Surgical Claims: A Deep Dive

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setting our sights on surgery

It’s a conundrum within medicine that has a long history: Is medicine, and surgery in particular, an art or a science? Most observers conclude that it is some mix of both.

Looking at recent advances in medicine, we find much to applaud. The skills of today’s healthcare professionals are more advanced than ever before. There has been significant progress in the use of data and technology—in how data is captured, and how it is leveraged in learning how medicine can be optimized for various target populations, and even for individuals.

And yet, we never seem to hear about the good work of healthcare professionals—only about the alleged (and staggering) numbers of “medical errors”; and only seldom is the rigor of these numbers analyzed in depth—or at all. One of the most recent of these was The BMJ study (May 3, 2016), which asserted that medical errors are “the third leading cause of death.”

In the 1998 IOM report, “To Err Is Human,” the number of such deaths, 98,000, was equated with the crash of a jumbo jet, every day. The flaws in that analysis were obscured by the sheer drama of the jumbo jet analogy. And yet, there is tremendous irony in the comparison chosen. The reality is that thousands of flights take off and land safely every day. But that is not news. What makes the news are accidents. Just so, thousands of surgeries, many requiring exquisite skills and exemplary judgment, are completed successfully every day.

In light of the glare of publicity that followed from the May BMJ report, surgeons, like all of healthcare, are under the microscope. With the possible exception of airline pilots—who work in pairs—there is no other profession in the world where a practitioner is expected to be perfect, every time he does his job.

Notwithstanding their long and impressive positive track record of providing quality healthcare to patients, PIAA and its members are always striving to make improvements in patient safety. That is why we are carefully studying what happens in surgery and in the broader scope of other procedures.

The cover story of this issue of Inside Medical Liability focuses on what can be learned from the recent data on surgical claims in order to pinpoint where improvements in the system can be made to optimize outcomes and maximize patient safety. There is also an article on retained objects after surgery, a problem that seems to persist despite many process improvements and common-sense measures. In this story, there are some well-researched, practical tips for minimizing the numbers of such events. Both of these articles are supplemented by information from the PIAA Data Sharing Project.

This issue also includes coverage on surgery with a global perspective with an insightful article from Canada, “Surgical Safety in Canada: A 10-Year Collaborative Review.”

You’ll also find within these pages some excellent guidance with how to work best with millennials, gaining insights on the differences between a professional with 40 years of experience in medicine and a millennial beginning the practice of medicine. Managing diverse generations appropriately is important to outcomes, as well as to the smooth running of a medical enterprise.

We also address an important development regarding the calculation of future medical damages for plaintiffs, which stems from the Affordable Care Act (ACA). We feature an article on the recent successes of some defense attorneys as they use the health insurance coverage guarantees mandated by the ACA to develop significantly lower lifetime costs in MPL/HPL cases.

Finally, this issue includes coverage of the 2016 Medical Liability Conference in Washington, D.C. We hope it will bring to mind many memorable moments for those who were able to attend, and also serve to whet the appetites of everyone with a stake in MPL/HPL for joining your colleagues at next year’s conference, May 17–19, 2017, at the world-famous Broadmoor in Colorado Springs, Colorado. I look forward to seeing you there.

PIAA
“The surgeon must reiterate to the patient and/or caregiver what symptoms to watch for and clearly explain what life will be like after a procedure in terms that the patient understands.”
—Cover story
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COMING ATTRACTIONS

EVENTS & CALENDAR

Technology, Human Resources, and Finance Workshop

Information Technology Track

A Pragmatic Approach to Cybersecurity

Protecting your IT assets is not as challenging as it might seem. Lisa Traina, CPA, CITP, CGMA, President, Traina & Associates, will explain why controls put in place for cybersecurity fail in hundreds of organizations each year, and then discuss her recommendations for protecting the health of your IT environment. There will be particular emphasis on patch management, mobile devices, cloud vendors, and incident detection and response.

Human Resources Track

Social Recruiting Strategies: Tips for Recruiting via LinkedIn, Facebook, Twitter, and Pinterest

Employers need to get their recruiting messages to the right people, in the right places. Competition for qualified candidates is intense now, and using social media strategies for recruitment is important for a successful recruiting campaign. In this session, Mary Gormandy White, MA, SHRM-SCP, SPHR, Director, Corporate Training & Talent Development, MTI Business Solutions, will explain how you can make the most of social media—and tell you about several free strategies that you can implement easily.

Finance Track

Accounting and NAIC Regulatory Update

The National Association of Insurance Commissioners (NAIC) continues to deliberate a wide range of accounting issues. Michelle M. Goss, CPA, Partner, Plante & Moran, PLLC, and John Fritz, CPA, Senior Manager, Plante & Moran, PLLC, will provide the latest information on recently adopted standards, and then offer a glimpse into the emerging statutory accounting issues on the NAIC’s agenda.

2016 Introduction to Medical Professional Liability Insurance Workshop

Designed for Professionals Who Want to Learn the Fundamentals of the MPL/HPL Business!

The operations of a medical and/or healthcare professional liability insurer are inherently complex. For industry newcomers, longer-term employees who need to broaden their understanding of this sector, and everyone new to governance in PIAA member companies, this event will expand their knowledge of the foundational concepts, and what’s involved in the day-to-day operation, of MPL/HPL insurance entities. Key areas examined at this meeting include the various elements of healthcare risks, rate-making and reserves, claims and underwriting administration, risk management and patient safety, and much more! Note: This event is open to both PIAA members and non-members.
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Changes in MPL Laws in Texas Prompt Dire Warning from Local Attorney ‘Big Al’

That’s all there is: just “Big Al.” No last name, kind of like Beyoncé and Madonna. What Big Al is warning the citizenry about is actually fairly technical fine points in the applicable standard of limitations for MPL suits. In particular, the Texas Supreme Court recently ruled that even though a corpse is not a patient [don’t ask], examinations of a deceased body can still be subject to Texas’s strict rules regarding MPL lawsuits, including a cap on damages and a two-year statute of limitations.

Big Al notes that, in light of the very real potential for changes in applicable MPL statutes, “Our firm suggests that citizens educate themselves about malpractice cases to recognize dangers before they occur.”

Al’s phone number? 1-800-HURT-123. That’s not much of a surprise, is it?

Source: PR Web, June 26, 2016
If radiologists aren’t able to prove that they can get the patient back to work faster, reduce admissions, or get the OR time down, radiologists risk commodification,” warns James Whitfill, MD, CMO of Scottsdale Health Partners. He cautions that, while the more traditional value metrics in radiology, like turnaround time and peer review, still matter—they now matter much less. “We are in a world where we need to show patient outcomes like not being dead, or being at work, or not being in the hospital—those are the tangible outcomes people are looking for.”

In most clinically integrated networks, radiologists instead follow metrics linked with congestive heart failure, coronary artery disease, diabetes, and COPD. Whitfill points out, “Besides some chest x-rays, there isn’t a ton of radiology changing those outcomes.”

He says that it is in bundled payments for oncology that radiology might best show its benefits. “Radiology has a particularly strong use case for showing the impact of being able to get to diagnosis faster and monitoring disease.”

He concludes, “If radiologists can show how to reduce total medical costs, they will be highly sought after. If they can’t, it will be a very unpleasant future.”

Source: Diagnostic Radiology, June 13, 2016

The market for robotic surgeries is estimated to reach $20 billion by 2021. But as the Florida Hospital’s Nicholson Center, a research and training group, points out, there is currently no standard training curriculum for robotic surgery. But now, using a grant from the Department of Defense, the center is trying to create one, and they’re using a video game to accomplish that.

Well, actually, the new Fundamental of Robotic Surgery Virtual Team game isn’t really a game per se. It just uses video game graphics and basic input mechanics to train surgeons in proper procedures for communicating with their team. (Note that Observer challenges anyone to endure, for more than 10 seconds, the endlessly repetitious background pulse-noise stalking behind the graphics.)

“Team communication is the biggest hurdle, especially in the medical field,” said Alyssa Tanaka, a research scientist at the Nicholson Center who focuses on robotic surgery simulation and effective surgeon training. “It’s very hard to get all these medical professionals available to do this kind of training. Video games have been an up-and-coming way to do so in several fields, especially in defense, which is where a lot of simulation efforts start.” Among other challenges, because the surgeon’s face is so carefully positioned on what’s happening on monitors in front of him, his vocal commands sometimes get muffled. The Nicholson Center’s training tool helps put surgeons in the habit of communicating clearly with the team on everything from patient preparedness to staff fatigue levels in order to improve patient safety.

Doctors are scored at the end of each of the six exercises, each of which presents various patient-safety situations that have to be overcome using TeamSTEPPS, a teamwork system developed jointly by the Department of Defense and the Agency for Healthcare Research and Quality.

The idea of encouraging surgeons to play more video games isn’t new. In 2007, a study by Dr. James Rosser, Jr., found that surgical residents and medical students who played specific video games did better on laparoscopic surgery simulators than those who did not. In 2012, a study at the University of Texas Medical Branch at Galveston pitted a number of groups against each other, to see who performed better using virtual surgery tools: high school sophomore gamers, college gamers, or medical residents.

In the end, the high schoolers won. (Need we say more?)

Source: cnbc.com, April 13, 2016
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Surgical Foreign Body Left in Patient After Procedure ranked ninth among top chief medical factors in the total number of claims and lawsuits closed between 2005 and 2014.

More money was spent defending a claim than the total indemnity paid.

Top 5 Operations/Procedures

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<th>Closed Claims</th>
<th>Paid Claims</th>
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<tr>
<td>24% Digestive System</td>
<td>24% Digestive System</td>
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<tr>
<td>14% Female Genital Organs</td>
<td>13% Female Genital Organs</td>
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<tr>
<td>11% Cardiovascular</td>
<td>11% Cardiovascular</td>
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<tr>
<td>Misc. Diagnostic and Therapeutic Procedures (9.1%)</td>
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Highest Average Indemnity

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<tr>
<td>$173k Eye</td>
<td>$148k Male Genital Organs</td>
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<td>$112k Female Genital Organs</td>
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<td>$45k Urinary System ($100k)</td>
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Highest Average ALAE

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<td>$120k Hemic and Lymphatic System ($70k)</td>
<td>$66k Endocrine System</td>
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<td>$65k Male Genital Organs</td>
<td>$40k Nervous System</td>
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Top Specialties by Closed Claims

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<td>25% General Surgery</td>
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<td>8% Orthopedic Surgery</td>
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<td>6% Urologic Surgery</td>
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Contact P. Divya Parikh at dparikh@piaa.us for more information.
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Let’s suppose for a moment that medical professional liability (MPL) insurance had never been invented. Suppose that in 2016 a group of insurance experts sat down around a table and came up with plans and designs for this product from scratch. How closely would it resemble what we have today?

A remark you’ll hear a lot is, “medical liability is more complicated than other insurance”—after all, it’s a “specialty” line of business. But is that necessarily the case? Is the complexity inherent in the business, or is it rather a result of what’s happened in the industry as it evolved?

MPL as we know it today began its life about 40 years ago, within what has been described as a time of “crisis.” The large carriers abandoned the market after heavy losses, and doctors were having difficulty in obtaining coverage—particularly so in certain states. In response, MPL startups were formed, often linked to medical societies, and set up to address the market within their own state. A few state administrations even got in on the act themselves, using one of two approaches—the joint underwriting (JUA) insurer of last resort, or the patient compensation fund (PCF), designed to expand availability by providing a layer of coverage in conjunction with the carriers’ policy.

Given these beginnings, it’s not surprising that we’ve arrived at the market we see today. In the past few years, changing market conditions have forced companies to offer new coverages or expand to other states, but the core approach to MPL really hasn’t changed much.

ACORD, the organization whose intent is to standardize elements of the insurance enterprise like forms, hasn’t made much headway in MPL—the forms are different for every company. The workflows that are used for business acquisition and renewals vary from carrier to carrier. Applications look different—and seem to get longer every year. “Risk management” has a very different meaning in different companies. Packaging of risks and coverages varies by company. In short, compared to other lines of business, there has been little in the way of standardization.
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zation, and companies have failed to come together to gain a consensus on, and adopt, “best practices.”

