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A national election inevitably acts like a kind of black hole for the attention of politicians, the media, and to a lesser extent, the average citizen as well. The preponderance of news coverage and commentary focuses on the issues of greatest importance to the electorate and the candidates—although not always in that order. This phenomenon is not limited to the U.S. There has been political drama in many countries during the past year: changes in government leadership in the U.K. and Canada, a historically close election in Australia, and major election campaigns on the horizon in France, the Netherlands, and Germany. Ultimately, the results of every major election can have repercussions for the professionals and institutions that provide healthcare.

Now that the U.S. election is finally behind us, we will be focusing on issues of vital importance to the success of medical and healthcare professional liability (MPL/HPL) insurers. The new congressional leaders will be charting a course that will inevitably include changes to the status quo—and require the vigilance and determination of PIAA and our members.

As a prime example, consider the Medicare Access and CHIP Reauthorization Act (MACRA). This complex law, enacted in 2015 with overwhelming bipartisan congressional support, will impact physicians and other healthcare professionals in many ways and for many years to come. It addresses issues such as data reporting, new practice models, evolving clinical standards, and physician evaluations; it also provides for hundreds of millions of dollars in penalties and bonuses. The metrics that will be applied in the MACRA program are scheduled to be implemented on January 1, 2017, with the first payment adjustments beginning in 2019.

PIAA will keep a close eye on new developments with MACRA, and we will represent your interests with every twist and turn, just as we are with respect to another important issue: the National Association of Insurance Commissioner’s (NAIC) Insurance Data Security Model Act. Stakeholders commenting on this draft concur that it doesn’t really do much to promote uniformity among the states or avoid multiple iterations of duplicative data security and breach notifications. PIAA submitted its formal comments to the NAIC on the proposed Model Act in September.

Other issues will doubtless reemerge post-election. Our cover story, “Changing Medicine, New Risks for Insurers,” discusses some of the most important areas that MPL/HPL insurers should keep an eye on, like robotic surgery and telemedicine.

Another will likely be the status of patient safety and what can be done to build on the progress made in recent years. Toward that end, we feature in this issue a fascinating story of a highly effective collaboration between a PIAA member and a hospital system.

Also, the U.S. economy will no doubt continue its prominence in many discussions. In this regard, this issue includes an article, “Money Market Reform—The Buck Stops Here?” The author discusses the economic conditions that gave rise to new regulations on money market funds from the Securities and Exchange Commission in the wake of the financial crisis of 2007. His takeaway is that the market dislocations that occurred as a result of the new money market regulations offer an attractive investment opportunity for investors looking to increase yield in high-quality short-maturity assets.

Now, as the dust settles following the election, people are once again focusing on the work at hand. There will be challenges ahead—and there will be opportunities. We will be patient, and monitor all of the many areas relevant to the MPL/HPL community, striving to preserve what we have gained over the years, and take advantage of any new possibilities to advance and defend the interests of PIAA members. But with this distinction: we assume change is inevitable, but will not rest on our laurels. PIAA will engage on your behalf to ensure that any changes to our healthcare or legal systems reflect the interests of those professionals and institutions you insure—and the patients they protect.
“One of the most important concerns is whether there is a difference in the standard of care for a face-to-face consultation versus a telemedicine consultation.”
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2017 Board Governance Roundtable

**Cyber Security: What the Board of Directors Should Know**

In this presentation, Major James Bourie, United States Army (Retired), Chief Executive & Co-Founder, Nisos Group, a seasoned cyber security and cybercrime expert, will explore the scope, and possible repercussions, of today’s emerging cyber risks for MPL/HPL insurers and their clients. He will identify and examine potential threats, including cyber terrorism, with particular emphasis on the likely sources of these threats, the most common types of threats, and the most prominent cyber vulnerabilities found in many organizations. He will also provide mitigation strategies for cyber risk for boards of directors, and he will detail the key actions they will need to take if a cyber breach does happen. He will offer in-depth guidance on the key questions board members should be asking about cyber risk, and explain how best to monitor and influence policies and practices involving cyber risks. The presentation will provide the key information and practical guidance that board members need in order to become active partners with management and staff in battling cybercrime.

2017 Dental Workshop

**Pain Management and the Opioid Epidemic**

The number of opioid prescriptions written in the U.S. has increased by 400% in the past 20 years. The main driver of the increase in opioid prescriptions is the widespread use of opioids for the management of chronic, nonmalignant pain in addition to other pain management issues. So it should come as no surprise that the number of drug poisoning-related emergency department visits, hospital admissions, and deaths involving natural and semi-synthetic opioid analgesics has increased dramatically as well. In this session, a panel of dental industry experts will explore the origins and current status of the opioid prescription epidemic and the impact opioids are having on dental and oral surgical practices. A clinician, Howard J. Pactovis, DMD, Managing Director, Dynamic Dental Safety, LLC, will explain some of the best options for managing pain and discuss what healthcare providers can do to stem the tide of adverse effects from opioids. Also, an attorney, John G. Bagley, JD, Partner, Morrison Mahoney, and a claims expert, Barry J. Regan, Vice President, Claims and Risk Management, Eastern Dentists Insurance Company, will discuss some significant high-profile cases that involved the use of opioids, and then talk about the key factors that determined the outcomes in these cases.
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The Quest for EHR Interoperability: Is Blockchain the Answer?

Just saying it makes you feel smarter somehow: “blockchain.” While most of the IT-related terms for data storage sound rather wistful, “the cloud” being a prime example, “blockchain” sounds like something that could easily lift up a truck.

The promise from vendors who promote blockchain is formidable. “It would automate the integrity of the data exchange. Not only would users know if their data had been maintained, they would see exactly how it was done,” notes an enthusiastic white paper on the topic, from Gem Health.

Another promise: “The technology does not require participating parties to trust one another.” Why? Because “trust automation is built into the way information is appended to a blockchain.”

So how does it work? (Those of you who found yourselves confounded by algebra might want to stop reading now.) A blockchain is a ledger of events replicated over a widely dispersed relay network. This network is basically like a hard drive on a computer, with minimal value as a stand-alone data store. It requires an operational system and applications to make it work. Every event that is entered into the EHR—including when a record is created, accessed, appended, or shared—is timestamped and assigned a hash. The hash becomes the unique record identifier for the event.

The hash is created by a cryptographic algorithm. The hash-labeled events are bundled into blocks, and these are then connected: and thus the term, “blockchain.”

Maybe this is one of those technologies, like the Palm Pilot, that will be superseded by something way snazzier pretty quickly. But for now, it might be worth keeping an eye on.

Source: www.distributedledger.com, September 27, 2016

Public Television Features Darth Vader (James Earl Jones) in Segment on MPL

It would be hard to imagine a voice more instantly recognizable, and more immediately commanding of authority, than that of James Earl Jones. He has been seen/heard in everything from the “Star Wars” series to “The Simpsons.”

More recently, as the host of the Public Television series, “Front Page,” Jones has been tackling the issue of medical professional liability (MPL), from what the publicist for the series claims is “different angles.”

And yet, there are the same widely disputed statistics for the impact of MPL: “68,000 to 200,000 deaths annually.” And the typical (not terribly illuminating) conclusion: “Reducing the number of these incidents is important.”

What might be more important, and revealing, is some rigorous investigative journalism into how these estimates are made—and then, some thoughts on what can be done to combat the likely errors lurking beneath these dodgy estimates—before they become unquestioned bits of Internet trivia.

Source: PRWeb, September 5, 2016
Citing mounting financial losses, Dartmouth has dropped out of the accountable care organization (ACO) initiative that it had helped create.

They got part of it to work. Medicare spending on hospital stays, medical procedures, imaging, and tests declined. But that wasn’t enough. The amounts saved were not sufficient to meet federal officials’ money-saving benchmarks.

So then, Dartmouth had to pay a penalty for missing the benchmarks. Robert A. Greene, MD, Executive Vice President at Dartmouth, says, “We would have loved to stay in the federal program, but it was just not sustainable.”

CMS Acting Administrator Andy Slavitt, commenting on the status of the early ACOs, compared them to “the iPhone 2.” And the director of Dartmouth’s Institute for Health Policy and Clinical Practice, the midwife of sorts for the birth of the ACO, conceded that “the model has yet to achieve the benefit many advocates had hoped for.”

This Must Be Irony: Dartmouth College Exits from the ACO Program It Helped Develop

Source: Becker’s Hospital Review, September 12, 2016

‘How to Find $1 Million or More in Your Reinsurance Contracts’

That might just be the best headline, ever. The article begins with the uplifting query, “Can you imagine finding a million dollars of surplus funds in your ledger?”

