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One consistent thread running through this year’s MPL Association Conference in Portland, Oregon, was the importance of data and the role it is playing in the medical liability world. We heard it in conversations between sessions in the hallways and exhibit areas, and in presentations by some terrific speakers, many of whom had something to say about the data being collected and how it will shape the future, particularly in risk identification, risk management, patient safety, and the delivery of quality medical care.

In his thought-provoking look at the disruptive factors in today’s healthcare industry, nationally recognized healthcare industry expert Kevin Kennedy spoke about some of the forces we’re already confronting—consolidations, vertical integration, and new market entrants—along with how artificial intelligence is shaping medical decision making. The data we’re collecting through electronic health records is staggering, and our management of and security for that information is critical. Concomitantly, incessant and sophisticated threats are made every day to breach the newest safeguards of this data.

Wendy Chung, MD, PhD, Kennedy Family Professor of Pediatrics and Medicine at Columbia University, gave a fascinating talk about the implications of precision medicine. Certainly the information gathered through genetic testing and its use by clinicians and even patients can create new diagnostic and treatment breakthroughs but also opens our industry to evolving liability challenges. We will be keeping a close eye on this issue and its implications.

The challenge for healthcare organizations and MPL companies is sifting through the wide range of data that is currently available in a competitive marketplace and figuring out what is most significant and potentially impactful. That’s one of the goals of the MPL Association’s Data Sharing Project (DSP).

Launched in 1985, the DSP is the largest ongoing independent collaborative database of medical professional liability claims and lawsuits. It is a repository of hundreds of thousands of medical and dental professional claims data from companies. In addition, beginning in 2016, we began collecting hospital/health system professional liability claims.

Data from the DSP can be used to study claim patterns and pinpoint the areas of medical practice most vulnerable to MPL lawsuits. In addition, the MPL expense and indemnity information maintained in the DSP provides a valuable tool to further efforts to pursue and advise effective medical liability reform at all levels of government.

This issue’s cover story on predictive modeling benefits from the rich resources of the DSP. In a recent analysis of tens of thousands of claims closed between 2006 and 2015, significant variables emerged relating to indemnity and/or expense severity, and the article takes a broad look at what we found. This work is a key step in exploring claim frequency and severity with an eye toward mitigating future risk.

The DSP continues to be a unique tool available only to those organizations that contribute their anonymous data and in return have access to an interactive dashboard available that contrasts...
their detailed claims experience with a large portion of the MPL marketplace.

Also, in this issue, we are pleased to share some additional data analysis regarding the recent uptick in severity and case claims drawn from a database that includes professional liability for hospitals, nursing homes, and long-term care facilities. This analysis provides useful insights into a marketplace that many believe may be on the cusp of change.

Meanwhile, the past few years have included developments in some other parts of the world that may illustrate challenges to physicians and MPL organizations, as health delivery evolves and government bodies may not always strike the correct balance when trying to protect the public’s interests while supporting the practice of medicine. The article by Ian Barker in the U.K. looks at the now infamous case of Dr. Hadiza Bawa-Garba that resulted in findings of gross negligent manslaughter. These and other recent developments are posing great challenges in the U.K. to those who practice medicine and the organizations that provide their medical liability protection and support.

As we look toward the future using what we learn from the past, we hope the valuable content and shared knowledge that come from attending our programs, reading our publications, and taking advantage of other Association resources help contribute to growth, learning, and greater expertise in our industry.
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“In a data-intensive world, MPL needs to be analytic, conclusive to the extent possible, and predictive.”
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COMING ATTRACTIONS

EVENTS & CALENDAR

Technology, Human Resources, and Finance Workshop
September 25-27, 2019
Fairmont Millennium Park, Chicago, IL

Information Technology Track
Disaster Recovery in the Cloud
As cloud services become more abundant, affordable, and secure, companies are exploring the various options for leveraging those services. One of the more intriguing new applications is in moving the disaster recovery (DR) function to the cloud, thereby avoiding the costly capital expenses that are required for equipment that has traditionally sat idle in a colocation. Attendees will hear from two presenters, who will share their first-hand experience in innovative ways to utilize the cloud—not just for DR, but also for their complete production environment.

Human Resources Track
The Impact of the Talent War on MPL Companies
The insurance industry is now in the midst of unprecedented new dynamic in its workforce: there is intense competition for people in all of its constitutive disciplines, and this can lead to unfulfilled business goals, if key positions remain open for an extended period of time. So, how can MPL companies adapt to this challenging environment, and still maintain their unique character as doctor-directed insurance companies? This session will feature four concise presentations, followed by an engaging discussion with experts in the field. After this session, participants will be able to understand the current recruitment climate, and know about some effective strategies for recruiting and retaining employees.

Finance Track
Data Analytics
Industry experts will provide an overview of the diverse applications of analytics, drawing on both internal and external data. Analytics are being used to gain valuable insights into emerging MPL trends. The presenters will discuss the new areas of emerging liability within telemedicine and wearable technology. The presenters will also explain how MPL insurance companies have been able to extract valuable information from internal claims data, which allows them to zero in on the root cause of the alleged negligence.

2019 Introduction to Medical Professional Liability Insurance Workshop
October 17-18, 2019
Hilton Alexandria Old Town, Alexandria, VA
This one-of-a-kind event is specifically designed for professionals who want to learn the fundamentals of the MPL business! Given the multiplicity of variables and disciplines involved, the operations of an MPL insurer are inherently complex. The event isn't just for industry newcomers. It's also valuable for longer-term employees who need to broaden their understanding of this sector, as well as everyone new to governance in an MPL Association member company. The workshop will expand their knowledge of the foundational concepts of MPL, as well as what's involved in the day-to-day operation of MPL insurance entities. Key topics discussed will 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 MPL Association members and nonmembers.

For continuing education information and special pricing details, visit MPLAssociation.org.
Some risks are simply more complex

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

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Download Tackling the Complex Challenges of Medical Professional Liability Insurance at info.duckcreek.com/MPL
How a Plaintiff Can Find a Worthy Attorney

The internet, as we know, has advice on nearly every possible topic, including the tricky assignment of selecting an attorney for an MPL claim in Texas. Observer has culled the following from a recent search on the latest advice for picking a plaintiff attorney:

- "Many people who are suffering from injuries and harm caused by medical errors have never hired an attorney before—for any reason. Some are tempted to take the easy route of calling a lawyer who they’ve seen on a TV or billboard ad. I can quickly tell you that this isn’t the best way to find a Texas medical malpractice attorney who can help you.
- "Medical malpractice law in Texas is complicated and challenging and requires an attorney who understands exacting requirements for things like pre-suit notice, the pre-suit disclosure of treaters and health records release, the ‘Chapter 74’ expert report requirement [it’s not likely future plaintiffs will have heard of Chapter 74, and thus a whole new search task will be needed], medical experts, and much more.
- "For each attorney that you consider, write down the answers to these questions, which you can easily find online.”

Observer’s pick, from among the myriad of important questions, is this: “Is the law firm established in the community, with a real office? Look for a photo of their office on their website, or search their address on Google Maps.”

In this regard, any building depicted that looks too much like a classic Pizza Hut, with its architectural giveaways, a perimeter composed almost entirely of trapezoids with a distinctive roof hump, may be little more than an illusion, plaintiff-attorney-wise.  

Source: www.painterlawfirm.com

Ontario Doctor Wins Cyber Libel Case Against Malicious Web Critic

Time for a small celebration?

Kingston, Ontario, doctor has won $50,000 in damages in a cyber libel case against a man who used RateMDs.com, a website where physicians are reviewed by patients, to attack the infectious disease specialist. In a recent decision, Ontario Superior Court Justice Graeme Mew also granted Dr. Dick Zoutman’s request for a permanent injunction against James Graham, prohibiting Graham from ever writing, speaking, publishing, or posting anything online about the physician.

"Mr. Graham is actuated by malice,” Judge Mew said. “It seems likely that there will be further reoccurrences if Mr. Graham’s conduct is not enjoined by an order of this court.”

The judge awarded Dr. Zoutman both general and aggravated damages in recognition of Graham’s persistent and malicious campaign that lasted about a year and a half.

Earlier this year, during two days of testimony in a Kingston courtroom, the judge heard that Graham had never been a patient of Zoutman.

Their only interaction came in a Hamilton courtroom, where Dr. Zoutman appeared as an expert witness in a 2013 medical professional liability suit. That lawsuit concerned the death of Graham’s brother, Matthew, 36, who contracted a fatal infection after elective surgery at Hamilton’s Juravinski Hospital. Dr. Zoutman offered his opinion on the patient’s treatment and care. (The suit was ultimately dismissed by a jury.)

One day after Zoutman’s testimony, Graham posted a review on RateMDs.com in which he gave the physician one star out of five for his helpfulness and knowledge despite never having stepped foot in his office.

Subpoenaed information from RateMDs.com showed that four defamatory postings came from the same IP address as the one to which Graham admitted authorship.

Graham claimed the posts amounted to fair comment since they were designed to warn prospective patients. But the judge rejected that argument, noting that Graham did not have a factual basis for his opinions—not least because he had never been treated by Zoutman.

Dr. Zoutman told the court that Graham’s reviews damaged his hard-won professional reputation and caused him distress. The doctor said he still lives with “the constant apprehension that a new posting from (Graham) will appear.”

Source: Ottawa Citizen, May 18, 2019
The MPL Association hosted member company leaders from across the country during its recent medical professional liability insurance industry Capitol Hill Day. The event kicked off with participants, including senior executives and healthcare professionals, hearing political and legislative updates from congressional aides and industry allies. MPL Association members met with congressional leaders to educate them on key legislative and policy issues, including the Good Samaritan Health Professionals Act, telemedicine liability, cybersecurity, and federal tort reform. The meetings were especially timely given that many of these issues are not partisan in nature, and thus even the current divided Congress could consider them before the 2020 elections.

"It is important for leaders from the MPL community to come together in the nation’s capital so they can deliver their messages directly to lawmakers," said MPL Association Vice President of Government Relations & Public Policy Mike Stinson. "Even the best lobbying efforts are improved when Members of Congress hear from their constituents. Personal, one-on-one meetings are a powerful way of educating federal lawmakers; and it is through these efforts that the interests of the Association’s members, as well as the interests of the healthcare professionals they insure and their patients will be advanced," he added.
It is true that the most profitable insurance companies have the best management information (reporting) systems? Having good reports will not necessarily lead to profits—but the opposite may well be true.

Whether there is a causative link between profitability and the quality of the management information that is available can be debated, but without question, having timely access to information can have a significant influence on the ability of a company to achieve its objectives.

An MIS is a computerized database of financial information from all of the operating units and functions within the company, organized and programmed in such a way that it produces regular reports on operations for every level of management in a company. It is also usually possible to obtain special reports from the system easily. The main purpose of the MIS is to give managers feedback about their own performance. Top management can monitor the company as a whole; information displayed by the MIS typically shows “actual” data against “planned” results, and results from a year before, so that it is possible to measure progress against goals.

Traditionally, most MISs have concentrated on the financial performance of the company. However, it is also important to monitor the non-financial aspects of a company’s operation, such as customer satisfaction, in order to get a more complete picture of current and likely future performance. This can be achieved by the “balanced scorecard” technique, which is designed to give managers a presentation that combines both the financial and operational measures.

There are three main categories of MIS

- **Transaction processing systems.** These produce regularly scheduled reports, based on data extracted and summarized from the operational data, to identify and inform decisions. These reports are used by department and middle managers. There can be some control over the format and selection criteria when the reports are requested, but in general, the format is fixed. Examples of these reports would be a “Loss Reserve Register,” “Aged Open Item Receivables,” or an “Unearned Premium Report.”
- **Decision support systems (DSS).** These systems are software applications used by middle and higher management to compile information from a wide range of sources, to support problem-solving and decision-making. A DSS—often called an ad hoc reporting tool—is used mostly for semi-structured and unstructured decision problems.
- **Executive information systems (EIS).** This type of MIS is a reporting tool that provides quick access to summarized reports coming from all levels and departments of a company, such as accounting, human resources, and operations. The content from the EIS is generally used by senior management to get a snapshot of the performance of the company. It is often referred to as a “dashboard,” with key performance indicators highlighted and included drill-down capabilities so that users can obtain supporting details.