Idiosyncrasies in setting rates
Great care and attention is paid in gathering and analyzing data to develop rates that are adequate for the exposure. And the claimsmade model evolved as an alternative to occurrence to simplify ratemaking in what is a long-tail business. That said, most companies then allow debits and credits for individual applicants, and thereby deviate from the premium. Many are founded on risk demographics and are controlled by enforceable underwriting guidelines. For example, it makes sense to adjust the premium for a part-time doctor because the exposure is demonstrably different. But then there are other, more subjectively based adjustments, like those offered for risk management and “scheduled credits.” These allow the underwriter to make an adjustment for the particular insured relative to the “average” risk that is contemplated in the base rates.

But all too often, these subjective factors are used (overused) to deviate from what all of the “science” in actuarial work has calculated, in order to win or retain the business. This happens more in soft markets. (Tellingly, most companies don’t, and don’t want to, track the component parts of a schedule credit that are written into their filing.) Is it a good thing? Well, it impedes the ability to adopt straight-through processing and automatic underwriting, and it makes the underwriting process more labor-intensive. Actuarially, it works around those carefully analyzed calculations that are figured to three decimal places!

Vagaries in coverage
At the coverage level, there are some “interesting” practices. There are a host of variations associated with offering tail coverage: definite (for X years), indefinite, prepaid, with refreshed or shared limits, installment payment choices, the premium calculation approach, and more. And the applications seem to have grown in size over the years; most likely, as some “new” claim event is found, another question gets added to the application to unearth the potential for that event. Some companies have entered the “alternative risk” market, where every policy can be customized for specific coverage and bespoke terms and conditions.

JUAs have faded in the current market, but a few states still have them, and they all operate in their own way. The PCFs survive even though the need for market capacity that they were formed to address is a thing of the past. They all work a bit differently in respect of rating, the entities they include, and their reporting requirements. They add a layer of complexity to the carrier’s life—complexity that is now unnecessary.

What is “good service”? Another aspect of complexity arises from some companies’ interpretation of “service” to the agent or the insurer. Being overly accommodating in the name of good service increases complexity and can encourage bad behavior. The most common example is making exceptions on overdue bills. Another, more hidden, example is disregarding the underwriting guidelines in marketing the company’s products. For agents, special deals are sometimes made for commissions. It isn’t service when it amounts to doing favors selectively. Good service comes through consistency in practices—and it also makes possible greater automation of the business.

Another contributing factor in “complexity” is the slow rate of adoption of new technologies. These are some examples that are starting to gain traction with the larger carriers, but they are not yet commonly used otherwise:
- Straight-through processing
- Electronic application submission and quoting
- Use of a web portal for true customer service
- Predictive analytics
- Maximizing the use of data.

So—while the historic evolution of MPL has led to some of the complexities in processing the business, there are changes that can be made to streamline and maximize efficiency and improve quality. And an efficient and quality organization can’t fail to provide good service.

Here then is the “three-step program.”

1. Simplify the operation of the business. Are all those “secret sauce” offerings really necessary? Do they benefit the business enough to justify their existence? Does complexity inevitably cause some confusion among insureds and agents? Can the business be segmented into clients that need lots of attention (like large hospital groups) versus those that can be automated to a greater extent?

2. Document the business processes that have been simplified, and enforce them. If exceptions are to be made, let them be driven by exceptional circumstances—and managed by an approval process.

3. Invest in technology. It can be painful, and it’s expensive and complicated—but over the long term, it is the best investment you can make, one that can’t be ignored. There are so many areas where technology can benefit your company—pick away at them, one at a time. But…make sure you’ve completed steps one and two first.
The medical professional liability system presents constant challenges to healthcare providers and other industry stakeholders. Accurate, timely and quantitative information, from indicated loss reserves and funding estimates to the impact of proposed legislation, is vital. Our experts understand the inherent risks of delivering healthcare services in today’s litigious and ever-evolving environment.

Pinnacle Actuarial Resources, Inc. provides actuarial consulting services for every aspect of the medical professional liability insurance industry at the local, state and national levels. Our wealth of experience drives our strategic solutions to manage your healthcare-related liability exposures. We deal with the unique issues of all specialties and insurance programs, including traditional, alternative and government.

To learn more about our medical professional liability expertise and our Commitment Beyond Numbers, visit us at pinnacleactuaries.com.
Make Your Brand Human

For an industry whose outcomes are really about the safety and wellness of physicians and patients, we are surprisingly tone-deaf at times, thinking only in terms of numbers and actuarial tables.

PIAA was fortunate to have Melanie Spring of Sisarina speak on branding and new approaches to content marketing at the 2015 Marketing Workshop, and I was pleased to have her contribute to this article. Melanie exudes an air of “Hey, come talk with me, because I will more than likely find you super fascinating!” And all this has nothing to do with her personality; it describes her brand.

The challenge is that too many of our companies have focused on the business-to-business side of the equation as we’ve worked to grow market share and win new accounts. We would advocate, instead, to make our brands more human.

Defining the brand

“Branding” has many definitions, and most of them are incomplete. Those who define a brand in terms of a logo, artwork, color scheme, or visual style simply miss the point. Nor is a brand the name of a company. Rather, a brand is an amalgamation of all these things, and more. If you add to these elements the idea that a brand is a promise, held in the mind of the audience, of an expected experience from your company, your products/services, and your people—at that point, you are on the path to understanding why your company’s brand isn’t about business-to-business, it’s about people-to-people.

The greatest challenge in this effort, though, to define and communicate a brand, is that if a company does manage to make the leap from stale and impersonal business branding, it often fails to create a compelling personality that consumers find attractive enough to seek out, or at the very least differentiates it from all of its competitors.

Think of your brand as a person at a party. Are other guests gravitating to your brand? Why? What is it that you’re doing that is attractive, interesting, compelling? How are you making the other guests feel about you, or about themselves while they’re hanging out with you? What would your business be or sound like if it was human? What kind of conversations would you have?

Branding as content and experience

Going back to the earlier definition of branding—a promise, held in the mind of the consumer, of an expected experience—what if you were to connect an emotion to each of those experiences? Or, in other words, what feelings does your brand create for consumers? This may seem almost counterintuitive to insurance professionals. Our focus has traditionally been on selecting the right premium and discounts in our rating methodologies, having adequate case reserves, growing surplus, controlling our combined ratios, and fiercely protecting our financial rating. But those activities, as cerebral as they may seem, have an emotion-based outcome in the experience we provide our members.

If our brand outcomes are feelings: Why do we list our features and benefits, instead of getting to the heart of the matter and getting them to experience an emotion? Most businesses talk like they’re speaking to another business, instead of people talking to people. My own (D.K.) personal experience has shown that businesses do not buy goods and services and that buildings do not contract with vendors—it’s the people in those buildings and businesses that make decisions.

David Kinard, MEd, PCM, is Senior Vice President of Business Development at Physicians Insurance A Mutual Company, and Melanie Spring is Chief Inspiration Officer of Sisarina, a national branding company headquartered in Washington, D.C.
often irrationally, usually emotionally.

Case in point: Consider the competition your company has faced during this extended soft market. It’s likely that there has been, in at least one account, a time when a competitor contacted him and offered a lower premium—sometimes significantly lower—but he chose to stay with you in spite of the savings. Was that a logical decision? Probably not. More than likely, it had something to do with how they felt about your company, the intangible value they feel they get from your team members, or the recognition that they’d feel bad or fearful if they had to move their policy with an open claim.

**Making it happen**

To help move our content and messaging away from cerebral checklists of benefits and positioning statements, here are four simple tips for keeping your brand and content real:

1. **There are no rules.** The rules that the brand gurus told you about in the 80s, 90s, and even early 2000s no longer exist. Today’s hyper-digital marketplace has fundamentally changed branding. And while your company may still have a bevy of mid- to late-career physicians and administrators as customers, they’re being replaced by a new generation of business leaders and care teams that expect something different.

2. **Make your brand human.** As we noted earlier, think of your brand as a person. Try to describe that person in terms of what he’s wearing or what he might do at a party. What is your brand doing to create interest in it among others? Does your brand only talk about itself, or is it inquisitive? Is your brand always selling, or is it a story teller?

3. **Find a parallel.** When you think about the type of content your brand wants to produce, consider looking outside the MPL world at a parallel company or industry. What do you like about the way it shares information, about how its website offers an invitation versus a brochure, or the characteristics of its engagement in social media? Write these things down, and adopt them for your own brand.

4. **Read your stuff.** Go through everything you have produced online and offline. Does it sound like it’s all from one source—the same brand—the same personality? Is it humanized to the level that you’re looking for? If not, figure out what standards you want for your brand’s voice, and work on updating each piece of content. Consistency is imperative when creating a brand. Remember the earlier definition that suggested a “consistent experience”?

If we’ve learned anything from the perpetual soft market it is that we can choose to be in the commodity insurance market, where people buy on price because of a lack of differentiation, or we can work to create a human-first brand, where people build relationships based on emotion-based experiences. Those insurers who successfully evolve from business-to-business to human-to-human interactions, across their organizations, will be the ones that will flourish in the new healthcare market.

For related information, see [www.sisarina.com](http://www.sisarina.com).
Providing clients a superior understanding of how risk affects financial performance and advising on the best ways to manage extreme outcomes.
In recent years, with the nation’s capital mired in what seems like permanent gridlock, some PIAA members have asked me, “Why do we need a presence on Capitol Hill now?” I understand why they’d ask that question. To be honest, Congress, with its limited bandwidth, isn’t that interested in traditional medical professional liability (MPL) reforms now, because we aren’t in a crisis at this point. Even if Congress were interested, partisanship would likely make it impossible for any substantive liability reform package to be passed. And, even if we could pass something, the current administration is hostile to any reforms that are not to the liking of the personal injury bar. So, why do we maintain a presence in Congress?

There are two reasons. First, while we may not be on the verge of passing comprehensive federal MPL reforms now, that doesn’t mean we won’t be able to make it happen in the future. As one congressman told me several years ago, you need to have something ready to move forward now, when your issues are getting scant attention. Then, when the next crisis hits, you’re prepared to propose real answers to the problem. If you don’t do that, your proposal will likely get lost amid the push of legislative ideas that inevitably emerge when the public demands an immediate response to a situation.

So that we have that potential crisis-solving legislation ready, we need to work regularly and consistently with our allies on Capitol Hill to remind them about the issues in MPL. We also need to work with them to make sure that we have their full support for our proposals before those proposals are advanced. If you’re discovering that people have problems with your legislation after your bill has been introduced, you may well lose precious time and momentum to some other competing concepts that may be detrimental to your interests.

In addition, there has been substantial turnover on Capitol Hill in recent years. While young staffers come and go on a fairly regular basis (it has been estimated that the average congressional staffer spends just two years on the Hill), the makeup of Congress itself has changed at a tremendous rate, too. Nearly half of the House of Representatives have served fewer than three full terms in office. As a result, many of them have very limited knowledge of issues beyond the ones that have been

Michael C. Stinson is Vice President of Government Relations and Public Policy at PIAA; mstinson@piaa.us.

Then, when the next crisis hits, you’re prepared to propose real answers to the problem.
debated over the past few years. So our work in educating them about MPL issues is critical to establishing the base of support that is vital for achieving our long-term goals.

Aside from our long-term goals, there is one other reason to engage on Capitol Hill on a regular basis—potentially harmful legislation could come up at any time. In fact, it happened just recently.

**A watchful eye**

Here’s how it came about: A few years ago, PIAA was asked to comment on legislation designed to ensure that sports medicine professionals could maintain their MPL insurance when they travelled with an athlete or athletic team to provide services as a team physician. The original draft bill, which would eventually be called the Sports Medicine Licensure Clarity Act, was in essence a mandate that insurers must provide coverage to sports medicine professionals. When the draft came to PIAA’s attention, we worked with advocates for the bill to protect insurers’ interests. With the input of our exceptional team on the Government Relations Committee, PIAA was able to alter the language to require that team physicians notify an insurer of their extracurricular activities, and that the laws of the team’s home state would be applicable in any lawsuit against the doctor. While PIAA expended few if any resources advocating for the bill (since it wasn’t one of our legislative priorities), we did continue to reach out to various stakeholders, and the denizens of Capitol Hill, to monitor the legislation’s progress for many months after that.

