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What does it take to become a physician or other healthcare professional? The study of medicine, alone, is a daunting proposition. In general, it takes eight years of schooling, followed by residency training of three to seven years, just to be eligible for medical licensing. And that’s only the beginning. It also requires compassion, tenacity, fortitude, and commitment. It takes a special sort of individual—one who is willing to dedicate her or his life to helping others.

And let’s not forget all of the challenges that every physician is up against in today’s environment. There’s little to no recognition for the long days and extra patience that are job requirements for anyone working in healthcare today. Yet, despite these obstacles, physicians throughout America and around the world spend each day dedicated to providing quality healthcare.

The members of the Medical Professional Liability Association spend each day working to protect these steadfast professionals, alongside our mission to fully understand the ever-expanding complexities of medical practice. Advances in technology have vastly increased the level of sophistication needed to deliver care in today’s world. Ongoing research and study must be sustained to make certain that physicians and their teams are doing everything possible to create optimal outcomes for patients.

The topics explored in this quarter’s issue of Inside Medical Liability comprise one component of a broad road map showing where medicine is headed—and illustrate the need for continued diligence on the part of MPL professionals to ensure that healthcare professionals are fully protected as care continues to evolve.

For example, genetic testing can augment our ability to forecast the onset of many diseases and either prevent them or modify their impact. However, it also generates some new medicolegal considerations that clinicians will need to appreciate and learn how to navigate. In addition, this issue considers the volatile liability environment for the professionals who provide services to the aging. The typical care-delivery situation involves a wide variety of risk-management concerns, from lawsuits occasioned by patient dissatisfaction to regulatory or licensure issues. But a far-too-common theme in many of these cases relates to the “scope of service.”

In light of these sorts of conundrums, the MPL Association recognizes the need for the continued fine-tuning of the procedures used in determining liability exposures, to ensure that the practice of medicine has the protection necessary for its advances, for the benefit of healthcare professionals and patients, alike.

As the MPL community comes together for the 2019 MPL Association Conference in Portland, Oregon, we are pleased to be meeting in close proximity to some of the nation’s finest medical and science institutions, which make regular contributions to significant advances in medical care. Organizations such as the Oregon Health and Science University, the University of Washington School of Medicine, and many others are world-renowned for their groundbreaking contributions, and we applaud their achievements.

It is fine institutions such as these, and the numerous individuals who deliver quality care every day, that ensure that the provision of quality healthcare remains a constant—and at the cutting edge of technological progress—for all in need.

As we look to the future, the MPL Association continues to focus on the many important and evolving elements of MPL: risk management and patient safety, continual analysis of what’s needed for loss prevention, and the medicolegal and financial elements of MPL coverage for physicians, hospitals, nurses, and all those providing care.

"Advances in technology have vastly increased the level of sophistication needed to deliver care in today’s world."
“In addition, because new pathogenic mutations continue to be discovered, many of these patients may be candidates for additional genetic testing in the future.”

—Cover story

“Cover story: Medicolegal Considerations in Genetic Testing
By Victor Cotton

Feature: Unsafe Mismatches Between Resident Needs and Care in Aging Services: How Scope of Service Can Help
By Victor Lane Rose

Feature: How Medical Professionals Can Tell the Truth in an Upside-Down World
By Jeff Dougherty

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Learn how Myriad Complete™ streamlines the genetic screening process.
myriadwomenshealth.com/provider/myriad-complete
As many of us prepare to gather in Portland, Oregon, for the annual conference, it is an appropriate time to consider new beginnings and change. For the MPL Association, beginnings and change are built on a solid strategic plan created by the Association’s Board of Directors, in collaboration with the professionals who are responsible for implementing and achieving the initiatives and objectives of the organization. Serving as a road map to our shared future, our goals are to (1) focus energy and resources on the priorities of the members, (2) ensure that the Association members, staff, and the MPL community are working toward common goals, and (3) assess and adjust the organization’s direction in response to a changing environment.

Last year, a key strategic initiative driven by the strategic plan included changing the Association’s name and brand. Overwhelmingly approved by the membership, the change fuels the Association’s continued growth, as well as its widely acknowledged leadership role within the healthcare community. The success of this initiative is a tribute to the openness of the membership to embrace and keep pace with the changes occurring in healthcare delivery and with its many stakeholders.

Like everyone in the MPL community with an eye to the future, the members of the Board are each examining the role of technology in the delivery of medicine—new and remarkable developments such as artificial intelligence and machine learning, remote delivery of care via telemedicine, and electronic health records, to name just a few—and the sophisticated impact it has on risk profiles. Like you, we are all studying and analyzing the changes in the business of medicine and how those shifts impact risk financing.

To keep you connected to peer learning and the ongoing discussions in the industry, the Association developed affinity groups to address the changing membership demographics and the different needs of the various members. These opportunities for information exchange include the Regional Member Roundtable, Hospital-Owned Liability Section, Chief Medical Officer Roundtable, and International Section. These forums are unique to the MPL Association and illustrate our commitment to continuous improvement and providing you with new and ever-increasing value.

As a diverse community, we can leverage our perspectives to not just respond to change but thrive in the midst of tectonic shifts. So, while continued change and growth are inevitable, the Board of Directors is committed to ensuring that the MPL Association remains an indispensable resource for each member. Our Association was founded to provide a forum for exchanging information and solving problems, to serve as an advocate for an affordable and dependable MPL insurance market, and to promote the practice of high-quality and safe medicine. These essential values endure and continue to guide our strategy and focus on you as a member.

As healthcare continues to evolve, our commitment remains steadfast: we will do everything possible to help MPL Association members successfully navigate new beginnings and change in their own organizations. Look to us to promote, protect, educate, and connect you in supporting and defending those who deliver healthcare and practice medicine.

Mary-Lou Misrahy, ARM, is President and CEO of Physicians Insurance A Mutual Company and Chair of the MPL Association Board of Directors.
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**Events & Calendar**

### 2019 Technology, Human Resources, and Finance Workshop

*Fairmont Chicago Millennium Park, Chicago, Illinois*

**September 25-27, 2019**

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 fields, there is one event in 2019 you can’t afford to miss: The MPL Association Technology, Human Resources, and Finance (THRF) Workshop! This event features general sessions that offer important information for all MPL professionals, breakout sessions that concentrate on each discipline, and the ever-popular roundtable discussions that examine issues—large and small—where you’ll have an opportunity to exchange information and share experiences with your colleagues—the individuals who can best relate to, and understand, your daily challenges.

This year, the program organizers remind you to think ahead to succession planning—bring your new team members, the future leaders of your company! **First-time attendees will receive half-off the registration fee.**

### Introduction to Medical Professional Liability Insurance Workshop

*Hilton Alexandria Old Town, Alexandria, Virginia*

**October 17-18, 2019**

The “Introduction to Medical Professional Liability Insurance Workshop” is back in 2019! This unique educational program gives attendees a comprehensive overview of all of the most important fundamentals and dynamics in MPL—knowledge that is invaluable for becoming a major contributor to an MPL insurer.

In just this one workshop, your staff members can learn about every aspect of the MPL business, including claims administration, underwriting, ratemaking and reserves, reinsurance, and more! This innovative program is designed for employees in the early phases of their insurance career; longer-term employees with relatively less experience in some of the disciplines or departmental procedures that comprise an insurance operation; and physicians or other directors who are new to insurance governance. The workshop also offers valuable information for the employees of companies that provide goods and services to the MPL community and who need to learn more about the inner workings of the enterprise they work with. **MPL**

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**Future Events**

- **June 26, 2019**
  - Webinar
- **August 28, 2019**
  - Webinar
- **September 9-11, 2019**
  - Underwriting Workshop
- **September 11, 2019**
  - Chief Medical Officer Roundtable (by invitation)
  - InterContinental Mark Hopkins
  - San Francisco, CA
- **September 11, 2019**
  - International Risk Management Seminar
  - InterContinental Mark Hopkins
  - San Francisco, CA
- **September 11-13, 2019**
  - Claims and Risk Management/Patient Safety Workshop
  - InterContinental Mark Hopkins
  - San Francisco, CA
- **September 25-27, 2019**
  - Technology, Human Resources, and Finance (THRF) Workshop
  - Fairmont Chicago Millennium Park
  - Chicago, IL
- **October 17-18, 2019**
  - Introduction to Medical Professional Liability Workshop
  - Hilton Alexandria Old Town
  - Alexandria, VA
- **October 24-25, 2019**
  - Corporate Counsel Workshop
  - The Mission Inn Hotel
  - Riverside, CA
- **November 20, 2019**
  - Webinar
  - Future Conferences
  - MPL Association Conference
  - May 6-8, 2020
  - Omni Shoreham Hotel
  - Washington, D.C.
  - MPL Association International Conference
  - October 7-9, 2020
  - Ottawa, Canada
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Spend More Time in Front of the Mirror, Less on Dull Stuff like Facts

W

We've located a useful tip from a jury consultant. He's dedicated a lot of prose to it, but the bottom line is: “Charisma and likability matter.”

Okay, it's possible to cultivate those two. But there's more: “The best set of facts may not save a trial lawyer who is unattractive and poorly dressed.”

Admittedly, the consultant notes, “This isn't fair or right, but it is a reality that science proves out. For these reasons and more, it is imperative to put your best foot forward.”

He suggests we accept that the jury will likely zone out on the actual evidence: “As your case becomes more complicated, jurors are more likely to seek shortcuts and give more weight to easier factors to understand, such as which attorney they like and which they don't. The less personally involved jurors are with evidence, such as information that is too dry or difficult, the more they tend to rely on peripheral cues rather than on an argument’s actual strength.”

There is no specific advice provided on what to wear, but more than likely, nothing less than what appears in the pages of GQ will pass muster.

Source: “See, Like It or Not: Likability Counts for Credibility in the Courtroom,” February 2019

MPL in Hollywood: Do You Remember ‘The Verdict’?