It is informative to consider the possible criteria that we can use to judge whether a particular piece of management information is effective and useful for those who may request it. Is it actionable information?

Does MIS help a company gain a competitive advantage? A competitive advantage is a firm’s ability to do something better, faster, cheaper, or uniquely, when compared with rival firms in the market.

Is the presentation of data helpful in interpretation, and can it be presented without being reworked?
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Can the reports be linked in a direct way to the decision-making process? Can the information act as a communication and planning tool?

- Does the information have sufficient breadth and depth? Do the reports convey an overall picture of the company?
- Is the information up-to-date and regularly updated at appropriate times?
- Is the information sufficiently accurate for its purpose?
- Is the process of collecting and providing the information cost-effective?
- Do the reports help to identify the company's strengths and weaknesses as early as possible? This can help a company improve its business processes and operations.
- Does the data contain customer information and feedback to help the company to align its business processes according to the needs of its customers?

The other way to judge executive information is by relating it to the functions and responsibilities of those that receive it. Does the information serve the mission of the user? The following are some key examples.

For board and senior management, check to see if the reports help with:
- Ensuring they obtain adequate return on capital for the level of risk accepted
- Ensuring that the level of risk accepted is in line with shareholders' expectations
- Protecting the capital of the company
- Raising additional capital
- Authorizing and monitoring expenditure.

Underwriting staff would be concerned with data to support:
- Pricing and selection of risks
- Monitoring accumulations
- Tracking growth and profitability
- Assessment of expenses
- Purchasing of reinsurance
- Service levels to the customer, for example, the time to issue a new policy.
- The “hit ratio” of quotes, and the reasons for declines
- Business retention—why policies are cancelled or non-renewed
- Underwriting expense ratio.

Claims staff would look at data to assist with:
- Controlling the overall cost of claims
- Satisfying needs of customers by looking at claim settlement time and other service-related metrics
- Applying appropriate claims management practices
- Recommending best estimates of reserves.

Finance management would need data to support:
- Recommending and payment of dividends
- Ensuring compliance with the relevant legislation and regulations
- Setting guidelines for, and monitoring, the executive
- Combined loss ratios.

An “information audit” is an exercise to identify company-wide gaps in the data in order to guide the progress of MIS. What questions are still unanswered because of insufficient information? That’s a good place for management to start.

For related information, see www.Delphi-Tech.com.
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Second Chair
Make better Litigation Decisions
As we pass the midpoint of the year, we have an excellent opportunity to contrast state and federal legislative bodies. A bitterly partisan Congress, as has become the norm, has accomplished relatively little, and done almost nothing on medical professional liability (MPL) issues. Despite extensive lobbying efforts, only one chamber has introduced the Good Samaritan Health Professionals Act, and our preferred tort reform legislation is still awaiting introduction. There is still sufficient time, however, to push our congressional agenda, so all hope is not lost. On the other hand, roughly 60% of state legislatures have already concluded their activities for 2019, so we have an opportunity for a reasonable assessment of their impact on the MPL industry. The impact, thus far, has not been insignificant.

Success
The legislative year started off on a positive note, when the Pennsylvania Senate passed S.R. 20, calling for the Legislative Budget & Finance Committee to review and analyze a proposed change to the Commonwealth’s civil venue rules. The legislation came in response to a surreptitious effort (the proposal was released on a Saturday, just three days before Christmas) by the state Supreme Court to reinstate rules that allowed the plaintiffs’ bar tovenue shop, in order to get cases that had no connection to Philadelphia or Pittsburgh into those decidedly defendant-unfriendly courts. Based on the senate’s action, the Supreme Court agreed to refrain from making any changes before the committee releases a report on the issue by January 2020. The MPL Association was pleased to work with local stakeholders and member companies to support the effort to protect the current venue rules.

Legislators in Kentucky continued their efforts to reform the MPL system there, by creating a certificate-of-merit requirement. Under the bill, H.B. 429, any individual filing an MPL claim must have a certificate of merit to accompany their claim. The new law requires that the certificate must be signed by an individual who has the appropriate qualifications to serve as an expert witness in the given case, who is familiar with the issues raised by the claim, and who will attest that there is a “reasonable basis” for filing the claim. The bill, which comes right on the heels of the Kentucky Supreme Court’s rejection of medical review panels, became law without the governor’s signature.

Not all of the legislative results that are positive for MPL come through the passage of legislation. Case in point: The MPL industry scored a huge victory in Oregon in June when it defeated H.B. 2014. That bill would have eliminated the noneconomic damage cap (set
at $500,000) for bodily injury cases, while maintaining it for wrongful death claims. While the bill overwhelmingly passed in the state House of Representatives, a successful advocacy effort in the Senate secured a one-vote margin to defeat the ill-advised legislation.

Disappointments
Unfortunately, not all the legislative news from the states was good. In Maine, the Legislature approved a bill (L.D. 841) to increase the cap on noneconomic damages in wrongful death cases by 50%, from $500,000 to $750,000. While this was certainly not the result for which the industry had hoped, the final bill was an improvement over the bill as first introduced, which would have raised the cap to $1 million, eliminated the state's cap on punitive damages, and allowed for damages based on “the probable duration of life of the deceased person but for the injury.”

Shifting focus to the West Coast, wrongful death was also a key issue for Washington state legislators. That state approved S.B. 5163, to greatly expand the pool of individuals eligible to seek damages in a wrongful death claim, as well as the list of injuries for which they may make claims. Under the new law, which takes effect on July 28 of this year, non-U.S. residents who are parents or siblings of the deceased will be able to file wrongful death suits in the state. In addition, parents of the deceased will be able to file wrongful death suits in the state. In addition, parents will no longer be required to demonstrate financial dependency on a deceased adult child in order to file suit; they can simply claim that they had “significant involvement” in the deceased’s life.

Finally, in Colorado, the Legislature approved S.B. 109, which increases the state’s noneconomic damage caps to account for inflation. The new law will raise the damage caps on January 1, 2020, and every two years thereafter, in perpetuity. The good news is that law does not apply to MPL claims. The bad news is that passage of the bill is likely to encourage the plaintiffs’ bar to go after the damage caps in MPL cases as its next target.

To be determined
Whether other bills that passed this year are “good” or “bad” may depend on one's perspective, and on what the alternatives to those bills happened to be. Several new state laws clearly fall into this category.

Two states, Mississippi and Alabama, enacted cybersecurity bills based on the National Association of Insurance Commissioner’s (NAIC) Insurance Data Security Model Act. Both bills include exemptions from the requirement to maintain written cybersecurity protocols for smaller insurers (based on the number of employees, annual revenue, or total assets of the company).

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The Mississippi bill (S.B. 2831) also specifies that the exemption applies to insurers that are HIPPA-compliant, while the Alabama bill (S.B. 54) exempts HIPPA-compliant insurers from the entire law. These states joined South Carolina, Ohio, and Michigan as early adopters of the NAIC model act.

Elsewhere in the South, South Carolina took decisive action to address substantial shortfalls in its Joint Underwriting Association (JUA) and Patient Compensation Fund (PCF). H. 3760 was the subject of significant discussion and debate for months, as stakeholders, legislators, and the state’s insurance department worked to find an equitable way to resolve the issue. In the end, what passed was a bill that merges the state’s JUA and PCF into a new entity called the South Carolina Medical Malpractice Association, and it gives MPL insurers a significant role on the Association’s board. It levies an assessment on all liability insurers, until the association’s deficits have been addressed, but allows non-MPL carriers to pay a one-time fee if they wish to withdraw from the new association. The law also includes requirements to ensure that the association is self-sustaining in the future, and that it functions as a true insurer of last resort. The Department of Insurance is now holding monthly meetings with interested parties to discuss how the law will be implemented.

**Conclusion**

With more than a dozen states still working on legislative activities, more could certainly still happen, but the discussion here should provide you with a good summary of the types of legislation we’ve seen this year and the direction that at least some legislatures are looking to pursue on MPL issues in the future. So, what’s next? While it’s impossible to say exactly what legislation will be proposed in a given state, it’s clear that the plaintiffs’ bar sees a winning formula in attacking wrongful death claims in an effort to increase the numbers of these claims and the awards associated with them. In addition, many states are likely to consider insurance-specific data security laws in the months, and years, ahead. MPL Association members should be prepared for both of these possibilities.

Being prepared, however, does not mean going it alone. The MPL Association stands ready to assist you in your legislative activities in numerous ways. We can provide data to support your advocacy efforts. We can provide strategy and intelligence on issues that we’ve seen arise in other states. And when fast, effective communications with elected officials can make the difference between success and failure, our grassroots system allows your colleagues, insureds, and others to quickly and easily contact their state legislators to express their support for, or opposition to, any piece of state legislation on which you are conducting an advocacy effort.

With Congress likely to remain in perpetual gridlock, state legislatures will continue to be the battleground where lobbying and advocacy activities are most critical. We look forward to helping you achieve legislative success, no matter what issues your company faces in the future. **MPL**
should physicians apologize in the face of an adverse medical outcome? Or, is it likely that such an apology would only serve to undermine defense arguments in the event of litigation? In fact, the answer depends on the jurisdiction where the incident occurred.

Apology statutes
So-called “apology statutes,” by now enacted in a majority of states, address the admissibility of medical providers’ statements, affirmations, gestures, or conduct expressing apology, fault, regret, sympathy, commiseration, or a general sense of benevolence. Typically, such statutes apply to any civil action or arbitration alleging medical malpractice against a healthcare provider.

Statements generally fall within the purview of “apology statutes” when the expressions or gestures are made by a healthcare provider or the provider’s employee to a patient, a relative of the patient, or a patient’s healthcare decision-maker. Such statutes generally apply to expressions made orally, through conduct, or in writing, and the scope of the expression has been interpreted to include mention of the patient’s discomfort, pain, suffering, injury, or death related to an unanticipated outcome of medical treatment or care.

Most states with apology statutes deem statements or gestures of apology, sympathy, compassion, or benevolence inadmissible as evidence of an admission of liability or as an admission against interest in a civil action. Admissions of fault, liability, or negligence, however, may be admissible in certain jurisdictions. Where an “apology statute” renders inadmissible a healthcare provider’s expression of apology regarding an “allegedly negligent medical outcome for which the provider is being sued,” there may lay an exception as to the healthcare provider’s “admission of liability or fault.”

Frequently, courts need to conduct a fact-based, case-by-case analysis to distinguish between what constitutes an apology versus an admission of fault or liability. A statement that “I am so sorry [for] what I have done,” however, was deemed inadmissible, as it constituted a simple expression of an “ordinary statement of apology.” Moreover, courts may admit portions of letters or statements that contain admissions of fault, even when the statements are coupled with others that may remain inadmissible.

The statements were admissible; they were not offered merely to console or offer sympathy to the plaintiff, but were, instead, characterized by the court as direct admissions of fault or liability. A statement that “I am so sorry [for] what I have done,” however, was deemed inadmissible, as it constituted a simple expression of an “ordinary statement of apology.” Moreover, courts may admit portions of letters or statements that contain admissions of fault, even when the statements are coupled with others that may remain inadmissible.