The author of the article on PropertyCasualty360, Steve Hummer, asserts, “That’s exactly what happened to us when we ran our reinsurance contracts through a popular data-driven audit analytics program.”

How can this be? It comes about because most reinsurance agreements have error-corrections features that have no statute of limitations. So the first step (not surprisingly) is to get a hold of a copy of the reinsurance contracts, and read and fully understand them. It might be necessary to get data from the company’s policy and claims administrations as well—reinsurance isn’t just another contract audit.

In many instances, P/C companies use reinsurance contracts that are industry standard; however, the old P/C systems were code driven. To apply reinsurance correctly, you had to know and enter a code. You couldn’t even extract a full description of a loss because the field only retained 15 characters.

As the systems improved, you could save and retrieve full loss descriptions. But the code-driven environment that fed reinsurance reporting still applied. So the available codes frequently failed to support a subsequent reinsurance agreement.

Or what was keyed in didn’t make any sense.

The remedy for this muddle: to correct the potential disparities between the actual claim and the submitted code, apply a simple keyword matching search through an auditing software program.

At this point, we find that there is a hook in all this—a plug for one suite of auditing software that enables this keyword-matching search, ACL.

Observer has no idea how much the ACL program might cost (and to us, these three letters will always indicate a singularly injury-prone ligament). But the result could well be considerably more profitable than poking around the couch, looking with increasing desperation for the quarters needed to pay the pizza guy.

Source: PropertyCasualty360, September 23, 2016
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PIAA Data Sharing Project

Opioid Claims and Related Narcotics*

A REVIEW OF CLAIMS AND LAWSUITS CLOSED BETWEEN 2005 AND 2014 IN THE PIAA Data Sharing Project reporting patient outcomes of Drug Dependence • Nondependent Abuse • Poisoning

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<tbody>
<tr>
<td>Paid/Closed Ratio</td>
<td>12.7%</td>
<td>36.3%</td>
<td>24%</td>
</tr>
<tr>
<td>Average Indemnity</td>
<td>$203,321</td>
<td>$239,428</td>
<td>18%</td>
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<tr>
<td>Average Defense Cost</td>
<td>$16,982</td>
<td>$67,827</td>
<td>300%</td>
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The majority of these claims and lawsuits were against Family Practice and Internal Medicine physicians.

*PIAA Research Notes, Volume 2, Number 2, PIAA. Copyright, 2016.
In the last five years, there has been a great deal of merger and acquisition activity in the medical professional liability (MPL) community—something that was rarely seen before that. And indications are that this will continue, as the industry responds to the most challenging times since the “availability crisis” days of the 1970s, when many of today’s companies were formed.

The words “merger” and “acquisition” imply different things.

A merger is said to have occurred when two companies in the same, or in a complementary, business come together to form a combined entity—generally, a friendly joining of equals or near equals. One of those companies is usually considered to be the surviving company, in the sense that it retains its name, and if it is a public company, stock does not change hands.

An acquisition is the term used for a deal in which the surviving company is bigger or has more money and “takes over” the target company while retaining its management, physical premises, and products. Acquisitions may not be as friendly as mergers. Sometimes, the two companies may not be in the same business; for example, a venture capital organization could acquire an MPL company as an investment.

If an acquisition did not involve two MPL companies—where the acquirer is an investor—this is the easiest case, because the two business entities do not have to be merged. Here, the acquired company must understand the objectives of its new owners and work toward them. Since there is no need to merge systems and IT resources, this is a relatively easy scenario.

It is far more complex when the merger occurs between two MPL companies. There will be two IT departments that, over time, will likely be combined into one. If they both use software from the same vendor, that would be a big plus; but often, that is not the case. And there will be varying degrees of integration among the several business units. Each deal has its own flavor, but in all cases information technology has an important role in the outcome, both in the short and long term. The event of the merger came about because both companies recognized the busi-

Some amount of stress is inevitable in any merger. Management must set the tone by conveying its vision for the new combined entity.
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ness benefits to be gained from the change in ownership. There is a strategic plan behind the transaction. This must be communicated to IT as much as to any other department if it is to be successful.

Objectives in a merger
Most commonly, there will be some combination of three objectives in these deals:

- Expense reduction—gaining economies of scale as quickly as possible
- Growth in market share—either by expanding the territory where coverage is sold or by opening new distribution channels
- Diversification—introducing new products or services to the market

These objectives can sometimes be in conflict. Lowering expenses can be at odds with growth, and so can diversification, in the short term. It is critical for management to balance and articulate its goals across a timeline so that IT can develop a plan that aligns with business goals.

Planning is key to success, because the organization will be entering a difficult period. It would be unusual for two MPL companies to be fully integrated in less than a year or two—maybe longer—and in that time some business conditions will most likely change; having a plan is therefore a prerequisite to effective change management.

Some of the IT challenges that are frequently encountered in mergers are:

- **Keeping the lights on.** IT will be tasked with keeping the existing operations running at the same time as it works on the operations needed for the merger, setting its direction for the full scope of technology required, and meeting new business goals. Even with good documentation (a rarity), success will depend on retaining the key technical employees who maintain the existing installation, who may be threatened by changes in ownership and possibly by the move to new technologies. This concern should be addressed by open communications, and incentives for staying with the company should be considered if it is clear that some of the staff who are key to a smooth transition will not be retained later on. It goes without saying that whatever else is in the plan, managing day-to-day operations trumps everything.

- **Integration of business units.** There will doubtless be some degree of realignment of operations to take advantage of staff skills and to gain economies of scale. With changes in IT infrastructure and the merging of business both on the table, the timing of all of this needs careful consideration.

- **Merging the two IT departments.** If the two companies share the same tech architecture (and even better, the same application software), and that architecture is deemed to be the choice going forward, that will make life easier. If the companies have different infrastructures, one or the other may be selected, or something new to both may be the way to go. The choices made will have implications for all aspects of IT, from personnel to hardware and software. The pace of work on integration should be driven by placing primacy on supporting the business goals.

- **Inventory what exists in both companies and compile the requirements for it.** The assessment of each company’s IT structure should have begun during due diligence. It should include all components of IT: software, hardware, networking, security, in-flight projects, and so on. The output should allow the CIO to see where synergies exist, and where there are risks to integration. The requirements-gathering phase will consider the company’s business objectives and assess how the technologies that are available will—or will not—fit the company’s needs in the future.

- **Establish priorities.** At a time when resources are likely to be stretched, the need for clarity in defining priorities is a must. Setting the priorities needs to include an analysis of competing demands and then an assessment of them, according to their impact on the business, ease of implementation, and the expected benefits that could potentially be posted on the expense or the revenue side of the operation.

- **Develop a project plan and road map.** With input from the two analyses above, a plan can be created indicating projects and tasks, with dates assigned, and with dependencies and contingencies identified and built in. Most mergers specify an end date for when management expects the process to be completed. The plan should include the resources needed to make that date; otherwise, IT will have to negotiate with business management to change priorities or extend the end date.

Some amount of stress is inevitable in any merger. Management must set the tone by conveying its vision for the new combined entity and the logic for making the deal, and then by ongoing communication to all levels of the company throughout the process.

IT provides the infrastructure that binds the entire organization across all departments. For the synergies expected of a merger to be realized, the role of IT must be more critical than ever.
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A t the time of this writing, the 2016 elections are still to come, so it’s too early to predict what will happen in the 115th Congress (read the next “Legislative Update” to find out about that). But while the 114th Congress isn’t officially over (its members will reconvene in December to consider a long-term government funding plan), it’s not too early to assess how medical and healthcare professional liability (MPL/HPL) insurers fared in Washington, D.C., policy-wise, from 2015 to 2016. A careful review tells us that it’s been a very successful period for PIAA and its member companies.

Early victory
The 114th Congress started out on a strong note for MPL/HPL insurers. Congressional leaders started the legislative session by renewing consideration of the Medicare Access and CHIP Reauthorization Act (MACRA), upon which they had reached agreement the previous year. This was advantageous for MPL/HPL insurers because, working closely with the medical community, PIAA and several of its members had successfully inserted the Standard of Care Protection Act into the MACRA text.

As a reminder, the Standard of Care Protection Act was drafted to prevent federal healthcare guidelines from being misused as legal standards of care in MPL lawsuits. The language included in the bill represented the culmination of more than five years of advocacy efforts, which included numerous meetings and discussions with key policymakers on Capitol Hill, in addition to intense negotiations with the trial bar.

Those years of work paid off: When Congress overwhelmingly passed MACRA, the Standard of Care Protection Act was included in the final legislative package. This achievement marked PIAA’s most significant federal legislative victory in recent history.