T

he review-aggregation website, Rotten Tomatoes, notes that “The Verdict” gleaned a full 96% of critically positive reviews. And it featured Paul Newman, James Mason, and Milo O'Shea. But why did the film make news on February 10, 2019? Because it also starred Charlotte Rampling. And ranker.com took upon itself the task of ranking every single one of the movies in Ms. Rampling’s oeuvre.

Now let’s tick off some of the lawyer movie clichés in 1982’s “The Verdict”:

- A promising young attorney (for the plaintiff) who's disintegrated into alcoholism and ambulance chasing
- Said attorney is given one last chance, in a case that is pretty much guaranteed to be a winner (MPL, in this instance)
- Irrefutable evidence of guilt by the guilty party
- Decline of an eminently reasonable settlement offer
- A key witness (in the medical expert witness category) disappears
- The written medical record has been altered in a way impossible not to spot (Wite-Out has been used so thickly that there is a recognizable topology on the recorded blood test values).

The newly sober plaintiff’s attorney redeems himself so completely that the jury foreman asks if the jury can award more than the amount the plaintiffs sought. Answer: Yes! High Fives all around. Even though that hasn't yet been invented. This movie is prescient in so many ways.

Source: ranker.com, February 10, 2019
A troubling enigma pertaining to AI was recently confronted head on by the intrepid editors at Forbes, via an interview with W. Nicholson Price, Assistant Professor at University of Michigan Law School. Artificial intelligence, we note, is a nearly impenetrable thicket of such conundrums. (In fact, it may well take an unusually large quantum of AI just to sort through the queries that the topic of AI brings to mind.)

Forbes asked, “Say, a radiologist uses AI to read an X-ray but misses an abnormality. Is he legally liable?”

And the eminently cogent answer, from Dr. Price: “There’s no precedent about AI that I’m aware of. Typically, a physician will be held to the standard of care in the relevant medical community. Often it’s a nationwide standard of care. The question is, ‘Would we expect that radiologist to catch this particular error?’ If you fall beneath the standard of care, then you’re likely going to be liable.

“As to exactly what the standard of care requires using AI, we just haven’t worked it out yet. The standard of care might be, no matter what tools you’re using, you have to identify the tumors that a radiologist would have identified. Or it might be that you have to use an AI once one’s available.”

Well, that clears up that issue nicely, doesn’t it?

Source: Forbes, February 11, 2019
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In a recent review, 26% of claims and lawsuits resulted in an indemnity payment to the claimant. Within these claims, *cardiac or cardiorespiratory arrest* is prevalent among the top resulting medical conditions for all age groups. Other top conditions named in these paid claims include:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age Group</th>
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<tbody>
<tr>
<td>• lung cancer</td>
<td>70 and Over</td>
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<tr>
<td>• retained foreign object</td>
<td></td>
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<tr>
<td>• accidental puncture or laceration during a procedure</td>
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<tr>
<td>• accidental puncture or laceration during a procedure</td>
<td></td>
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<tr>
<td>• moderate to severe visual impairment</td>
<td></td>
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<tr>
<td>• fracture of femur</td>
<td></td>
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<tr>
<td>• acute myocardial infarction</td>
<td>50-69</td>
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<tr>
<td>• lung cancer</td>
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<td>• prostate cancer</td>
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<td>• pulmonary embolism</td>
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<td>• paraplegia</td>
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<td>• breast cancer</td>
<td>30-49</td>
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<tr>
<td>• accidental puncture or laceration during a procedure</td>
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<td>• lung cancer</td>
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<td>• postoperative infection</td>
<td></td>
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<tr>
<td>• retained foreign object</td>
<td></td>
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<tr>
<td>• unhappy results of plastic surgery</td>
<td></td>
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<tr>
<td>• appendicitis</td>
<td>19-29</td>
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<tr>
<td>• poisoning by other opiates and related narcotics</td>
<td></td>
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<tr>
<td>• emotional distress</td>
<td></td>
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<tr>
<td>• retained foreign object</td>
<td></td>
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<tr>
<td>• brain damaged infant</td>
<td>18 and Under</td>
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<tr>
<td>• birth trauma</td>
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<tr>
<td>• brain damaged infant</td>
<td></td>
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<td>• birth trauma</td>
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Contact for more information:
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dparikh@MPLassociation.org
Insurance is ranked well behind other industries such as retail and banking in ratings of “the customer experience.” Over the last 10 years, the world has moved from a static and transactional application of technology to one that is connected, mobile, and collaborative.

This transition has rocked the foundation of many industries—notably, retail. And as these changes have occurred, people's expectations have also changed dramatically.

While digital transformation is designed to improve efficiency, it seems that a higher objective is to make the customer experience a more “high value” and relevant interaction, and a differentiator for the company. A survey by Celent indicates that 77% of insurers say that a “significant motivator” for digital and technology investment is transforming the customer/channel experience. Many insurers have modernized their back-end systems over the last few years, so that they're now better prepared for this task. Data is more readily accessible, and it can be used to drive a personalized relationship.

Amazon is a company that has mastered the art of using technology to drive its business. Its success is the result of a combination: being innovative, plus the clever use of technology as an enabler to that innovation. The company started off as a bookseller, but rather than simply decline like the other booksellers on the internet, it adapted to the change by introducing its Kindle e-readers and also by diversifying to selling almost anything else.

What can insurers learn from Amazon? Their success can be summarized as “incredible customer service.” This is manifested in several ways:

- **Choice.** Amazon can fulfill such a wide selection of retail goods that it has become regarded as a one-stop shop, and the place to go where you will find lots of merchandise not available on Main Street.
- **Overnight delivery.** It provides almost instant gratification and convenience for the customer.
- **Free shipping and returns.** The shipping and return process may not exactly be “free,” but Amazon saw this as the one area where it was being compared unfavorably with brick-and-mortar sales, and so the company introduced the “Prime” approach to disguise it, as well as to provide several other added values—and foster loyalty.
- **Great customer service.** Amazon.com includes features for resolution of customer service issues, with customer service reps available for those occasions when things escalate—with 24/7 coverage.

Amazon has created a business that has engendered an emotional resonance in the hearts and minds of its customers, by understanding and respecting the buying public and then building technology to support it. The understanding and customer focus are the hard part; the technology on the Amazon website is nothing extraordinary from a tech perspective.

Now ask yourself: Who in your company is responsible for understanding the customer’s needs? It should be Sales and Marketing, but do they approach customers thoughtfully and effectively?

Turning to MPL, let’s look at the “customer” : what has changed about them, and what could be done to create that loyalty and passion for his insurer. Note that in using the term “customer,” I am including agents, for the purposes of this discussion.
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Expectations
Just like 30 years ago, when Japanese cars showed us how quality and reliability could be achieved at an affordable price point (and set a standard for Detroit to match), Amazon has shown how a focus on customer satisfaction, through well-designed technology and service innovation, can revolutionize an industry. And it’s not just Amazon; airlines, brokerages, banks, and more have led people to expect personalized 24/7 service.

From one-man practices to large groups
Back when most MPL companies were formed, most insureds were solo practitioners; a group as large as 15 was unusual. Today, that is not the case. In servicing a policyholder with hundreds of physicians, MPL insurers must realize that the needs are different, and the demands of the policyholder need to be addressed with more flexibility:
- Some coverage elements may need to be at the policy level, rather than at the risk (physician) level.
- Risk management may need to have a different emphasis; be more customized; and delivered differently to a large group.
- Large groups may be suited to sophisticated experience rating.
- Billing methods and billing information may need to offer greater flexibility, to allow payments in the many forms available and from different entities. And the billing information may need to have a breakdown to support chargebacks and the group’s internal accounting needs.
- New rating methods may be needed for certain specialties, for example, a per-visit premium basis. The debit and credit factors may need to be reflective of the group as a whole rather than the individual physician, for example, group size.
- With a group administrator dealing with the insurer, the level of access to data would need to more closely approximate what would be provided to an agent than a solo practitioner, and it should be available 24/7. The administrators may want to have added permissions to be able to do limited quoting and policy changes themselves.
- A large client may have expectations of preferred access to legal advice.
- It would be reasonable to suppose that a large group might have additional expectations in terms of data analytics that are available from the carrier—data downloads and ad hoc reporting on the group, and (anonymously) perhaps for peer groups.

Greater use of agents
Alongside increased group size, and the move into new states by most insurers, there has been an increase in the share of business conducted through agents. Though not the “end user” of the product, agents, acting as the gateway to new sales, will need to have an efficient relationship with the companies they represent. Their needs overlap with those of the insured, but at the same time, they have additional functional requirements to assist them in tracking activity across their book of business, tracking commissions, and more. The agent will need to feel fully supported by the carrier but, at the same time, he will be looking for steps in the process flow where he can intervene, in order to maintain contact and sustain a relationship with the insured. This means that the insurer’s website should include notifications of events like a late payment or a new claim, to keep the agent in the loop and give him an opportunity to help the insured if possible.

Changes in medical specialties
Modern medicine is changing how healthcare providers work. The role of a physician assistant has evolved, and there are now hospitalists who are looking for coverage. And the practice of some specialties has changed; for example, dentists are increasingly doing cosmetic work, and with telemedicine, a radiologist may work in one state and service clients in another.

These changes lead to questions of risk, coverage, and rating.

Movement of doctors and mergers of groups
Doctors are more mobile than ever. When a physician transfers into or out of a group, the insurer may need to offer additional facilities to transfer his history with him, particularly if the old and the new policyholder are with the same carrier.

Cyber threats
Most MPL companies provide cyber coverage today. But this is a relatively new risk and one that is evolving and growing at a worrying pace. How many companies have stepped up their risk management offerings in this area to help the insured with loss prevention? Also, because as cybercrime takes many different forms, the policy language will need to be adapted to the emerging risk.

The responsibility for customer satisfaction rests squarely with the business outside of IT, and with an innovative perspective that looks at what the customer wants and needs—not just at what the competitors are doing. IT is an important enabler that is called upon to support most business changes these days. But it should also be more than a passive enabler—it should alert the business to new tech capabilities and trends that can improve the business, including customer satisfaction.