Related statutory provisions
Topics related to a medical professional’s expression of sympathy or apology are addressed by a number of states where specific statutory provisions on apologies have
not been enacted. For example, some states deem evidence of a healthcare provider’s or medical professional liability (MPL) insurance company’s payment, or promise to pay, medical, hospital, or related expenses occasioned by an injury inadmissible when offered as proof of liability for the injury. Other states without statutes pertaining to expressions of sympathy or apology in MPL actions address such statements in the context of an accident. California and Florida deem an expression of sympathy or a general sense of benevolence related to the pain, suffering, or death of an accident victim and made to the person or the person’s family inadmissible as evidence of liability; however, a statement of fault is admissible in those states. 11

**Communication and resolution**

Legislation regarding medical professionals’ expressions to patients or their families after an adverse outcome reflects the fact that apologies may mitigate the anger and frustration that drive some potential plaintiffs to file lawsuits. According to a study published in the *Journal of Patient Safety and Risk Management*, hospital staff and doctors willing to discuss, apologize for, and resolve adverse medical events through a “collaborative communication resolution program” experienced a significant decrease in legal claims, defense costs, liability costs, and time required to close cases.13 In 2017, consistent with studies demonstrating the efficacy of resolution programs as a means of learning from “medical errors and near misses,” enhancing patient safety, and improving the liability system, the American Medical Association expressed its support for a pre-litigation option.14

Notwithstanding the existence of apology legislation in a number of jurisdictions, many institutions have adopted an attitude that promotes acknowledgement of an adverse outcome and support for the patient. This approach is highlighted by *The Washington Post’s* illustration of the impact of medical providers’ divergent responses to two patients who suffered devastating consequences during surgery.15 Following a surgical procedure that did not proceed routinely, the first patient spent weeks in a coma, endured five surgeries to correct medical errors, and suffers from permanent injuries. The patient’s quest for an explanation, met by “a white wall of silence,” drove the victim to spend years seeking elusive answers as to what went wrong. In stark contrast, another patient, rendered quadriplegic following surgery, was immediately provided with an apology from his surgeon and an explanation for the events that led to his injury. Following the communication of what had transpired, the patient and an explanation for the events that led to his injury. The hospital paid for the patient’s rehabilitation and additional significant expenses, thereby negotiating an undisclosed settlement—without litigation.

**The apology dilemma**

Notwithstanding our increasing litigious society, the fact remains that a negative medical outcome does not necessarily equate to medical malpractice. In the wake of an adverse event, physicians often face a conundrum as they consider whether to express regret or sympathy or even to extend an apology to the patient and his or her loved ones. Physicians may choose to avoid entirely a discussion of an adverse outcome, due to fear of MPL litigation, but such a decision may leave patients and their loved ones feeling even further victimized, as they grapple with the impact of an unanticipated medical outcome, while believing that they have been abandoned by their physician.

While the victims’ feelings of abandonment can trigger the filing of MPL lawsuits, physicians may be wise to pause before they make any statement or gesture of regret, sympathy, benevolence, or apology. As the language of apologies or expressions of sympathy may be nuanced and vary among jurisdictions, physicians should consult with counsel in their respective states before an adverse medical outcome arises. This proactive approach enables physicians to fully understand the potential impact of expressions of apology, sympathy, or benevolence—in the context of the language and scope of any applicable law.

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**For related information, see** www.wilsonelser.com.

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**References**

4. Id.  
5. Id; see also, DeBussy v. Graybeal, 2016 Del. Super. LEXIS 616.  
7. Honey and DeBussy.  
Cyber Risks. Human Solutions.

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Lessons Learned from Analysis of Periprocedural Aspiration MPL Claims

My study, entitled “Periprocedural pulmonary aspiration: An analysis of medical malpractice cases and alleged causative factors,” was born of a desire to more precisely identify the causative mechanisms in aspiration events.

Anesthesiologists greatly fear aspiration and its sequelae for patients, which can include pneumonitis, pneumonia, and a requirement for prolonged postoperative mechanical ventilation.

Practice guidelines published by the American Society of Anesthesiologists recommend NPO (nil per os) durations of between two and eight hours for various liquids and solids ingested, and they state that gastrointestinal stimulants such as metoclopramide, antacids, or medications blocking gastric acid secretion “may” be given to patients at increased risk of aspiration. However, no other specific aspiration-prevention recommendations are provided, so anesthesiologists must rely on other means of identifying high-risk patients and modifying their practices accordingly.

I wrote that my study “demonstrates that careful review of medical professional liability litigation can elucidate common contributory factors and facilitate improvements in clinical practice and decision-making.”

I reviewed the details of each periprocedural pulmonary aspiration lawsuit published in a large nationwide legal database, VerdictSearch, to obtain a clearer picture of the mechanisms implicated.

The most common alleged mechanism for aspiration was failure to secure the patient’s airway with an endotracheal tube (ETT) perioperatively when an elevated risk existed, cited in 37% of claims. Next most common (33%) was the failure to perform a rapid-sequence induction (RSI), including the application of cricoid pressure, and/or place a nasogastric tube (NGT) for decompression prior to induction. Poor case timing was allegedly the cause of aspiration in 16.3% of cases. In 57.1% of these cases, it was argued that surgery ought to have been delayed until a condition leading to elevated aspiration risk had been resolved, and these ranged from increasing abdominal distension despite NGT, to ongoing projectile emesis, to inadequate NPO time, to witnessed aspiration the previous evening.

Other cases in the “poor timing” category alleged that failure to cancel a procedure already in progress caused harm, including an orthopedic surgical procedure where aspiration had occurred on induction, and surgeons continued advancement of an esophagogastroduodenoscopy (EGD) probe despite visualization of food in the stomach (with a non-secured airway). The final case in this category alleged that an orthopedic procedure, which was delayed due to elevated aspiration risk from inadequate NPO status, should have been performed sooner to minimize the risk of permanent nerve damage. Premature extubation, aspiration after excessive administration of anesthetic or sedating medications, and aspiration of a portion of an ETT comprised the rest of the aspiration data set.

Applications

The first important application of my findings to clinical practice is that the failure to perform RSI and/or place an NGT is among the

Ashley Szabo Eltorai, MD, is assistant professor of anesthesiology, Yale School of Medicine.
most common alleged mechanisms in aspiration litigation, despite the paucity of evidence of these procedures’ efficacy in reducing aspiration risk. Cricoid pressure, originally described in 1961, was declared efficacious when, out of a study population of 26 patients deemed at high risk for aspiration, three immediately regurgitated gastrointestinal tract contents after cricoid pressure was released; however, this was not a randomized controlled trial (RCT). A recent large RCT of cricoid pressure versus a sham procedure did show increased intubation time in the cricoid-pressure group, but it failed to demonstrate noninferiority of the sham procedure, because the incidence of aspiration was overestimated, and no other RCTs exist aside from one very small trial. One study even found that cricoid pressure decreased lower esophageal sphincter tone, which could paradoxically increase the risk of aspiration.

Nonetheless, because these procedures are currently widely employed by anesthesiologists concerned about elevated aspiration risk, litigation frequently ensues after what is judged to be failure to uphold the current standard of care, even though the published evidence is quite weak. Though future research should critically examine RSI and NGT placement in RCT format, fear of litigation will undoubtedly influence countless anesthesiologists to continue these practices even in the absence of this data. When juries consistently align with current practice standards despite a paucity of evidence, they de-incentivize clinicians to make carefully considered, individualized decisions or to invest in research undertakings that more critically examine current practice.

Overall, my study elucidates the precise circumstances in which aspiration-related MPL litigation is pursued, highlighting the extent to which clinicians are held to currently accepted standards of practice (such as RSI), even when strong evidence for such practice does not exist. Knowledge of other allegation categories, such as premature extubation and failure to cancel a surgical procedure and anesthetic in the face of heightened aspiration risk, will only enhance clinical practice by prompting providers to think carefully about the risks versus benefits of every decision.

References

For related information, see https://medicine.yale.edu/anesthesiology.
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Bringing Predictive Modeling to the DSP: An Investigation of Claim Severity

By Emilie Dubois, Alison Milford, and P. Divya Parikh
In studying the drivers of medical professional liability (MPL) claims, there is an ongoing need to find reliable ways to identify and mitigate risk and to control costs. In a data-intensive world, MPL needs to be analytic, conclusive to the extent possible, and predictive. For these reasons, predictive models are more important than ever for making sense of the information we have and for estimating and planning for what might happen in the future.

The Medical Professional Liability Association (MPL Association) has been collecting data on closed claims, via its Data Sharing Project (DSP), since 1985. Today, this data includes details on the type of events that gave rise to the claim, among many other data elements. Analyses of the DSP data have provided a foundation for risk management and patient safety programs for MPL Association insurers for decades, and this effort continues today. The DSP database contains more than 300,000 claims closed between 1985 and 2017 (approximately 29% of the claims closed with an indemnity payment), representing $22 billion in indemnity payments and $9 billion in defense costs.

Information is voluntarily submitted to the DSP semiannually from a subgroup of MPL Association member companies. This article presents a summary of one predictive model that was constructed with the DSP data. (Greater detail is presented in a forthcoming white paper on this project, to be published later this year.) In this context, predictive modeling is understood to be the use of statistical techniques to extract knowledge from large volumes of data. It is the use of data and models that are empirically derived and statistically valid to make decisions and inform actions.

**Methodology**

Predictive modeling, one type of multivariate analysis, makes possible simultaneous consideration of many variables, as well as the assessment of their overall effect. When a large set of claims is analyzed, patterns begin to emerge, revealing a number of characteristics to consider.

More specifically, the analysis discussed here relies on generalized linear models, a predictive modeling approach that is commonly used in the insurance industry. Such models have many potential uses throughout the insurance business, including pricing and underwriting, marketing, claims, and risk management.

The goal in this analysis is to understand the drivers of claim severity, on the assumption that if we understand the particular circumstances that are likely to give rise to large claims, the severity can be mitigated, avoided altogether, or at least better managed once reported to the insurance carrier. Note that the DSP data cannot be used to analyze claim frequency because criteria were established at the outset of the

**Table 1. Model Variables by Importance**

<table>
<thead>
<tr>
<th>Model Variables by Importance</th>
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</thead>
<tbody>
<tr>
<td>Outcome (e.g., infection, disease, cancer)</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>Important</td>
</tr>
<tr>
<td>Chief medical factor (e.g., communication, diagnostic error)</td>
</tr>
<tr>
<td>Patient age</td>
</tr>
<tr>
<td>Procedure (e.g., physical exam, surgery)</td>
</tr>
<tr>
<td>Less Important</td>
</tr>
<tr>
<td>Facility (e.g., hospital, physician office)</td>
</tr>
<tr>
<td>Full time / part time</td>
</tr>
<tr>
<td>Insured gender</td>
</tr>
<tr>
<td>Patient gender</td>
</tr>
<tr>
<td>Patient gender / patient age interaction</td>
</tr>
<tr>
<td>Specialty</td>
</tr>
</tbody>
</table>

Footnote: Within each importance group, variables are listed alphabetically, not ranked. In addition, we have excluded the control variables of coverage type, policy limit, and report year.

DSP to intentionally exclude any information that might be used for competitive rate-making purposes, including insured counts.

For this analysis, we focus on DSP claims settled between 2006 and 2015. Two models were built, one for each of two target variables: (1) paid indemnity and (2) paid expense. The final data set for the indemnity model, which will be the focus of our discussion here, includes approximately 24,000 claims. (The complete analysis is reviewed in the white paper.)

The data set includes 24 potential explanatory variables. Various interactions are studied by analyzing the combined impact of multiple explanatory variables. Because the objective of the modeling exercise is to provide information for claims or risk management professionals, the variables reviewed are limited to those that could reasonably be known from an initial investigation of the claim. For this reason, claim outcome variables are excluded from the modeling exercise.

The indemnity model includes nine variables and one interaction variable that combines multiple factors, in addition to the control variables of state, policy limit, coverage type, and report year. In Table 1, the full listing of variables included in the model is shown with a broad ranking of their relative importance, as defined by the magnitude of their impact on claim severity. The two most important variables are found to be medical outcome and state. Chief medical factor, patient age, and med-
The results for the key model variables are summarized as a relativity for each variable level. For each variable, a base level was selected as the reference point. The relativity for this base level is 1.00, and the results for all other levels are expressed relative to this base level. For example, a variable level with an indicated relativity of 2.00 implies that, in the context of this multivariate analysis, the level has an average severity that is twice that of the base level, holding all other factors constant. Thus, each relativity indicates the impact of that particular variable alone.

Also included in the results is the observed average relativity. This is the typical result of a univariate analysis, which will thereby reflect the impact of any correlation across variable levels, since all of the other factors are not held constant. The results of a few variables are highlighted below; a more complete discussion of the model results can be found in the white paper.