Advancing priorities
Not resting on our laurels, PIAA continued its efforts to advance our other congressional objectives. At the top of that list was the Good Samaritan Health Professionals Act—a top priority for several years. This legislation grants immunity from liability for healthcare professionals who provide volunteer services to victims of federally declared disasters.

Intentionally designed to be limited in scope (it applies only after a state has requested federal disaster assistance), the bill, it was hoped, could avoid some of the contentious states’ rights arguments that had plagued previous tort reform efforts, and be considered less partisan than those efforts as well.

Since the start of 2015, we’ve gained a new Democratic cosponsor for the bill in the House—Cong. David Scott (GA-13), who delivered a rousing speech about the bill at the 2016 Medical Liability Conference in Washington, D.C. With intensified lobbying efforts and ramped-up grassroots support, we’ve secured the greatest number of cocon-
Not all of PIAA’s legislative efforts are focused on increasing support for bills or advancing them through the legislative process.

Defensive postures

Not all of PIAA’s legislative efforts are focused on increasing support for bills or advancing them through the legislative process.

Sometimes, we need to take a more defensive position, to ensure that potentially harmful legislation (even a bill that was not intended to cause us problems) is stopped outright or substantially altered. Two such proposals arose over the last two years.

The first of these was the Saving Lives, Saving Costs Act, a well-meaning piece of legislation that unfortunately raises more questions than it answers. Also known as “safe harbors” legislation, the bill aims to shield healthcare providers from lawsuits if they can demonstrate that they adhered to certain treatment guidelines. While the bill does ensure that the government could only accept guidelines that had been previously approved by the medical community, it does nothing to ensure that such guidelines actually keep up with the rapid pace of advances in medicine. So the bill could, potentially, deter healthcare professionals from providing the latest therapies because doing so may expose them to liability claims. In addition, the bill could encourage “cookbook” medicine. Healthcare providers might be discouraged from using their own experience and training to determine the best course of action for a patient. PIAA has continued to communicate with the bill’s congressional advocates to recommend that they not move forward with the legislation until significant adjustments have been made.

The second bill in this category was the Sports Medicine Licensure Clarity Act, legislation that was the focus of my last “Legislative Update” (Inside Medical Liability, Third Quarter 2016, page 17). As I noted there, even though the bill was not a legislative priority for PIAA, we invested a substantial amount of time to ensure that it would not have negative ramifications for MPL/HPL insurers. Our work included meetings with medical society...
stakeholders, discussions with Capitol Hill staff, and negotiations (once again) with the trial bar. The end result was a bill that had at one point included dangerous mandates for MPL/HPL insurers now, instead, ensured that questions about out-of-state coverage for team physicians could be addressed in a way that was fair to all parties.

Phoenix rising
As in much of life, not everything on PIAA’s wish list turned out as we hoped. Early in 2016, the House Judiciary Committee scheduled a markup (i.e., an opportunity to amend and approve legislation) for the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act, the tort reform legislation long favored by PIAA. Unfortunately, the committee action was scheduled such that PIAA had little time to prepare an adequate advocacy strategy, and congressional leaders underestimated the states’-rights-based opposition in the Judiciary Committee. As a result, the bill had to be withdrawn from consideration so it wouldn’t be voted down by the committee.

Subsequent discussion with key Capitol Hill staff indicated that it was unlikely that the HEALTH Act, as it had existed for more than a decade, could pass in the current political environment. Democratic opposition remained as strong as ever (perhaps stronger, given the election losses in recent years of so many of the Blue Dog Democrats who had previously supported the bill), and the states’ rights concerns that had taken hold among a significant number of Republicans.

While certainly not good news, this turn of events did have an upside. PIAA had long contemplated updating the HEALTH Act to increase its level of support, and this provided us with the perfect opportunity to develop a new bill. For months, PIAA has been working closely with a variety of medical associations to develop a new bill from the ashes of the old. While more work remains to be done, it is safe to say several things about the draft bill: It will retain all the traditional reforms we’ve always supported (caps on damages, limitations on attorney fees, etc.); it will be narrowly focused, covering only healthcare professionals and entities; and it will include some new reforms that have proved successful in the states. Discussions are nearing the final stage, and we look forward to sharing more about this important bill with you in the near future.

Conclusion
On the whole, the 2015–2016 legislative period in Washington, D.C. has definitely been positive for PIAA and its members. There’s always more work to be done, but we can look back on the successes of the 114th Congress and be proud of what we have accomplished together. As we look forward, we can also find opportunities for additional success, with both old and new proposals, in the future.
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On September 29, 2015, the Supreme Court of New Jersey decided Jarrell v. Kaul, 223 N.J. 294, 123 A.3d 1022 (2015), a case that simultaneously restricts and expands theories of medical professional liability (MPL) against healthcare providers. Addressing three issues relating to the statutory requirement that physicians licensed to practice medicine in New Jersey must obtain and maintain MPL insurance pursuant to N.J.S.A. 45:9-19.17, the court considered whether: (1) an injured patient may bring a direct action against a negligent, uninsured physician; (2) failure to comply with the statutory MPL insurance requirement gives rise to an informed consent claim; and (3) a healthcare facility granting privileges to a physician to treat patients in its facility has a duty to determine and monitor a physician’s compliance with the statutory MPL insurance requirement.

Jarrell is an MPL case in which the plaintiff was treated by defendant Richard A. Kaul, MD, a board-certified anesthesiologist who focused on pain management and minimally invasive spinal procedures. Dr. Kaul saw patients and performed procedures at defendant Market Street Surgical Center (MSSC). The plaintiff saw Dr. Kaul for back pain that Dr. Kaul diagnosed as a herniated lumbar disc, lumbar radiculopathy, and discogenic back pain. Dr. Kaul performed a spinal fusion procedure on the plaintiff. After the surgery, the plaintiff experienced new pain in his left side that worsened over time, eventually resulting in a “drop foot,” chronic pain, and limitations in his physical activities, which persisted even after a subsequent procedure by another doctor to address the plaintiff’s new symptoms.

The plaintiff and his wife sued Dr. Kaul and MSSC for malpractice in a multi-count complaint that included several claims based on Dr. Kaul’s failure to maintain MPL insurance as required by New Jersey statute, N.J.S.A. 45:9-19.17. The plaintiff also asserted a claim that defendant MSSC negligently and unreasonably facilitated performance of an unauthorized surgical procedure by a physician who was unqualified to perform the plaintiff’s surgery based on the physician’s failure to carry the requisite minimum MPL insurance.

The court responds
After reviewing the legislative and regulatory history of the MPL insurance requirement, the
New Jersey Supreme Court first addressed the question of whether an injured patient has a direct cause of action against a treating physician who does not comply with the statutory insurance requirements. Noting that neither the statute nor its implementing regulations expressly provide a direct cause of action for an injured patient, the court held that the legislative history and statutory language did not support either an express or implied private cause of action.

The New Jersey Supreme Court explained that under New Jersey law, the Board of Medical Examiners (BME) is charged with regulating the practice of medicine in New Jersey, and the State Legislature “expressly concluded” that the BME “would be the most likely vehicle to ensure compliance with the MPL insurance requirement.” Jarrell, 223 N.J. at 309, 123 A.3d at 1031. As the court explained: “Administrative oversight and enforcement is the declared enforcement mechanism and that choice reflects a legislative decision to encourage and force compliance rather than wait for a complaint by an injured patient that may never be filed.” Id. at 309, 123 A.3d 1031. The New Jersey Supreme Court thus concluded that the statute, N.J.S.A. 45:9-19.17, does not expressly or implicitly recognize a direct cause of action by an injured patient against a physician who fails to obtain the requisite MPL insurance. Id. at 309, 123 A.3d at 1031.

Second, the New Jersey Supreme Court addressed the plaintiff’s informed consent theory, framing the question as, “whether the absence of statutorily mandated medical malpractice liability insurance may be information that a reasonably prudent patient would consider material to his or her decision to proceed with the course of medical treatment or surgical procedure.” Id. at 309, 123 A.3d at 1031. The court reaffirmed prior case law holding that the doctrine of informed consent is based on negligence concepts with a focus on risks pertaining to the specific proposed medical treatment: “[I]nformed consent is predicated on the duty of the physician to disclose to the patient the information that will enable the patient to make a reasoned evaluation of the nature of the proposed treatment, any risks associated with it, and those risks associated with any alternative treatments.” Id. at 315, 123 A.3d at 1035. (citing Largey v. Rothman, 110 N.J. 204, 208 (1988)).

The absence of insurance, the court explained, “bears no relation to the nature of the proposed medical course or to the risks attendant to a proposed procedure or treatment.”

