the NPDB is required, but not enforced.

Other than NPDB, the MPL insurance sector and MPL carriers do not have the same tools available to them. As with all contributory data sets, there are limitations that result in significant gaps in reporting:

1. Most contributory data sets require voluntary reporting under a "push" model. The database custodian relies on reporters to push data to them. However, this does not happen consistently or in a timely fashion for a variety of reasons, including government budget constraints, reporting requirements, and a lack of enforcement.

2. There are loopholes in reporting requirements or limitations in what gets reported and when.

3. All events that should be reported aren't reported because of the places where the data becomes evident. For instance, if a carrier receives a claim, depending on the outcome, they may or may not have to report it. If the claim makes it to the courthouse steps, there is no means to capture and report that information. And if the practitioner who ends up on the courthouse steps is uninsured, that data likely never gets reported—anywhere. There are 3,144 counties in the U.S. with at least two court systems, plus 94 U.S. district courts, and publishers of contributory data sets don't effectively monitor all those primary sources for MPL filings. Further, data that can be captured via the individual practitioner's licensing board may never show up in any aggregated data set, including the NPDB, in spite of their efforts and intentions.

So: where to look? Underwriting is the base-critical function for a successful insurance operation,
and there are two gatekeeping strategies that can minimize your risk and provide your underwriting systems with the data needed to maximize the effectiveness of your uniquely specific algorithms.

Gatekeeping involves:
Accessing as many commercially available third-party primary-source data sets as possible to feed your data-hungry systems. There are tools that let you accomplish this, which provide (for example) an historical, longitudinal, nationwide practitioner database on provider exclusions, debarments, sanctions and disciplinary actions across all license types. Many underwriters do not run an address history on an applicant and only check data within the jurisdiction where they are currently practicing. This practice creates a gap in first, not verifying the identity of an applicant and, second, not checking for multiple licenses. These tools solve that problem: the data covers every U.S. jurisdiction, and it has been in existence since 1993, covering virtually all practicing providers in the U.S. These tools also cover early-warning content from press releases on indictments from the 94 U.S. District courts and every State Attorney General.

There are also national licensing databases that provide a full licensing history on a provider and also deliver near real-time monitoring with status change alerts.

Monitoring the insureds
Once you underwrite a practitioner who has been fully vetted, it is essential to monitor him for key risk factors and early-warning events that could necessitate a reassessment of risk, which may result in a price increase, or a policy cancellation for a material misrepresentation.

Here are the data points you should monitor:
1. Professional licensing, verification, and monitoring.
2. Comprehensive databases for historical and current sanctions, exclusions, debarment, and disciplinary actions plus minutes and reports from primary sources as part and parcel of disciplinary actions, MPL claims, substance abuse arrests/convictions, criminal convictions, abuse adverse actions, and civil and criminal actions related to fraud.
3. DEA Registrant that may show prescriptive authority impairments.
4. NPI verification (NPIs are often misappropriated or providers use multiple or entity numbers).
5. National Sex Offender Registry (sadly, there are thousands of practicing, registered sex offenders).
6. You can also find a registry that contains records on individuals who have been accused, investigated, or sanctioned for physical, mental or financial abuse of a patient.
7. Social Security Administration/Death Master File identifies individuals misappropriating the Social Security number of a deceased individual.
8. NPDB.

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**Interview with... Matt Mitcham**

*Matt Mitcham*, who retired from MagMutual in March of this year, was the company’s Senior Vice President of Claims. Mitcham spent more than 20 years aggressively working to defend Mag’s medical insureds and has worked tirelessly to defend the industry on big-picture issues as well. *Inside Medical Liability* sat down with him, and asked him to reflect back on his long and distinguished career.

*Inside Medical Liability*: During your tenure, you have built up the MagMutual Claims staff from 12 professionals, in a single office, to 43 staff, in six offices. What overall principles, and specific strategies, have guided this growth?

*Mitcham*: As for overall principles, we tried to bring our fierce determination to defend good medicine to each state we entered, and we of course had a very good track record to reference with our success in litigating cases in Georgia. We also looked for quality people who we believed could easily adapt to our strong culture for defending the medical community.

As for strategies, when we made the decision to expand into additional states, we felt it was very important to find local claims people who were familiar with the nuances of the state, to include venues, plaintiff attorneys, defense attorneys and a familiarity with the laws that governed medical professional liability in that state.

Also, once a state had hit a critical mass of insureds, we started local claim committees by involving physicians from within the state. Our belief was they would not only help us understand the medicine and locate good in-state experts, but also help us with the dynamics that might exist between local medical providers. This resource has proven to be very effective in helping provide the best outcomes for our physicians and policy owners for any given state.