Now, fast forward to June of this year: It was announced that the Sports Medicine Licensure Clarity Act would be considered by the Energy and Commerce Committee’s Subcommittee on Health. Since the bill’s language had already been vetted, PIAA was stunned to find out, only 90 minutes before the subcommittee was to take action, that substantial changes had been made in the bill at the request of the American Association of Justice (i.e., the trial bar), and that advocates for the bill had acquiesced to those demands. Essentially, the bill had once again become a coverage mandate, and all of the liability protections had been stripped from the legislation. PIAA immediately went into action.

Reaching out to the congressman who sponsored the bill, Brett Guthrie (R-KY), PIAA expressed its deep concern about the changes, and said that we would be forced to oppose the bill publicly if it were to remain in its current form. The same message was conveyed to the medical groups that were advocating for the legislation. This was especially problematic for the bill’s most ardent supporters (and advantageous for us), because the subcommittee and committee leadership had said it would not move forward with the legislation unless it was deemed noncontroversial, i.e., no one was opposed to it.

**Negotiations commence**

A meeting was soon arranged with Cong. Guthrie’s staff and the lead staffer handling the bill on the Energy & Commerce Committee. During a lengthy discussion, we explained why the changes the trial bar had requested were injurious to insurers (and in the end, sports medicine professionals as well), and offered our thoughts on what corrections would be necessary. Both staffers expressed appreciation for our input, as well as our deep knowledge of MPL issues, and asked us to provide specific legislative language that would address our concerns. The one caveat was that our recommendations had to make a good faith effort to also address concerns about the original bill that had been expressed by the trial bar, so that no new opposition to the bill would arise.

What proceeded from there were many days of discussions, negotiations, and legislative drafting. Everything, from the definition of what an athletic team was, to determining what a physician’s home state was, to deciding what state laws would apply when a team travelled out of state, was reviewed, redrafted, and debated. Negotiations between PIAA and AAJ, with Hill staffers serving as the go-between, went through multiple rounds until, finally, it seemed like everyone found the bill acceptable.

In the end, the bill wasn’t everything PIAA wanted (our goal of applying the physician’s home state tort laws to acts undertaken in a different state was blocked by the personal injury bar), but it was, arguably, an improvement over the status quo. Perhaps more important, it did not include any mandates on MPL insurers or subject them to additional risk.

What would have happened if PIAA hadn’t already established relationships with the other stakeholders in the sports medicine field and the key players on Capitol Hill? It’s impossible to say for sure, but in light of what transpired in the recent negotiations, I think it’s safe to say that it wouldn’t have been good for MPL insurers. And that is why we maintain a presence on Capitol Hill—because we can never be completely sure what Congress, or the administration, will do next. And if we aren’t there to defend our interests—your interests—no one else will be there to do it for us.
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Third-party claims against insurers for bad faith are often threatened when claimants obtain verdicts against insureds that are in excess of policy limits. Bad faith damages may include compensatory damages for financial loss, non-economic damages for emotional distress, and punitive damages. They can also be costly to defend. Exposure may far exceed policy limits. The commercial rationale for an insurance policy (a stated premium in exchange for stated limits) evaporates. While many jurors may love, or at least have empathy for, individual defendants like doctors, jurors frequently view insurers and contractual claims against them more harshly.

Meanwhile, there is often a close alliance between medical professional liability (MPL) insurers and their insureds. Facing litigation against the insureds is uncomfortable, apart from the costs and exposure. Fortunately, bad faith claims by or on behalf of physician insureds seems rare, perhaps because physicians usually understand the risks of litigation, and insurers retain experienced defense counsel and employ sophisticated claims personnel. Bad faith, traditionally defined as demonstrating malice or "evil intent" against an insured, is antithetical to the way MPL carriers routinely handle cases and evaluate claims.

However, the law is frequently evolving. Plaintiff’s lawyers are known for their creativity in devising novel theories of liability, and some courts are known for expanding rights of injured parties. Further, the law of bad faith is state-specific, and the proclivities of judges vary. Consequently, trying to predict where the law of bad faith will go, and how cases will be resolved, is increasingly difficult.

Bad faith refers to a broad range of theories of liability against insurers, including failure to investigate or failure to defend, among others. The traditional bad faith failure to settle claim is one where the potential verdict exceeds policy limits and the case is indefensible. The emerging problem discussed here is the trend of plaintiff’s attorneys in large-exposure cases to raise the specter of bad faith claims whenever potential verdicts may exceed policy limits and implicate an insured’s personal assets even where cases are defensible. Thus, plaintiff’s attorneys make inflated demands in large cases, hoping that they will be rejected, in order to lay the groundwork for a bad faith claim in the event of a blow-up verdict. Settlement demands are coupled with threats of bad faith claims, including pursuit of an insured’s personal assets. For physicians who operate their own practices, the threats are concerning. The threat is reduced in instances where physicians are member of large healthcare organizations in which physicians may avoid personal exposure but, while healthcare is transforming in that regard, there are still a significant number of relatively small practices.

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Horror stories

A November 11, 2015, newspaper reported a case in which an MPL insurer was hit with a $14.3 million judgment, including punitive damages, in a case involving a baby born with severe brain damage. The jury found that the insurer acted in bad faith by not offering to settle a medical negligence case for $5 million when it knew that a jury “might” award damages of more than that amount. The jury awarded compensatory damages of $1.35 million to the plaintiffs, whose daughter was born in 2004 with a brain injury caused by oxygen deprivation. She lived for three years. The MPL company also had to pay $13 million in punitive damages, according to court documents.

Defense counsel in this case had stated that the verdict was clearly unjustified, and he’s probably right. Insurers are unlikely to take such cases to verdict unless the defense is strong. The newspaper article noted that the MPL insurer faced other bad faith claims, and in those instances was successful at trial or able to settle in order to avoid trial. The problem, of course, is that some jurors don’t appreciate the strength of the evidence for defendants and may be swayed by emotion.

In December 2015, a Florida plastic surgeon was hit with a $43 million judgment in a case over the death of a patient following liposuction. A Florida appeals court approved of a bad faith claim against his MPL insurer, reversing a lower-court judgment for the insurer. The complaint alleged that the insurer acted in bad faith in making an offer to arbitrate that entailed admitting liability, without making the offer “contingent upon a limit of general damages.” The complaint asserted that the deceased patient earned more than $2 million a year and that admitting liability for economic damages (by offering to arbitrate) could not have been in the surgeon's best interest.

The complaint also maintained that the insurer breached a duty owed to advise him fully of the consequences of admitting liability, including waiving any defense of proximate cause or third parties’ comparative negligence, and that the insurer failed to recognize that the patient’s claim was defensible (or at least that damages could be reduced by apportioning fault to the patient or to third parties). The surgeon also claimed that the insurer acted in its own best interest, not his, by offering to submit the claim to binding arbitration, thereby limiting its exposure to attorney’s fees and costs that it would have incurred if the claim had gone to trial and liability had been litigated.

Theories of liability

As noted, traditional bad faith (willful, malevo-
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ent conduct by the insurer against the insured) creates a high burden of proof for a claimant to overcome. However, this test appears to have been diluted, and new and different theories of extra-contractual liability for failure to settle have emerged. These include negligent failure to settle, breach of fiduciary duty to protect insureds from excess verdicts and putting an insurer’s interests ahead of the policyholder’s interests, even though MPL policies routinely state that the insurers have the right to determine the amount of settlement where insureds have consented or waived the right to consent.

As noted, the law is state-dependent. States like New York appear to be more pro-insurer. States like Florida are less unfavorable to insurers. Different states also have different theories. This article simply addresses theories that have arisen in some states and cites Connecticut cases to illustrate the ambiguity in the traditional definition of bad faith and outline other theories of liability. It is not intended to be either exhaustive or comprehensive in terms of the cases, the theories of liability, or all the arguments that may be made. Thus, the theories of liability do not apply in all states, and they are not applied uniformly even where accepted.

Bad faith

Bad faith traditionally requires deprivation of an intended, expected benefit to the insured and denial of that benefit in “bad faith.” The classic case is failure to settle a clear liability case with policy limits significantly less than the damages. “Bad faith” signifies malice or intent to defraud. Plaintiffs try to dilute this theory by claiming that policies give insureds implied rights of protection from adverse verdicts above policy limits. They claim that evidence of malice can be implied by excess verdicts and that such verdicts signify intentional failure to act reasonably in evaluating cases and/or putting the insurer’s interests ahead of the insured’s interests.

Some cases refer to a right to protection under a policy without explaining precisely what that means. Others refer to “expected benefits.” Bad faith is also defined as “actual or constructive fraud or a design to mislead or deceive another, or a neglect or refusal to fulfill some duty or some contractual obligation, not prompted by an honest mistake as to one’s rights or duties, but by some interested or sinis-
the personal assets of insureds, thereby putting the insurers in a difficult position.

Insurers need to be aware of the different ways that plaintiffs may resort to characterizing rights of insureds vis-a-vis insurers in terms of (1) balancing of rights or (2) not having the insurer put its rights ahead of insureds. They must also be aware of theories of liability other than bad faith, including “breach of fiduciary duties,” and “negligent failure to settle.” Claims of negligent failure to settle and breach of fiduciary duties seem to be used only rarely, but they may permit an action in instances where malice cannot be demonstrated, and they may make it easier to raise a factual issue that requires a determination by a jury. If negligence is asserted, it is important to remember that such a claim may not be viable if the damages claimed are purely economic, but that it is easy to allege “emotional distress.”

Ideally, insurers should articulate the basis for evaluations of settlement demands and communicate them to their insureds. Insurers are aware of the importance of the claim file and the difficulties that claims handlers have in that regard—in articulating the pros and cons of trying a case. Meanwhile, many insurers simply want insurers to “handle” their claims with minimal involvement on their part.

Defense counsel customarily advises insureds of demands, but they do not usually advise insureds about the rationale for an insurer’s evaluation. Defense counsel often provides evaluations; i.e., the likelihood of success or failure and the expected range of the verdict amount, but these are only educated guesses and they are often imprecise. I doubt that there are any empirical studies of predictions compared with outcomes, but it would be interesting to see the divergence between predictions and results. Insofar as defense counsel act as advisors, not decision-makers, defense counsel cannot fully explain why a demand is rejected. Thus, insurers may consider communicating their rationale for accepting or rejecting settlement demands to insureds before verdicts to avoid acrimonious situations after verdicts exceed limits. If this cannot be done directly, it may be done through counsel, who can then advise the insured or the insured’s personal counsel.

When excess verdicts occur, second-guessing can lead to recrimination at a time when it is especially important for insurers to forge alliances with insureds. Communication is vital. Personal meetings—at least, with the insured’s personal counsel—are essential. The insurer may offer to defray the costs of the insured’s personal counsel or other expenses (e.g., financial, public relations) to reduce other pressures while post-verdict proceedings ensue. Insureds also have to be educated. They need to know that threats of the plaintiff’s counsel are often little more than a negotiating tool.

References

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Medical professional liability (MPL) insurer and PIAA member MMIC investigated the thematic drivers of surgery-related claims made against MMIC policyholders, for the period 2010-2013. Each claim is coded for more than 600 data points per case, for purposes of analysis. The key findings of this study include:

- Surgical allegations are most prevalent across all claims.
- Risks differed between the stages of surgery—pre-, intra-, and post-surgical.
- Themes emerged that are grounded by allegation type and procedures by system.
Between 2010 and 2013, there were 1,843 cases (claims and suits) against MMIC policyholders representing $240 million in total incurred costs. Overall, 28% (N=517) of MMIC cases involved surgical allegations representing 29% of total incurred cost ($70.9 million). Thus, surgical allegations are most prevalent in both occurrence and cost.

Although the cases span across many surgical specialties, the top services responsible in these allegations were general and orthopedic surgery. Almost half of the surgical allegations (49%) were accounted for by these two specialties. Amongst all the types of surgical allegations, two specific allegations encompassed 84% of cases—improper performance of surgery and improper management of surgical patients.

Surgical allegations—improper performance

Allegations of improper performance of surgery accounted for 339 MPL cases and costs totaling $48 million (2010–2013). The great majority (90%) of these allegations originated from events that occurred within the walls of the operating room, where the preponderance (76%) of outcomes were of medium severity. Overall, 53% of these cases involve musculoskeletal (29%) or digestive system (24%) procedures, which closely aligns, but is not inclusive of, the top services responsible.