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ever contemplated. Applying the informed consent jurisprudence to the financial consequences of negligent care by an uninsured physician untethers the remedy from its theoretical underpinnings and is a stark departure from our prior jurisprudence. We discern no principled reason to extend the additional and questionable relief that the informed consent doctrine may provide to an injured patient to address the financial insecurity of a physician.

Id. at 316, 123 A.3d 1035. The New Jersey Supreme Court affirmed the dismissal of the informed consent claim.

Is Jarrell the only case? Recognizing, as the New Jersey Supreme Court did, the attenuated nature of the relationship between a physician’s insurance standing and a proposed procedure or treatment, it is not surprising that the theory presented by the plaintiffs in Jarrell appears to be the only reported case nationwide in which such a theory was advanced, although a similar theory has been used in some cases. A number of state courts have addressed claims by patients alleging that their physician misrepresented his or her credentials and background prior to a procedure. In most of these instances, the courts have also dismissed such claims. A number of state courts have addressed claims by patients alleging that their physician misrepresented his or her credentials and background prior to a procedure. In most of these instances, the courts have also dismissed such claims. Some courts have suggested a basis for a potential theory of liability against a hospital, surgical center, or other facility that grants privileges to an uninsured doctor or fails to check regularly to confirm that its doctors maintain the requisite MPL insurance. Consequently, hospitals, surgical centers, and other facilities operating in New Jersey should ascertain that they have procedures and protocols in place to confirm periodically that all doctors with privileges in their facility have, and provide proof of, MPL insurance coverage in compliance with N.J.S.A 45:9-17 and related regulations.

The takeaways
The takeaways from Jarrell are a mixed bag for healthcare professionals. On the one hand, Jarrell provides restrictions on MPL claims against uninsured and insured doctors. On a basic level, Jarrell holds that an injured patient does not have a direct cause of action against a physician who fails to obtain or maintain the statutorily required MPL insurance or letter of credit in New Jersey.

Beyond this direct ruling, Jarrell’s analysis of the informed consent doctrine will be beneficial to both insured and uninsured physicians, because the case confirms that under New Jersey law, the scope of the informed consent doctrine is limited to disclosure and discussion of information pertaining to the specific medical risks associated with proposed or alternative treatments being considered by the patient. The New Jersey Supreme Court explicitly rejected any effort to expand the application of the informed consent doctrine based upon alternative theories, such as fraud, deceit, or other improper conduct resulting in a financial loss other than risks inherent in the treatment. Jarrell thus precludes using the informed consent doctrine to assert novel theories of liability against doctors and other healthcare providers.

On the other hand, Jarrell provides a basis for a potential theory of liability against a hospital, surgical center, or other facility that grants privileges to an uninsured doctor or fails to check regularly to confirm that its doctors maintain the requisite MPL insurance.

Disclaimer
This article was prepared and published for informational purposes only and should not be construed as legal advice. The views expressed in this article are those of the author and do not necessarily reflect the views of the author’s law firm or its individual partners.

References
1. Wisconsin is the only other state that allows a misrepresentation of credentials or background to proceed under an informed consent theory. Johnson v. Kokernoot, 199 Wis.2d 615, (Wis. 1996).
2. See, e.g., Bethue v. Conulli, 248 Ga.App. 853, 546 S.E.2d 542, 544 (Ga.Ct.App. 2001) (holding that patient may not bring claim for fraud independent of claim of medical malpractice); Ditto v. McCurdy, 86 Haw. 84, 947 P2d 952, 958 (1997) (holding that failure to disclose lack of board certification as plastic surgeon, as opposed to other board certifications possessed, did not violate requirements for informed consent or render doctor liable for fraud); Duttry v. Patterson, 565 Pa. 130, 771 A.2d 1255, 1259 (2001) (holding that alleged affirmative misstatement of credentials does not support claims for lack of informed consent, but suggesting that claim for misrepresentation may be appropriate).
The plaintiff’s bar may consider the use of new medical devices and the introduction of new modes of healthcare delivery as potential new focal points for medical professional liability (MPL) litigation. What types of emerging new claims, or tactics, arising from medical advancements might insurers encounter? In this article, I present some insights gleaned from interviews with attorneys on both sides of the bar and, in addition, a review of recent trial-lawyer literature, focusing on three representative areas to help understand potential new claims trends and new sources of litigation.

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Jerry Theodorou is Vice President, Insurance Research, at Conning.
In contrast to the traditional operating environment where a senior surgeon is supported by “hands-on” surgical assistants who receive valuable training there, in the surgical robot environment the training aspect is minimized, with a senior surgeon controlling the operation. If the robot model predominates, and residents have less of an opportunity to acquire the practical apprenticeship skills at a mentor’s side, they may in the future be less equipped to handle difficult situations, giving rise to more medical misadventures and, subsequently, more MPL claims. What is more, experienced physicians have said that robot-controlled procedures are difficult to teach to residents when they are using the dual-console approach, which some have compared to video games or the dual-control cars used in driver education.

In fact, surgical robotics seems to have become an area attracting interest from personal injury lawyers. Any Internet search for information on the technology leads one to dozens of plaintiff’s attorneys advertising for potential individual or class action clients. According to a recent study by the Food and Drug Administration, there has been a 0.47% incidence of accidents resulting from surgical robot malfunction. These incidents included burnt or broken pieces of tools falling into the patient, electrical sparking, and the robot making an unexpected sudden movement. Some sources have indicated, however, that adverse events are actually more commonly caused by improper training on the device, rendering the risk more like those in traditional physicians’ MPL-related adverse events, rather than linked with product liability.

New medical technology developments represent a premium growth opportunity for medical and healthcare professional liability insurers, in a line of the insurance business that has been characterized by shrinking premium. At the same time, however, insurers should enter these new vistas with their eyes wide open, aware of the inherent risks and knowing how this technology attracts the attention of the plaintiff’s bar.

Telemedicine

According to our discussions with defense counsel, the growth of telemedicine, enabling long-distance contact between physicians and patients, is another area that raises questions and may expose vulnerabilities for MPL-related litigation. Telemedicine has attracted the plaintiff’s bar’s interest in potential attendant new risks. Areas with unanswered questions that could lead to MPL exposure include the applicable standard of care, physician licensing, credentialing, and privileging. In general, the jurisdiction and choice of laws applicable are the state where the patient is located, which determines the standard of care applicable, regardless of where the remote physician is located.

Although personal injury attorneys advertise for clients alleging telemedicine-related negligence, our research shows that there have been relatively few telemedicine-related MPL lawsuits. Some ambiguous points regarding jurisdiction have still not yet been fully tested in court. One of the most important concerns is whether there is a difference in the standard of care for a face-to-face consultation versus a telemedicine consultation.

Cases that have arisen related to telemedicine have involved telemedicine practitioners prescribing medications over the Internet. Most of these cases involved physicians prescribing medications to patients in other states without a prior examination of the patients. In a representative case, Hageseth v. Superior Court, a California physician prescribed a generic version of the antidepressant Prozac to a patient in Colorado. The patient filled out an online questionnaire, but there was no other communication between the physician and the patient.
Following the patient’s suicide, the doctor was sued by a California district attorney. The California court held that California had jurisdiction because the physician intended his acts to have effect in California. Other cases also involved customers receiving prescription drugs via the Internet by filling out an online application, without the doctor ever seeing the patient.

Notwithstanding the current paucity of telemedicine MPL cases, there is some potential that ambiguities in developing rules for “privileging by proxy,” and the application of traditional guidelines for credentialing and privileging of physicians providing telemedicine services, may lead to MPL-related litigation. Because telemedicine often involves parties from several states, there could be a significant opportunity to exploit any procedural chinks in the complex process at the intersection of telehealth and the formal granting of credentials and privileges at the receiving institution.

Corporate medicine

The mass migration of physicians from private and small-group practice to hospital employment, coupled with the increasing volume of private equity investment in healthcare delivery facilities, constitutes another locus of attention from the plaintiff’s bar and thus potential MPL claims. To the extent that medical decisions, doctors’ workloads, and compensation structures are established by non-physicians, there may be greater potential for adverse outcomes and litigation that has been exacerbated by overwork and volume-based bonus incentives. Some corporate dentistry cases may be illustrative of future litigation in other areas of corporate medicine.

There have been several instances of Medicaid-focused dental chains allegedly engaging in activities motivated by revenue generation rather than patient care, and children were harmed in the process. Medicaid-focused dental chains were the subject of a joint staff report for the Senate Finance Committee in 2013. The report found numerous incidents of overtreatment, including unnecessary root canals and excessive silver crowns, and this resulted in multi-million-dollar settlements. A mass-tort attorney characterized the clinics as practicing “assembly line dentistry.”