In Figure 1, a univariate review of the data indicates that female physicians have lower-severity claims, on average. However, female physicians in this data set are more likely to work part-time, are disproportionately concentrated in certain specialties, and are more likely to perform certain types of procedures, thereby potentially confounding the impact of gender on claim severity. Our model was used to isolate the impact of the single factor, physician gender, and in fact indicates a greater impact from physician gender on indemnity severity—an approximately 8.5% lower severity for female physicians with otherwise similar claims.

In Figure 2, medical procedures are ordered from less invasive (including the base class of general physical exam) on the left to more invasive (surgical) procedures on the right. Procedures are grouped by bodily system. For several less invasive procedures, the relativity as obtained from the model is broadly in line with the relativity derived from a univariate analysis. However, the observed average severities based on the data for claims related to most surgical procedures are lower than the average severity for claims associated with general physical exams, an unexpected result. The results for the model-derived severities for surgical procedures are more in line with what one might anticipate. Once other factors are controlled for, the average severity for surgical procedures is expected to be higher than that associated with general physical exams, as indicated by the fact that most of the severities are greater than 1.00, and only the severities for the generally less invasive surgeries (skin, eyes, nose, mouth, throat) are less than 1.00.

**Potential model applications**

Risk management/patient safety and claims departments are the two areas most likely to benefit from applications of these results. One potential application is based on a claim-scoring exercise. Scoring a claim involves deriving the expected indemnity for the claim, based on its specific characteristics and the associated model-derived severities. The expected severity for each claim can then be used in sorting a batch of claims.

Once the claims are sorted, claims identified as high or low severity can be analyzed to determine which groups of factors tend to be associated with particular severity outcomes. The results of such an exercise can be used to answer any number of questions, including:

- What risk management programs can be designed or improved to reduce payouts?
- Are the limited resources of claims departments being deployed in an optimal way?

The results of this sort of exercise may serve to confirm current knowledge of claim outcomes. For instance, it is well known in the MPL community that claims related to adverse birth outcomes have a higher than average severity. It is likely, however, that such an exercise, if based on a sufficiently rich data source, will identify pairs, or groups, of characteristics associated with high-severity outcomes not previously known that may be difficult to identify based on univariate analysis alone. The multivariate analysis would of necessity combine medical and analytical expertise.

Thus, the analysis described here is only a starting point for the many possibilities in future research and investigation. As expected, the multivariate analysis of thousands of claims showed that variables related to the medical features of the case, including the outcome of the medical interaction at issue, the medical procedure involved, and the chief medical factor in the claim, have a significant relationship to the eventual size of the claim payment. Multivariate analysis of claim...
severity has significant potential benefit for risk management and claims departments: it allows combinations of characteristics contributing to claim severity to be identified and, possibly, mitigated.

Future research opportunities beyond this review of the DSP are abundant, with the potential for additional detailed modeling of claim severity, similar modeling of claim frequency, and deeper analysis of the applications of the results presented here. The key is leveraging all of the available information to produce estimates and forecasts that are relevant to the medical community and insurers, thereby improving quality, lowering costs, and optimizing decision making.

For related information, see www.mplassociation.org.
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Looking Outside MPL in the Competitive Labor Market

Increased staffing demands, a substantial mid-level talent gap, impending mass retirements, and low unemployment have, together, led to a challenging recruiting climate for the insurance industry.

To remain successful as needs change and business evolves, medical professional liability (MPL) carriers should reevaluate their traditional recruiting methods.

The overall U.S. unemployment rate dropped to a near 50-year low in April, 3.6%, where it remained in May. The category, insurance carriers and related activities, is experiencing even lower unemployment: 1%, in May 2019.

But despite this lack of available talent, the industry continues to add jobs. According to the Bureau of Labor Statistics, the finance and insurance sector alone has had an average of more than 289,000 open jobs throughout the past 12 months. There’s not enough talent to meet the industry’s hiring needs—let alone supply the innovative and business-oriented minds needed to propel organizations toward future success.

In brief, MPL carriers are challenged to expand...
their candidate pools and harness talent from outside of their immediate specialization to stay competitive.

Growing demand for talent
The talent crisis is impacting virtually every area of insurance. Baby boomers are retiring in droves, and a lack of industry awareness and interest among young professionals and recent college graduates makes recruiting new talent difficult. The candidate pool is shrinking, yet at the same time, the industry is projecting employment growth.

According to the 2019 Q1 Insurance Labor Market Study, conducted by The Jacobson Group and Aon, the majority of property/casualty (P/C) insurers (60%) plan to increase their staff in 2019 (Figure 1). Thirty-one percent expect to maintain their staff size, while only 9% anticipate a reduction in staff. If the industry follows through on its plans, P/C employment will grow by 1.76% this year. For comparison, the sector grew by 1.43% from January 2018 to January 2019 and 0.84% from January 2017 to January 2018.

Within the broader insurance industry, half of study respondents credit expanding their businesses and venturing into new markets as the primary driver for staff increases. This is closely followed by an expected increase in business volume, which 49% of respondents cite as the main reason for adding staff. Of the organizations planning to reduce staff, most attribute the decrease to automation and reorganization efforts. With an increase in job openings, staffing expectations, and anticipated revenue growth, there are no signs that the tight labor market will be letting up any time soon.

As organizations evolve and modernize their teams and processes, it’s not surprising that P/C insurers name technology roles as one of their greatest hiring needs. An increased focus on analytics and the rise of “the future of work” has made innovation and technological transformation necessary for every insurer looking to provide positive and efficient customer experiences. Unfortunately, technology tops the list as the most difficult type of position to fill within the sector.

MPL insurers in particular are likely to see a skills gap in technology- and innovation-related roles. According to a recent report from A.M. Best, about 90% of MPL insurers believe that innovation can help overcome system and process challenges, yet only 4% have a team completely dedicated to innovation. Although MPL insurers are looking to invest more in innovation, a talent gap is one of the biggest obstacles. As MPL evolves to meet customers’ demands and expectations, while also streamlining and automating time-consuming processes, employing individuals with these skill sets is essential to future success.

Techniques for staying competitive in the tightening labor market
There are several ways MPL carriers can attract and retain the talent necessary to stay competitive in today’s candidate-driven market. Creating a positive candidate experience, offering an attractive compensation package and work culture, and committing to career opportunities and growth are all viable techniques. However, given the intensifying war for talent, one of the most crucial factors for long-term success is the ability to expand the talent pool by looking beyond traditional MPL candidates.

To achieve this, it’s important for MPL carriers to first determine what is, versus what isn’t, critical to employee success. Often, insurers are focused on finding individuals who have spent their whole careers within a particular specialty line. However, the MPL market is small, and looking only within its confines leads to a very limited candidate base. While these individuals often bring a vast amount of experience to the table, excluding candidates within other lines of P/C insurance can limit access to top talent, especially within the mid-level. It’s important for hiring managers to determine the critical traits and attributes for a hire, as opposed to the skills that can be learned or gained on the job.

For example, desired traits may include strategic vision, a growth mindset, ability to prioritize, and excellent communication skills. These characteristics are often innate and difficult to teach, yet have a direct correlation to success—no matter the specialization. Additionally, leaders who are emotionally intelligent, influential, and agile will be successful in a multitude of environments and quickly gain respect from their team members, regardless of their backgrounds. An innate curiosity and desire to learn may make a more effective employee than someone who is less inquisitive, despite meeting all other experience requirements.

MPL is a unique specialization, yet other lines of insurance require similar attributes that may easily translate. For instance, MPL carriers have a duty to the medical industry and its providers, helping healthcare professionals prac-
tice medicine safely, and in a way that helps a vast population of individuals. Professionals who thrive within MPL are generally mission-oriented. Research has shown that mission-driven individuals are 30% more likely to be high performers than those who are primarily driven by money. Identifying individuals with a passion for mission-driven work can open up a fresh pool of talent for MPL organizations.

As a changing business environment and physician consolidation continue to threaten their profitability, many MPL companies have opted to diversify their service offerings. Consulting, training, and legal skills are becoming more desirable and have the potential to create value where specialty line experience is lacking. Technology and automation are also redefining the industry; making technological adeptness, agility, and communication skills more important than ever. Transferable skills are abundant in the greater P/C industry. However, unless they clearly define their needs and understand which attributes are vital to success, organizations may miss out on top talent.

Managers can interview for key attributes through open-ended behavioral questions that can reveal skill proficiency. For instance, questions may include: “In what ways do you guide your team to advance the goals of the organization?” or “How do you expand your value across the organization to exceed expectations for your division and company?” Responses to these and similar questions can provide insights on a candidate’s ability to prioritize and whether he or she can offer a mindset likely to foster growth, along with the individual’s capacity for strategic vision, coaching, and communication. Strengths in these areas are often more telling of future performance and abilities than a certain number of years working in MPL.

In the current employment climate, defining transferable skills and translating those skills to MPL is key to maintaining a strong and viable talent pool. The companies that will continue to grow and innovate are likely those that open their searches to the greater P/C market. MPL carriers must look beyond candidates’ specific experience and, instead, focus on the particular skills that are necessary for driving future organizational success.

References
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Given the nature of ASCs and their common business model—to treat patients safely but quickly (thereby conserving resources)—certain theories of MPL predominate. Unfortunately, plaintiffs’ attorneys often seek to take advantage of a profit-for-motive theme, given the financial benefit to physicians afforded by ASCs.

One of the more common claims against an ASC is a failure to recognize an injury prior to the patient’s discharge; in fact, the most common allegation against ASCs surrounds a physician or nurse’s alleged failure to appreciate the signs of a colon perforation. Other common claims involve postoperative bleeding after a tonsillectomy, deep vein thrombosis after a plastic surgery procedure, or electrocautery burns. Most likely, the frequency and severity of claims will continue to rise, given the increasing number of procedures at ASCs overall, as well as the increasingly complicated nature of the procedures performed there.

Defense of Claims Against Ambulatory Surgical Centers

More than 35 million surgical procedures are performed at ambulatory surgical centers (ASCs) or hospital-based outpatient departments each year. There can be benefits to performing a surgical procedure at an ASC, to the patient as well as the surgical center. For instance, on average, at an ASC the procedure time is 50 minutes, while at a hospital it is 63 minutes. Likewise, on average, postoperative care time at an ASC is 51 minutes; at a hospital, it is 89 minutes. This has altered the model of medical professional liability (MPL) claims and the factual and legal issues that must be examined by a defense attorney when an ASC is faced with such a claim.

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Vicarious liability

When defending ASCs, defense counsel is also faced with the question of whether the ASC is vicariously liable for the conduct of a surgeon or anesthesiologist. A good first step in evaluating the potential for vicarious liability is to determine whether the doctor is an employee, owner, or independent contractor. However, the potential for vicarious liability often depends entirely on the venue of a plaintiff’s lawsuit.

For instance, in New York, under Mduba v. Benedictine Hospital 52 A.D.2d 450 (3rd Dept 1976) and its progeny, the ASC may be held vicariously liable for a nonemployee doctor under an apparent or ostensible agency theory if the surgical center gives the appearance that the physician, or anesthesiologist, was acting on the surgical center’s behalf. On the other hand, if the claim accrued in Virginia, you may have a very different outcome, given that Virginia does not recognize apparent agency in these situations. See Sanchez v. Medicorp Health System, 618 S.E.2d 33 (2005).

To handle such a claim, defense counsel must also familiarize themselves with the local jurisdictions’ laws relative to joint and several liability. Given that there are oftentimes multiple, separately insured, providers involved in the care, defense counsel must determine the physician’s exposure to joint liability: they may be on the hook for an entire jury award, despite the fact that other providers also contributed to the negligence. On the other hand, if the physician is found to be severally liable, he may only be responsible for his proportional share of liability. This will clearly impact the potential exposure of your client, as well as help determine whether additional healthcare providers should also be named in the lawsuit.

In sum, even though the same factual and legal issues arise in the ASC context as we see in cases involving procedures at acute-care hospitals, early recognition of the issues that are most often found in ASC claims can lead to a more efficient and effective disposition of the claim.
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Industry Data Shows Increase in Large Claims and Uptick in Severity

Analysis of key claims data from healthcare entities shows trends that impact the MPL industry.