The key questions, then, are:
- Does the company look at customer service in an innovative way, rather than settling for a “me-too” approach of merely keeping up with the rest of the industry?
- Is the IT infrastructure and the IT staff capable of delivering on innovation?
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When I first arrived at what was then called the Physician Insurers Association of America, more than 15 years ago, our major policy focus was on Congress. It wasn’t our exclusive focus—we also monitored state legislation and tracked the federal executive-branch activities that impacted “medical malpractice” insurers—but it certainly represented a major percentage of what we did. That’s one of the reasons I was brought on board—to utilize a decade’s worth of experience on Capitol Hill, to bolster the Association’s lobbying activities.

Well, times have certainly changed. We are now the Medical Professional Liability (MPL) Association, and the term “malpractice” has largely been replaced. And Congress, which at times seems hopelessly gridlocked in not just partisan strife but, increasingly, in intra-party ideological warfare as well, seems incapable of accomplishing much of anything.

States are again becoming the major battleground for MPL issues. It’s no longer all about the legislature, however. Having lost legislative battles over tort reform in a majority of states, the personal injury bar has turned its attention to another venue, the courts. It is on that front where our adversaries are most extensively engaged in efforts to undo effective reforms and put in their place precedents that undermine our attempts to improve access to, and the efficiency of, our healthcare system.

Damage caps
Everyone knows that when a state enacts MPL reform, it won’t be long before personal injury lawyers flock to the courts, in an effort to have those reforms struck down. Stopping caps on non-economic damages stands as one of their highest priorities, and that effort has been very much on display in recent years.

The most recent example, in terms of the highest court in a state rendering a decision, came in 2017, in North Broward Hospital District v. Kalitan. At that time, the Florida Supreme Court, which had already expressed clear hostility to MPL reforms, ruled that caps on non-economic damages “arbitrarily reduce damage awards for plaintiffs who suffer the most drastic injuries,” and thus violated the equal protection clause of the state constitution. The opinion further concluded that because no evidence exists of a continuing MPL insurance crisis, no relationship exists between the caps and “alleviating this purported crisis.” While the decision was certainly disappointing, it is worth noting that three of the four justices who signed the
majority opinion have since retired from the court, and new legislation to establish damage caps has already been introduced in the Florida legislature.

A year later, the results were much more positive, when the Wisconsin Supreme Court not only upheld a new non-economic damage cap, but in so doing overturned a 2005 ruling that had deemed an earlier cap unconstitutional. This time, the court found that the legislature had a rational basis for enacting the cap, thus making it constitutional. In sometimes blistering language, the majority opinion went on to state that the previous ruling had no legal basis and that the court had simply issued its own “policy choice for Wisconsin.” The MPL Association joined other stakeholders in filing an amicus brief in the case, Mayo v. Wisconsin Injured Patients and Families Compensation Fund, to defend the cap.

This year, more rulings are on the way. The Oregon Supreme Court is poised to rule on Vásquez v. Double Press Mfg., Inc., a non-MPL case that is challenging whether the state’s non-economic damage cap violates the state constitution’s remedy clause (“every man shall have remedy by due course of law for injury done him in his person, property, or reputation”). Arguments were heard last September. Another case wending its way through the courts is Siebert v. Okun in New Mexico, in which a lower court judge found the state’s $600,000 cap on damages (excluding medical expenses) unconstitutional. The case is currently proceeding through the appeals process, so it is not clear when the supreme court will address this important question.

Other reforms under attack

The personal injury bar doesn’t stop at just trying to eliminate damage caps, however. It has the resources to attack any liability reforms that may make their way through the legislative process, and it does just that. Most recently, they were successful late last year in Kentucky: the supreme court there invalidated a one-year-old law requiring that MPL claims be considered by a medical review panel before proceeding to litigation. In the case of Kentucky v. Claycomb, the court said the requirement conflicted with the commonwealth’s constitutional “open courts” provision, by denying “a claimant’s freedom to access the adjudicatory method of his or her choosing at the time of his or her choosing.”

Just a month earlier, the Florida Supreme Court found that the enactment of a law establishing expert witness requirements...
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that coincided with the U.S. Supreme Court’s Daubert standard was unconstitutional. In DeLisle v. Crane, the court said that such legislative action infringed on the court’s rule-making authority, and in the process returned Florida to a weaker expert-witness standard, one that most states had long since rejected.

The MPL Association weighed in on a somewhat different kind of case (Pebley v. Santa Clara Organics) in the summer of 2018, when it joined in an amicus letter asking the California Supreme Court to address the issue of medical liens. Medical liens, as you may know, involve the growing practice of plaintiffs forgoing their health insurance to seek medical care on a lien basis, in order to dramatically increase medical bills and thus any subsequent economic damages. Physicians who work on a lien basis then sell the liens to litigation financing companies, which can then reap a substantial profit if the plaintiff is victorious. Unfortunately, the court declined to take up the issue.

The state of Oklahoma was dealt a blow in 2017, when its affidavit of merit requirement was struck down as unconstitutional for the third time. Despite changes to the statute attempting to address the prior negative court rulings, in John v. Saint Francis Hospital the state’s supreme court once again stated that the effort to address meritless lawsuits was “a costly, meaningless, and arbitrary barrier to court access,” which violated the state constitution.

Conclusion
These are just a sample of the many challenges our industry has faced in trying to reform a broken MPL system. Not only is it likely that these challenges will continue in the future, it is guaranteed. This is why it’s important to engage in the judicial process to the extent possible. If your state has elected judges, by all means get involved in those campaigns. If not, find other ways to let your elected officials know what you expect when they consider filling the next court vacancy. You can also weigh in on non-MPL cases that may have indirect ramifications for your company by filing an amicus brief in those cases. Whatever approach you decide to take, the MPL Association will be there to help. We’ll also keep up our efforts to monitor, report on, and engage in state court activities whenever it is appropriate to do so. With Congress frequently tied up in knots, and some state legislatures simply not favorably disposed to our issues, the courts are a battleground that we cannot afford to ignore.
Plaintiff’s lawyers have been attempting to invoke emotional responses in the jury by using the reptile method for many years. The next step on the ladder is using the principles of psychodrama in the courtroom: showing the story, not telling the story. Instead of merely inquiring as to what happened, lawyers using psychodrama principles will include “why it happened” and, most important, “what did you experience?” This involves the jury emotionally, not logically.

What is psychodrama?
In 1932, Jacob Levy Moreno presented the concept of psychodrama to the American Psychiatric Association. Dr. Moreno spent the next 40 years of his career perfecting the therapeutic technique. With roots in improvisational theater, psychodrama is psychotherapy that utilizes spontaneous dramatizations and role-plays of past events. Psychodrama is part psychology, and part improvisational theater, combining communication and emotion. A psychodrama is a three-dimensional spontaneous reenactment of a traumatic event presented in the moment, with no script or rehearsal. The purpose of the exercise is to feel the same emotions and invoke those emotions in those participating in or watching the psychodrama.

In psychodrama, the roles are a director, the protagonist, the auxiliary actors, and the audience. The psychotherapy group’s leader is trained in the method and acts as the director; setting the scene, engaging the protagonist and the auxiliary actors, and bringing the scene to its conclusion. The psychotherapy group participants are the protagonist, the auxiliary actors, or the audience. The protagonist is the star. The auxiliary actors play supporting roles. The audience watches and comments.

The director sets the scene of the protagonist’s choosing. The core techniques include mirroring, doubling, role playing, soliloquy, and role reversal. The purpose is for the protagonist to experience the scene, likely a trauma, again. The director prompts, “What did it sound like?” “How did it smell?” “How loud were the sirens?” “Were you anxious?” “Were you angry?” The reexperience of the event leads to the same (or similar) emotional response as the original scene.

The auxiliary actors have roles in the scene or roles in modifications of the scene. The director may direct the participants to modify the scene and then discuss the outcomes.

The purpose of psychodrama is for participants to gain insight or understanding of the self, or of significant others, or of significant life events. Psychodrama achieves its purpose by adding “why it happened” and “how did you feel” to the “what happened” of telling a story. The director’s subtle guidance to the jury then becomes, how do we right this situation?

Psychodrama in the courtroom
The plaintiff’s lawyer is a natural fit for the director, and the plaintiff serves as the protagonist. Psychodrama is bringing the jury inside the plaintiff’s story. The jury unwittingly becomes the audience.

The plaintiff’s lawyer sets the scene for the plaintiff. This is a three-dimensional scene for multiple senses: sight, hearing, and feeling. The plaintiff may use props to effectively act out his experience. Through questioning, the plaintiff’s lawyer directs the plaintiff to relive the scene and re-experience his emotional response to
the scene, in front of the jury. The plaintiff experiences the trauma, the surgical complication, or the birth injury in front of the jury.

The “what happened” and “why it happened” are not as important or compelling as the “what did you experience?” Consider a birth injury case. The plaintiff mother takes the stand. She discusses the gushing sensation of her water breaking too early and rushing to the hospital. Next comes the sound of the fetal heart tones, starting to beat out of rhythm. And then, the rush of nurses and a physician into the room; the emergent C-section and the deafening silence of the baby not crying.

In the psychodrama approach, the jury is right in the operating room with the plaintiff. The skillful plaintiff’s lawyer will question the plaintiff so as to invoke the plaintiff’s emotional response within the jury. And then, the jury is experiencing the trauma with the plaintiff. The jury may identify with the trauma just as the audience does and thereby gain an insight into their own lives. The jury is now in a position to seek to correct the scene to the plaintiff’s benefit, driven by their emotional alliance with the plaintiff. The goal is for the jury to ask, “how do we right this situation?”

How do we respond?
Once we as defense counsel become aware that psychodrama is being used, we can file the appropriate pretrial motions to limit its use. Birth injury cases are particularly appropriate for pretrial motions. Speaking to the jury from the perspective of the injured baby can be excluded as inflammatory. Having the plaintiff mother hold a prop of the injured baby and speak to the prop can also be excluded as inflammatory.