The increasing amount of investments in healthcare sectors by non-physicians begs the question of whether unlicensed professionals can own practices and, in so doing, can direct care. Some have argued that corporately owned hospitals and physician practices driven by short-term interests may push doctors to favor quantity over quality with compensation arrangements involving production quotas and bonuses. There may be relevant lessons to be learned from litigation involving private equity-owned nursing home facilities a decade ago.

Should similar situations ensue in other healthcare sectors, we might see a greater likelihood of mistakes and adverse outcomes, leading to lawsuits and liability claims. In North America, there was $15.6 billion in healthcare buyout activity, in 80 deals, according to the 2015 Bain Healthcare Private Equity Report. This represents a quadrupling of activity since 2001.

Historically, healthcare private equity investments have focused on areas with high reimbursement, such as dermatology and pain management, but now we see a shift to areas of primary and managed care. The top five areas of investment, according to Becker’s Hospital Review, are for-profit hospitals and health systems, health IT and electronic health records, laboratory businesses, medical devices, and behavioral health.

A prepared mind

Pasteur’s famous quote emphasizing the importance of a “prepared mind” for medical researchers applies in spades to underwriters facing the challenge of evaluating and pricing risks from new medical technologies and processes.

Changes and advances in the medical field represent much needed new potential premium in the shrinking healthcare professional liability line. At the same time, however, they are already attracting the interest of personal injury attorneys seeking to allege negligence in the adverse outcomes associated with the developments.

In today’s rapidly changing medical landscape, with limited data on the impact of the latest advances, insurers can only venture to provide cover when equipped with a thorough understanding of the new risks and the strategies the plaintiff’s bar will use in alleging negligence. Favorable underwriting results in the MPL line in the past decade have been attained by virtue of active loss prevention and heightened emphasis on patient safety, where the interests of insurers and insureds are fully aligned. Medical and healthcare professional liability insurers can minimize surprises when they adopt a similar partnership arrangement as they venture into emerging risks in underwriting.

Before plaintiff’s attorneys decide to initiate litigation, they evaluate the economics of a suit to answer the question, “Is the game worth the candle?” The more they encounter potential defendants that are prepared with a sound understanding of today’s emerging risks, the more likely it will be that the answer is “no.”
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Joe Montgomery, Judy Halstead, Christine Stiles, TC Wilson, Bryce Lee, Robin Wilcox, Cathleen Dillon, Kathryn Jenkins, Brian Moore, Loughan Campbell, Karen Hawkridge, Vicki Smith, Brad Stewart and James Johnson
Crafting an Ambitious Plan to Improve Surgical Safety

How Saint Francis Hospital and Medical Center, with Support from Coverys, is Improving Surgical Safety at 22 Hospitals across Connecticut

By Gregg Hanson and John F. Rodis, MD
Safe surgery—it’s what every surgeon and hospital staff aims to achieve each time a patient is prepped for an operation. And, in most cases, that’s exactly what happens: positive outcomes, controlled healthcare costs.

But try as we might, healthcare organizations in America today still face major challenges when it comes to reducing the risk of preventable error in the perioperative process (i.e., preoperative, intraoperative, and postoperative). Managing the risks associated with surgery requires a bold vision, adequate resources, and ongoing vigilance on the part of practitioners and organizational leaders alike. So when Coverys was approached by Saint Francis Hospital and Medical Center (Hartford, Connecticut) with a grant application to support an initiative to ultimately eliminate the risks of preventable errors during the perioperative process, the Coverys Community Healthcare Foundation saw an opportunity to fulfill its own commitment to improve patient safety.

Coverys is committed to serving the needs of the healthcare community. And thus Coverys is taking proactive measures to work strategically as risk management consultants to prevent liability and improve patient care. And through its foundation, Coverys also supports the outstanding work of others in the pursuit of improving patient safety and quality of care.

The Saint Francis-Coverys collaboration

In 2014, the Connecticut Department of Public Health released a report to the state legislature that was alarming. It showed that many Connecticut hospitals were experiencing serious issues with patient safety—that iatrogenic errors were causing adverse patient outcomes. In 2014, the number of reportable events in Connecticut hospitals (534) was twice as high as in any of the previous eight years.

Specifically, two types of errors were on the rise: perforations during open, laparoscopic, and/or endoscopic procedures, and retention of foreign objects in patients following surgery.

Not long after the report was released came an opportunity for a coalition of organizations to take action to save lives, prevent hospital readmissions, and reduce healthcare costs across the state. Saint Francis Hospital and Medical Center—an integrated healthcare system known for its commitment to quality care—was three years into an ambitious plan to improve surgical safety as part of a statewide initiative led by the Connecticut Surgical Quality Collaborative (see sidebar, “By the Numbers” for more about the collaborative).

Saint Francis and the collaborative had achieved outstanding results, and they were seeking significant support to sustain their efforts over the long term when they applied to the Coverys Community Healthcare Foundation for a three-year, $990,000 grant. The grant was awarded in 2015.

Saint Francis Hospital, partnering with the newly formed Connecticut State Quality Collaborative, had three clear goals:

1. Decrease the number of iatrogenic postsurgical complications/occurrences in patients undergoing surgery in all 22 partnering hospitals.
2. Train all teams in evidence-based protocols and strategies that are designed to reduce the risk of error by improving teamwork and intra- and inter-team communication.
3. Embed innovative technology for goal-directed fluid therapy in surgical suites, to turn each surgical suite into a “smart OR” that collects data that can be shared weekly through a database, where collaborative-affiliated practitioners participate in a forum for feedback on the effectiveness of new technologies and best practices.

“Patient safety is the highest priority at Saint Francis,” said David S. Shapiro, MD, Chairman of Surgery at Saint Francis. “The significant changes in protocols and procedures that we’ve made are resulting in dramatic reductions in perioperative errors and in adverse patient outcomes. I’m convinced that the success achieved at Saint Francis can be replicated in many hospitals.”

Between 2010 and 2014, the extensive training on surgical safety protocols, training that improved multidisciplinary team communication, and the flattening of the traditional hierarchical culture of the surgical suite at Saint Francis led to:

- More than 400 averted readmissions
- A reduction of more than 2,500 hospital days
- Zero retained foreign objects in patients
- A 20% reduction in surgical-site infections
- An estimated 150 lives saved
- A savings of $7.5 million in healthcare costs.

Understanding the changes made at Saint Francis

Saving lives, preventing readmissions and infections, and savings millions in healthcare costs has not been an easy task. The changes at Saint Francis have been many and involve a dedication to using new processes and procedures that improve teamwork and communication, change the patient care protocols, and embed innovative technologies into the surgical experience.

The ERAS patient care system. Saint Francis has undergone extensive staff training to implement the enhanced recovery after surgery (ERAS) protocol. ERAS represents a paradigm shift in perioperative care because it replaces traditional practices with evidence-based best practices, like new approaches to fasting and fluids for patients prior to surgery, and providing a drink fortified with minerals, vitamins, and electrolytes a few hours prior to surgery, plus non-narcotic painkillers and epidurals.

The smart OR with innovative technologies. New, significant training at Saint Francis that has enhanced the ERAS protocol is training in the use of “smart OR” technology during the perioperative process that enhances the precision of goal-directed fluid therapy. It
Surgical Safety

uses a noninvasive and more accurate monitor that is placed on the patient’s finger and replaces the use of invasive artery monitors. Saint Francis is using the ClearSight System™ with the EV1000 monitor.

The teamwork and communication enhancements. All multidisciplinary perioperative teams in the 22-hospital collaborative are receiving ongoing training in the following:

- Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS), a methodology that increases the effectiveness of multidisciplinary perioperative teams that are working under stressful, high-stakes situations, and that employs four core principles: leadership, situation monitoring, mutual support, and communication
- The Situation, Background, Assessment, and Recommendation (SBAR) toolkit, which is used in briefings prior to surgery, in “time outs” and huddles during surgery, and prior to the transition of care after surgery is completed
- The Association of periOperative Registered Nurses’ (AORN) Surgical Safety Checklist.

The Saint Francis simulation studio. Saint Francis knows that practice makes perfect. That’s why its state-of-the-art simulation studio is available to all perioperative teams for critical training. In the studio, teams can practice new protocols, use new technologies, hone their teamwork skills and communication, and try out new clinical procedures on manikins prior to working with live patients.