Tony Bloemer, FCAS, MAAA, Rachel Soich, ACAS, MAAA, and Tim Vosicky, FCAS, MAAA, are with Milliman.
Using key claims information from healthcare entities nationwide, including hospitals, nursing homes, and long-term care facilities, Milliman has built a medical professional liability (MPL) database that contains more than $20 billion in incurred losses for the most recent evaluation date, and includes claims occurring in the last 30 years. In addition to loss data, Milliman collected other details such as claim state and hospital department.

Part of our analysis includes creating industry loss-development factors and increased-limit factors. These become especially critical in instances where a hospital’s data is not credible on its own. Using other specific claim details collected, such as state/region or exposure (hospital, nursing home, etc.), we can develop industry patterns tailored to the specific characteristics of the program.
Lastly, this database has also allowed us to summarize several claim diagnostics that impact the entire MPL industry. Key findings are shown in the figures here.

**Large claims**

As shown in Figure 1, there has been a significant increase in the number of large claims over the last few years. The percentage of claims that closed with an indemnity payment of $1 million or more was relatively flat between 2003 and 2013, but has increased from 2014 to 2016. There was an even more significant increase in the percentage of claims that closed with an indemnity payment of $5 million or more (Figure 2).

**Severity trends**

The MPL market has seen an uptick in severity in recent years, as indicated in Figures 1 and 2. Using roughly 100,000 closed claims, the study estimates an unlimited severity trend of 3.5%. This conclusion was derived by fitting incurred losses to an exponential distribution...
Figure 3 presents rolling severity trend estimates, calculated using rolling trends for 10-year periods. As an example, the 10-year rolling trend for 2017 would be the estimated severity trend using claims closed in years 2008 through 2017. As shown in Figure 3, the severity trends declined from 2008 to 2014. However, the severity trend abruptly changed direction beginning in 2015.

Limited loss and excess loss severity trends are analyzed below. Figure 3 shows rolling severity trends for losses limited to and in excess of $2 million. Both layers of losses contribute to the severity trend shift, starting in 2015. However, severity for losses of more than $2 million is growing more quickly than those of limited severity, exceeding 10% by 2016. Therefore, this analysis concludes that the unlimited severity trend increases are due to the recent increase in very large claims.

Teaching versus non-teaching hospitals
The average closed claim severity for teaching hospitals is 20% higher than for non-teaching hospitals, over the last 30 years. There is also a higher percentage of large claims at teaching hospitals (Figures 4 and 5).

Expense payment versus indemnity payment
Figure 6 summarizes the amount of expense payments for claims closed in the last 10 years, based on the size of the indemnity payment. As expected, the average expenses increase along with the size of the indemnity payments. The box represents the 25th to 75th percentile, with the line in the shaded box as the median. The top and bottom bars extend to the 90th and 10th percentiles, respectively.

Expense to indemnity ratios
Figure 7 summarizes the ratio of expense payments to indemnity payments for closed claims by close year. With the exception of 2016, the expense ratios are slightly higher, on average, beginning in 2012. The average after 2012 is 28%, which is 4 percentage points higher than the average expense ratio prior to 2012. This increased expense ratio is evident across all segments of the data. In the MPL insurance company space, some companies have used predictive analytics to gain...
greater insights for managing this expense item, so it is reduced to its historical levels. This use of predictive analysis is in its early stages in hospital, nursing home, and long-term care, a trend that could lead to significant savings opportunities.

**Lag by claim size**
Set forth below is an analysis of the lag periods, both from occurrence date to report date and from report date to close date, based on the indemnity payment amount. As anticipated, the lag from report date to close date increases as the amount of the indemnity payment increases. Interestingly, the occurrence to report lag is not linearly correlated with the size of the indemnity payment. Claims that end up closing without an indemnity payment typically take longer to be reported than those with indemnity payments less than $1 million. One possible reason is that more of these claims without indemnity payments are reported as the statute of limitations is expiring. It is also interesting that claims that end up with $10 million or greater indemnity payments are reported more quickly than those with indemnity payments between $1 million and $10 million. In some of these more severe cases, it may be more evident to the hospital that a significant incident has occurred and thus it is reported more quickly (Figure 8).

**Severity by specialty**
Figure 9 shows the average closed claim severity by specialty, including both loss and allocated loss adjustment expenses. Claims have been trended from their close date to 2018 by 3.5% per year. All specialties shown contain a minimum of 200 closed claims.

Figure 10 shows the breakout of claims greater than $1 million by specialty. More than 70% of claims that exceed $1 million fall into one of the 10 categories shown, with the top four categories making up more than 50% of claims. More than 25% of the claims exceeding $1 million are obstetrics claims, significantly surpassing those for the next largest specialty, emergency physicians. Each specialty shown has a minimum of 25 closed claims.

**Retention**
Figure 11 plots the current retention of each entity along the x-axis and the average unlimited claim severity along the y-axis. It appears that the average claim size increases as the retention increases. One plausible reason for this is that the market will force those with a history of large claims to retain more risk. Another possibility is that claims are more likely to settle at or near the retention, therefore increasing the average claim severity for those with higher retentions. It is also possible that the entities with higher retentions have higher overall coverage limits, which may affect the severity of large claims.
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Commitment Beyond Numbers
The 2019 Medical Liability Conference (MLC) in Portland, Oregon, brought together hundreds of professionals who work in insurance and alternative risk transfer, all looking for key insights into the issues facing the medical professional liability (MPL) community.

Attendees heard from leading experts on topics including the latest developments in handling claims, how to use enterprise risk management to drive performance and mitigate risk, and the impact of quality measures such as those of the Leapfrog Group for MPL. Meeting participants gained a clearer perspective on the present and future, and specific strategies for meeting the challenges of the evolving healthcare system, both in the U.S. and around the world.

Keynote Address: The Disruptive Forces in Healthcare; A Look at Today, Tomorrow, and Beyond

Kevin M. Kennedy, principal with ECG Management Consultants, provided a comprehensive overview of what companies can expect to see in healthcare in the coming years, much of it dramatically different—"disruptive"—compared with what we have known in the past.

Kennedy asked, "Is the next innovation in healthcare already here?" It may well be, and leadership should keep that in mind as they consider MPL and its customers. He pointed to the story of Nokia, a company which was still selling record numbers of phones when the iPhone had been introduced. "Things can happen really quickly," he said.

The pressures for change in healthcare stem from two different trends, Kennedy pointed out. "One is horizontal and vertical integration," and the other comes from the new entrants into the market.

Horizontal integration has been a major force for several years—medical groups become larger by swallowing up smaller groups and hospitals acquire former competitors. Vertical integration is a more recent phenomenon, involving different levels in the buying chain. "Folks might be different suppliers to
each other, or in the healthcare market, referring entities to each other,” Kennedy said. This has been really common among physicians, many of whom have signed on as employees of larger entities.

Also, there are new combinations such as pharmacy benefit managers, retail pharmacies, and insurance companies, all coming together in ways we haven’t seen.

Finally, there is digital health, with venture capitalists lining up to fund promising innovations.

One example of a merger is Wake Forest and Atrium, typical in that they are in a fairly localized geography in North Carolina. Together, they have almost 50 hospitals in a single market. This offers many benefits. The merge entity will have some market power. The merger also makes it possible, for example, to have one large open heart program, instead of several smaller ones, and thereby optimize both cost and quality.

At the other end of the spectrum there is Dignity Health and CHI, which are both already very large systems. There were issues with this merger. There was disagreement about who the CEO would be and the location of the corporate headquarters. There were layers of overhead. And there were not a lot of opportunities for clinical integration, since there wasn’t much overlap in services offered.

“So how big is too big?” Kennedy asked, noting that he has seen mega-systems like this “develop dis-economies of scale.” Major systems, he said, are experiencing operating losses.

In fact, Kennedy pointed out, “Centralization among these big hospital systems has produced an incredible amount of frustration among people who actually have to deliver care.”

At the same time, there are novel integrations, such as the one between Aetna and CVS. These companies are striving to create a healthcare experience that is more customer-focused. Companies like Amazon and Walmart are becoming “catalysts for deals.” They see the healthcare space as being “ripe for disruption.”

There has been a flood of venture capital pouring into new health startups. 98.6 is a Seattle-based startup that is designed to have a longitudinal relationship with patients.

Another example is Health Tap, which started as a question-and-answer service and quickly had 100,000 physicians sign on. This app taps into an artificial learning database and provides patients with health information and even the ability to make appointments for consultations by video, phone, or text.

New joint initiatives like the one by Amazon, Berkshire Hathaway, and J.P. Morgan will be more typical in the future. There are not as yet any specifics, but, said Kennedy, “It will be something that you, and your customers, will need to respond to.”

From the MLC sessions
“Quality Measures: How Are They Impacting MPL?”

There is a tricky, still-ambiguous relationship between provider rankings and MPL claims, according to Jill Berger, Senior Advisor, The LeapFrog Group, and Ben Harder, Managing Editor and Chief, Health Analysis, U.S. News & World Report. In a session moderated by John Evanko, MD, Chief Medical Officer and Senior Vice President of Patient Safety and Loss Prevention from MCIC Vermont LLC, presenters discussed the components of their respective ratings and the relationship between those measures and outcomes. While there are not yet definitive conclusions linking performance rankings and MPL claims, further study may yet provide some insights.
“MPL Implications of Precision Medicine”

Genetics is a fast-moving field where there can be a tremendous gap among healthcare providers in terms of knowledge and experience. In her session, Wendy Chung, MD, PhD, Kennedy Family Professor of Pediatrics and Medicine at Columbia University, discussed the MPL risks in the genetics field, including the misinterpretation of test reports, a failure to appropriately offer testing, and the failure to take appropriate action after testing. Her recommendations to prevent error and maximize benefit focused on provider reeducation, embedded genetics counselors, and great patient involvement through patient portals, among other things.

https://www.genome.gov/10000464/online-genetics-education-resources/w.familialcancerdatabase.nl/

At the 2019 conference, the MPL Association awarded Dan McLamb, Esq., with its “MPL Industry Defender Award.” Mr. McLamb was recognized for his exceptional support of the industry.

Mr. McLamb is a founding partner of Yates, McLamb & Weyher, LLP, a North Carolina-based firm. Recognized as one of the top professional liability defense litigators in North Carolina, his practice is focused on commercial litigation and professional liability defense. He represents businesses, physicians, hospitals, and attorneys throughout North Carolina and has spoken at numerous litigation and professionalism seminars, as well as to healthcare providers on medical/legal issues.

Mr. McLamb is a member of the American, North Carolina, and Wake County Bar Associations; the North Carolina Association of Defense Attorneys; and the American Board of Trial Advocates. He is a fellow of the American College of Trial Lawyers, the International Association of Trial Attorneys. In 2014, Mr. McLamb was named “Lawyer of the Year” for Raleigh in the category “Professional Malpractice Law—Defendants” by Best Lawyers and U.S. News & World Report.

“The MPL Association also awarded Bertie Leigh, Esq., with its “MPL Industry Defender Award.””

Mr. Leigh was recognized for his exceptional support of the industry. Currently a Consultant Solicitor to Hempson’s, a U.K. law firm, Mr. Leigh has conducted many of the leading cases in clinical negligence and regulatory law in the U.K. during the past 30 years, specializing in clinical negligence, professional regulation and training, National Health Service administration, and employment.

He served as president of the Medico-Legal Society, 2006-2008, was chair of the National Confidential Enquiry into Patient Outcome and Death from 2009–2015, and is an Honorary Fellow of the Royal College of Paediatrics & Child Health and a Fellow ad eundem of the Royal College of Obstetrics and Gynaecology. Mr. Leigh has contributed to Dewhurst’s Obstetrics and Gynaecology, Rennie and Roberton’s Neonatology, and Hardman et al.’s Consent to Anaesthesia.