Among the musculoskeletal cases, 90% were related to technical skill factors. Within these, there were possible technical issues (58%) including potential complications not recognized in the OR and poor technique (18%). In 46% of cases, there were issues related to clinical judgment, such as decisions regarding selection or management of surgical procedures, and failure to respond to repeated patient complaints or symptoms during patient assessment.

Other issues were cited as well. In 31% of cases, there were patient-related issues, such as patients seeking consultations from a new surgeon because of dissatisfaction with a procedure or noncompliance with a treatment regimen. Communication issues were present in 25% of cases, and these included inadequate informed consent and poor rapport with the patient.

Among the digestive surgery-related claims with allegations of improper performance of surgery, there was a clear majority of medium-severity injuries (80%), although there was a greater proportion with high severity (20%) than with the musculoskeletal procedures. This is not surprising due to the nature of the procedure as well as the general health of patients receiving surgical treatment.

This article is based on a presentation by MMIC, February 17, 2016.

PIAA Data Sharing Project reported improper performance as the top chief medical factor named in a claim or lawsuit closed between 2005 and 2014. A total of 7,901 claims and lawsuits paid $2.5 billion in indemnity and incurred $1 billion in defense expenses. Approximately 38% resulted in moderate injury and 15% in death.

The most prevalent outcome by the number of paid claims from an improperly performed procedure was accidental puncture or laceration during a procedure, resulting in an average indemnity of $315,925.

- Accidental puncture of laceration during a procedure: $315,925
- Birth trauma: $567,485
- Cardiac or cardiorespiratory arrest: $404,097
- Postoperative infection: $358,655
- Disorder of intestine: $427,839

This article is based on a presentation by MMIC, February 17, 2016.
Technical performance factors present in 98% of these cases included complications such as laceration of an iliac artery during a laparoscopic appendectomy, a transected common bile duct during laparoscopic colon surgery, and a colostomy during which the wrong end of the intestine was reconnected.

Intra-operative decision-making was an issue in 58% of the cases. For example, one case resulted from a failure to convert from laparoscopic to an open approach during appendectomy, and another was due to a delay in ordering appropriate tests during surgery.

In addition, communication issues were the third highest factor in 12% of cases. Some cases involved inadequate informed consent and other communication issues between provider and patient and family. There were also patient-related factors identified, such as noncompliance with the treatment regimen that further contributed to the allegations.

**Surgical allegations—improper patient management**

The second bucket (18%) of surgical allegations—improper management of surgical patients—represents 95 cases at $18 million in total incurred cost. Overall, 56% of cases with this allegation are linked with musculoskeletal (36%) or digestive system (20%) procedures.

Ninety percent of the improper performance cases had originated in the OR. But here, with improper management, there is a shift—only 26% originate in the OR. For digestive system procedures, only 33% originate in the OR. Thus, the majority of allegations involving improper management of surgical patients are happening once the patient leaves the OR.

And although occurrence is low in these cases, injury severity is quite high. While only 11% of cases in the improper performance category culminated in high severity injury, here they increase to 29% for musculoskeletal system procedures, where infection is the number one injury; 68% of digestive system procedures resulted in high-severity outcomes, including death (53%).

Looking at contributing factors, we see issues with technical skill in the musculoskeletal cases. In one case, there was numbness after a total knee replacement. The patient was told the symptoms would resolve, but after ongoing complaints, further investigation showed arterial occlusion which caused damage to the peroneal nerve.

These cases also illustrated that clinical judgment continues to be an issue. For example, a patient complained of ongoing pain after a shoulder replacement. The exams were unremarkable, so no further investigation of the cause of the pain was done. However, subsequent investigation revealed a deep-tissue infection, which required the removal of all hardware.

Communication issues between provider and patient and other patient factors also came into play. One case involved another late diagnosis of infected hardware after a total knee replacement, and the frustrated patient ended up seeking a different surgeon for follow-up care.

The overall lesson in the musculoskeletal cases is that, in many instances, patients with symptoms or complaints are not being responded to, or fully worked up. Gaps in communication among providers, patients, and caregivers are an issue as well.

In this allegation category, with limited digestive system procedures (N=19), the same combination of contributing factors can lead us to a major conclusion that differs from that of musculoskeletal procedures. In digestive system procedures with allegations of improper management of surgical patient, the communication gap is between the provider and the hospital care team while the patient is still recovering in the hospital, but outside of the OR.

**Lessons learned—some examples**

MMIC learned a few lessons from its analysis. The key challenge for musculoskeletal cases is centered in the communication issues and patient factors of these allegations. Communication and setting expectations—both before and after surgery—are crucial to a better outcome. The surgeon must reiterate to the patient and/or caregiver what symptoms to watch for and clearly explain what life will be like after a procedure in terms that the patient understands. In follow-up consultations with patients, it is important to revisit these symptoms and expectations in light of the patient complaints—by whoever assesses the patient, including physician assistants and other physician extenders.

On the other hand, when we look at digestive system cases, the key challenge becomes communication among the care team and their ability to recognize post-operative complications, rather than communication with the patient himself.

It is essential to realize that each patient has his own story, and communicating it well with the right people at the right time is intimately involved in attaining high-quality care. 

**Editor’s note:** For more on surgical claims, see the articles, “Retained Objects; Why They Keep Happening—and What You Can Do About It;” page 32; “Surgical Safety in Canada: A 10-Year Collaborative Review;” page 49; and the PIAA DSP Data Snapshot, page 9.
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From two perspectives, that of patient safety and that of potential medical professional liability (MPL) claims, episodes of unintentional retention of foreign objects are high-severity events. In fact, unintentionally retained objects, despite correct counts of them before and after surgery, comprised one of ECRI Institute’s top 10 patient safety concerns for 2016 (see www.ecri.org/PatientSafetyTop10).

Retained items can cause serious harm. On reviewing all claims or incident reports involving retained items filed with one MPL insurer over 16 years, researchers identified 54 cases involving retained objects. Most of these patients required reoperation, hospital readmission or a longer stay, or both. Sequelae included infection, sepsis, and complications involving the bowel (e.g., fistula, obstruction, visceral perforation). One patient died. The harm these events can cause is exacerbated by the fact that some retained items go unrecognized for years, and subsequent removal may be risky or contraindicated.

Events involving retained items are rare, but they do happen. Reviewing four years’ worth of data, Mayo Clinic researchers found that one confirmed case occurred in every 5,500 operations. Although 68% of retained items were sponges, another 20% were miscellaneous items (neither sponges, needles, nor instruments). Retained-item events are costly for both providers and insurers. Foreign objects retained after surgery are among the hospital-acquired conditions for which the Centers for Medicare and Medicaid Services effectively denies payment. And, according to the PIAA Data Sharing Project, for the most recent 10-year period, the retention of surgical foreign bodies left in a patient after a procedure was the ninth most frequent chief medical factor leading to closed MPL claims. Of the 94,000 total closed claims reported for this 10-year analysis, 1,741 named retention of surgical objects. Of these, 29% resulted in an indemnity payment to the patient, for a total of $44,581,330 and an average payment of $87,243.

In many jurisdictions, statutes of limitations allow plaintiffs to bring an action within a certain amount of time after the alleged negligence is discovered, even if the precipitating event happened years earlier. If these cases do get to court, they are usually challenging to defend. Plaintiffs often rely on res ipsa loquitur, a doctrine that may be applied to injuries that normally do not occur without negligence. This doctrine lets judges and juries infer negligence, shifting the burden of proof to the defendant, and in some jurisdictions, the plaintiff does not need to retain an expert witness to establish the standard of care in these cases. Which defendants are responsible for the event is another oft-debated issue. This blame game, which is exacerbated if the defendants are insured by different insurers, may make it easier for plaintiffs to “divide and conquer.”

Why these events keep happening
Both systems and human factors frequently underlie events involving retained objects. According to The Joint Commission, the three most common categories of root causes identified in reviewed sentinel events from 2004 through 2015 involving retained objects were leadership, human factors, and communication. And in root-cause analyses of the events involving retained objects, the Mayo Clinic identified
breakdown in communication, such as failing to communicate placement of an item within a body cavity to other team members, as the most commonly cited contributing factor. The study authors concluded that their findings “highlight the importance of human factors in contributing to both the successes and failures in the operating theaters.”

Researchers have also identified specific risk factors for item retention:  
- Emergency surgery  
- Multiple procedures or surgical teams  
- Protracted procedure time  
- Unexpected change in procedure  
- Unexpected intraoperative factors  
- High body-mass index  
- Blood loss exceeding 500 mL  
- No count or incorrect count.

Although counting is crucial, it is an error-prone process. Researchers in the MPL claims study found that among the instances in which counts were performed, the count had been reported as correct for 88% of patients with retained objects. In the Mayo Clinic study, the count had been reported as correct in 62% of the cases with retained items.

Many factors can cause an item to be retained, despite a seemingly correct count. First, the count may be incorrect. In one reported event, staff counted and reconciled to 19 clamps, but 20 clamps were actually used in the case. In other situations, the item that is retained is one that was not included in the count—as in the reported case of a distention balloon used for laparoscopic hernia repair. Alternatively, a piece of a device, such as a guidewire fragment, may be left behind.

**What you can do about it**

Having a robust process for accounting for all items, including items that are not formally counted, is crucial. The Association of periOperative Registered Nurses (AORN) recently updated its guideline on preventing retained surgical items (www.aornstandards.org/content/1/SEC19.body). It describes accounting for all items as “a long-standing and evidence-based strategy,” but notes that manual counting alone poses substantial potential for error.

Therefore, a multifaceted systems and human factors approach is needed. Healthcare organizations can proactively evaluate work sys-
Some technologies seem to help in preventing or detecting retained items when they are used to supplement counting. In a simulation model of measures to prevent cases involving retained surgical sponges, researchers found that standard counting alone detects 82% of retained sponges, at a cost of $1,500 for each case averted. Bar coding prevents at least 97.5% of cases, costing $95,000 for each case averted. Radio-frequency tagging prevents 97.5% to 100% of cases, costing $95,000 for each case averted. Universal x-ray and selective x-ray are less effective than bar coding at detecting sponges, and they cost more, ranging from $1.1 million to $1.4 million per case averted. However, the simulation model is limited in that it considered only sponges as the retained object.

Any technology used should serve as an adjunct to, not a replacement for, a robust manual counting process. In the Mayo Clinic study, 59% of retained items were found “unexpectedly” on routine postoperative x-ray, as counts had been reconciled and no retained object was suspected. However, intraoperative or postoperative x-ray did not detect all of the retained items.

Ultimately, multifaceted, systems-based strategies are needed to address the persistent problem of retained items. Healthcare organizations and providers can:

- Nurture a culture of safety by garnering visible leadership support and resources and providing team training.
- Consult guidelines, such as the AORN guidelines, and the literature.
- Proactively evaluate work systems and processes, and modify them as needed to facilitate patient safety practices.
- Develop standardized practices with input from the frontline staff.
- Consider adding a technology—but only as an adjunct to a well-designed counting process.
- Perform robust reactive analyses of near misses and events involving retained items.

Do not stop at “It was a miscount.” Dig deeper, to identify the systems factors that may have contributed to the mishap.

References
Optimizing Today’s Workplace Reality

By Anna Liotta

Healthcare leaders today have the unique experience of providing care to, and leading, six generations at once. This dynamic reality brings opportunities and some challenges. To lead effectively, we need to understand each generation’s unique attitudes, beliefs, and the values that drive their expectations and perspectives.

Why is it so important now? In 2015, a major shift happened, as 45% of the workforce came to be comprised of Millennials (born 1978–1999). Baby Boomers (born 1946–1964), once the dominate force of nature in the workplace, currently make up only 32%, and Gen Xers (born 1965–1977) come in at 23%, with the remaining 1% held by the cohort termed “Traditionalists” (born 1927–1945).

With an overwhelmingly Millennial workforce it’s imperative that leaders understand What Makes Generations Tick and What Ticks Them OFF™. The standard practices and policies that seem to be just good common sense don’t get the same adaption or adoption.

Which leads to the Generationally Savvy™ Mantra, “Common Sense Is not Common.”

When people say, “It’s just good common sense,” they are referencing a certain set of common experiences that they expect people, across the generations, will all share. Unfortunately, this is no
WORKPLACE REALITY

What's in a name?