Awareness of psychodrama also changes our courtroom presentations. The core objective of psychodrama in the courtroom is emotional manipulation. Pointing out the plaintiff’s lawyer’s emotional manipulation may help the jury recognize that manipulation and alter the tide of the trial. If there is one thing jurors do not like, it is feeling manipulated.

How do we use psychodrama principles in our favor? We are storytellers, and it is our job to present the correct interpretation of the story to the jury. The most important is to include the why it happened and what did you experience with the what happened with our own clients. Why did the physician make the disputed decision? What was the physician’s thought process? Was the thought process behind the decision reasonable and competent? Did you believe you gave good care to the plaintiff? Were you upset that this complication occurred? Why did you include these items on the treatment plan? By asking these types of questions, we are humanizing our clients and placing the jury in their shoes.

Conclusion
Medical professional liability litigation seems to be particularly conducive to the plaintiff’s lawyer’s use of psychodrama in the courtroom. By recognizing that psychodrama is an emotionally grounded method of manipulation, like the reptile method, we can engage in pretrial motions and objections that will limit the scope of what the plaintiff lawyer can do as “director” and the plaintiff as the star in a dramatization of main events that are the subject of the dispute. We can also use psychodrama to our advantage and go into some detail as to the “why” and “how” of the story for our clients.
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Because genetic testing improves clinical outcomes, it has the potential to reduce MPL exposure. However, it also generates some unique medicolegal considerations that clinicians will need to navigate.

Managing negative results

Due in part to the expanding criteria for genetic testing, up to 24% of women may now be candidates for BRCA testing. Fortunately, most of these patients will test negative for a pathogenic (i.e., cancer-causing) mutation. While a negative result is certainly good news, it does not mean that these patients are not at risk of developing breast cancer. In fact, because cancer risk is driven by both genetic and nongenetic factors, some of these women will still be at very high risk and should be followed closely with both mammography and breast MRI. For example, a woman who smokes cigarettes, had her first child after the age of 30, and has certain patterns of genetic variation known as “single nucleotide polymorphism” may have a lifetime risk of cancer similar to that of women who test positive for pathogenic BRCA mutations.
In addition, because new pathogenic mutations continue to be discovered, many of these patients may be candidates for additional genetic testing in the future. To cover these possibilities, clinicians should remind patients that even though they tested negative for a pathogenic mutation, they may still be at increased risk of developing cancer and should continue to seek care on a regular basis.3

Managing positive results
Patients who test positive for genetic mutations are often faced with the challenge of making major healthcare decisions. In the case of a pathogenic BRCA mutation, the patient will likely have to choose between a double mastectomy and a lifetime of frequent screening tests. And, a patient whose fetus has serious genetic abnormalities must decide about the future of her pregnancy.

Given the gravity of the circumstances, clinicians must be prepared to provide these patients with timely and accurate information about their options and have established referral networks in place to manage them. In terms of reducing medical professional liability (MPL) exposure, a genetic test should not be ordered unless there is a process in place to efficiently manage whatever the result may be.

Managing variant of undetermined significance (VUS)
Although our understanding of the human genome has greatly expanded, there are still significant gaps in our knowledge. It is therefore quite common for even the most experienced labs to report a genetic test as “variant of undetermined significance.” In layman’s terms, this means: “We don’t know.”

Although most VUSs are eventually determined to be benign, some will be pathogenic. A VUS is therefore something that should be followed rather than treated. Unfortunately, the fact that many physicians are unfamiliar with genetic testing, combined with variations in the manner in which labs report VUSs, has already resulted in litigation, in particular: against a physician who performed a double mastectomy on a patient whose only genetic finding was a VUS.1

Absence of FDA regulation
Genetic testing is regulated under the Clinical Laboratory Improvement Act (CLIA) rather than by the Food and Drug Administration (FDA). The distinction is important because CLIA focuses on consistency of process, whereas the FDA requires accuracy of results. In addition, because genetic testing is classified as a “laboratory developed test,” CLIA permits each lab to use its own methodology, rather than mandating a standardized approach.

The variation in methodology and absence of an accuracy standard combine to create a situation where two labs will commonly issue different results for the same specimen—meaning at least one of them must be wrong.4 The impact of these errors is magnified by the fact that significant patient care decisions are often made solely on the basis of a genetic test (e.g., double mastectomy for a BRCA mutation). Given the significant potential for patient harm, clinicians should rely on only the most reputable and well-established labs.

Direct-to-consumer genetic testing
The difficulties caused by lab-to-lab variation are compounded by direct-to-consumer (DTC) genetic testing. DTC genetics began as an intriguing way to learn about one’s ancestry, but it entered the clinical realm last year when 23 and Me added BRCA testing to its analysis. And, many patients now share their 23 and Me results with their healthcare provider. In terms of how clinicians should manage this information, the prudent approach is never to rely on it.

The BRCA analysis performed by 23 and Me is significantly limited in many ways. First, although there are more than 1,000 pathogenic BRCA mutations, 23 and Me tests for only three of them (the three Ashkenazi founder mutations). In addition, 23 and Me does not actually examine the BRCA gene. Instead, it looks for a genetic marker (SNP) that is commonly associated with the Ashkenazi mutations. The 23 and Me methodology is thus an indirect analysis of just three possible mutations. In contrast, clinical-grade testing involves a direct analysis for more than 1,000 possible pathogenic mutations. Because of these and other significant limitations, clinicians should not make treatment decisions based solely on DTC genetic testing.

Genetic information and healthcare insurance
A few years ago, patients who tested positive for genetic mutations might have found it very difficult to purchase or maintain healthcare insurance coverage. Genetic testing was thus a double-edged sword: It identified patients who were at risk of developing disease and then negated their healthcare insurance.

Fortunately, this no longer occurs, because two federal laws prevent healthcare insurers from discriminating on the basis of genetic information. First, the Affordable Care Act prevents insurers from making coverage decisions based on preexisting conditions, including genetic conditions. Second, the Genetic Information Nondiscrimination Act (GINA) prohibits healthcare insurers from adjusting premiums, altering coverage, or refusing to issue a policy on the basis of an individual’s genetic profile.

Although the Affordable Care Act remains at risk in the ongoing political debate, GINA has never been at risk. Clinicians can therefore assure patients that genetic testing will not adversely affect their healthcare insurance—no matter what the result.

Victor R. Cotton MD, JD, is President of Law and Medicine. Dr. Cotton is a consultant for Myriad Genetics, Inc. (Myriad). Myriad collaborated in the drafting of this article.
Duty to notify at-risk family members

When a patient is found to have a genetically based disease, that has implications for his family members, who may have also inherited the disease. And, when genetic abnormalities are found in a fetus, that has implications for future pregnancies, which may also be affected. Because many of these family members and parents will be unaware of these risks, it is reasonable to ask whether physicians have a legal duty to warn them.

As a general rule, a physician’s legal duty is limited to his patients (and not family members or future pregnancies). However, our courts have occasionally extended this duty to include non-patients when those persons are deemed to be in harm’s way. Known as “third party liability,” most of the cases have involved communicable diseases or patients who threaten to physically harm someone. Because genetic conditions are not communicable and are not a threat to anyone other than the patients who possess them, logic dictates that third party liability should not apply. However, in the few cases that have reached the appellate level, our courts have held that it does apply and that clinicians can be held liable if they fail to warn these persons.5,6

Fortunately, this duty is easily fulfilled: In the case of at-risk family members, by educating the patient and instructing him or her to share the information with family; and, in the case of prenatal conditions, by educating the affected parents and counseling them appropriately. Clinicians who identify genetic abnormalities should therefore engage in these conversations and document their efforts.

Conclusion

As the use of genetic testing expands, the overall impact on MPL can be effectively minimized by addressing the points discussed in this article.

References

5. Pate v Threlkel, 661 So.2d 278 (Fla. 1995).

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1. As an aging services community adopts person-centered care and promotes aging in place, it gains a growing population of independent-living residents who need assistance with various services. Eventually, the provider determines that one resident requires a transfer to assisted living. The resident wants to stay in independent living and retain private care, but her care needs exceed that which state law allows to be provided in independent living.

2. In accordance with a preferred provider agreement, the hospital sends a referral for post-acute care. Although the person could benefit from rehabilitation, the prospective patient has multiple comorbidities as well—including a recent history of suicidal ideation.

While these situations raise a variety of risk-management concerns, from lawsuits due to resident or family dissatisfaction to regulatory or licensure problems, the common theme in these cases is scope of service. Scope-of-service challenges can financially harm an organization, especially given the liability insurance environment for aging services today. In a report about the realities of aging services insurance in 2019, Willis Towers Watson forecasts, “The senior living and long-term care insurance marketplace remains in stark contrast to the overall health care industry, with less favorable conditions for buyers due, in part, to rising frequency and severity of claims.”
The report cites several factors contributing to emerging risks in the sector, including the potential for class-action lawsuits alleging staffing, marketing, anti-consumer, and Americans with Disabilities Act (ADA) claims. The report goes on to project liability rate increases of 5% to 30%. (Willis Towers Watson).

**Mismatched resident needs and provider services: risk and liability**

In the ideal situation, a resident's needs will fall neatly within the scope of service within a service line. However, the potential for harm for persons served and liability exposure for the provider can emerge when an organization admits a person whose needs fall outside the capabilities of a delivery system, because those needs cannot be met consistently.

Risks associated with such mismatches have the potential for great harm to all stakeholders and can even be deadly. Organizational processes that lead to mismatches are potential root causes of many different types of problems (Figure 1).

Many factors can result in these mismatches, each leading back to multiple root causes. For example, perhaps the delivery system was never designed to meet needs at that acuity level, staffing levels do not safely or consistently allow those needs to be met, or care-critical competencies do not exist to the degree necessary to deliver those services (e.g., intravenous medications). Thus, when a person is admitted to a care setting where these mismatches occur, risks related to unmet needs can exist from the start (Figure 2). Examples of such risks include falls, medication errors, delays in treatment, and even neglect.

However, care delivery systems need to be aware of the ever-changing needs of persons served within the scope of service. Because a person's needs tend to change over time, risk can develop as those needs drift beyond what the scope of service is capable of meeting (Figure 3). Thus, delivery systems must determine individuals' needs not just prior to admission, but also over time.