The power of collaboration

What is happening at Saint Francis and across the Connecticut Surgical Quality Collaborative is a testament to the remarkable results that can be generated when dynamic leaders at several organizations come together with a shared set of values and goals. Many noteworthy changes have been implemented across 22 hospitals in Connecticut due in part to the critical funding from Coverys and others. In 2015 alone, the Collaborative has seen additional benefits such as:

- 20% reduction in surgical-site infections for colon procedures
- A strong culture of patient safety in the perioperative process
- Overall decreased risk of adverse events and unintended patient outcomes.

Prior to the nearly $1 million grant to Saint Francis from Coverys, the collaborative had suffered more than 2,000 layoffs across its hospitals and was forced to cut budgets for critical patient-safety training because the funding wasn’t there.

“It’s so important to support such significant efforts and such a deep commitment to improving patient outcomes,” said Donna M. Norris, MD, committee chair of the Coverys Community Healthcare Foundation, when asked why Coverys chose to support Saint Francis in such a big way. “Eliminating preventable human error in the perioperative process is not just a bold goal but an achievable one. We are proud to have provided the resources needed to help save lives and improve health throughout Connecticut.”

Standing behind physicians, in more ways than one

By offering grant support in addition to insurance coverage for Saint Francis, Coverys has demonstrated an excellent approach to extending its mission to improve patient outcomes. The Saint Francis story is a case in point that demonstrates how closely aligned the areas of focus and concern can be at both hospitals and insurance companies. In fact, Coverys recently completed a root-cause analysis of five years of claims data and discovered that alleged surgical error accounted for 22% of all claims—the second-highest category of claims. The trends seen in Connecticut were the same trends Coverys has been seeing across the nation.

“What has been achieved at Saint Francis and what we expect will be replicated throughout the Connecticut Surgical Quality Collaborative is inspiring proof that the statistics can be changed when the right process, procedural, and communications improvements are implemented,” said Dr. Norris. “Saint Francis has made outstanding strides and should be commended. By supporting them along the way, we’re doing our part to improve patient safety and reduce perioperative risk in integrated and comprehensive ways.”

The Connecticut Surgical Quality Collaborative (CtSQC): By the Numbers

| Founded in 2011 |
| 22 member hospitals, with more hospitals planning to join in the next three years |
| Has saved 150+ lives |
| Prevented more than 400 readmissions |
| Reduced healthcare costs by $7.5 million |
| Experienced a 20% reduction in surgical-site infections |
| Have secured nearly $3 million in funding from organizations like Coverys to make its work possible |
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Burned-out Physicians in Litigation: Providing the Support They Need

By James W. Saxton, Esq., and Daniel Shapiro, PhD

The phone call was unsettling, because our preparation had been significant. We’d conducted multiple sessions, including videotaping and exhausting mock cross-examinations. Over time, the doctor’s demeanor had improved. Before, he’d rocked nervously and answered with a halting cadence, his eyes down and looking away—now, he was sitting with his chin up, speaking clearly, and with that calm authority we knew the jury would appreciate.

To us, it seemed he had finally relaxed enough to tell the court his story effectively. He was ready, and not a moment too soon.

But then the call, and his reedy voice saying, “I just can’t. I can’t think about it anymore. I don’t trust any of them, not the jury, not the judge. I can’t sleep, I have headaches. You have to make this go away. Please.”

Although we believed him, we thought that with some additional pressure we could get his cooperation, but we also knew that in his current state he’d be a terrible witness. So, another winnable case, or perhaps at least a compromise verdict or negotiated settlement in a more rea-
BURNED-OUT PHYSICIANS

sonable range, was going to be settled at a number more in line with the plaintiff’s demand.

This has to stop. Not only because of the financial repercussions, but because it isn’t just. A physician who loses a winnable suit because he’s frozen at the intersection of his psychological state and the arduous nature of litigation has revealed another flaw in our system. Not to mention that it encourages plaintiff’s attorneys to pursue unjustifiable cases aggressively, just because they feel they can ultimately intimidate a physician.

In addition, the doctor may never be at peace about what has transpired. While in the short term it will doubtless feel good not to wake up thinking about the case, the long-term consequences, including the need to report the inflated settlement on credentialing applications and responding to the state board inquiry, will be bitter reminders. No: A win, well within our sights, would be much better.

Laurie C. Drill-Mellum, MD, was right in her comments in the Second Quarter 2016 issue of Inside Medical Liability (“The Evolution of the Chief Medical Officer Role in MPL,” page 41). Physicians’ health (both mental and physical) must assume a more prominent position in society and in our approach to litigation. Physician well-being impacts not only their productivity and liability; it also challenges this group of professionals we all need so badly, down to their very souls.

Why the focus on physicians’ health now? Not just because the statistics on it are so alarming, but also because healthcare is going through a period of transition and with transition comes additional stress.

Why the focus on physicians’ health now? Not just because the statistics on it are so alarming, but also because healthcare is going through a period of transition, and with transition comes additional stress. So if anything, now is the time to focus on understanding better the root cause of physicians’ stress and, equally important, learn how to support, manage, or defuse it.

Our firm has invested in understanding how to better recognize stress and help in light of this growing concern. We recently hired a Director of Physician Health, a noted national psychologist on the subject, Daniel Shapiro, PhD. The following summarizes some of the work Dr. Shapiro has done and highlights some statistics that show just how severe this problem has become.

Psychological status of physicians

By any occupational measure, physicians are a psychologically vulnerable population. Whereas status, economic power, job security, and education are typically protective factors against distress, physicians score at the very top of distress scales, including measures of burnout—the latest studies show that 54.4% of physicians have at least one symptom of burnout and depending on specialty, upwards of 40% to 55% of physicians are severely burned-out, demonstrating symptoms of fatigue, withdrawal, irritability, and depersonalization. And the rates are getting worse. A repeated Medscape survey of thousands of physicians has found that rates of burnout have increased by 16% in the last two years. In profound cases, physicians experience severe depression, substance abuse, and even commit suicide at higher rates than we see in professionals of equal status and economic power.

Notably, burned-out physicians are more likely to be sued. They are less productive and practice medicine less safely, have significantly higher medical professional liability (MPL) claim rates, and are at risk of leaving their practice abruptly. Burnout worsens morale and can rapidly corrode a brand that may have taken decades to create. Recognizing the importance of burnout, healthcare enterprises around the world have called for the expansion of the Triple Aim to include health professional wellness as a fourth aim. But progress in ameliorating burnout has been painfully slow and lags well behind the powerful forces that are exacerbating distress, including increased patient loads, time-consuming and frustrating electronic health records, reduced compensation, and the increasingly public nature of safety, quality, and satisfaction reports. In addition, mergers and acquisitions are upending the career trajectories of many physicians whose paychecks and work environments are quickly changing.

Put simply, today’s physicians often feel that they are practicing high-stakes medicine in a public fishbowl with too many patients, too little support, and in systems in which they feel they have little input or control.

As a result, physicians are coming into the stressful MPL system with their psychological tanks already on “empty.” And then, when we most need them to be able to advocate for themselves, we are doing a poor job in recognizing and addressing the psychological distress they experience.

Unlike attorneys, who have been professionally acculturated to litigation and are familiar with its feigns and parries, strategies and tactics, physicians often have surprisingly little familiarity with the system and are unaccustomed to being accused of negligence, ignoring
patients’ pain, or recklessness. Nor have they had hundreds of hours to pore over every decision they’ve made on each of their many patients. The hot, and overly critical, magnifying glass of the plaintiff’s attorney is typically unlike any review of care they’ve experienced at the hands of teachers and colleagues who naturally understand the realistic confines of care.

As a result, physicians often describe MPL litigation as among the worst experiences of their entire lives. A Medscape survey of 4,000 physicians revealed that 46% of men and 57% of women who were sued describe it as either one of the worst experiences of their lives or as a very bad, disruptive, and humiliating experience.11 Unfortunately, many defense attorneys either don’t recognize this distress or underappreciate it, preferring to focus on the challenging case at hand. Worse, some attorneys mistakenly believe that if a case is defensible, the physician must feel optimistic when, in reality, the majority of physicians are distressed during litigation and a significant percentage are so distressed that they are even considering abandoning the case, medicine, or both.

What can be done in the litigation arena?
The first step is identifying which doctors need greater support. This is not obvious. In colleges of medicine, we train physicians, often covertly, to ignore their own needs in the service of their patients. They learn during medical school and residency to grind out care even when they feel unwell, exhausted, or stressed. In fact, in recent surveys 83% of physicians and advanced practice clinicians admitted that they had worked at least once in the past year when they were too ill to work effectively.12 They are taught not to complain and to meet the needs of their team as soon as they arrive at their practice setting. As a result, most physicians are not quick to share when they feel anxious, upset, or distressed.