*IML*: You have helped hundreds of physicians over the course of your career. What advice would you give to claims professionals in terms of the best way to communicate with, and provide support for, a physician involved in a claim?

*Mitcham*: Great question. Over the years, I have seen the huge impact that litigation has had on our physicians, so it is very important that the claim representative personally meet with physician defendants as soon as possible, to provide a caring and empathic approach. Also, along with the attorney assigned to the case, they need to impress upon the defendant(s) that this is a highly specialized team, whose sole purpose is to provide the physician(s) with the best outcome for the claim.

While that was our approach for number of years, over time, it has evolved and become more supportive and also more educational.

We came to understand that even though the claim representative and the attorney had the medical provider’s best interest at heart it just wasn’t enough in dealing with the emotional component of the litigation. We developed our Doctor2Doctor (D2D) program, which trains all types of medical providers to act as mentors (they have all been through the complete litigation process) to work with our defendants to help them deal with, and prepare for, the emotional and mental challenges of being in litigation.

*In addition to adding the D2D component to our initial meeting, we also wanted to fully educate our physicians and policy owners about the litigation process.*

It has been a very successful program, and over the years a number of physicians after going through the litigation process have themselves volunteered to become a part of the program and give back to the medical...
community in appreciation for the support they received during their litigation. This is the greatest legacy that I leave behind and the program I am most proud of in my tenure as Senior VP of Claims.

In addition to adding the D2D component to our initial meeting, we also wanted to fully educate our physicians and policy owners about the litigation process. We decided to use the large amount of data collected over the years to provide them with statistics that reflect the potential outcomes (i.e., win, loss, dismissed, or settle) based on the data for similar events, injuries, and specialties. In addition, we are able to provide them with a timeline for the litigation process based on the data we have compiled, so they fully understand what will be expected of them, the time commitment required to fully defend their care, and how long it will take on average to litigate the case. This report presented to them at the initial meeting along with the explanation of the D2D program has really been well received, as we continue to try to educate and support our physicians and hopefully give them the best possible outcome for their case.

**IML:** Is there one case or claim outcome that you are particularly proud of or had an impact on the way MagMutual handles cases?

**Mitcham:** There is one that sticks out in my mind. In my early days with the company, I was monitoring a trial that involved a brain-damaged child. The trial was not going as well as I would have liked, so I approached the plaintiff’s attorney after the jury went out and introduced a concept that I had brought with me from my prior employer, called a high/low. The concept caps the verdict at a high number with the understanding that a low number would be paid if we should win the case. It was the first time this concept had been used at MagMutual. I was able to get a high/low in place literally minutes before the jury announced that they had a verdict. We lost the case, and the agreement saved the company over $5 million and eliminated any excess exposure to the insured and our company.

The funny part was that I had been involved in the largest verdict to date for the company, and yet I got Employee of the Month for the outcome. Needless to say, the high/low concept is a big part of our arsenal in defending our physicians and policy owners today.

**IML:** What notable trends in the sources, and numbers, of claims have you observed in recent years?

**Mitcham:** I think one of the issues that I see trending upward is the increase in multiple defendants in a single case. With the combination of managed healthcare, hospital-employed physician groups, hospitalists, and mid-level providers, we are seeing an increase in the number of medical providers laying hands on patients. This has resulted in the plaintiff’s attorney having access to a lot more defendants, which increases the available limits and sets up the potential for finger point-
ing, which we all know can make a case indefensible. I strongly believe that it is imperative whether there are multiple carriers or just one that an early meeting of all parties be held, to discuss the defense of the case, to provide a proper defense in the long run.

IML: In your opinion, what are the most prominent landmarks in the evolution of the MPL sector as a whole?

Mitcham: I think the biggest evolution has been the move away from single or small physician groups to large, corporate-driven medical provider groups and hospital-employed physicians. The makeup of our policy owners has seen a pretty dramatic shift away from individual or small physician groups to corporate entities and hospitals that might have a different opinion on what a successful outcome may be on any given case. This has brought challenges for the staff in marketing, underwriting, and patient safety and especially claims that need to be addressed if mutual companies plan to remain relevant in the future.

Another area that I think warrants analysis is the continued growth of mid-level providers. This growing sector of the medical community has not only individual negligence challenges but supervisory issues that must be addressed. Clearly, this is a trend that will only increase as we deal with the shortage of doctors and the profitability of medicine.

IML: What challenges do you see in the future for MPL insurers, particularly as they relate to claims?