**Understanding scope of service**

Processes for preadmission, admission, discharge, and transitions in care are at the very heart of every provider organization. These daily processes result in decisions that can either align with the scope of service or lead to mismatches between a person's needs and the scope of service within a service line.

Scope of service describes the many types of care and services a delivery system provides to care for and support the ongoing health and needs of the person served. It thereby helps draw a picture of the organization's capabilities.

Benefits of having a well-defined scope of service for each service line include the following:
SCOPE OF SERVICE

Case in Point: CCRC Decision to Transfer Independent-Living Resident Not Discriminatory, Court Rules

A decision by a continuing-care retirement community (CCRC) to transfer a resident to a higher level of care did not violate the ADA or the Fair Housing Amendments Act, a federal district court in California has ruled. The resident had resided in independent living for about 13 years when she was hospitalized. The CCRC determined that she needed to move to assisted living or skilled nursing on her return.

The resident sued the CCRC, alleging violations of federal antidiscrimination laws. The court found that the CCRC’s policy of transferring residents to higher levels of care when necessary did not constitute disability discrimination because it was not applied less favorably to people with disabilities as a group. Rather, the transfer policy complied with state regulations and upheld the CCRC’s continuum-of-care model. The court also found that the resident required a degree of care that the CCRC could not legally provide in independent living and could not delegate to privately paid assistants.

Further, the ADA did not require the CCRC to provide accommodations that would fundamentally alter the nature of its business, the court opined. The court granted the defendants’ motion for summary judgment. (Herriot v. Channing House, 2009 U.S. Dist. LEXIS 6617 [N.D. Cal. Jan. 29, 2009].)

It provides a framework for making decisions about admissions, transfers, and discharges of individual residents, helping to determine if the service line can meet each individual’s needs.

It supports decision makers when they determine that the service line cannot meet the individual’s needs.

It promotes realistic expectations and a shared understanding among stakeholders and guides development of materials like admission agreements, marketing materials, and brochures.

It guides management decisions and policy development, such as expansion of services and contracts for additional services.

Mapping out service lines and considering the degree of overlap between scopes of service can also help to identify potential gaps between service lines (Figure 4), where those served might fall through.

Conversely, a lack of service-line definition can compress scopes of service and service lines so much that it becomes difficult to distinguish where one service line starts and the other stops (Figure 5). Industry forces can unintentionally contribute to this compression. For example, with person-centered care and aging in place, customer expectations can change rapidly, and organizations may feel considerable pressure to expand each scope of service in order to serve higher levels of acuity in environments that in fact have inherent delivery-system limitations. These pressures can make it difficult to match an individual’s needs with the care and services available, or even permitted, within a service line. Because truly person-centered care takes into account not just the individual’s and family’s wishes, but also the individual’s needs, scope of service can enhance person-centered care practices by helping to define a shared understanding of capabilities and expectations. It also contributes to relationships that mutually respect the independence of the person served and the duty of care that is established when a provider shoulders the responsibility of care.

Figure 4. Service Line Gaps

Figure 5. Overlapping Services
Many elements influence scope of service, including changing customer needs and wants, organizational capabilities, regulations, competition, new services and service lines, and technologies. Once developed and put in place, scope-of-service documents serve as management tools that help shape effective policies, guidelines, and decision making to match a person’s needs with care and services necessary to meet them. Therefore, they also help manage risks by inhibiting the occurrence of adverse events rather than proliferating them.

**Action recommendations**

- Develop and maintain a written scope of service for each service line.
- Focus on preadmission and admission assessments to ascertain the needs of the person served.
- Establish a multidisciplinary preadmission screening and decision-making process based on the scope of service for each service line.
- Review regulatory guidelines and requirements when developing, reviewing, and revising scope-of-service documents.
- Involve your organization’s legal counsel when creating scope-of-service documents.
- Maintain consistent communication about care and services, both in print and on the organization’s website and social media forums.
- Establish a decision-making process and identify positions that may accept, decline, or transition prospective and current residents.
- Regularly review scope-of-service documents, and amend them as necessary.

To read more about the role of scope of service in aging services, download the ECRI Institute white paper “Mismatched Needs and Services Can Lead to Harm: A Systems REThinking Approach” at https://www.ecri.org/aging-services-white-paper/.

For related information, see www.ecri.org.

**References**

Willis Towers Watson: The leading actuarial consultant to the medical professional liability industry.
If you are a medical professional liability (MPL) defense attorney, have you ever wondered why your MPL witnesses sometimes do puzzling things in depositions or under cross-examination:

- Agree with things that aren’t true.
- Volunteer information when you instructed them not to.
- Agree with something you know they don’t believe.
- Keep trying to explain answers when no explanation was needed.
- Agree with the opposing lawyer’s characterizations of what the facts meant.
- Agree they should have done something different.
- Argue with opposing counsel.
- Act defensive.
- Acquiesce so easily.
- Look “guilty.”
- Admit they were negligent when they really weren’t.
- Keep second-guessing or changing their answers, etc.

**Why do witnesses do these things?**

We all have a set of communication skills we use with friends, family, and coworkers. When speaking with another, it’s important to know how to interpret and understand communication cues in various situations, which also includes knowing how to respond to the cues appropriately depending on the specific environment. Some examples of cues we receive from people we speak with include tone of voice, facial expressions, body language, and emotional responses. Because the objectives of communicating in the various settings can differ, our feedback also differs in response.

This is especially poignant for medical professionals because their interactions with patients and their families require a special sensitivity and understanding due to the nature of the communication environment.

While medical professionals may have communication rules that work for them as professionals, none has developed a set of communication skills and rules that work in the litigation setting—particularly under adverse questioning. So, what happens to the medical witness with no knowledge of litigation cues? They borrow the communication skills and rules that work for them professionally and then apply them in the litigation setting—and they fail miserably. Why? Because cues and
rules of communication in the litigation setting aren't just different from what applies in the medical world; they can mean the exact opposite and for that reason, require a counterintuitive response.

**How it works**

Table 1 presents some examples of types of communication cues medical professionals might encounter during the course of a communication interaction with a patient or his or her family member, or that a witness might encounter while under cross-examination. Note how the meaning of the same cues and the appropriate responses to those cues differ dramatically, depending on whether the interactions occur in the medical world or the litigation world.

Table 1. Communication in the Medical World, versus the Litigation World

<table>
<thead>
<tr>
<th>Setting</th>
<th>Meaning</th>
<th>Correct Response</th>
<th>Wrong Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical World</td>
<td>Your answer was probably unclear.</td>
<td>Start explaining.</td>
<td>Stop talking.</td>
</tr>
<tr>
<td>Medical World</td>
<td>Your answer was bad or unclear.</td>
<td>Start explaining.</td>
<td>Stop talking.</td>
</tr>
<tr>
<td>Medical World</td>
<td>Your answer was probably incomplete, the person needs more information</td>
<td>Start explaining.</td>
<td>Stop talking.</td>
</tr>
<tr>
<td>Medical World</td>
<td>Your answer was good.</td>
<td>Stop talking.</td>
<td>Fill in the silence with more information.</td>
</tr>
<tr>
<td>Medical World</td>
<td>Your answer needs an explanation.</td>
<td>Start explaining.</td>
<td>Stop talking.</td>
</tr>
<tr>
<td>Medical World</td>
<td>Your answer was good.</td>
<td>Stop talking.</td>
<td>Second-guess your answer and start explaining.</td>
</tr>
<tr>
<td>Medical World</td>
<td>You might have said something in an insensitive way.</td>
<td>Apologize and explain.</td>
<td>Stop talking.</td>
</tr>
<tr>
<td>Medical World</td>
<td>Your answer was good.</td>
<td>Stop talking.</td>
<td>Become sarcastic and reemphasize your answer.</td>
</tr>
</tbody>
</table>

**What can be done?**

Before witnesses in the medical profession will be able to understand why the communication cues in litigation aren't what they seem, they need to understand how the communication objectives in litigation differ from any other environment they've ever experienced. This is a vital step to effective witness preparation and one that is often underappreciated and sometimes skipped completely.

For example, if not taught otherwise, witnesses will assume that the more information they provide to opposing counsel, the better. They will think: "If I can just explain things more clearly, I can convince this lawyer of 'X', and he will get it and move on." The problem with this thinking is that witnesses don't intuitively realize that the opposing lawyer will advocate for his client no matter what the witness says. So, what might be a perfect answer to any given question will never "satisfy" the opposing lawyer; he will never change his mind, and explana-
tions will only make things worse.

Compounding this misperception is the fact that all the cues the witnesses receive from opposing counsel suggest the opposite (more information will help), resulting in a futile attempt by witnesses to clear up the seeming miscommunication with more and lengthier explanations, which only makes things worse. This is a major challenge for medical professionals because many of them are helpers by nature, and when they try to “help” in the litigation setting, things just continue to get worse, their anxiety and frustration increase, and the deposition becomes a catastrophe.

Conclusion
The good news is that medical professionals can be taught how to communicate effectively in the litigation world, but it takes a substantial amount of time due to the required drastic changes in both thinking and behavior. And it goes even further. After teaching such witnesses how to communicate under adverse questioning, you must never believe a witness who says, “I get it,” or “I understand.” Real understanding only comes after doing. This is why one of the most important components of a proper witness preparation session must include having the witness perform under a rigorous and realistic question-and-answer simulation, with targeted feedback. When this is done correctly, even the most challenging medical professional witnesses can avoid some of the major snags of deposition and cross-examination testimony and not only survive adverse questioning but thrive.
Cyber Risks.
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In 2018, the industry’s combined ratio increased to 107%, 4 points over the prior year. Driving this increase was a significant decline in reserve releases, compounded by somewhat higher expenses.

While investment gains increased slightly, to 26% of premium, surplus declined by 5%, primarily due to unrealized capital losses from common stock investments. Yet the underwriting income and investment gains produced a return on revenue of nearly 20%, thus, once again, making it possible for the MPL industry to return a substantial portion of its income as dividends to policyholders. And despite the modest decline in surplus, measures of surplus adequacy remained consistent with the past several calendar years.