Scenario One

In clinic, Maryann prefers formal and respectful communications. She is the CEO; her husband is one of the founding physicians. Yet, while in clinic, they refer to each other as Mrs. McCabe and Mr. McCabe. Some of the younger physicians may ask others to call them by first name, and prefer that it be more informal, but Maryann says, "That's not what we do here." Overall, she believes the formality maintains a level of professionalism and respect, so that issues can be handled in a manner that remains professional, not personal. She believes the takeaway for the patients is a higher level of professionalism. For her, professional delivery and style carry over into the bedside manner—which is what patients care about more than increases in medical skills.

Scenario Two

Denise relates that with younger staff, a more casual communication style is common, for instance, the use of first names with patients, rather than "Mr." or "Mrs./Ms.," because this practice manager has a rather young patient population.

Internally, however, there are some challenges around this. While management may emphasize various credentials by referring to the MDs and DOs as "Dr.," some younger physicians prefer to be called by their first name, wishing to relate to their staff in a different way than was used in the generations that preceded them.

Which one is right, and which one wrong? Neither. With a multi-generational workforce and patient mix, it’s a Both/And approach, not an Either/Or. But what is most important is that you are EXPLICIT NOT IMPLICIT with your practices.

To tattoo or not to tattoo?

Another highly visible area where we see a Generational Friction point is in dress code. The term “professional attire” has been morphed and stretched to mean many things. It’s not obvious to Millennials why it makes such a big difference to the prior generations that they all dress alike. Millennials have been encouraged since they could choose clothing to express themselves with it. They grew up on messaging from their parents saying, "You’re unique, special, a snowflake. There is no one like you." They applied this maxim to their choice of what to wear and how to decorate their bodies.

Clinic One

This large clinic has a conservative policy on tattoos and piercings: Tattoos must be covered and facial piercings must be removed. They say, "We are not sure if we are losing good candidates with that requirement. However, with a young patient population, we have heard at least some feedback that our staff is 'less relatable,' because they cover their tattoos, while the patients coming in showing plenty of them."

Clinic Two

We have a conservative policy and require that all tattoos be covered, and also ask that facial piercings be removed while at work. However, we have heard complaints about some patients who come in with a lot of tattoos and feel uncomfortable that they’re being greeted and treated by someone who is required to cover up their own tattoos!

Many young talented people are using body art to express their unique story. Not allowing Millennials, and Gen Xers too, to show them can have a surprising effect. When you are making a policy around it make sure to check in with the patient’s Generational CODES™, as well. Is your practice composed of a majority of Baby Boomers and Traditionalists? Do you have, or do you want to have, more Gen Xer and Millennial patients? The choice you make should include this information.

Are you a destination workplace, or a layover stop on the career journey?

Workplace loyalty has undergone a transformation. Millennials are the first generation to enter the workplace with no expectation of retiring with the company they start with, or even the next two or three companies. Where Boomers thought of themselves as employees that joined a company and then worked their way up the ladder, Millennials consider themselves talent who look for a gig to work and learn from, before they move on to the next opportunity.

Not understanding or ignoring the priorities and deal-breakers of younger staff can be very costly. The average Millennial employee job tenure is between six and 18 months. This becomes very expensive for an organization to acquire and train staff and then “rinse and repeat” the experience all over again in a few months because they didn’t understand their Generational CODES™.

What to do?

1. Clearly communicate the real details of what the job entails—the gritty and boring aspects, as well as the fun and fabulous. This begins
with what’s in the job description and continues into the interview and throughout the onboarding process.

Millennials are unwilling to stay with an organization that described a "Dream Job" and then expected them to deal with a "nightmare reality."

2. Be ready to deliver more feedback and coaching than you received. Weekly or monthly check-ins to discuss their career path and progress are a must, if you don’t want to be doing exit interviews six months into their tenure.

Millennials grew up with coaches, mentors, and advisors and they expect their boss, leader, or manager to facilitate and foster their growth. Millennials expect to be inspired, challenged, and stretched in the workplace. The cost of not having this experience is that they will pick up their skill set and take it to another organization.

Instagram, Facebook, and Snap Chat—productivity pitfall or social lifeline?
The ubiquitous smartphone is commonly a hotspot and pain point for many:

- “We can’t keep them off their phones.” Rather than doing something that is productive with any downtime, they jump to their phones to text, Instagram, FB with their friends—rather than doing something that needs to be done at work. So, the same people demanding a high income don't think to contribute at a higher level.

- “Extremely social.” They spend a lot of time talking with each other. It is important for them to feel culturally connected with each other.

- “Everyone has a cell phone that distracts them.” It’s easy for people to be doing 800 things at once rather than doing their job.

Employers feel that employees used to be more likely to spend their down time proactively finding more work to do, ways to contribute at work. They implicitly understood that showing initiative was the way to get noticed for promotions or salary increases.

This brings us back to our Generationally Savvy Mantras:

“Common Sense is NOT Common™” and “Be Explicit NOT Implicit about your Expectations™”

Because Millennials are not planning to retire with your company, they are not looking at long-term social capital building in the same way as Baby Boomers or even Gen Xers. Once they have done what you asked them to do, in their minds, they have fulfilled the requirements of the job. If you want them to look for productive ways to fill their time, you will need to coach them explicitly about this, or find yourself frustrated that they did not read your mind. And this, by the way—your expectation that they can read your mind—is one of the Millennials’ great frustrations. TM

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Leveraging the ACA to Mitigate the Cost of Future Medical Damages

By Tom Geroulo, Richard Henderson, and Dennis Costello

Leveraging the Patient Protection and Affordable Care Act (ACA) as a resource for mitigating the total cost of future-medical damages has been an emerging topic over the past two years.

It is such an important element in the defense of medical and healthcare professional liability (MPL/HPL) claims—one that can serve to rectify long years of inequitable rulings and verdicts predicated on out-of-pocket medical cost projections—that we cannot lose sight of what is needed to build the defense properly and carefully.

We must start with a foundation for the defense that gives the attorneys a logical framework upon which to build. That framework was sensibly revealed in Leung v. Verdugo Hills Hospital 2013 WL 221654 (Cal. App. 2 Dist.). In Leung, the Court of Appeals considered the potential for this defense, if it was properly presented.
LEVERAGING ACA

1. 18 months gives us encouragement to push forward: around this issue. A brief overview of published case law from the past broader initiative wherein the defense industry will be synchronized room (and in mediation settings as well) and in anticipation of a aged by the very fact that the defense has succeeded inside the court-

2. It should not be brought up at the eleventh hour of a case—that it changes in every matter.

3. It is not a one-size-fits-all defense—it changes in every matter.

2. It should not be brought up at the eleventh hour of a case—that rarely works.

3. It should not be brought up at the eleventh hour of a case—that rarely works.

2. Defense attorneys should be reasonable—use discovery, use experts, use creativity.

The defense industry, and all PIAA members, should be encour-

aged by the very fact that the defense has succeeded inside the court-

room (and in mediation settings as well) and in anticipation of a broader initiative wherein the defense industry will be synchronized around this issue. A brief overview of published case law from the past 18 months gives us encouragement to push forward:

1. Jones v. MetroHealth (Ohio, Cuyahoga County)—Judge reduces

verdict by nearly $2 million in post-verdict collateral source setoff, finding ACA will provide eight years of coverage to a child.

On July 7, 2016, the Court of Appeals for Ohio upheld this portion of the verdict reduction as it related to the ACA commenting, in part, that plaintiff’s assertions that the ACA and separate social programs are subject to potential repeal or financial instability were not credible and therefore unpersuasive. The appeals court found that making such arguments surrounding politics cannot meet a reasonable certainty standard on which a trial judge may effectively conduct post-verdict setoff proceedings. This is arguably the highest court of any jurisdiction to favorably address the ACA on damages-related concepts.

2. Christy v. Humility (Ohio, Trumbull County)—Judge declares that ACA is the “law of the land” and cannot restrict reference at trial.

3. Brewington v. U.S. (Central District of California)—In a bench trial, judge takes judicial notice of ACA exchange-based insurance and awards plaintiff nearly $2 million less than claimed.

4. Donaldson v. Advantage Health Partners (Michigan trial court)—Court finds that reference to the ACA expressly does NOT violate Michigan’s collateral source rule.

To be clear, there are additional cases that allow certain elements of the ACA into court; and there are also many more cases that have harshly rebuked ACA-based defenses, citing a wide range of issues but with a primary focus on the collateral source rule and the potential repeal of the ACA. None of this can be ignored. But, it is the very fact that the ACA can be admissible at trial (or after trial in some states) and that it can be highly useful in mediation that we should give serious considera-
tion to unifying as an industry and delivering the best legal product we possibly can.

Consequently, we have been working closely with insurers, reins-

urers, and PIAA to promote this issue, recruit collaborators, share ideas, discuss strategy, and attempt to refine what we do in each and every case.

Essential role of PIAA companies

From our perch, we have seen the ideas about how to leverage the ACA utilized in various stages of claims and in disparate venues, with different attorneys and insurers, and with a wide range of outcomes. What we saw: a mildly positive outcome here, a moderately poor outcome there, a fortunate decision in one venue but an unexpected setback in another. A common thread was the lack of communication and collaboration amongst the defense and claims communities, leading to uncoordinat-
ed legal arguments and less than optimal tactical strategies.

Of course, by now, virtually everyone has been to a conference where “ACA strategies” were discussed, and invariably we come away thinking, “That’s a great idea, but how do we actually go about putting this into action?” What struck us was the need for the industry to “take

Thomas Geroulo, Esq., is a Partner with Weber Gallagher Simpson Stapleton Fires & Newby, LLP; Richard Henderson is Vice President, TransRe; and Dennis Costello is President and CEO, Second Chair, LLC.
the next step” and get as many as possible together, so that (1) we could create a mechanism for broadly educating and continually providing updates for claims and legal professionals across the country, (2) do all that we could to ensure, as an industry, that we are not reinventing the wheel with every claim, (3) formulate these positions as consistently as possible, including learning from our collective experiences to refine each future argument in a way that provides us with the best chance to make favorable law—and to avoid making “bad” law, (4) create a “living” and secure mechanism to collaborate in a real-time manner and be united in the one aspect of MPL/HPL claims that all defendants can agree on, regardless of standard of care or differences in causation, so that we have a shared approach to mitigating future medical damages.

Why are the PIAA companies so important to this initiative? Simply stated, PIAA is embedded within the fabric of the MPL/HPL space, in every venue of every state. It is difficult to find many claims in which a PIAA member is not, in one way or another, an insurer of one or more of the defendants. This should lead to an environment conducive to good communication, collaboration, and a focus on achieving the common goal of minimizing damages after a claim is filed.

Creating a Compilation Mechanism

To present a unified claims position and consistent arguments in the ACA challenge of a plaintiff economist, Second Chair Software LLC will provide a technology platform for an ACA Database. The ACA Database will serve as a resource to keep people informed of the various developments across the country. The material in the database will be contributed by defense counsel and claims professionals as they find new developments or information that they think will be helpful in meeting the objective of a unified approach.

The ACA Database will consist of articles, filed motions, court decisions, and testimony of those who testify in economic analyses, life care plans, or in regard to ACA expertise.

There will be no cost to access the ACA Database. Those carriers who participate in the MPL Expert Witness Database will have access for their defense counsel and claims professionals. Those carriers that do not want to participate in the MPL Expert Witness Database can assign a company representative, who will be provided a user ID and password for the ACA Database. More information can be obtained via e-mail at dcostello@secondchair.com.
The 2016 Medical Liability Conference in Washington, D.C., brought together more than 500 insurance professionals, all looking to gain key insights into the global—and day-to-day—issues facing the medical and healthcare professional liability (MPL/HPL) community. The meeting addressed the most important issues these professionals needed to learn about and discuss.

Topics covered included claims misadventures, millennials in healthcare, retail medicine, telemedicine, and more. Attendees left the meeting with a clearer perspective on the present and the future, and with specific strategies for meeting the challenges of the evolving healthcare system, both in the U.S. and around the world.

Keynote address

It is “an exciting time to be in healthcare,” Kathleen Sebelius said, noting that PIAA’s focus on quality care at a time when healthcare is changing rapidly “is terrific.” Some of the changes, she said, may alter the patterns of risk that characterize the liability market.