One of us (D.S.), a psychologist who has treated physicians for many years, has noticed that they present for psychotherapy or even couples therapy at a significantly later point in their difficulty than others. Whereas other clients typically acknowledge the point when their discomfort has grown severe enough to prompt them to seek help, physicians tolerate that level of anguish and refuse to seek help until they approach a total loss of function or are referred because of aberrant behavior. As a result of this tendency to ignore discomfort until it has grown severe, it is usually impossible for attorneys to accurately assess the psychological states of their physician clients simply through observation.

For that reason, our team has developed two assessment tools. The first, a clinical effectiveness survey, is designed to detect and prevent specialty-specific, high-risk behaviors (for example, surgeons failing to routinely administer prophylactic antibiotics within one hour of skin incision) and general risk factors (such as burnout). This clinical effectiveness survey helps hospital administrators, practice managers, and other leaders identify their systematic medical-legal vulnerabilities.
BURNED-OUT PHYSICIANS

The second tool assesses physicians after they’ve been named in a suit. Dr. Shapiro developed the Witness Inventory for Health Professionals (WIP), a 10-question survey in three sections. The first assesses the physician’s psychological response to being sued and provides a score that can be compared with that of other litigants. The second section is designed to assess their typical responses to stress, especially observable behaviors that might worsen their ability to serve as advocates for themselves as a witness. The final section assesses their routines for self-care, including activities that improve or worsen their sense of stress.

In our initial meetings with physician clients who have been named as defendants in MPL actions, our lawyers now provide each doctor with the WIP survey. The assessment enables our legal team to identify providers who are in need of additional psychological support and coaching during the litigation process. Many attorneys are hesitant to inquire prospectively about the psychological status of their clients out of respect and perhaps over concerns about the firm’s clients out of respect and perhaps over concerns about the firm’s resources. But it’s our experience that physicians will readily acknowledge their psychological distress on the WIP and indeed, many are well accustomed to responding to burnout and engagement surveys that are ubiquitous in hospital systems. Unfortunately, insurers and lawyers have been too slow to embrace this scientific approach to assessing the well-being of physicians.

Developing a plan
Once we understand the psychological strengths and deficits facing our clients, we can begin to craft a personalized plan that improves their well-being and their ability to navigate the legal system as a witness. This may translate into seeing fewer patients for a while, improving self-care activities, and taking an honest look at their priorities. In the best situations, a suit can be a wake-up call that helps physicians transition to healthier lifestyles and practice patterns. This, in turn, can make them a more confident, capable witness.

Dr. Shapiro has brought into focus a number of issues at our firm. We can help identify at an earlier point when our healthcare professionals need help and actually support them in a fashion that works. There is science behind this, and privacy can and should be respected. Significantly, for the MPL industry, and certainly for defense counsel, we can develop more confident witnesses, who are ready and able to take the stand and tell their story. We know that when this happens the result is overwhelmingly positive.

First, it is what our doctors deserve. Second, it has the potential to transform a case from one in which the healthcare professional is truly engaged and a full contributor to the team. We need this counterbalance. Plaintiff’s strategies around the country include adding punitive damages, asset discovery, and threatening attachment of personal property, all in an effort to intimidate. It is easy for us to say such findings are remote; we are not in the proverbial hot seat. Of course we need to continue to fight the legal and strategic battle aggressively, but, in addition, providing an additional level of scientifically based psychological support, along the lines Dr. Shapiro is suggesting, will make a difference. We have seen the results. Since bringing Dr. Shapiro aboard, we don’t get calls like the one related in the opening sentences of this article. Our physicians are in a better position to endure litigation and are able to use the experience as a reminder that they need to make a greater investment in self-care and other protective activities.

References
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When dental patients undergo procedures like a root canal, they’ve come to expect that they will receive a prescription for a potent opioid such as Vicodin before they leave the dentist’s office. But in recent months, opioids have been implicated in a national crisis of drug addiction.
So the question is: Can dentists achieve an appropriate level of pain mitigation for most procedures without opioids, by using other kinds of medications instead?

In fact, recent work has shown that other medicines such as nonsteroidal anti-inflammatory drugs (NSAIDs) can do at least as well—and in some cases, better—than opioids in stopping pain. But some dentists have been prescribing opioids since they were first shown to be effective in relieving pain, back in the 1970s. They may not be aware of what the newer research has brought to light.

The research: salient highlights

Writing in the July 2016 Journal of the American Dental Association, Paul A. Moore, DDS, and colleagues summarize some of the salient literature underscoring the wisdom of prescribing NSAIDs for pain. They discuss a statistically rigorous review, done in 2015, of the relative efficacy of oral analgesics. The review included meta-analyses from 350 studies of nearly every sort of oral analgesic. Both surgical and dental patients were included.

There were two important conclusions from this review, Dr. Moore and colleagues note. (1) NSAIDs are very effective in mitigating postoperative pain. (2) The opioid analgesics are linked with a high frequency of side effects, including vomiting, nausea, and constipation.

Dr. Moore and co-authors then comment on why dentists are nevertheless still prescribing opioids: “As health care providers, our attitude is to stay with what we know and trust. Although this attitude is not surprising, it is not always in the patient’s best interest.”

They advise that, instead, the NSAID analgesics serve as the first choice for alleviating postsurgical pain. When needed for more severe pain, they can be combined with acetaminophen (Tylenol). Or, in a multi-modal approach, NSAIDs can be given preemptively (prior to the procedure), with long-acting local anesthetics that serve to delay pain onset, and corticosteroids to limit inflammation and swelling after surgery.

In fact, there is no one strategy for minimizing the prescribing of opioids for pain after dental surgery. And so it behooves dentists, and dental professional liability companies as well, to monitor the dental and medical literature, to find out what’s new in pain management, followed by a close analysis of the relative rigor of the studies involved, and perhaps consider new dental education courses for the approaches deemed most promising.

NSAIDs at the site of injury

During a dental surgery, locally released mediators of the body’s inflammatory response, such as prostaglandin, may directly signal peripheral nerve endings, producing pain, and they may also amplify the local response to other inflammatory mediators such as cytokines, and thereby increase pain sensation.

This is why pretreating patients with agents like NSAIDs that block the precursors of these inflammatory agents (like cyclooxygenase) serves to limit their capacity for tissue injury. They provide an immediate analgesic effect, and also block the amplification of pain perception.

At the level of the central nervous system (CNS) things get much more complicated, in light of the complex modulation throughout its cells, coupled with the redundant pathways that mediate transmission of impulses throughout its structure.

In the CNS, there is also the phenomenon of hyperalgesia, or increased pain perception, where-in the CNS responds to local injury via sensitization. Here, again, NSAIDs are effective. Inhibition
of hyperalgesia can be achieved by the preventive use of these agents. And this effect can be enhanced by adding a long-acting anesthetic to minimize immediate postoperative pain.

One such long-acting anesthetic, bupivacaine, commercially available as Marcaine, induces local anesthesia that is 2.5 to 3 times longer than lidocaine. One strategy for getting the most from bupivacaine is to inject it at the end of a surgical procedure that was performed with 2% lidocaine.

When used in a mandibular periodontal procedure, it provides:

- A significantly greater duration of anesthesia
- A reduction in postoperative pain
- Decreased requirements for analgesics.

The usual duration of pain mitigation is seven hours, but the effect, for some patients, can last as long as 48 hours.

Unfortunately, there is no totally free lunch in pain relief. There is some evidence that bupivacaine itself stimulates the inflammatory response. But this effect can be overcome by adding anti-inflammato-

Current prescribing patterns

In one study of dental opioid prescribing patterns in South Carolina,14 a majority of respondents (75.8%) reported that they prescribed opioids. Nearly all of the prescriptions were for immediate-release opioids. Hydrocodone (76.1%) and oxycodone (12.2%) were the most frequently dispensed opioids prescribed by dentists. People younger than 21 received 11.2% of dentist-prescribed opioids. Many prescriptions are given out after removal of wisdom teeth, which most patients undergo between the ages of 16 and 24, when they are more prone to addiction than in later life.

Also, a notable minority of patients had had multiple preexisting opioid prescriptions—a factor implicated in patient misuse, abuse overdose, and diversion. Only 38% of the respondents said they had accessed a prescription drug monitoring program (PMDP) and only 4.7% said they used a PMDP consistently.

The dentists included in the survey expressed interest in continuing education in the assessment of prescription drug abuse and diversion and use of drug-monitoring programs.

The study’s authors concluded that there are “gaps in the implementa-
tion of risk mitigation strategies, including for prescription drug abuse, consistent provision of patient education, and use of a PMDP prior to prescribing opioids.”