Mitcham: I think there will be several challenges. The first is tied to my earlier thoughts concerning multiple defendants within a single case. I am concerned that if we can’t get together and put aside our differences as individual carriers, and adopt a philosophy that we need to do what’s best for medicine overall, then we are going to create the perfect storm for the plaintiff’s bar and I suspect we will continue to see an uptick in frequency and severity—not to mention the legal cost of defending multiple doctors, medical providers, hospitals, and corporations.

The second is the overall emphasis on managing the cost of the litigation process. I completely understand the need to manage this escalating cost with creative ideas, efficiency, and data analysis. I would hope we don’t do what St. Paul did back in the late 1980s by overreacting and treating their legal partners as the enemy. As a result we saw a number of good attorneys leave the defense side and go plaintiff, and we all know what happened to St. Paul. The legal team and the company should be a partnership, with everyone understanding the need to manage the cost to the best of each one’s abilities and to achieve an outcome that is not only cost efficient but is also in the best interest of the physicians and policy owners.

The third area is addressing large damage cases. The plaintiff bar has gotten really good at demonstrating future costs for treatment through life care plans and economists, and we need to address this in two ways. Legislatively or through the courts to do away with the collateral source rule and allow evidence to come in of actual payments and available insurance to cover these expenses. Secondly, we cannot continue to sit on the sidelines and let plaintiff’s attorneys put up huge life care plans and damage witnesses without corresponding testimony from our experts. I realize this is frowned upon by the defense bar, as there is a belief that it will weaken your liability arguments. But we can’t just let these astronomical numbers sit with the jury in the event they find against us. I am crazy enough to think that for say a leg lost case where the testimony from the plaintiff is that his life is ruined and he has limited abilities to enjoy life that putting a person with a similar injury who has overcome his disability and is living a full and productive life would be effective. Also, I think that if we could ever get to bifurcating liability and damages this would be a great opportunity to try this in the event we lose the liability portion. Just a thought.

IML: What will you miss most about your job? And, what are your current plans for retirement?

Mitcham: Everything. The people I work with every day, my staff, the lawyers, and most of all the physicians and medical providers I deal with on a daily basis. They have become a second family and working for a mutual company like MagMutual that truly puts its Policy Owners first, not just in name but also in spirit. I came from another company that had become so focused on managing cost that I think they lost their way when it came to taking care of their customers. Coming to this company and watching our efforts to do what is best for our physicians and policy owners has been very rewarding.

I will miss being an active participant in directing the files as I have enjoyed being a part of shaping direction, mentoring, and finding creative solutions to bring cases to a proper conclusion and doing what is best for our owners.

As for my future plans, I have bought a lake house up in Northeast Georgia and plan to spend time up there improving the community and my golf game, and hanging with my family, especially my two grandchildren.
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- Attorney – “Thank you so much. I really appreciate your help.”
- Paralegal – “Wow, thank you.”

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As discussed in our previous article, “Fed Tightening Cycles and Their Impact on Treasury Rates” (Inside Medical Liability, Fourth Quarter 2017, p. 57), much of the flattening of the yield curve that occurred at the end of 2017 can be explained by low levels of inflation. Low inflation has long been a thorn in the side of the Fed, as they have consistently predicted higher inflation than the economy was able to deliver. Despite a weaker dollar, low unemployment, and strong economic growth, inflation has persistently missed expectations. However, as we move into 2018, and synchronized global growth continues to progress, there are signs that inflation is starting to wake from its winter hibernation.

To help gauge the changes in inflation, we begin by looking at the data. The two most frequently utilized measures of inflation are the Consumer Price Index (CPI) and the Personal Consumption Expenditures Index (PCE). Both indices attempt to measure the prices paid by consumers for a basket of consumer goods and services. Because some commodity-related components of inflation have been shown to be highly volatile over time, most economists (including the Fed) tend to focus on “core” inflation, which strips out food and energy prices from the broader basket of goods.

As you can see from Figure 1, neither measure has been able to consistently achieve the 2% Fed target. After a surge in 2016, both measures peaked in early 2017, and subsequently fell over the remainder of the year. However, more recently, they have started trending higher again; and several factors are pointing toward a more sustained pace this time around.

Inflation: pace of increases
Focusing on the Fed’s preferred measure of core PCE, the most recent data releases have shown an acceleration in the pace of inflation. While the year-over-year figure increased by 1.5% in December, the three-month annualized pace increased from 1.7% to 1.9% in November. This three-month annualized value was as low as 0.9% back in June 2017, so the recent improvement has been dramatic.

Additionally, several of the individual components of inflation that dragged the core PCE lower in early 2017, such as wireless telephone services, are rolling out of the year-over-year calculation, and should result in a boost to calculated inflation.