For more than a decade, the favorable operating ratios in the MPL industry have had one primary cause—the release of prior-year reserves. In 2017 and 2018, reserve releases contributed an average of 15 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 2017, reserve releases contributed an average of 28 points to the industry’s operating ratio each year. Without these reserve releases, the industry would have remained profitable in 2018, albeit by a much smaller margin.

The industry’s long-term trend of declining frequency appears to have ended several years ago. Since then, we have seen the reporting of claim counts stabilize for most companies, with some volatility evidenced for certain writers and both increases and decreases seen. Per annum trends in defense costs remain in the mid-single digits. Indemnity severity trends remain manageable for smaller-dollar claims, but an increased frequency of larger claims has fueled overall increases in indemnity costs.

In part, consolidation in healthcare has driven this trend toward higher indemnity payments. 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, although this pattern seems to have stabilized, as evidenced by the small increase in premium volume of the industry as a whole. Yet certain markets have seen a cumulative decline in rate levels in excess of 25% over the past half-decade. 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 that they themselves believe are unprofitable. While this trend in declining rate levels has somewhat abated, any rate increases seen have been modest.

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 systems rather than enter into independent practice. MPL carriers continue to face consolidation, as evidenced by the acquisition rate increases seen have been modest.

Declining rate levels were only one factor driving premium decreases during this timeframe. Also contributing to the lower level of premium was the loss of business to self-insurance mechanisms. Throughout this timeframe, MPL companies lost business due to healthcare system acquisitions of both hospitals and physician practices, which typically then joined the self-insurance mechanisms of these systems. In earlier years—through about 2008—companies also frequently lost business due to the formation of new captives.

A distinct difference between the current market and the previous soft market, of the

### Figure 1. Direct Written MPL Premium ($ Billions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Premium ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>5.0</td>
</tr>
<tr>
<td>2001</td>
<td>4.5</td>
</tr>
<tr>
<td>2002</td>
<td>4.2</td>
</tr>
<tr>
<td>2003</td>
<td>4.0</td>
</tr>
<tr>
<td>2004</td>
<td>3.8</td>
</tr>
<tr>
<td>2005</td>
<td>3.5</td>
</tr>
<tr>
<td>2006</td>
<td>3.3</td>
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<td>2007</td>
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<td>2011</td>
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<tr>
<td>2012</td>
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<tr>
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<tr>
<td>2016</td>
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<tr>
<td>2017</td>
<td>0.8</td>
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<tr>
<td>2018</td>
<td>0.6</td>
</tr>
</tbody>
</table>
mid-to-late 1990s through the early 2000s, lies in the degree of rate adequacy within each time period. Both the current and prior soft markets have shown inadequate rate levels, though to a lesser extent, 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 rate inadequacies in a number of markets and have observed significant premium reductions on nonrenewed, 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 58%, which has risen to about 80% since that time (Figure 2). Reserve releases have driven this deterioration in the operating ratio, beginning in 2013, and an increase in underwriting expenses exacerbated it. The 2018 combined ratio for the industry was 107%, up 30 points since 2008 (Figure 3). This is the third year in a row that the industry’s combined ratio has exceeded 100%, meaning that the industry would have been unprofitable each year since 2016 without its investment income.

The investment gain ratio of 26% in 2018 was the highest achieved by the composite since 2012. This is a noticeable increase from 2015 and 2016 in particular, in which the investment gain ratio averaged 18%. 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 composite’s capital gains ratio increased to 7% in 2017 and 5% in 2018, up from an average of 0% in 2015 and 2016.

The 2018 calendar-year loss and loss adjustment expense (LAE) ratio of 75% is higher than any year since 2005, and represents an increase of about 20 points since the 2008 to 2011 time period. As noted earlier, reserve releases have driven this increase. We discuss these further below. The starting loss and LAE ratio for each coverage year has changed little during this time period.

Information from the composite on the 2018 coverage year, such as claims relative to premium, suggests the 2018 coverage year may be comparable to 2017, but it is starting from a slightly weaker position than other recent coverage years. This suggests that reserve releases will continue to decline prospectively.

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 timeframe.
Cumulatively, reported claim frequency (measured relative to premium) has increased by almost 40% since 2009. This increase is largely the result of rate decreases (mostly in the form of greater premium credits, as opposed to manual rate changes).

Reserve releases
The composite released $510 million in reserves during 2018, an amount that has declined annually from the $1.1 billion to $1.5 billion released in each of the years 2008 through 2013 (Figure 4). Despite this decline, the reserve releases remain material. Yet, when considered in the context of the reserves carried by the composite, they represent 5% of the $9.9 billion reserve carried as of year-end 2017. A relatively benign trend in indemnity severity during the past several calendar years has driven these reserve releases, along with, for some companies, a lower-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’s reserves are theoretically exactly adequate as of year-end 2018, history would suggest that we will see favorable reserve development, on a calendar-year basis, through 2020 or 2021. Adverse development would then follow in subsequent calendar years (at least for the older coverage years).

Capitalization
The composite’s surplus decreased during 2018 from about $14.3 billion to $13.6 billion (Figure 5). This represents the first noticeable decline in surplus for the composite since 2002. The decline was primarily due to unrealized capital losses in the companies’ common stock portfolios. While net income for the composite was $720 million, companies returned a third of this income to policyholders in the form of dividends, discussed further below.

However, 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 1150% in 2018, approximately the same level it has had since 2013. However, individual RBC ratios vary considerably within the composite.

Policyholder dividends
The decrease in the composite’s surplus is in part due to the significant amount of policyholder dividends that MPL writers have continued to pay. In 2018, the composite writers paid almost $240 million in policyholder dividends, representing more than 6% of net earned premium (Figure 3). Cumulatively, the composite has paid $3.2 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 funded these dividends. Since 2013, policyholder dividends have constituted approximately one-third of net
income in each year. This represents an increase from an average of approximately 25% of net income in each of the preceding six years.

Typically, companies pay these dividends 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 consistency over the past decade 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 $2.8 billion for the MPL line of business as a whole. This is approximately 10% of the carried net reserves, which implies a redundancy for our composite of $1.0 billion. Thus, we expect that reserve releases will continue to mask underwriting results on current business. Insurers face other risks to the bottom line as well: possible increases in frequency and severity, including challenges to tort laws in multiple states; uncertainty surrounding the push for single-payer healthcare; and a declining market share, among other factors.

Although the soft market will exert further pressure on the industry’s rate adequacy in many states, certain markets will see rate increases. In spite of stock market volatility, MPL companies’ capital remains strong, and we expect that discussion of its appropriate deployment will continue to be a common topic of conversation.

Despite the rate increases seen in multiple states, we see the overall soft market extending several years into the future. The small magnitude of these rate increases, the relative flatness of trends in frequency, stagnant rate levels in most states, and consistent capital adequacy, in particular, combine to suggest that the current equilibrium may persist for some time.

In the past, we have attempted to speculate on when the market might harden, writing that we know not much more than that the market will harden only when it finishes softening. Looking back at 2018, we have seen not only the continuation of aggressive competition in most regions, but also small rate increases in certain markets. It seems that, for the first time in this market cycle, we are able to foresee the end of the soft market approaching, although perhaps not the beginning of the hard market. In an industry that remains profitable, we expect that it will be at least several years before the hard market appears on the horizon. MPL.
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As the healthcare sector develops and transforms, in line with international standards, the medical professional liability (MPL) landscape and regulatory framework in the United Arab Emirates is also developing in major ways. In this article, we provide a snapshot of what MPL currently looks like in the UAE and outline some of the recent key developments and trends.

**Healthcare developments in the UAE**

Establishing a world-class healthcare system is at the top of the National Agenda, in line with Vision 2021, a long-term plan launched by Sheikh Mohammed bin Rashid Al Maktoum aimed at promoting social and economic development in the UAE. One of the aims of this plan, and of the various strategic initiatives that fall under it, is to elevate the UAE’s status as a go-to global healthcare tourism hub. Among these initiatives are innovation, advanced technologies, and an overhaul of the fundamental healthcare laws, regulations, and guidelines. It is anticipated that such reforms will mirror international standards of high-quality care and drive more medical tourism to the region.

The enactment of Law No. 22 of 2015, Regulating Partnership between Public and Private Sectors in Dubai (PPP), has also been instrumental in diversifying the healthcare sector. This initiative has encouraged government bodies and private organizations to collaborate on projects and to combine their experience, knowledge, resources, and funds. This has attracted both local and foreign investment for developing state-of-the-art healthcare facilities, and one example is the establishment of Moorfields Eye Hospital in the Dubai Healthcare City (DHCC), the world’s largest healthcare economic free zone. Free Zones are designated areas in the UAE which are set up to ease the establishment of foreign companies or where separate regulatory bodies exist to oversee those business activities, such as the Healthcare City Regulatory Authority.

**MPL in the UAE**

The key provisions that patients usually rely on when bringing claims in the UAE are contained within the UAE Civil Code and the Medical Liability Law (Federal Law No. 4 of 2016; the 2016 Law). The UAE Civil Code contains general provisions that explain an individual’s entitlement to claim damages where one person has caused harm to another. The 2016 Law is a specific law, which sets out the basis of liability for institutions and practitioners and lists the obligations of doctors. An additional law was passed in 2019 to ensure that medical practitioners were being properly licensed, to prevent any practice that compromised medical ethics.
The claims process
Focusing on Dubai, the usual claims process at present is that the claimant files a regulatory complaint with the Dubai Health Authority (DHA), as a first step. The DHA will request a copy of the medical file from the relevant hospital or clinic and review this with a panel of medical experts, following which they will issue a decision that may include a warning, a license suspension, or a finding of medical error.

During this process, the parties will likely be called to meet with the DHA expert panel to discuss the treatment provided and the complaint made. However, under the current process, legal representation of the parties is not permitted.

In some instances, the claimant might, as a first step, proceed to make a complaint to the police, alleging bodily injury and seeking a Sharia remedy of blood money. In those instances, a matter can progress before the criminal courts, but the number of instances of this has fallen in recent years.