“There are clearly new risk management issues,” Sebelius pointed out, “that come along with change, and they will alter your business models in the future.

“Medicare is now moving from the role of a passive payer to that of an active purchaser,” Sebelius said, “to use the $1 trillion-a-year buying power in Medicare, and begin to align financial interests with outcomes.”

It starts with data, she said, “And I think the future is controlled by data and data analytics. You can only leverage the $1 trillion in spending if you have a platform that
measures and analyzes and identifies ways that costs can be reduced and value be increased.”

Sebelius posed several questions for MPL/HPL insurers: “What do data, what does transparency, what do those propositions—accessible to patients, available to payers—what does that do to liability? What do you insure for in the future? How do you look at risk in the future, when data is measurable and available?”

Recently, Sebelius said, there has been an initiative to develop seven sets of quality measures for providers. Providers will be rated on an individual level, based on value and this will change the payment propositions based on that value. “What does that do to risk?” she said—“what do you do with outliers, and how do you respond when patients can compare outcomes among providers?”

Sebelius also considered the ramifications of telehealth which raises questions like this: “Who bears the risk?” There are signs, Sebelius said, that some of these new ways to provide care are creating safer environments for patients.

Based on these developments, Sebelius said, especially in regard to outliers, MPL/HPL insurers may need to segment their insureds on factors that include data on outcomes.

The issues are not small, Sebelius concluded. Besides the issue of which party or parties bear the risk there will be questions about appropriate levels of training and how telemedicine figures in. With all of these, there are critical risk issues.

“There is a major transformation underway,” she said, “and one thing is certain: data will change the world of medicine forever.”

PIAA Award of Excellence in Honor of Peter Sweetland

PIAA recognized Ted J. Clarke, MD, as the recipient of the 2016 PIAA Award of Excellence in Honor of Peter Sweetland. Dr. Clarke was honored for his singular contributions and long-time dedication to the MPL/HPL insurance community, PIAA, and healthcare professionals.

Dr. Clarke, an insurance executive and physician, has spent more than 14 years representing the interests of the medical community through his work in the MPL/HPL industry. He is Chief Executive Officer and Chairman of the Board of PIAA member company COPIC.

Dr. Clarke has dedicated many years of service to PIAA. In 2015, he completed a full, nine-year term on the PIAA Board of Directors, as a member and also as its Chair. He has served as Chair of the Association’s Nominating Committee and as a member of the Finance and Audit Committee and the Leadership Camp Section. He is currently a member of the Strategic Planning Committee, Data Sharing Advisory Committee, and Board Governance

nearly 20 years as an orthopaedic surgeon and partner with Western Orthopaedics, a medical practice based in Denver, Colorado.

“Ted has worked tirelessly on behalf of healthcare professionals and their patients and PIAA throughout his career to improve the medical liability environment and further the safe delivery of patient care,” said Gloria H. Everett, outgoing Chair of PIAA and President and CEO of The Mutual RRG. “We are honored to present Ted with our highest award in recognition of his dedication and commitment to PIAA and those who provide healthcare.”

The PIAA Award of Excellence in Honor of Peter Sweetland, established in 1993 by PIAA’s Board of Directors, was created in honor of the late Peter Sweetland, one of PIAA’s chief architects and most fervent supporters. The award recognizes an individual who has provided exemplary service to the industry and to PIAA, and who epitomizes the high ideals and ethics for which Peter Sweetland stood.
The literature identifies causative factors like breakdown in the social contract and lack of trust. But it is also true that a small number of doctors were found to be responsible for a high number of events. The challenge for the company was to get enough data to predict which doctors would be linked with claims, according to Dr. Tiernan.

Quality of patient communication and professional attitude emerged as reliable factors in claims. Then, the challenge was to render them into predictions, said Dr. Tiernan.

MPS developed an algorithm that identified the outliers on the high side of the distribution in terms of events. In trying to find something to say about these people, MPS came up with this: “Doctor, of all the people I have met in your specialty, you have the best capacity to improve.”

The approach toward these professionals was to use early warning and self-correction. “We know that if you tell people that they are moving from their peers, they will generally do something,” Dr. Tiernan said. Also, MPS holds a 24-week clinical communications program (CCP), which all of the outliers—the top 2% to 3% of doctors—must attend. There is also a risk management program that focuses on the kinds of patients who are likely to sue because they have higher expectations—and with less ability to have those expectations met.

Pre-CCP, there were 4.7 events per member year; after the CCP, it was 1 in every 10 member years.

Ebbo van Gelderen, CEO of the Netherlands-based MediRisk, said that the company has a database that they have been maintaining for 34 years, and they have built up a sizable compilation of data for analysis and prevention. On average, there are 1,000 new claims annually and average costs per claim, in U.S. dollars, is $46,500. MediRisk has successfully handled 20,000 claims since 1992, and only 5% go to court.

However, the damages paid out have doubled since 2008. One reason has been the emergence of “smarter patients,” who, with the help of lawyers, have been asserting “their rights.” MediRisk has countered by using a shared approach between the insurer and the hospital members, with both collaborating on prevention schemes. There is continuous screening of the database, with an alert sent out on any unusual claim pattern.

Recently, the company has enriched its data compilation. The number of categories for root cause analysis has increased from seven to 56. Risk data can now be delivered a lot earlier, and with more specificity. Predictive modeling is used to predict ultimate damages; identify risks for individual hospitals; reveal early warning of anomalies; set pricing; and optimize the claims handling process.

Walid Jammal, MD, Senior Medical Advisor-Advocacy at Avant, provided an Australian perspective on how to leverage data to modify risk.

Claims numbers in Australia peaked in 2001, but then, in the wake of tort reforms, declined fairly steadily until 2005. From then until 2014, claims held steady at 20 claims per Avant member. However, there has been a coincident increase in disciplinary claims, and an increased need for medico-legal advice.

Avant has initiated a new coding scheme for claims, Dr. Jammal said, whose goal is to “extract usable data from our claims, to create an evidence base around the drivers of medico-legal risk for the benefit of our members.” Claims coding helps Avant to advance its medico-legal risk knowledge, including: identification of features, characteristics, or deficiencies in care that commonly give rise to claims or complaints, and to help inform advocacy for regulatory and/or system change.

Predictive modeling is used to determine risk premiums.
for various specialties. In addition, Avant uses modelling to identify the higher-risk practitioners, based on prior claims experience (less than 1% of the members) and also to monitor aggregated trends. But the biggest challenge, Dr. Jammal said, is moving from noticing trends to changing behavior.

**Focus on a Session**

“The Rapid Growth of Retail Medicine”

Kavita S. Patel, MD, MS, is a practicing primary care internist at Johns Hopkins Medicine, who also served as the Obama Administration’s Director of Policy for the Office of Intergovernmental Affairs and Public Engagement in the White House. She pointed out that, traditionally, retail clinics have been situated inside a store, such as a drugstore or a mass merchandise store. The earliest retail model, with clinics inside stores, limits the scope of services to reduce the cost and increase consumer appeal. These clinics offer transparent pricing, short wait times, and fast diagnosis and treatment.

Healthcare professionals can opt to work with a retail clinic, set up their own clinic—or just watch and learn from the sidelines. And hospitals will be a force in this market, Dr. Patel said, as they operate and affiliate with retail clinics, connecting

**PIAA Recognizes Jim McGuire with Award of Excellence for Lifetime Achievement**

The PIAA Award of Excellence for Lifetime Achievement was presented to Jim McGuire for his outstanding contributions to PIAA and development of the PIAA MPL insurance marketplace.

McGuire has a long and distinguished career specializing in insurance and reinsurance casualty coverages and claims, with a particular focus on healthcare portfolios. He has provided legal advice to numerous underwriters worldwide who are involved in treaty physician, facultative hospital professional liability, and various affiliated programs. Formerly, he was an equity partner at Mendes & Mount from 1983 until his retirement in 2014. After retirement, he became a board member of AHRQA Solutions, Inc., the management company of PIAA member Academic Health Professionals Insurance Association.

“Jim’s contributions to the establishment

**AHRQ Receives Award of Excellence in Health Research**

The Agency for Healthcare Research and Quality (AHRQ) received the PIAA Award of Excellence in Health Research. AHRQ, a division of the Department of Health and Human Services (HHS), was honored for its contributions to improving the safety and quality of America’s healthcare system.

“AHRQ excels in bringing together stakeholders to develop the knowledge, tools, and data needed to advance the U.S. healthcare system,” said PIAA Vice President of Research & Risk Management P. Divya Parihar. “The agency’s focus on what is needed for continuous improvement in care delivery is leading to better care, smarter spending of healthcare dollars, and a healthier public.”

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Dr. Sharon Arnold, Deputy Director, Agency for Healthcare Research and Quality, accepts the Award of Excellence in Health Research on behalf of AHRQ.

PIAA President and CEO Brian K. Atchinson said, “In particular, we applaud the agency’s Center for Quality Improvement and Patient Safety for its focus on improving healthcare-associated infections, patient safety, and patient communication.”

“AHRQ has also been at the forefront of government agencies in researching ways to improve the medical professional liability system,” Atchinson continued. “For example, it was tasked with overseeing the Medical Liability Reform & Patient Safety Initiative, whose intent was to develop demonstration projects designed to enhance patient safety, improve patient/provider communications, and reduce the incidence of non-meritorious lawsuits.”
the clinics to mainstream healthcare.

Walmart was set to open 400 clinics in its stores by end of 2009. All were to be operated by, or affiliated with, local hospitals, and sited in the front of the stores. But at present, Walmart has only 103 clinics, with a mere 6% of the market. CVS, with its MinuteClinic, holds 50% of the market, with 901 clinics.

Patient satisfaction with retail clinics is high, and they are very much open to the idea of using the clinics for broader purposes.

While common acute conditions will nonetheless remain the core of what is treated at retail clinics, owners hope to attract a broader demographic, including more seniors. A recent promotion announced, “RediClinic now accepts Medicare.”

Technology, including telemedicine, it is hoped, will increase the scope of retail clinics, and also serve to bring physicians into the clinics. Also, telehealth connections will make possible the networking of the various clinic sites. In California, there are 28 MinuteClinics; the networking allows patients at one site that is very busy to be seen by a nurse practitioner at a site that is not so busy. Screening tests and consumer devices may be sold through the clinic.

There are pilot studies now underway that will test the efficacy of the retail clinic model for treating more complex diseases, like bronchitis, pharyngitis, and otitis media, via telehealth. Surveys show that 95% of patients think that their telemedicine experience was a good as, or better than, an in-person visit.

**Congressman Marsha Blackburn**

Marsha Blackburn has represented Tennessee’s Seventh Congressional District since 2002, serving on the majority and minority whip teams since she was first elected. She holds a seat on the House Budget Committee, and she has been a strong advocate for numerous issues of importance to MPL/HPL insurers.

Congressman Blackburn has earned a special reputation as a bipartisan leader and policy expert, as demonstrated in her work to advance the Good Samaritan Health Professionals Act. She was one of the first in Congress to cosponsor the bill when it was introduced in 2011, and she became its lead sponsor in 2013. Since that time, support for the bill has steadily climbed.

**Congressman David Scott**

David Scott, first welcomed to the U.S. Congress in 2002, is currently in his seventh term representing Georgia’s Thirteenth Congressional District. He serves on the Financial Services Committee, the Agriculture Committee, and the NATO Parliamentary Assembly.

Congressman Scott is a strong voice for MPL/HPL insurers, where he has resisted the partisanship that sometimes surrounds PIAA’s issues.

While a state senator, Congressman Scott was a strong advocate for issues important to liability insurers and organized medicine. Today, he is influential in Washington: His leadership has helped bring record levels of Democratic support to the Good Samaritan Health Professionals Act.

**Award of Excellence in Public Policy**

The PIAA Award of Excellence in Public Policy recognizes outstanding achievement in the areas of policy advocacy and government. Recipients are chosen by the PIAA Board of Directors for their extraordinary efforts to advance the interests of MPL/HPL insurers and their insureds. In 2016 two such awards were presented to acknowledge a pair of outstanding elected officials for their support of volunteer healthcare providers.