Another way to measure inflation is by looking at what the market is expecting. We can evaluate this by looking at the break-even
rate of inflation that is priced into Treasury-Inflation-Protected Securities (TIPS). Investors in TIPS receive a small yield, as well as an increase to their principal equal to the annual change in the CPI. The key consideration when buying a TIPS bond is the break-even rate of inflation, or the annual increase in CPI necessary for a TIPS investor to generate the same return as an investor holding a Treasury bond of the same maturity. It can be measured by subtracting the yield on the 10-year TIPS bond from the yield on the 10-year Treasury bond. Since TIPS bonds carry the same default risks as nominal Treasuries, the 10-year break-even rate is roughly equivalent to the annual inflation rate bond that investors expect over the next 10 years.

Figure 2 illustrates the rebound in inflation expectations since the middle of 2017, with the most recent number surpassing 2.10%—a level not seen since August 2014. While the improvement in the 10-year measure is interesting, it doesn’t necessarily indicate that a rapid increase is imminent, since it is measuring the expected average inflation over the next 10 years. This average masks both the magnitude and the timing of any changes over the time period. However, the equivalent measures for one-year and five-year breakeven inflation have also increased recently. The one-year level has increased from 0.5% at the end of 2017 to 2.15% at the end of January 2018; and the five-year level has gone from 1.75% to 2% over that same time frame. This indicates that the market is expecting inflation to increase in the next 12 months, before leveling off as we get into 2020 and beyond.

If sustained, the recent acceleration in inflation represents a risk for markets in 2018, as it would represent a big change in market psychology. The U.S. has spent most of the past 10 years with inflation below 2%, and those low levels of inflation have become ingrained in investors’ psyche. Expectations for future inflation during the next 5–10 years, as measured by the University of Michigan survey, have fallen from 3% 10 years ago to 2.5% today. As a result, you wouldn’t need a major uptick in inflation to generate an inflation scare in 2018. The paradigm shift from low inflation to moderate inflation could be very disruptive, especially when paired with the winding down of central bank balance sheets across the globe. These factors decrease the margin for error at a time when risk assets continue to reach new all-time highs.

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**Inside Medical Liability** 63  **Second Quarter 2018**
CONTRACT DOCTORS: MORE PROS THAN CONS?

BY ERIC R. ANDERSON

At one time, the ambition of doctors coming out of residency was to launch a new practice or join an established medical group. But somewhere along the way, things changed. Today, many doctors have realized that all of the effort required for running a practice might detract from what they enjoy most: delivering care.

How have they resolved this dilemma? Many are electing to go freelance.

In the MPL insurance industry, we are familiar with the practice known as “locum tenens” (Latin for “holding a place”). This has become a popular employment option—physicians are working shorter, contract-based jobs instead of taking a full-time position.

This career path used to come with a stigma: Some experts suggested that freelance doctors weren’t as accomplished as their colleagues with more steady careers. But this presumption has eroded, as more and more doctors opt for the flexibility of contract work—and more and more hospitals, anxious to fill gaps in staffing, bring them on board.

According to a survey from Staff Care, since 2002, the number of freelance physicians in the U.S. has nearly doubled, to 48,000.

Why is this happening? Contract doctors say the benefits are indisputable at a time when there is significant dissatisfaction among the full-time ranks within the profession: They frequently earn more on an hourly basis, they don’t have to wait for insurance reimbursements, and they get to decide when and where to work.

Thanks to locum tenens, a physician can live on a sailboat and travel between jobs. Or a family practice doctor can try out different clinical settings to see which she likes best. And there are perks for using a healthcare staffing company to find work; these firms may provide everything from housing to MPL insurance.

What role do hospitals play in all of this? According to the Association of American Medical Colleges, we are now in the midst of a doctor shortage that could increase to more than 100,000 by 2030. This is why medical facilities are relying more and more on physician temp agencies to fill needed positions.

Like most trends in healthcare, this one necessitates vigilance for its potential ramifications in terms of patient safety and liability.

It is our role, as the MPL industry, to help ensure that this expanding group of healthcare professionals is well-equipped for dealing with all that is needed for safe, quality care. For example, imagine a physician traveling to a new city, seeing patients she’s never seen before, operating within an unfamiliar hospital system, and interacting with nurses and doctors who are also strangers. Any combination of these could be a recipe for an adverse outcome.

However, there is a flip side to the potential risk associated with the burgeoning number of freelancers: Physicians will have more time off. That will help them avoid burnout, along with the other debilitating conditions, that can compromise their well-being, as well as patient care.

We owe it to our doctors, hospitals, and patients to help them make this work.

Eric R. Anderson is Vice President of Marketing and Communications at PIAA; eanderson@piaa.us.

According to a survey from Staff Care, since 2002, the number of freelance physicians in the U.S. has nearly doubled, to 48,000.
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