“Bertie has been involved in a great many ground-breaking cases which have influenced medical law in this country,” said Christine Tomkins, CEO of The Medical Defence Union, Ltd. “He has made a lifelong contribution to defending physicians and other healthcare professionals, and he has a wide-ranging and prominent role in multiple fora where patient safety, the management of clinical risk, and the ramifications of the medico-legal climate are pertinent.”
Gloria Everett Recognized with 2019 MPL Association Award of Excellence in Honor of Peter Sweetland

The MPL Association has recognized Gloria Everett, President and CEO of The Mutual RRG, with the 2019 Award of Excellence in Honor of Peter Sweetland. Everett is being honored for her singular contributions and long-time dedication to the MPL insurance community, the MPL Association, and healthcare professionals.

Everett, President and CEO of The Mutual RRG, is an insurance executive who has spent more than 30 years representing the interests of the MPL community through her leadership in the industry. She attended her first MPL Association (formerly, PIAA) meeting in 1987, where she had the honor and privilege of meeting Peter Sweetland.

For decades, she has championed the heart and soul of the industry to advocate, educate, and defend physicians and the healthcare team to improve access to quality healthcare across the country.

In 2017 Everett completed a nine-year term on the MPL Association Board of Directors, as a member and also as its first female Chair. She served on the following committees, just to name a few: CEO & COO Section, Leadership Camp Section, and the Strategic Planning Committee.

As the president and CEO of The Mutual RRG for the past 17 years, she has also served on numerous boards, including Insurance Industry Charitable Foundation; National Risk Retention Association; and the University of California, Berkeley Equity & Inclusion Advisory Board. Everett currently serves on the Pacific University Board of Trustees.

“Gloria Everett is a tenacious pathfinder. She was the first woman chair of the then PIAA, she initiated a board assessment which masterfully guided the association to expanding its value proposition across the industry, she brought consensus about our future while still honoring the history of our mission. Her seminal work laid the platform for long-term success of the now MPL Association,” said Mary-Lou Misrahy, ARM, Chair of the MPL Association, and President and CEO of Physicians Insurance A Mutual Company. “Her work in support of physicians, other healthcare professionals, and the MPL community has been exceptional. We are honored to present her with our highest award and thank her for her dedication and commitment.”

Brian K. Atchinson, President and CEO of the MPL Association, stated, “We are extremely pleased to honor Gloria for her extraordinary dedication and commitment to the physician community and this Association. We commend Gloria for her remarkable commitment of time and energy for many years in support of this organization and its members.”

The MPL Association Award of Excellence in Honor of Peter Sweetland, established in 1993 by MPL Association’s Board of Directors, was created in honor of the late Peter Sweetland, one of the MPL Association’s (then, PIAA’s) chief architects and most fervent supporters. The award recognizes an individual who has provided exemplary service to the industry and to the MPL Association, and who epitomizes the high ideals and ethics for which Peter Sweetland stood.
good medicine and actively assisting healthcare providers protect everything else flows from there. We are in the business of defending care provider practice good medicine? That is the starting point and cannot yet master.

Q: How have claims procedures changed, for you, in the last five years? Has there been a revolution—or just a gradual evolution?
A: Nothing has changed procedurally. We still thoroughly work up cases the same way with an eye towards defending good medicine. However, I am seeing a change in the types of claims we are handling. Telemedicine claims are starting to roll in and we are working through the challenges with that type of practice. We are finding that there are communication and proximity issues with these claims. For example, communication problems may occur when the off-campus healthcare providers either do not relay pertinent information or when that information is not relayed to the proper professionals on-site, which can result in delayed treatment. We also are unearthing some legal questions pertaining to diversity jurisdiction and noneconomic damage cap applications. For instance, if the patient is treated in California, but the films are read in Minnesota by a company that is incorporated in New Jersey, should it be a California state court case or a federal case due to diversity jurisdiction? Using the same scenario, should the physician who read the films in Minnesota be afforded protections under the MICRA cap in California?

Q: What role does artificial intelligence play in claims handling?
A: Professional liability claims should always involve the decision-making judgment of an experienced professional. While some insurers may choose to take shortcuts with claims evaluation, physicians would be wise to insist on coverage that provides expert claims handling that carefully evaluates the many nuances to be factored into each claims decision. At this point, computers do not have the empathy and experiential learning necessary to fully and accurately digest the multiple factors required to properly evaluate a complicated medical liability claim. Unlike auto or property, when adequately evaluating a claim, we must take into consideration numerous factors such as accurate documentation, the venue, the skill of the attorneys, likeability of the witness, proficiency of the judge, and the litigation environment, just to name a few. That is why it is essential to have “boots on the ground” and know firsthand what is happening in the state or city where the case is filed. Much of what we do is feel, experience, and intuit—human traits that AI cannot yet master.

Q: Is your approach to high-value cases substantially different from what is used in cases of lower value?
A: My approach always begins with one question: Did the healthcare provider practice good medicine? That is the starting point and everything else flows from there. We are in the business of defending good medicine and actively assisting healthcare providers protect their reputations. We partner with experienced, effective trial attorneys whose proven track records in successfully defending many claims ensures that practitioners can have their day in court and explain their treatments to a jury. Having said that, we will not hesitate to resolve a case if the medicine does not rise to the proper standards and, in the rare instances when that is the situation, we guide the healthcare practitioner through the settlement process no matter how high or low the value of the claim. There are risks to trying cases and there are ramifications for settlements. Because suits often take a deep emotional toll on our insureds, we shepherd them through the process and support them every step of the way.

Q: How do the AMA Ethical Guidelines for Telemedicine play a role in what you do? Telemedicine can seem a bit like the Wild West at times
A: The AMA Guidelines are important and should be followed closely and monitored often because they are ever changing with each new technological breakthrough. Diligence is necessary—there is nothing worse than having a plaintiff attorney use any form of guideline to show how a defendant violated them. Displays like that are easy for a jury to understand and can be very effective. What is more concerning to me about telemedicine is the distance of the healthcare provider from the patient. There have been allegations that because the healthcare provider did not lay hands on the patient and/or examine the whole patient, it was impossible for the provider to fully evaluate, observe, and provide proper treatment. However, I think the most intriguing issues in telemedicine will come with jury trials and the acceptance of this type of technology. Younger jurors who are tech savvy will most likely embrace telemedicine as normal and the way medicine should be practiced. In the minds of many younger jurors, nobody should have to leave home to receive a diagnosis for a minor condition. On the flip side, you will see an older group of jurors bring a healthy dose of skepticism to the process because this isn’t the healthcare that they know. Defense attorneys will need to walk a fine line when presenting their case to this disparate group of fact finders. It will be an interesting exercise to see how the acceptance of telemedicine evolves over time.

Q: How can MPL entities ensure that there will be a steady pipeline of talented new claims staff in the years to come?
A: I worry about this a lot, particularly since no young person says, “I want to grow up to be a professional liability claims specialist.” In fact, I didn’t know this job existed until I was in my late 20s, but I’m certainly glad I found it. Aspects of this profession are incredibly rewarding and I’m so proud of what we provide to the men and women who help patients every day. Being a professional liability claims specialist requires curiosity along with an interest in law, medicine, and insurance. It is incumbent upon all of us to identify smart people in all walks of life and tell them about our companies, what we do and how we do it. We need to find tomorrow’s professionals to ensure talented people are in the pipeline. IML
The offense gross negligence manslaughter (GNM) is a common law offense in England and Wales. The law is judge-made, with no statutory definition. Sadly, over recent years there has been an increasing willingness to consider, and embark on, prosecution of doctors for errors made resulting in the death of patients, in contrast to the approach in many other jurisdictions.

While there has been an increase in GNM cases, prosecution of "carers" is nothing new, with the earliest recorded prosecution in relation to the death of a patient being as early as 1329, and GNM prosecutions involving doctors in a more modern sense have been taking place since the early nineteenth century. What judges have struggled with ever since has been a precise definition of the offense.

In 1994, the House of Lords case of Dr. John Adomako established that the test essentially comprised:
- The defendant owed a duty of care to the deceased.
- The defendant breached that duty.
- The breach of that duty caused the death of the victim.
- If so, the jury must go on to consider whether that breach of duty should be characterized as gross negligence and, therefore, as a crime.

With no precise formulation of just how bad or gross something had to be to amount to a crime, there was an unsatisfactory variation in the nature of the explanation given by judges to juries. Some provided directions that made it clear that the conduct had to be utterly dreadful for it to be criminal, while others were profoundly limited, failing to make it clear that something much worse than civil negligence was required.

One example of a judge providing clarity about just how bad conduct would have to be to be criminally liable came in the case of Drs. Amit Misra and Rajeev Srivastava in 2003, with the trial judge explaining:

"Mistakes, even very serious mistakes, and errors of judgement, even very serious errors of judgement ... are nowhere near enough for a crime as serious as manslaughter to be committed ..."

"Concentrate on whether or not the prosecution has made you sure that the conduct ... in all the circumstances ... as you find them to be, fell so far below the standard to be expected of a reasonably competent and careful [doctor] that it was something, in your assessment, truly exceptionally bad, and which showed such an indifference to an obviously serious risk to the life of [the patient] and such a departure from the standard to be expected as to amount, in your judgement, to a criminal act or omission, and so to be the very serious crime of manslaughter."

In 2013, surgeon Mr. David Sellu was convicted of GNM following the death of a patient. He...
served his sentence of imprisonment before an appeal was 
brought against his conviction. At his trial, the judge had given a 
limited explanation of the sort of conduct that would be deemed 
criminal. In 2016, the Court of Appeal quashed his conviction, 
ruling that a direction not matching the weight of that in Misra 
was not appropriate.

It is at least clear, from this point, that there is a very high bar 
to meet before criminality is established, and judges will have 
to make plain to juries that conduct must have been “truly exceptionally bad” for there to be 
a conviction.

**The furor and the reviews**

In 2015, though, a jury provided with that Misra-type direction 
convicted Dr. Hadiza Bawa-Garba of GNM in relation to the death of 
her patient. The U.K. healthcare regulator, the General Medical 
Council (GMC), then took action on the basis of that conviction, 
arguing that she should be erased from the Medical Register (and 
unable to practice as a doctor). The Medical Practitioners 
Tribunal deciding her case ruled that her registration should be 
suspended. The GMC appealed that decision to the High Court, 
which agreed she should be erased. That ruling, though itself 
subsequently overturned by the Court of Appeal, ignited a huge 
protest in the medical profession about the treatment of doctors 
investigated and prosecuted for GNM. That resulted in the 
Government and the GMC setting up reviews about doctors faced 
with GNM allegations, the former chaired by Professor Sir Norman 
Williams, and the latter by Dr. Leslie Hamilton.

These reviews have provided an opportunity to address a number 
of the significant flaws in the system.

**Over-investigation**

Many of the cases investigated by the police are referred by coroners 
who are reluctant to hold inquest proceedings if there is the possibility 
of criminal conduct. In the MDU’s experience, there is a ratio of 
at least 10 medical cases investigated for only one prosecution, 
broadly matching the Crown Prosecution Service (CPS) figures for healthcare worker 
prosecutions generally. That represents over-investigation, with the consequent profound 
distress and damage that such investigations cause doctors. Extraordinarily, the section of the chief 
coroner’s law note that gives guidance to coroners about GNM is out of date and inaccurate. The MDU advised 
both reviews that coroners should seek the view of the chief coroner 
before making a police referral for GNM (to ensure consistency) 
and/or the chief coroner should produce up-to-date legal guidance, 
making plain the high bar for criminality. The Williams Review recommended the latter, 
and the Hamilton Review has recommended the former. The effect of both should drive down the number of 
unnecessary investigations and avoid the considerable disruption they bring.

**Delay**

Cases are investigated by the police, and the decision about prosecution is then made by the Special Crime and Counter 
Terrorism Division of the CPS. The length of time from the start of the investigation through to the 
prosecution decision is rarely less than six months, frequently well 
over a year, and in two cases has been in excess of three years.

Such unwarranted delay is hugely destructive for the doctors who must remain in the spotlight.

There is no national police force and no dedicated unit dealing with medical GNM cases. 
They are investigated at a local level, with the result that most police officers who investigate a case will not have done so before. 
There is a resulting reinvention of the wheel, and considerable time 
is expended in doing so.