**Cong. Blackburn (left) receives award from outgoing PIAA Board member Paul C. McNabb, II, MD, Chair Emeritus, SVMIC.**

**Cong. Scott (left) receives award from PIAA Board member Joseph S. Wilson, Jr., MD, FACC, Chairman & CEO, MAG Mutual Insurance Company.**

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More than 1 million surgical procedures are performed annually in Canada, each with associated benefits and risks. While healthcare providers and organizations strive to provide safe care, surgical patient safety incidents still occur.

A recent report from two national organizations, the Canadian Medical Protective Association (CMPA), which provides medical liability protection for most Canadian physicians, and the Healthcare Insurance Reciprocal of Canada (HIROC), the country’s leading provider of liability insurance for healthcare organizations and their employees, offers insight into the factors contributing to surgical safety incidents and suggestions to improve care.

Collaborating on surgical safety at the request of the National Patient Safety Consortium, representing a group of key healthcare stakeholders, the CMPA and HIROC conducted an in-depth retrospective analysis of surgical safety incident data. The collaborative report supports the CPSI’s Surgical Care Safety Action Plan and provides an opportunity for shared learning from the medico-legal data.

On the release of this research report, the organizations affirmed that, “Patient safety is a collective responsibility, achievable only through the collaboration of governments, healthcare organizations, educational institutions, individual providers, and patients,” and that “the CMPA and HIROC are committed to improving patient safety through continued sharing of data to identify and address priority areas for system and practice improvements.”

Learning from medico-legal cases
The analysis of medico-legal files identified 1,583 CMPA cases and 1,391 HIROC cases involving in-hospital surgical safety incidents that were resolved within the past 10 years. A surgical safety incident was defined as a patient safety incident that occurred prior to, during, or after a surgical procedure. Contributing factors were categorized as resulting from system failures and provider performance issues. Obstetrical cases were excluded from the analysis. Because the CMPA and HIROC use distinct coding methods for capturing contributing factors, the interpretation of cases may have differed between the organizations.

Key findings from the analysis
Peer expert reviews of the identified cases found system and provider issues in 53% of CMPA
and 49% of HIROC surgical-incident cases. No criticism of the care provided was identified in 42% of the CMPA cases and in 25% of HIROC cases. Table 1, below, illustrates the categories of contributing factors.

Almost two-thirds of cases (950/1,583 of CMPA and 928/1,391 of HIROC) involved non-oncology/non-trauma repair or excision procedures (e.g., inflammation and infection). Trauma-related cases made up 12% of the CMPA and 3% of the HIROC datasets, and oncology-related cases made up 14% of the CMPA and 8% of the HIROC datasets.

Patient harm, including physical and psychological outcomes, involved injury to organs, blood vessels or nerves; wrong surgery (i.e., wrong body part, patient, procedure); unintended retained surgical items; hemorrhages; or burns. Incidents of retained surgical items or wrong surgery were identified in 12% of CMPA and 18% of HIROC surgical incidents. Severe patient outcomes, including death and catastrophic harm, were identified in 32% of CMPA and 39% of HIROC cases.

Most incidents occurred during the intra-operative phase. While data on specialty involvement was not available for HIROC cases, analysis of the CMPA dataset found that neurosurgeons and orthopedic surgeons had the highest incidence of cases per 1,000 CMPA members. Anesthesiologists’ care was a contributing factor in 4% of CMPA surgical incidents. Residents were involved in 4% of the CMPA and 1% of the HIROC surgical incident cases.

The most common system issues (Figure 1) included an inadequate or absent surgical safety protocol, or a provider’s failure to follow a surgical safety protocol (e.g., a surgical safety checklist).

**Influencing surgical safety**

Surgical incidents result in patient harm and personal costs to the patients and their families; but they also impact providers, institutions, and society. Analysis of the legal data, including the peer expert reviews, advances the opportunity for shared learning and identifies priorities for health system improvements that are crucial to reducing surgical harm.

“The CMPA is committed to empowering the medical community to further improve healthcare quality and safety,” said Dr. Hartley Stern, CEO and Executive Director, CMPA. “We work with HIROC and other healthcare partners to identify and address gaps and promote knowledge in areas that have the

### Table 1. Categories of contributing system factors

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<thead>
<tr>
<th>System factors</th>
<th>HIROC (n=1391)</th>
<th>CMPA (n=1583)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failsafe issues (issues with a process/protocol)</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Communication issues</td>
<td>11%</td>
<td>14%</td>
</tr>
<tr>
<td>Documentation issues (e.g., absent, sparse, illegible, non-contemporaneous)</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Mechanical equipment issues: faulty equipment; wrong application, improper or non-approved use of equipment</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Resource issues and wait times (e.g., equipment, beds, staff)</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Administrative issues (e.g. OR booking, delayed report, health information technology)</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Figure 1. System factors identified in peer expert reviews, CMPA and HIROC closed cases, 2004–2013**

Administrative issues (e.g. OR booking, delayed report, health information technology)

Resource issues and wait times (e.g. equipment, beds, staff)

Mechanical equipment issues: faulty equipment; wrong application, improper or non-approved use of equipment

Documentation issues (e.g., absent, sparse, illegible, non-contemporaneous)

Communication issues

Failsafe issues (issues with a process/protocol)
potential for greatest positive impact. As a result of this review, both HIROC and the CMPA will push even harder for systemic and workplace cultural changes in healthcare.”

Based on the expert opinions contained in the CMPA and HIROC analysis, the following surgical safety improvement measures were recommended:

**System factors**

- Implement more consistently the standardized protocols (e.g., surgical safety checklist) to support interdisciplinary team communication, ensure situational awareness (i.e., keeping track of what is happening and anticipating what might need to be done) and improve verification practices (e.g., patient, site, procedure, and count).
- Evaluate protocols through outcome measurement (e.g., trigger tool chart review), use the results to inform quality improvement, and close the loop through education and feedback.
- Foster a workplace culture of safety with open and respectful communication that welcomes patients, families, and providers to speak up (e.g., Stop the line, SpeakUp!), and committed leaders who support disclosure and escalation procedures.
- Provide multidisciplinary education programs to support teamwork, communication, and situational awareness.

**Physician factors**

**Pre-operative assessment and informed consent**

- Perform a comprehensive patient assessment, including review of current status and completed and pending investigations (e.g., lab tests, x-rays).
- Obtain and document informed consent, which should include discussion of the risks and benefits of surgery and any alternative options.

**Intra-operative decision-making**

- Adopt strategies to identify and mitigate errors in clinical-decision-making, including those resulting from cognitive biases.
- Employ self-reflective practices to allow for clinical improvement and shared learning.

**Post-operative management and follow-up**

- Provide clear team instructions on assessment and monitoring.
- Ensure that documentation reflects the treatment plan to enhance continuity of care.
- Clearly communicate to the patient or family all of the elements in an informed discharge, including the signs and symptoms to watch for and when to seek medical attention.

**Other healthcare provider factors (e.g., nursing)**

- Ensure all standard and non-standard surgical items are counted (e.g., sponges, towels, packing, needles, instruments, and items “too large/obvious” to be left behind); separate the sponges to view them concurrently; ensure all new items added during surgery are documented.
- Employ self-reflective practices to allow for clinical improvement and shared learning.

**Concluding thoughts**

A culture of safety, with improved surgical outcomes, requires the cooperation and commitment of the entire healthcare team in the adoption of safe practices. In addition, experts in patient safety are gaining a better understanding of the supportive work environments and tools required that will help clinicians practice effectively and safely. All healthcare professionals, including leaders and administrators, need to be engaged in, and advocate for, the development of safe systems of care.

This analysis supports the value of learning from medicolegal cases involving surgical patient safety incidents to advance quality and safety improvement. The collaboration in the work of this analysis, and its results, have renewed the partners’ commitment to further advocate for systemic and workplace cultural changes in healthcare.

“HIROC was most pleased to have been designated by CPSI as co-lead with CMPA in the 10-year retrospective analysis of surgical claims,” said Arlene Kraft, Manager, Healthcare Risk Management at HIROC. “This study provided data identifying the culmination of individual and system factors. The collaboration between the two organizations and opportunity to share this information with the healthcare community in an effort of improving patient care has been truly inspiring.”

The report, Surgical Safety in Canada: A 10-year review of CMPA and HIROC medicolegal data, is available at: www.patientsafetyinstitute.ca.

**Acknowledgments**

We thank Jun Ji, MHA, for her contribution to the research, Dr Lorraine LeGrand Westfall, FRCS, CSPQ, Dr Lisa Calder, MSc, FRCP, and Arlene Kraft, BSc, CPHRM, CPPS, CHIM, for their direction and guidance, and Kristen Hines for editorial support.

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**Reserve Requirements**

The officials of the fourth-largest insurance market, China, sounded a lot like U.S. regulators, lawmakers, and industry officials who have steadily pushed back against the International Association of Insurance Supervisors (IAIS) proposal for global insurance capital reserve requirements. U.S. officials have argued that those requirements are unfair to countries with insurance governance styles dissimilar to the European Union’s Solvency II regulatory regime.”

—BNA, July 25, 2016
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**Where Did the Inflation Go?**

When the Federal Reserve Board of Governors embarked on its quantitative easing (QE) program in an effort to stem the impact of the Great Recession, many began to fear the long-term effects this program might have on future inflation.

While the first easing program (QE1) was widely accepted as necessary and beneficial in stabilizing the panicked financial markets, the Fed’s repeated use of the technique in the subsequent programs (labeled QE2, Operation Twist, and QE3) troubled those who feared that uncontrollable inflation would undoubtedly be the result.

**The sum of all fears**

The U.S. has been in a period of generally decreasing inflation since the early 1980s. After reaching nearly 15% in 1980, annual inflation fell sharply and then remained between 3% and 5% for most of the 80s, and between 2% and 4% for most of the 1990s and 2000s. In 2008, inflation, as measured by the Core PCE (one of the Fed’s preferred indicators), plunged below 2% amid the recession, then continued to fall, bottoming out near 0.9% in late 2010. This was after the first QE program had ended, and no plans for any further measures had yet been announced by the Fed.

Then, as the Fed announced and implemented the QE2 in 2011, the PCE measure reversed direction and increased throughout the year to peak at more than 2.0%, but subsequently fell for the next several years, even as Operation Twist and QE3 were implemented. Only in February 2016 did the PCE rise back above 1.7%, and the most recent measure (April 2016) showed a reading of 1.6%, still below the Fed’s target of 2.0%. Figure 1 shows the changes in the PCE price index since late 2010.

This muted inflation response is in contrast to the expectations of many investors who had been predicting considerably higher inflation as a result of the expansion in the Fed’s balance sheet. Their belief was that the increase in the money supply brought on by QE would certainly show up in dramatically higher prices for consumers. This surmise seemed to be supported by some economic research, which had shown a relationship between broad measures of the U.S. money supply (such as those labeled M-2 and M-3) and future inflation. One of the best-known economists of the twentieth century, Milton Friedman, had famously proclaimed that, “inflation is always and everywhere a monetary phenomenon.” Therefore, the Fed-promoted sharp increase in the money supply was cited as clear evidence that inflation would soon follow.

Between 2009 and 2011, investors bid up Treasury-Inflation Protected Securities (TIPS) by nearly 30%, in an effort to add inflation protection to their portfolios. Other investors reduced fixed-income holdings or reduced the duration (interest rate sensitivity) of their holdings, in anticipation of higher interest rates. Gold skyrocketed to $1,900 per ounce in 2011, after trading at $681 in October 2008, largely because of its value as a hedge against inflation.

Why have all these predictions, thus far, turned out to be incorrect?

**Show me the money**

There are many possible explanations for why the U.S. has not experienced significant inflation stemming from the Fed’s monetary policy actions. We will briefly explore two of the most compelling reasons why dramatic increases in prices have not occurred.

First, the broad money supply has not increased as sharply as many had expected. As the Federal Reserve purchased U.S. Treasury and mortgage bonds from 2008 to 2014, its assets increased significantly. This was referred...
to as the Fed “expanding its balance sheet,” and a chart showing the increase in the amount of assets owned by the Fed often accompanied analyses predicting higher inflation.