Civil claims
It is often the case that in the wake of an adverse regulatory or criminal decision, a claimant will proceed with a claim before the civil courts. The aim of a civil claim will be to seek compensation in the form of “moral” and “material” damages (i.e. (i) a PSLA type of award and (ii) an award for financial losses).

The court procedure in the UAE involves court-appointed experts; the court mandates a panel of medical experts to review the technicalities of the case and produce a report for the court. Experts retained by the parties in the case are not usually admitted in the process, although they are free to seek the court’s permission to submit their experts’ reports.

As there is no system of judicial precedent in the UAE, or a specific formula or method of calculation applied to the level of damages awarded, it can be difficult to assess the likely exposure of a healthcare institution or a practitioner.

As set out in the 2016 Law, there are some anticipated changes to the civil claims process, but these will become clearer once the Executive Regulations to that Law have been passed. Currently, this has not yet happened.

Practical issues
Lack of settlement culture.
While there is a low frequency of claims in the UAE when compared with most Western jurisdictions, the number of claims is now on the rise, as patients come to gain a better awareness of their rights.

There are, however, structural difficulties involved in settling claims out of court. For example, there is no recognized “without prejudice” rule in the UAE, which can make defendants cautious about engaging in any settlement negotiations that may later prove detrimental to them.

Further, there is little incentive for a claimant to settle when there is a low risk of any significant costs being awarded against them in an unsuccessful action.

Visiting doctors.
It is common for Western expat doctors to fly in for consultations and surgeries. This practice is encouraged, as it enables specialist doctors to provide medical consultations in Dubai (keeping
INTERNATIONAL PERSPECTIVE

revenue within the country and attracting specialist talent), instead of having patients travel abroad for those services.

To facilitate visiting doctors coming to Dubai, a new medical license was approved by the Dubai Healthcare City Free Zone authorities in January 2019. This new license now allows visiting doctors to work at multiple facilities for up to two years at a time.

There has often been some uncertainty about where liability falls when a patient has received treatment at one healthcare facility, but by a visiting doctor who may not be employed by that facility. A visiting doctor may only have minimal MPL insurance coverage for himself, whereas the facility would have more significant insurance coverage. The facility, however, may not have coverage in place for visiting doctors, unless there is a specific extension to its policy for that situation.

The 2016 Law provided clarity and stipulated that the health facility receiving the visiting doctor should assume responsibility for any medical errors. The Executive Regulations to the Law are awaited, and we expect that these will provide further clarity on this issue.

Consent and language issues. Claims relating to whether informed consent was obtained before a procedure or surgery are increasing.

The healthcare sector is heavily reliant on expat doctors and practitioners and, with the diverse international population of Dubai, patients often have a different primary language than their treating doctor. Because of this, healthcare facilities regularly use translators to communicate the risks of a procedure that a doctor is advising on in a different language. However, there have been several recent cases where patients have alleged that they were not fully informed of the risk, either because the language used was not their first language or because of the poor quality of the translation.

Finally, the issue of language arises during court proceedings as well. UAE Court proceedings take place in Arabic, which means that documents from the medical file (commonly in English) must be legally translated into Arabic for submission.

What’s next?
The UAE’s healthcare system is rapidly developing, with the assistance of government initiatives such as Vision 2021 and the PPP to boost investment and attract talent into the healthcare sector.

Local regulators and legislators are looking at international benchmarking standards to transform the regulation of the sector and to attract both international medical talent and medical tourism to Dubai, which is conveniently connected to more than a third of the world’s population by just a four-hour flight.

For related information, see www.clydeco.ae.

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Global trade wars, political tensions, and concerns about growth slowdowns all combined to drive an unexpected selloff of risk assets in December, with U.S. equities falling 14% during fourth quarter 2018 and oil falling 30% from its highs in early 2018. The 10-year Treasury yield fell almost 70 basis points from peak to trough; and the Fed was forced to pause its rate-hiking campaign in the face of all the volatility. With all these moving parts, it can be difficult to forecast how the coming year will unfold. However, one useful analysis is a comparison of the various sectors that make up the fixed income market.

Spreads
In comparing different sectors of the market, it is helpful to look at the spreads of those sectors, rather than the yields. The yield of a bond can be broken down into a risk-free rate of return and a spread. The risk-free rate is typically determined by the rate of a Treasury bond with a similar maturity date to the bond in question and represents a zero-risk sum. The spread, therefore, is the additional yield that investors are being offered above what they could get for holding a comparable Treasury security. The most common measure of spread is the option-adjusted spread (OAS). The OAS measure attempts to remove the unpredictability of total spread that comes from prepayment optionality, which is found in mortgage bonds callable bonds; and it is therefore a better way to compare sectors with more optionality (i.e., mortgage-backed securities) with sectors that are more bulletted (i.e., corporates).

Figure 1 shows how the OAS data of the main sectors of the fixed income market have changed over the past year. After a steady tightening in spreads during the first half of 2018, risks returned over the second half, culminating in the pronounced widening seen in the last two months of the year.

From this chart, several conclusions can be drawn. The sectors that offer the highest spreads are the ones with the most “credit” risk, meaning risk of default. Those are the corporate sectors, expressed in this chart as their major components: financials (FIN), industrials (IND), and utilities (UTE). The higher-quality asset-backed securities (ABS) and mortgage-backed securities (MBS) sectors offer significantly lower spreads. There also appears to be more volatility in the spread line of the corporate sectors, which oscillates more than the lines of the ABS or MBS sectors.

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This brings up an important element in assessing relative value across sectors: spreads alone do not tell us the whole story. This is because not all sectors are created equal; they have different risks that are not captured in spread alone. Some additional risks include credit quality, duration, extension, and volatility. In order to get a better picture of the value offered by a sector, we must also look at spread offered per unit of risk.

**Duration**

While there are several methods for normalizing spreads (looking at spread per unit of risk), one of the most practical is to adjust for duration. Duration is defined as the sensitivity of a bond’s price to changes in interest rates, expressed in years. For example, a typical 10-year bullet maturity bond will carry a duration of eight to 8.5 years. We can look at normalized spreads across sectors by dividing a sector’s OAS by its duration. This will show us the amount of spread that each sector offers per unit of duration risk.

Table 1 shows the spread per unit of duration for each sector, as well as the average, high, low, and Z-score for each, over a three-year time horizon. Using this lens, the ABS and financial sectors jump out as offering compelling value, compared with the other sectors. This is due, in large part, to the shorter duration of most asset-backed securities, which is also true of the majority of the bonds in the financial sector. The financial sector spread per unit of duration is also above its three-year average, as indicated by the positive Z-score of 1.6, higher than virtually all of the other sector values.

**Volatility**

While duration is a widely used measure of risk in the fixed income market, it is not the only one. Another useful indicator of risk is the volatility of a data series. If we, again, look at the OAS for each sector and calculate the standard deviation for each series (using the past rolling one-year daily data set), we can generate a volatility-adjusted spread number, which shows the spread per unit of volatility.

After accounting for the differences in volatility across sectors, the commercial CMBS sector stands out as attractive, offering 30%
more spread per unit of volatility than the next closest sector, corporate industrials. Looking just at the corporate sectors, it is interesting to note that utilities, which offered the lowest spread per unit of duration on the previous table, now offers some of the highest spread per unit of volatility. This is evidence of the relatively longer duration of the utility sector (resulting in lower spread per unit of duration), as well as lower volatility in utility spreads. Additionally, the industrial sector looks attractive, with one of the highest volatility-adjusted spreads and a Z-Score of 1.9, indicating that this value is well above its three-year average.

These examples are just a few of the ways that you can incorporate risk management into an analysis for fixed income investing.

Having a solid understanding of the risks present in a given portfolio ensures that the risks taken are intentional, that there is adequate compensation for bearing those risks, and that the portfolio’s exposure is to a prudently diversified combination of risks.

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Footnote
1. Z-score is a method used for assessing how far above or below a value is from its historical average. Z-score is calculated as the difference between the most recent value and the average, divided by the standard deviation of the series. A negative value indicates that the current value is below its average.

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Employing Technology to Simplify Records Organization and Accelerate Records Analysis

By Melanie Pita, Chief Legal Officer—Ontellus

Anyone familiar with the claims investigation and litigation discovery process knows that obtaining medical, pharmacy, employment, and other key records requires time and resources. Not only are there multiple steps required to retrieve records, but then, in order to gain insight from them, the records still need to be sorted, organized, and digitized, so that they can be electronically searched, displayed online, and used in machine processes—all of which speeds review.

Technology-based solutions now enable insurers and litigators to eliminate the cumbersome and inconsistent manual processes and can automate the time-intensive work that claims departments and law firms perform to make them “usable.” Saving valuable time, reducing cost, and creating a consistent record format that enables the data in the record to be maximized to its full potential.

Finally, it can be a difficult task to quickly and securely share the records in a safe, fully HIPAA-compliant environment. Many industry professionals need a fully digital, secure platform for delivery of records to be able to collaborate safely with claims staff, consultants, independent medical exam (IME) professionals, and other key case stakeholders.

This article shows how Ontellus, the nation’s largest records retrieval and claims intelligence company, is adapting technology to simplify records organization and accelerate records analysis, by impacting the various stages of record automation: records ordering, processing, usability, and secure records distribution.

Records ordering

Our journey begins with ordering records via a proprietary, HIPAA-compliant platform, enabling the automated, back-end processing and secure delivery of records. Claim/case records can come from a variety of sources including pharmacies, physicians’ offices, hospitals—all of varying sizes and file types, and spread across many cities and states.

There are endless numbers of records custodians—each with its own policies and procedures for the release of records, payment of records, and systems for delivering records. It is no wonder records retrieval can be burdensome and time-consuming for claims departments and law firms.