That is exacerbated by the fact that the guidance available to senior investigating police officers (SIOs) for medical GNM is out of date and contains no explanation of the law, including the high bar for criminality.

We advocated that the police guidance needed to be overhauled, and that there should be a national or regional police unit(s) to investigate this specialist kind of case. With familiarity should come increased speed. In the face of police opposition, the Williams Review did not feel able to endorse fully a national unit, but did recommend a “virtual specialist unit” to support SIos by making available the experience from prior cases, which we hope will improve learning and thereby increase the speed of the process. Williams also recommended a revision of the SIO guidance.

**Excessive prosecution**

In our experience, only about 25% of medical GNM cases prosecuted result in conviction.

Although the conviction rate overall is higher, it is nowhere near the national conviction rate of about 80% achieved by CPS for all offenses. This suggests that some of the cases that have been prosecuted should not have been brought, with all the damage that brings. This may have resulted in part from previous uncertainty about the nature of the offense, and a lack of clarity for medical experts when asked to provide opinions about cases.

We had previously offered to agree to a formulation of the law with the CPS to ensure that experts were properly instructed and thus to avoid any dispute about the law. The Williams Review recommended that a working group be set up to provide a clear explanatory statement of the law on GNM. This working group includes representatives from the CPS, the coroner services, and healthcare defense organizations. The joint statement can then be incorporated into the revised SIO guidance. The Hamilton Review endorsed the need for an agreed-upon statement of the law.

Williams has also made recommendations aimed at ensuring higher standards and more training for experts.

There are many other recommendations from both reviews that may make possible significant improvement in the way such cases are dealt with in future. What is surprising has been the collective outpouring of discontent from the profession at what has been happening, and that for once was heard. Prosecutions for GNM make no sensible contribution to improving patient safety. Faulty systems and individual errors are not made better by imprisoning a doctor. For too long, our approach has been to apportion blame for mistake. Let’s hope we start to recognize the wisdom of the Japanese proverb, “Fix the problem, not the blame.”

For related information, see www.themdu.com.
Q&A...With Ann Whitehead

The Cooperative of American Physicians (CAP) has published a new resource, The Physician's Action Guide to an Outstanding Patient Experience, to help physicians and their staff optimize the patient experience. They are offering this guide for free at www.CAPphysicians.com/PEML. Intrigued by the publication's title, Inside Medical Liability spoke about it with Ann Whitehead, Vice President of Risk Management & Patient Safety for CAP.

Q: Do you think that some physicians don’t understand the full meaning of the phrase “patient experience”?
A: The patient experience encompasses the range of interactions that the individual has with the physician and his or her staff. Sometimes physicians may be so focused on clinical activities (“What is being done for the patient’s health?”) and outcomes (“Did our treatment work?”) that process feels less important to them.

Our view is that patients who perceive they are being cared for are happier, less anxious, more likely to comply with a physician’s advice, and more likely to build a long relationship with the practice. Those are all very powerful reasons to improve the patient experience.

Q: Why has the patient experience come to assume more importance in recent years?
A: First, healthcare costs have risen dramatically. People who pay more, expect more. Also, as consumers in the digital age, we’re trained to believe everything is easy, one-click away, and time efficient. If Amazon can ship a customer almost anything on Earth in two days, then surely a medical practice should value the patient’s time and efficiently address their needs and/or complaints.

Q: What are the five key elements in any attempt at improvement?
A: Yes, and here they are:
1. Positive culture—What does the team believe, and how do they act under pressure?
2. Good communication—Good communication is core to both the patient experience and safety. Failures in communication are the leading cause of all adverse events that cause harm to a patient.
3. Trained staff—If your staff is calm, patient, kind, and organized, it immediately helps everyone to relax, and goes a long way to providing a good patient experience.
4. Established systems and processes—Map out and review the entire patient experience, from the time a patient first contacts your office through final billing. How does the work get done?
5. Efficient technology—Has your practice maximized the latest technologies to increase efficiency and reduce patient frustration?

Q: What practical considerations are included in the phrase “culture of safety”? “Culture” can seem like a very fluid sort of word.
A: The word “culture” may sound fuzzy, but it’s where the rubber meets the road. Culture boils down to what the staff in the practice really believe, how they really act day-to-day, in the moment, and if the organization encourages questions and values suggestions and improvement opportunities. Consider these elements, for good communication:
1. Does your practice have defined guidelines about what you communicate and how that is accomplished?
2. Does your practice have clear rules about how the staff engages with patients and caregivers?
3. Does your practice have organized, established systems and processes in place?

If Amazon can ship a customer almost anything on Earth in two days, then surely a medical practice should value the patient’s time and efficiently address their needs and/or complaints.
There is an excellent (very full) list of points on communication. So often, the people who check people in, take vital signs, etc., can seem almost cold—not interested in the individuals standing right in front of them. Isn’t it important to stress that communication failures are the leading cause of adverse events?

Absolutely. Staff need to remember that for them, it’s one appointment out of dozens or hundreds in the normal course of business. For the patient, it’s THE appointment, and one they may have lost sleep worrying about. Effective communication is a basic requirement for safe healthcare and is essential to good relationships with patients and families. Staff who encourage active communication with patients will have a positive impact on the patient experience.

What are the three critical things to get right in the patient experience?

1. Create and maintain a good communication link between physicians and staff, between staff and patients, and between care providers.
2. Design and maintain a tickler, recall, or tracking system for patient follow-up. Ensure that patients are always updated about lab results, and always know the next steps.
3. Establish and maintain a complaint management system. Responding when patients complain is an important strategy to improve communication and improve the patient experience. Taking the time to understand the patient’s concerns will build rapport, demonstrate empathy, and hopefully prevent negative online comments.

If a better experience is achieved, how often should there be a checkup to make sure the improvement is being sustained?

Most practitioners assume that “no news is good news,” and that silent patients are happy, which is not always the case. A better practice is to routinely check in with staff and look for signs of trouble. Are complaints rising? Does staff look more harried? Are tempers short? These are all clear, visible signs that things aren’t running smoothly. Excellence is a daily exercise.

To summarize, as out-of-pocket healthcare expenses increase, consumers seek comparable increases in value, which most people think of as service. Service drives the patient experience, reduces patient harm, and decreases liability. Patients expect good communication, a responsive staff, efficiency, and consistency. These elements help to create a culture that is focused on the patient experience.

Disclaimer
This information should not be considered legal advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.
Clients are facing unprecedented challenges brought on by rapid change in an ever-evolving healthcare environment. Guy Carpenter’s unique approach and innovative tools and solutions help clients successfully realize their potential for profitable growth.
Furthermore, the credit cycle is in its late stages, economic growth is beginning to slow, and the risk from geopolitical events has never been higher. All told, there is no shortage of externalities to consider, let alone plan for. Yet as Einstein once said, “In the middle of difficulty lies opportunity.” I’d ask you to keep that sentiment in mind, as we examine the challenges—and potential opportunities—to come.

The thoughts that follow are intended to complement the slew of investment outlook pieces published at this time of year, understanding that the capital markets are only one piece of the insurance asset-management mosaic. Although many of the points raised here are based on U.S. industry data, our conversations with some non-U.S. clients indicate that they tend to apply globally as well.

**Theme 1: Revisiting strategic asset allocations**

We think that robust strategic asset allocation studies are crucial at this mature stage in the business and credit cycles. (Indeed, in our work with insurers, we see that the demand for consultative asset allocation services has never been greater.)

As a starting point, such a study should consider the appropriate size of exposures to various asset classes. But it should also examine whether each asset class is conforming to its expected risk and return profile, and whether all of the asset types are performing holistically, as intended, in terms of their cross-correlations with each other. Fine-tuning allocations within the insurer’s existing risk-asset budget will become increasingly important as market volatility intensifies.

Strategic asset allocation must address not only the potential for fluctuations in capital markets, but also the prospect of significant climate change in coming decades—and insurance companies are on the front lines with this issue, given the long-term nature of their risk exposures. Alternative investments offer investors potential return streams with little or no correlation to traditional public-market invested assets—a characteristic that may be especially useful in the later stages of a cycle. In addition, alternatives can be a gateway to investing with a focus on climate change, as discussed later in this article.

In the U.S., insurance companies have likely reached a ceiling in terms of the absolute dollars they’re willing to allocate to traditional risk assets such as equities and high-yield bonds (Figure 1)—thereby adding further incentive to allocate wisely within the return-seeking bucket.

Meanwhile, the 10-year Treasury yield has remained below 3.0%; many insurers may consider this insufficient compensation for taking on the duration risk involved. So where should an investor place new funds?

**Theme 2: Continued flows into private bonds**

Many insurers have answered this question by investing in private bonds (“privates”). Recent flows into this asset class have been significant. Privates made up more than 30% of the...
U.S. life industry’s fixed income allocations as of year-end 2017 (Figure 2), and 2018 was another year of strong inflows. Given the long-term nature of their liabilities, life insurers are better equipped to handle the illiquidity risk embedded in privates, but investments by health and property/casualty (P/C) companies have also been sizable.

In recent times, private bonds have generally been a great trade for investors, delivering a yield premium over their public counterparts without triggering higher capital charges. However, the market for privates has yet to be tested by a significant crisis; insurers facing potentially large unexpected liquidity needs should be cautious before initiating or increasing exposure to this asset class.

**Theme 3: Growing focus on sustainable investing**

Sustainability has been on the radar of many insurance companies outside the U.S. for some time; some European insurers have been active in the space for over five years. In the U.S., 2018 saw increasing support for embedding climate risks in the NAIC Own Risk and Solvency Assessments. Globally, the G-20 Financial Stability Board Task Force on Climate-related Financial Disclosures (TCFD) has pushed hard for adoption of its recommendations on board oversight and management practices in assessing climate risk and opportunities. The TCFD has suggested a five-year time frame for phasing in its guidance, but we think insurers should begin preparing immediately.

Measuring sustainability and climate risk should not be considered a mere exercise in disclosure. The potential link between climate change and the increase in the severity and frequency of natural disasters makes this risk a critical concern for the insurance industry overall. Figure 3 paints a comprehensive picture of the trickle-down effect of natural disasters on insurers and banks.

The evolving nature of this segment of the investable universe could provide opportunities for asset managers and insurance companies to get creative, not only through exclusionary investment policies (for example, coal-related securities), but also through inclusionary investment practices as well.

One recent example of a market innovation is a Forest Resilience Bond (FRB). In brief, an FRB is issued by a public-private partnership that brings in private capital to finance forest restoration. To date, FRBs have been focused on areas in the western U.S. Entities such as water-utilities, state governments, and the U.S. Forest Service (USFS) that benefit from forest restoration make cost-share and pay-for-success payments over, say, a 10-year period to bondholders, based on the verified success of the restoration efforts. Water utilities can benefit from increased flows into reservoirs and improved water qual-
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ity, and the USFS and state governments can better protect communities from wildfires caused partly by overgrown forests. In many ways this is similar to infrastructure finance (indeed, it has been nicknamed “natural infrastructure” investing), but with environmental (e.g., carbon capture) and social benefits driving repayment.

If you’re an insurer offering coverage in affected regions, not only might FRBs make sense from a purely investment perspective—they may also help mitigate catastrophic risks on the underwriting side of the business, creating a potential win-win for both sides of an insurer’s balance sheet (Figure 4).

Theme 4: Overhaul of accounting practices on both sides of the balance sheet
Regulators across the globe have focused on improving the accuracy of financial statements with new accounting standards. While terminology can differ between generally

Management of insurance assets will undoubtedly continue to move in the direction of greater regulation, constraints, and complexities.

Conceptual illustration; not intended as an investment recommendation | Source: Georgetown Climate Center, via its Adaptation Clearinghouse ©2017 Trust for Conservation Innovation/Private Capital for Public Good, produced in partnership with Blue Forest Conservation and Encourage Capital. More information on FRBs is available at ForestResilienceBond.com
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accepted accounting principles (GAAP) in the U.S. and International Financial Reporting Standards (IFRS) outside the U.S., the end results are similar. On the asset side, standard-setting bodies in both regimes are moving toward accruing for expected credit losses before an asset is actually impaired. For liabilities, standards are moving toward more frequent and accurate updates—of longer-duration insurance contracts under GAAP, and of all contracts under IFRS. Figure 5 lists the key accounting practices of the two regimes.