These actions did lead to a large and rapid increase in one measurement of the money supply—the narrowest measure, referred to as the “monetary base.” Under the multiple Fed programs, the monetary base increased from around $800 billion in 2008 to more than $4 trillion by 2014, quintupling in less than six years. This rise can be seen in Figure 2, with the red line depicting the increase in the monetary base as compared to its level on January 1, 2008.

The conventional wisdom was that the increased amount of money in the economy would inevitably be reflected in the prices of goods and services purchased by consumers. Normally, increases in the monetary base are multiplied greatly throughout the economy, as they generate loanable funds for banks to lend to consumers and businesses looking to buy goods or invest in new productive capital. These funds make up a broader measure of money supply, called M3, which includes the monetary base plus checking, savings, CD, and money market mutual fund balances.

What happened from 2008 through 2016, however, is that a much broader measure of the money supply saw only a fraction of the increase that occurred in the monetary base. Most of the increase in the monetary base was re-deposited back at the Federal Reserve (where it earned a very small but guaranteed return) rather than making its way into the broader economy.

As a result, the broad money supply, M3, did increase, but at a slower pace than expected. From an initial level of about $17 trillion in October 2008, M3 has increased to about $22 trillion as of May 2016. Over this 7.5-year period, that translates into an average annual increase of 3.8% in the money supply—roughly in line with the increase in nominal GDP. By contrast, the monetary base increased by approximately 20% annually over the same time period. The modest increase in the broad money supply has not been sufficient to produce significant inflation over the past several years.

A second reason why inflation has been muted since the recession is grounded in one of the most basic concepts in economics: the relationship of supply and demand and their impact on prices. The actions taken by the Federal Reserve were designed to spur consumer demand in the U.S. By holding short-term interest rates near zero, the Fed hoped to induce more spending and make borrowing less costly. Rather than increase debt by taking advantage of low interest rates, over-leveraged consumers have instead chosen to pay down debt; as a result, household debt relative to GDP has fallen steadily since the recession. This will likely result in a healthier and more stable economy in the long term, but it has meant a reduction in overall demand in the short term. A reduction in demand (or a lower-than-anticipated increase in demand) is accompanied by a lower-than-anticipated level of prices.

Supply, the other component of equilibri-
um pricing, has also had an effect on the level of inflation in the U.S. Two of the required inputs to the supply of goods and services are labor and raw materials. When these components are in plentiful supply, their costs remain low and they do not contribute to increasing inflation. The continued globalization of the workforce has brought an increasing supply of workers into the global economy and has thus exerted downward pressure on labor costs.

Commodity prices have also fallen sharply, as growth in emerging economies such as China has moderated from the very high levels of the past decade. As their growth has slowed, their need for raw materials has declined in tandem. Materials such as iron ore, coal, industrial metals, oil, and natural gas are highly sensitive to marginal changes in the supply-and-demand balance, so we have seen large readjustments in the equilibrium prices of these inputs.

**Low for longer?**

It is clear that the inflation anticipated by so many just a few years ago has not yet become a reality in the U.S. economy. In just the past couple of months, we have seen a slight increase in the annual inflation rate, but it remains below the target set by the Federal Reserve. Given the current leadership of the Fed, we expect that it will be very cautious and deliberate before raising rates, as policymakers have a greater fear of deflation (falling prices) than a modest uptick in inflation from its current low levels.

Because of the dovish outlook of the Fed, we don’t expect that the inflation rate will fall below its recent lows, seen in 2015 amid the collapse in commodity and energy prices. What we will be watching for is an acceleration in the growth of the broad money supply, which would occur if bank lending increases and the excess reserves currently held at the Fed make their way out into the real economy. The primary causes of rapidly increasing inflation, however, do not seem likely to reappear and hit us with a repeat of the massive inflationary wave of the 1970s and 1980s. The few remaining holdouts anticipating the specter of inflation may indeed find that it still remains further off than they’d originally feared.

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A Difficult Choice

BY STEPHEN J. Koca AND RICHARD B. LORD

If no news is good news, then PIAA members and other medical professional liability (MPL) insurers should be elated. Ten years of strong profitability have left them with massive stores of capital. But all is not well.

The relentless erosion of their market has also imbued them with a sense of foreboding about their future. How will they compete in a shrinking market? What will their role be? The answers lie much too far into the future, but the present does provide some hints about what may be ahead.

Over the past 10 to 15 years, the proportion of physicians who own their own practice has shrunk. One study by Accenture estimated that the figure was as low as 39% in 2012, down from 57% in 2000. But a benchmark survey by the American Medical Association (AMA) more optimistically pegged the number at 53% for 2012. That being said, the private physician market still contracted by 8% over the previous five years, according to the AMA survey.

No matter which starting point is used, though, the flight from private practice is undeniable. Over the years, independent physicians have been confronted with an onslaught of pressures, from reduced Medicare reimbursements to higher technology, costs that have taken their toll on income and fueled physicians’ decisions to seek employment in hospitals or group practices. The trend has only accelerated with implementation of the Affordable Care Act (ACA), whose payment incentives have added yet another stress to physicians’ top-line results.

During this time, MPL insurers have been fortunate to have enjoyed profitability strong enough to take the edge off the necessity of confronting this deep structural market change. But the time is drawing near when insurers will have to face the reality.

Tenuous steps

One option is to hunker down and try to sit out the storm of intensifying competition. Its effects are likely to first hit the specialty, single-state PIAA members that may lack the expertise to serve the risk needs of large hospital or group systems with broader reach. While these companies have excelled with vast expertise in their markets over the past 20 to 30 years, their limited scope and smaller capital base could make them fall victims to competitive market pressures and become acquisition targets of their larger, more diversified rivals.

Meanwhile, other PIAA insurers aren’t waiting for the inevitable; they’ve made strategic acquisitions to gain economies of scale, and have used some of their large store of capital to diversify into other products or sectors. Some are more active in the large MPL excess-insurance market, taking sizable layers of risk that are typically well above the primary layer that has been their base of expertise for many years. And few have also been more active as risk-facilitators instead of risk-takers, providing fronting arrangements and/or unbundled underwriting, risk, and claims services. As the underlying exposures have become more sophisticated in the alternative risk market, so too must the PIAA companies become more sophisticated in how they provide their services to these risks.

The continuing growth in captive insurance companies and risk retention groups is one example of the greater sophistication exhibited by the underlying risks. But frequently, a health system captive is not able to directly insure its affiliated physicians, and PIAA members can step in with a fronting arrangement, insuring the physicians but ceding the risk back to the captive.

For some MPL insurers whose premium base has already transitioned to employment within a hospital or large practice, a fronting arrangement has allowed them to maintain a connection with their formerly insured members. If the pendulum were to swing back in the direction of independent practices, or if a health system captive were to have a misstep and need to scale back, the MPL fronting company...

Stephen J. Koca, FCAS, MAAA, and Richard B. Lord, FCAS, MAAA, are Principals and Consulting Actuaries in the Los Angeles office of Milliman.
would be well positioned to pick up the risk it once had in the fully insured market.

Wisely exploited, a captive arrangement can provide MPL insurers with an opportunity to continue to play a role as one element in the risk-handling mechanism, in ways that go beyond a mere paper exchange. For example, a deeper value in the relationship could stem from the MPL fronting company’s ability to make use of one strategic asset still under its control: data on the physicians. With priority access to application and claims data, the MPL fronting company could build on its risk management services, moving from a defensive or purely preventive role to that of a strategic partner, by extracting latent information buried in the data that can be used to develop targeted improvements. By capitalizing on its expertise in analyzing and interpreting the data to determine major risk factors, for example, the MPL fronting company can cement its relationship with the captive and its physicians, and, at the same time boost the importance of its role.

The additional insight into the captive’s MPL risks has also provided some MPL fronting companies with a point of entry into the excess reinsurance market, a market that was previously largely untapped by PIIA insurers. But the close working relationship with a captive can provide an opportunity for the MPL fronting company to build distinct knowledge of the captive’s risks, based on which it could safely price the excess reinsurance that the captive or a health system might need.

**Sounds like a plan?**

But the fronting relationship comes at a considerable sacrifice. Since the fronting company does not bear the risk, it receives only a small percentage of the gross written premium. Pursued on a small scale, fronting

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**Figure 1. Medical Professional Liability 30-Year Net Earned Premium**

- **1986 to 1996:** 4.2% Annual Increase
- **1996 to 2006:** 7.4% Annual Increase

**Figure 2. Medical Professional Liability 10-Year Combined Ratio Results**

- **2006 to 2015:** 2.1% Annual Decrease
could serve as bridge between a fully insured model and the next phase of the MPL market, but widespread adoption of fronting as a new business model may cannibalize the companies’ revenue base. As more MPL insurers opt to front for captive programs, their revenues would fall, gradually at first, but then, at some point, the decrease could reach a tipping point and, from there, accelerate beyond expectations.

Such a potentially precipitous falloff in revenue would likely pressure insurers to either cut costs or, more likely, lower prices on their remaining fully insured business in order to maintain market share. Like the sudden and still somewhat unexplained drop in loss frequency in the last decade, MPL insurers could reach another inflection point, but this time with declines in revenue. Rather than benefiting from a surge in net income as they did when frequency decreased, in this case, MPL insurers could struggle to remain relevant.

But the decision to transform may not be entirely in the hands of the MPL insurers. Hospitals and large group practices have already adopted alternative risk platforms as a risk management strategy, setting in motion the wheels of change. It remains for MPL insurers to decide what role they will assume in the new market (Figure 1).

This scenario is admittedly couched in a number of “what ifs,” but it is still worth considering. Commercial MPL insurers’ premium base has contracted at unprecedented rates and this contraction shows little signs of easing. And while it is difficult to discern how much of the decrease in premium is due to competitive rate environments versus the departure of exposures for alternative risk programs, both pose their own separate concerns.

A little breathing room

More than a decade of positive operating results, led by significant reserve releases, has provided significant resources to explore and redefine roles where necessary. MPL insurers posted a combined ratio of 98% in 2015, marking the 10th straight year the MPL industry aggregate has been profitable even before the accounting of investment income.

However, creeping signs of difficulty continue to emerge as the 2015 combined ratio represents a 3-point deterioration from 2014, following immediately after what had been a 6-point deterioration from 2013 to 2014 (Figure 2).

The increase in combined ratio from 2014 to 2015 is largely related to a diminished release of prior-year reserves (i.e., the income that has typically been associated with reevaluation of losses on prior policy years). Meanwhile, despite the fact that the combined ratio is inching toward the break-even point before the investment barrier of 100%, policyholder dividends (or price competition by another name) have largely held steady, increasing slightly, at 4% of premiums returned to policyholders as a dividend during 2015.

Despite the slowdown, there are still likely some significant reserve releases remaining for future years, and MPL insurers may yet have some reprieve before they are forced to take more decisive action. What will it be? Competition, consolidation, and external market forces have defined the course of events in the past. But as markets change, the traditional insurers may have to evolve as well. TM&LA

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INGENUITY IN MEDICINE NEVER WANE

BY ERIC R. ANDERSON

Ingenious? Without question. In fact, these researchers are blazing a whole new trail by combining years of medical records with the minutiae of DNA sequence data. The work they are undertaking could change the practice of disease prevention in ways we could never have imagined.

But sometimes, unlike the example of using something as complex as genome science to solve a problem, the answer is right in front of you—you just have to see the forest for the trees.

Take the case of University of Alabama at Birmingham Medicine’s Stroke/Surgical Step Down unit, which had moved from an ICU environment, where nurses could look in and see their patients, to rooms with no windows. Because stroke patients tend to be at higher risk of falling than other patients, as the staff began working in their new unit, they found their inability to view the patients distressing.

What could be done? An assistant nurse manager and his colleague thought about the problem for a while—and then they had an epiphany. A week later, the nurse manager discovered a baby monitor in her in-box, with a brief note: “I have ever thought about using these?” That was a moment of clarity; a simple, but effective, solution had been discovered: ingenuity.

Now, the unit has seven baby monitors in use. And, according to UAB Medicine, the number of falls on the unit has dropped from 5.09 per 1,000 patient-days to 2.29. And, just as important, there have been 250 “near misses”—instances when a nurse went into a patient’s room before a fall, because something had been observed on a monitor.

So, as we think about the people we insure, let’s take a moment to applaud them for their ingenuity. Many of them continue to forge a path of progress in healthcare. It really doesn’t matter which road they both lead to the same place.

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