With the use of legal document automation at the time when the request to obtain records is submitted, this platform automatically generates the legal documentation necessary to fulfill a records request. Relying on nationwide capabilities, this particular technology provider, Ontellus, is well-versed with all the rules of procedure that can vary greatly from state to state and built algorithms within the document automation platform to create the right legal forms, depending on the data submitted at the time of the request. For instance, a subpoena for medical records in New Mexico is very different from a subpoena for business records in Texas.

There are several record request + state + case type combinations that clients can order via this platform. Each order requires different information, and for this reason, a different order form process occurs within the platform. The platform’s order form is “smart” in that it dynamically generates the next required form field based on information previously entered. In addition, it prepopulates as much information as possible, proactively offering answer options.

Once legal documents are complete, the platform calculates waiver/wait periods to ensure they are served upon the records custodian in accordance with the rules of procedure (when the request is via subpoena), and follow-up custodian calls are placed in a timely manner. Custodian fees are also verified against the jurisdiction’s requirements.

Getting the records into adjuster/legal staff’s hands quickly (cycle time/turnaround time) and securely is critical. The goal of encouraging records custodians to deliver records electronically, rather than mailing paper copies (time-consuming and vulnerable) or e-mailing them in an unencrypted (vulnerable) version, prompted Ontellus to create a secure records delivery (SRD) service. Using secure file-transfer protocol (SFTP) technology, records custodians use a two-factor identification standard to identify the request they are completing to quickly and safely deliver the responsive records to the Ontellus.

Records processing

Once a record is delivered, it is routed through proprietary Ontellus tool. The record is scanned with optical character recognition (OCR) software and then converted into a searchable and extractable PDF document.

OCR is a technology that recognizes text within a digital image. It is commonly used to recognize text in scanned documents, but it serves many other purposes as well. OCR software processes a digital image by locating and recognizing characters, such as letters, numbers, and symbols. Some OCR software will simply export the text, while other programs can convert the characters to editable text directly in the image.

Advanced OCR software can export the size and formatting of the text as well as its layout as it would appear on a page. OCR technology can be used to convert a hard copy of a document into an electronic version. For example, if you scan a multipage document into a digital image, such as a TIFF file, you can load the document into an OCR program, which will recognize the text and convert the document to an editable text file.

Regardless of which source path is used or how records are captured and incorporated into the platform, all records go through the same charting and...
indexing process. Ontellus provides automated records organizing (or "charting") procedure that includes the following:

1. **Scan and OCR:** The OCR software scans documents and converts printed characters into readable text that can be "searched" for key words or terms.

2. **Charting:**
   - Metadata is attached to the record source location, date, and record type.
   - Index fields adhere to American Health Information Management Association charting standards.
   - Indexing for complex document types (e.g., electronic medical record) is completed, using a secondary set of index fields for specific document types.

3. **Cover page:** This identifies core case information (case name, patient/business name, location, order number)

4. **Table of contents:** Expandable, and a hyperlinked guide eases navigation.

5. **Bates stamp:** Used to place identifying numbers, case information, location names, and date marks on records as they are processed, for ease of use by all parties in the discovery stage of preparation for trial. This process provides identification, protection, and automatic consecutive numbering of the records.

**Records usability**

The “charting” of records makes them usable, but Ontellus has also devised a solution that takes records organization one step further and automates the labor and time-intensive work needed to create a chronologically organized set of records.

In gathering valuable client input, we learned that claims and legal professionals spend hours manually sorting records into a single set organized by date. For this reason, we developed another tool, which can do that for them—automatically.

The tool combines the power of "charting” with sophisticated algorithms to help claims and legal professionals turn unorganized records from several records custodians into a complete chronologically organized set—providing a clear timeline of documented events that aids in recognizing nuances, patterns, and analysis. As each new single set of records is retrieved from records custodians, the charting + organizing algorithms are triggered to create an up-to-date timeline, thereby turns records into valuable and actionable information that can be used throughout the duration of the claim/case.

**Records distribution**

Claims and legal staff are looking to enhance records review by exchanging information (records distributions), but they are also concerned about the security of the data. Electronic sharing of records that have been retrieved can help speed review and the development of the case strategy, while decreasing paper/hard copy expense and data vulnerability.

The Ontellus offers one possible solution, which distributes records securely. With this, claims and legal professionals can identify the records, the person(s) to receive access, and the duration of access to the records that are being shared securely. A notification is sent and the person receiving the notification accesses them using a two-factor identification. An access log tracks when the records were accessed and by whom—the claims staff are not left to wonder if the IME records were received (and a patient evaluation can be scheduled) and a paralegal is not left in limbo, uncertain about whether the time is right to call in the expert to discuss the case.

Technology advancements, like those developed by Ontellus, make records data more visible, usable, and valuable for clients. On the company’s horizon are insights for digital, machine learning, and artificial intelligence as these are used in multiple types of records. Our continued expansion of technology and automation opportunities will make records review more efficient and accurate, aid in claims investigation and evaluation, and may well become a game changer for the industry.

Melanie Pita is Chief Legal Officer, Ontellus. For related information, see www.ontellus.com.

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**A TIME STUDY**

Ontellus partnered with an insurance carrier to perform a time study assessment using lean Six Sigma process improvement methodologies.

The Goal: Help Claims Teams Quantify Time Investments & Pinpoint Efficiency Losses

The study explored the processes and policies of four in-house claims offices across three states, related to records ordering, custodian follow-up, and preparation of records for review.

The Result: How Ontellus Impacted Their Business Processes

- Reduced records order times by at least 3 hours per adjuster per week
- Eliminated time-consuming custodian follow-ups, saving each adjuster at least 2 hours per week
- Eliminated records preparation, saving each adjuster at least 3 hours per week

By selecting Ontellus as your records retrieval partner, you will experience a minimum total productivity savings of 8 hours per week, per adjuster, and receive records 30 to 45 days faster.
LAST WORD: A FAREWELL TO ERIC R. ANDERSON

In this issue of Inside Medical Liability, we bid farewell to Eric R. Anderson, who is stepping down after serving the Association and our members for nearly 13 years. This issue marks the last that will be published under his tireless guidance, as he leaves to pursue a new opportunity. The Association staff concurs that it has been a pleasure working closely with Eric on the magazine and the many other publications and initiatives of the organization. There have been many changes during his tenure, and the magazine and our organization are much better thanks to Eric’s great contributions and leadership.

Perhaps one of the most striking changes has been to the magazine itself. In fact, it was Eric who renamed Physician Insurer magazine as Inside Medical Liability, long before the Association was rebranded to reflect a new, broader scope of members and issues.

The first “Last Word” column was written by Eric for the 2008 Fourth Quarter issue. In that column, he wrote: “The true strength of this trade association lies in its ability to connect like-minded professionals who work in the medical professional liability insurance industry—although they may come from disparate backgrounds—together to share experiences, information, or even, sometimes, just advice, to make the best possible decisions.”

Eric was always cognizant of the many connections that run through the Association and with our members and other stakeholders. During his tenure, he led the rebranding efforts that moved the organization from the Physicians Insurers Association of America (PIAA) to the Medical Professional Liability (MPL) Association. Throughout these transitions, Eric knew the importance of embracing the changing face of the industry—and welcoming those disparate backgrounds—while balancing the strong legacy—the shared experience—that formed the Association 42 years ago.

Eric’s involvement was also seen in the marketing and communication of the Association’s annual Conference and triannual International Conference. He understood the importance and power of gathering MPL industry leaders together. He wrote in his 2008 Last Word: "Apply the knowledge gained from these encounters to your particular problem or circumstance. In the right environment, you might just achieve a heroic outcome.”

“Eric’s involvement with Inside Medical Liability will be missed, both personally and professionally by all of us at the MPL Association,” said Brian Atchinson, president and CEO. “I know that you, as members of the MPL community, join me in expressing appreciation to Eric for his contribution as vice president of marketing and communications and best wishes for much success in his future endeavors. We give him our sincere thanks for years of outstanding service.”

As we wish Eric well for his continuing career in the MPL insurance industry, we also encourage you to make the most of your time at this year’s MPL Conference, or if not this year, be sure to join us next year or for the International Conference in October 2020. We leave you with Eric’s last words from the first column: “Take this opportunity to meet with old colleagues and talk with those from around the world whom you may have never met. You might be surprised at what you learn.”

Thanks, Eric, we sure learned a lot from you!
WillisRe

The leading reinsurance expert in the medical professional liability industry
Underwriting Workshop

Monday, September 9, 2019
Wednesday, September 11

This workshop brings together MPL insurance underwriters of every level of experience and background, professionals with an interest in underwriting issues, and the top experts in the field. Get the information you need for identifying, and accurately assessing, the impact of the multiple risks and exposures in healthcare. Sessions include:

- **MPL Claims: Lesson’s Learned**—An Underwriter’s Perspective
- **The Clinical and Legal Worlds**—Hot Topics from the Risk Management Perspective
- **Emerging Issues Involving Genetic Testing and Personalized Medicine**
- **Professional Outlook**—Transform from Burnout to Engaged
- **Reinsurance Strategies Impacting Underwriting**—What You Need to Know when the Market Shifts

CME and CE credits available

Claims and Risk Management/Patient Safety Workshop

Wednesday, September 11
Friday, September 13

Join colleagues from claims, risk management, and patient safety, as well as industry experts from the MPL community for thought-provoking panels and unparalleled networking opportunities. Get the most up-to-date information—use it immediately and share with your organization.

**Keynote**
Burnout Proof—Reduce Risk, Lower Stress & Prevent Burnout
Raj Ratwani, PhD, Director, National Center for Human Factors in Healthcare, MedStar Institute for Innovation, Medstar Health Research Institute

Sessions
- **Electronic Health Records**: Human Factors: Usability and the Impact on Patient Safety
- **What’s New in MPL Claims**—Emerging Risks: Opioids, Spinal Surgery, Communicating Diagnostic Results
- **Workplace Violence and Mental Health Risk**

CME and CE credits available

International Risk Management Seminar (half-day)

Wednesday, September 11

Join us for an international perspective for MPL insurers on the Innovative Use of Medical Legal Data! Presentations led by an MPL member company chief actuary and a board director include, A World of Medical Legal Data and Medical Care Analytics.