On the asset side, the new standards for initial reporting (the solely payments of principal and interest, or SPPI test, in IFRS) and ongoing reporting (impairment testing) substantially increase the data requirements for insurance companies (Figure 6). Third-party asset managers need to be prepared for the greater requirements well ahead of the official go-live dates. This data can take many forms. But understanding the SPPI test in detail for each position purchased, providing extensive cash-flow reporting, and calculating expected loss rates based on historical, current, and future macroeconomic variables are baseline capabilities for a best-in-class manager of insurance assets.

A key goal of the changes to the liability side of the balance sheet is to improve financial reporting via more frequent updates of the assumptions underlying liabilities valuation. Another objective is to achieve greater consistency of insurance-contract valuation across jurisdictions. However, much like the asset-accounting changes, the incremental demands on insurance companies’ data-capture capabilities and infrastructure needed to comply with these changes are massive. The effective date for IFRS 17 has already been postponed by one year (currently, the effective date is 2022), and several insurance industry groups have asked for an additional year. In fact, almost 90% of insurers responding to a Deloitte survey last year said they would need system upgrades to handle the greater reporting requirements.

**Global trends**

While acknowledging that the environments in which insurers operate vary significantly by region, it’s possible to find common global themes and draw useful lessons from peers across the globe. To that end, the new standards for initial reporting (the solely payments of principal and interest, or SPPI test, in IFRS) and ongoing reporting (impairment testing) substantially increase the data requirements for insurance companies (Figure 6). Third-party asset managers need to be prepared for the greater requirements well ahead of the official go-live dates. This data can take many forms. But understanding the SPPI test in detail for each position purchased, providing extensive cash-flow reporting, and calculating expected loss rates based on historical, current, and future macroeconomic variables are baseline capabilities for a best-in-class manager of insurance assets.

**For illustrative purposes only. This is not an exhaustive list of all of the differences and changes between IFRS 9 and GAAP ASU 2016-13 and is not to be construed as tax, legal, accounting, and/or investment advice.**

**Figure 5. Accounting practices of IFRS versus GAAP**

<table>
<thead>
<tr>
<th></th>
<th>IFRS 9</th>
<th>GAAP (ASU 2016-13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business model test</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cash-flow test</td>
<td>Solely payments of principal and interest</td>
<td>No</td>
</tr>
<tr>
<td>Measurement of fixed income</td>
<td>Amortized cost</td>
<td>Held-to-maturity (HTM)</td>
</tr>
<tr>
<td>Fair value other-comprehensive-income</td>
<td>Available for sale (AFS)</td>
<td></td>
</tr>
<tr>
<td>Fair value profit &amp; loss</td>
<td>Trading (P&amp;L)</td>
<td></td>
</tr>
<tr>
<td>Measurement of equities</td>
<td>Fair value profit &amp; loss (typically)</td>
<td>Trading (P&amp;L)</td>
</tr>
<tr>
<td>Impairments</td>
<td>Expected credit loss model (12 month or lifetime)</td>
<td>AFS – cash-flow testing HTM – expected credit-loss model</td>
</tr>
<tr>
<td>Statutory equivalent</td>
<td>N/A</td>
<td>In discussion</td>
</tr>
<tr>
<td>Effective date</td>
<td>2018, with deferral option until 2022</td>
<td>SEC filers: 2020 Other public entities: 2021</td>
</tr>
</tbody>
</table>

**Figure 6. Accounting changes in IFRS 17 and GAAP**

<table>
<thead>
<tr>
<th></th>
<th>IFRS 17</th>
<th>GAAP (ASU 2018-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracts in scope</td>
<td>All insurance contracts</td>
<td>Long-duration contracts only</td>
</tr>
<tr>
<td>Principles based</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Key changes</td>
<td>Consistency in measurement of liabilities</td>
<td>Improve liability reporting by maximizing the use of “observable inputs” (e.g., discount rates, mortality rates, expenses)</td>
</tr>
<tr>
<td></td>
<td>Distinguish contracts by profit making or loss making</td>
<td>Better reflection of market risk benefits embedded in contracts</td>
</tr>
<tr>
<td></td>
<td>Instant P&amp;L recognition of loss-making contracts</td>
<td>Reconfigure amortization of deferred acquisition costs for long contracts</td>
</tr>
<tr>
<td>Refresh of liability cash-flow data at each reporting period</td>
<td>Enhanced disclosure on long-duration contracts</td>
<td></td>
</tr>
<tr>
<td>Enhanced disclosure on all contracts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective date</td>
<td>All filers: 2022</td>
<td>SEC filers: 2021</td>
</tr>
</tbody>
</table>

For illustrative purposes only. This is not an exhaustive list of all of the differences and changes between IFRS 17 and GAAP ASU 2018-12 accounting practices, and is not to be construed as tax, legal, accounting, and/or investment advice.
end, in November 2018, Schroders released the results of a global survey of 157 insurance companies based in 15 countries and representing a total of around US$10 trillion in assets under management.²

It should come as no surprise that risk management and strategic asset allocation continue to drive insurers’ investment decision-making process (Figure 7). How investments perform within the context of the organization’s overall business and enterprise risk framework remains top of mind for all those charged with the allocation of capital. That said, the investment time horizon of the majority of companies continues to shorten, with only 10% evaluating their investments over an entire market cycle. This is an important development; traditionally, it has been a strategic asset allocation best practice to focus on the long term. Instead, respondents noted increased turnover of investments (19%, versus 13% in 2017), as well as lower expected returns on those investments (60% expect less than 5% total return).

Notably, 33% of respondents said sustainability plays a role in their investment decision making (up from 24% in 2017), while approximately 75% said they expect that it will play a more significant role within five years.

Finally, the survey highlighted expected key trends over the coming year and beyond. As one example, insurers are looking for more ways to invest without taking on substantially more market risk. Risk-managed multi-asset solutions, alternative investments with a focus on minimizing downside capture, and capital-efficient investment products are some of the approaches under consideration at this point in the credit cycle.

Strategies for managing risk will remain a central focus for insurers in putting assets to work (Figure 8), potentially heightening the usefulness of a third-party asset manager who can assist on both a consultative and investing basis.

In conclusion

Management of insurance assets will undoubtedly continue to move in the direction of greater regulation, constraints, and complexities. Taking forthright actions to adapt to new accounting standards, implement a robust and capital-efficient strategic asset allocation framework, demonstrate strong asset-liability management practices, and find creative solutions for embedding sustainability in the investment process could mean the difference between struggling with the challenges, versus turning them into enterprise-accrative opportunities. We look forward to partnering with our insurance clients to address these themes in the coming year.

References


This group is in the midst of developing core curricula that will include ownership of patient safety and quality embedded within the professional identity formation for all health caregivers and a core curriculum common to all health professions. The fundamental elements of the core curriculum will include leadership training, interprofessional team-based models and definition of competencies to be achieved, outcomes to be assessed, and milestones (which will be specialty-specific) to be identified for each stage of one's professional career (undergraduate studies, graduate medical education and unsupervised practice, across all professions), focusing beyond care of the individual patient to address systems of care.

**Scheinman:** We have a general structure of eight domains, such as error science, technology, and communication. Within each domain, there are subdomains of knowledge. For each subdomain, we have defined learning objectives of knowledge. Those objectives are different for a novice than they are for an advanced beginner or for an expert practitioner.

For each of the learning objectives, we define five developmental levels. And for each of those, there are links to resource materials: videos of patient stories, examples of that kind of error occurring, standard textual materials. The instructor can then choose the level of learning objective for the level of learner that they are working with, and can choose the resource material that they think will most effectively illustrate what they need to teach to that level of learner.

So the instructor becomes an active participant in choosing the material. What the curriculum provides is a framework, and links to material for every competency and every domain.

**IML:** Are there tests or certification exams after the students have heard all of this?

**Scheinman:** We intend to work with licensing agencies and certifying boards in a range of professions to have material on patient safety incorporated into those board exams and those licensing exams. The students will know that they need to master this material in order to do well on their licensing exams.

**IML:** I note that one of the foundational domains is error science. How detailed is the curriculum in advising on how to minimize this sort of error?

**Scheinman:** I’m going to step over to my computer now, and open up the chapter on error science. Let's see what it says. “This domain addresses the spectrum of error introducing concepts of human factors, human and technology interface, and error-prone complex systems. Content to improve patient safety through understanding and management of clinical risk, utilization of effective error reporting systems, root cause analysis performance, and application of continuous quality improvement is highlighted.”

The first subdomain focuses on “Spectrum of error and understanding and managing clinical risk.”

For this, the curriculum includes a list of ways that competency can be demonstrated for each level of professional. For example, the novice learner, after the discussion of an inpatient case, would need to identify the human factors involved, elements of the human and tech interface, and complex systems that impact clinical risk.

And then, in contrast, the competent professional would need to, for example, state how to utilize the emergency department setting to model application of clinical risk assessment.

The second subdomain is “Error reporting systems; root cause analysis; quality...
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improvement (QI).” The novice, after a didactic session, could show competency by, for example, discussing the rationale for error reporting and investigation. The competent professional could demonstrate competency by demonstrating the reporting of a “near miss” insulin dosing error.

There are diverse resources for this domain, including a video and text on a patient who survived an error (Alicia Cole), text on a patient who suffered a preventable death, provider stories, and case studies.

**IML:** Is there any contradiction in the sources you use—or are they all in sync?

**Scheinman:** That’s an interesting question. I think that overall, they have been very complementary to each other.

**IML:** Does what you’re doing relate in any way to standards of care?

**Scheinman:** Each of the domains touches on how the competencies needed relates to The Joint Commission’s National Patient Safety Goals and National Quality Forum Safe Practices.

Specifically, a goal of The Joint Commission’s National Patient Safety Goals is to reduce errors associated with anticoagulant therapy. The National Quality Forum Safe Practices stipulate that disclosures should be timely, transparent, and clear.

**IML:** Do you have all of the medical specialties represented?

**Scheinman:** That usually refers to a specialty within medicine—for physicians. Ours is a broad curriculum. We don’t—for instance—address issues of safety in regard to cardiac catheterization. Instead, we focus on the larger issues like patient handoffs.

**IML:** Has the curriculum been tested in any sort of way—by a double blind sort of test, for instance? It would be difficult to design this sort of study, right?

**Scheinman:** Yes, it would be very difficult to design such a study. We announced this just three weeks ago. It hasn’t been out there long enough, even though people are starting to adopt the curriculum.

I think it would be very good to assess what works and what doesn’t. There is a broad opportunity for scholarship around educational efficacy that would focus on doing that.

**IML:** Is the foundation also working on other safety tools, like checklists?

**Scheinman:** Yes, the foundation is working on checklists for various circumstances. This was announced at a recent meeting for patient handoffs.

**IML:** What was your biggest challenge in working on the curriculum?

**Scheinman:** I would say that was at the beginning, arriving at the framework. We had some very wide-ranging discussions at the beginning. They were so broad that it was not clear how we would provide shape to these very exciting discussions. Then we came upon the idea of establishing domains, and then subdomains, and that framework made everything else possible.

**IML:** Do you have a plan for how often the curriculum will be updated?

**Scheinman:** Our group meets monthly, and we plan to update it at least every six months. But we will also be collecting data in real time as people start using the curriculum.
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Intercontinental Stephen F. Austin
Austin, TX
26-28 Dental Workshop
Intercontinental Stephen F. Austin
Austin, TX

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Hyatt Regency at Gainey Ranch
Scottsdale, AZ
12-14 Board Governance Roundtable
Hyatt Regency at Gainey Ranch
Scottsdale, AZ

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Washington, DC
6 Leadership Forum
Omni Shoreham Hotel
Washington, DC

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Portland, OR
21-23 Underwriting Workshop
The Seelbach Hilton
Louisville, KY
23 Chief Medical Officer Roundtable (by invitation)
The Seelbach Hilton
Louisville, KY
23-25 Claims and Risk Management/Patient Safety Workshop
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