The impact of a mandatory PDMP, on the frequency and quantity of opioid prescription by dentists in a dental urgent care center, was studied in New York state. New York law mandates that prescribers must consult the PDMP before they can prescribe any controlled substance like an opioid.

The authors analyzed three sets of patient records, before the implementation of the requirement and then two consecutive three-month periods after the mandatory PDMP went into effect.

The change in prescribing patterns was dramatic. Prior to the PDMP, for patients who were prescribed pain-relieving medications, 452 (30.6%) were for opioids. After the PDMP, the numbers dropped to 190 (14.1%) and then to 140 (9.6%). Total numbers of pills prescribed in a three-month period fell, too, from 5,096 to 1,120, a 78% reduction in absolute quantity.

Here, the authors comment, “Such change in prescription pattern represents a shift toward evidence-based prescription practices for acute postoperative pain.”

How many pills do patients actually take?

The problem of diversion was examined in a 2015 study by B.M. Weiland et al.1 They note that the instructions of the bottle say, “as needed for pain,” so it is difficult to know how many pills are actually needed and taken. To find out, 48 patients, ages 15 to 30 years, who had had third molars removed, were interviewed via telephone.

The median number of opioid-containing pills prescribed was 20 tablets (range, 10 to 40). The median consumption during the first 24 hours was reported to be three tablets (range, 0 to 34). Total consumption over seven days was eight tablets (range, 0 to 34).

The differences between prescribed quantities and those actually used obviously increases the likelihood of diversion to some person other than the patient, to a family member or outside the family via an illicit sale.

But: repercussions of not giving a prescription

But in today’s hyper-connected (and hyper-sur-
veyed) world, there may be swift repercussion for not giving a patient the opioid prescription he’s been expecting. Provider reviews done by corporate and hospital administrators can yield poor ratings from
patients irked that they have not received their opioid of choice. Similar complaints from patients on social media sites can result in loss of referrals from other patients and practitioners.

So: what is the best strategy for dentists wishing to limit opioid prescriptions to instances where they are really needed?

Patients need to be counseled about what they can expect after surgery, and why the dentist is customizing his care to suit both the specific procedure and the specific patient.

Most patients, by now, have heard about the national crisis with opioids, and they will likely be receptive to counseling about why they are to be avoided after dental procedures, and why other agents like NSAIDs will be more effective in promoting healing, as well as in alleviating pain.

Recently (February 2016), three dental schools in Massachusetts announced that they will teach skills in managing pain, prescribing painkillers, and detecting improper use of those drugs. The schools are Harvard School of Dental Medicine, Boston University Henry M. Goldman School of Dental Medicine, and Tufts University School of Dental Medicine.

Says Dr. David Keith, co-chairman of the Governor’s Dental Education Working Group and professor at the Harvard dental school, “Previous generations have sort of reached for their prescription pad as a first line of treating the patient. If the prescription pad only contains opioids, that’s not a good thing.”

References
The rules have changed. So have the risks.
Risk managers need to juggle issues across the continuum of care.

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Revalidation for Australian Doctors

The challenge of ensuring that all doctors maintain and enhance their professional skills and knowledge, and are fit to practice medicine, is not unique to Australia. Faced with increasing demands for accountability, medical regulators around the world have implemented recertification or revalidation processes with the aim of ensuring public safety in healthcare.

By Dr. Sara Bird

Proposed model for revalidation in Australia

In 2012, the Medical Board of Australia (the Board) commenced a “conversation” with the medical profession and the community about options for the introduction of revalidation in Australia. In August 2016, the Board released an Interim Report1 to guide the discussion. By mid-2017, a final recommendation will be made to the Board for a pilot phase, or a full rollout of revalidation for Australia’s 100,000 registered doctors.

The Interim Report identifies two distinct components of revalidation:

- Strengthened continuing professional development (CPD). CPD, developed in consultation with the medical profession and the community, is the recommended pillar for revalidation in Australia. This will involve evidence-based CPD that is relevant to the doctor’s scope of practice.

- Identifying and assessing at-risk and poorly performing doctors. A small proportion of doctors in every country do not perform to expected standards at any one time, or over time.

Who are the poorly performing doctors?

The strongest risk factors associated with an increasing regulatory risk profile that have been identified internationally are:

- Age (from 35 years, increasing into middle and older age)
- Male gender
- Number of prior complaints
- Time since last prior complaint
- Unrecognised cognitive impairment
- Practicing in isolation from peers or outside an organization’s structured clinical governance system
- Infrequent high-quality CPD activities
- Change in scope of practice.

A review of more than 18,000 patient complaints filed against doctors with health complaints entities in Australia between 2000 and 2011 revealed that the distribution of complaints among doctors was highly skewed: 3% of all doctors accounted for 49% of the complaints, and 1% accounted for a quarter of complaints.3

The number of prior complaints a doctor had received was a

Compared with doctors with one prior complaint, doctors with two complaints had nearly double the risk of recurrence, and doctors with five prior complaints had six times the risk of recurrence.

Another group of doctors is at risk of poor performance. Developing accurate and reliable ways of identifying those doctors who are at risk of poor performance and remediating them early is critical, with significant potential to improve patient safety. It is equally critical to identify, assess, and ensure that there is effective remediation for doctors who are already performing poorly.

Additional individual risk factors found in some studies include:

- Primary medical qualification acquired in some countries of origin
- Speciality
- Lack of response to feedback
strong predictor of subsequent complaints, and a dose-response relationship was evident.
Compared with doctors with one prior complaint, doctors with two complaints had nearly double the risk of recurrence, and doctors with five prior complaints had six times the risk of recurrence. Doctors with 10 or more complaints had 30 times the risk of recurrence.

Doctors named in a third complaint had a 38% chance of being the subject of a further complaint within a year, and a 57% probability of being complained about again within two years.

Doctors named in a fifth complaint had a 59% one-year complaint probability and a 79% two-year complaint probability. Recurrence was virtually certain for doctors who had had 10 or more complaints, with 97% incurring another complaint within a year.

A tiered revalidation assessment process
The Interim Report proposes a tiered, multi-faceted assessment strategy, starting with multi-source feedback for low-risk cases, escalating through peer review and feedback processes, to more thorough in-situ evaluation to determine the precise nature of serious underperformance in doctors, as required by the medical regulator.

The future
Revalidation in its many forms is moving ahead internationally and is continuing to evolve. Processes have been implemented in a number of countries to try to ensure public safety in healthcare, and it is inevitable that this trend will continue. It is essential that revalidation is evaluated to ensure that poorly performing outliers are appropriately identified and remediated, and that the process has no adverse impact on the vast majority of doctors who provide high-quality and safe patient care.

References
Providing clients superior insight to implement the most effective and efficient risk management strategies
Q&A WITH JOSEPH McMENAMIN, MD, JD

Joseph McMenamin, MD, JD, is a Principal at McMenamin Law Offices, PLLC (MLO), in Richmond, Virginia. MLO is a healthcare law-focused firm serving healthcare providers and life sciences companies, focusing on legal issues pertinent to distance care, general health law, risk management, and reimbursement. Dr. McMenamin has 30 years of experience in defending healthcare providers and pharmaceutical, medical device, and biotech companies against a variety of allegations in state and federal court.

Dr. McMenamin was a presenter at the 2016 PIAA Medical Liability Conference in Washington, D.C., in the session, “Telemedicine: Identifying, Assessing, and Mitigating Risks.” Here, Inside Medical Liability poses some important questions about the issues inherent in telemedicine.

Inside Medical Liability: There seems to be something of a “Wild West” environment when it comes to standards and regulation of telemedicine. Do you see any indications that we can expect convergence of standards and regulation in the near future?

McMenamin: Based upon what we have seen so far, convergence is not likely to happen soon. On the contrary: Numerous groups, often very prestigious, frequently promulgate competing clinical practice guidelines (CPGs) on common clinical questions. Presently, there are 1,984 individual guideline summaries in the National Guideline Clearinghouse, developed by some 235 entities. New content is added every Monday. (National Guideline Clearinghouse, Guideline Index, http://www.guideline.gov/browse/index.aspx?alpha=A.)

CPGs often conflict, even when they cite the same randomized clinical trials. That should come as no surprise to experienced medical professional liability (MPL) lawyers, or to MPL insurers. If you attend just one trial, you’ll note that experts can and do disagree, and many CPGs are little more than compilations of expert opinions. When the practitioner is confronted with inconsistent guidelines, what should he do? Neither law nor science seems to offer much of an answer.

Inconsistencies may be unavoidable. First, we haven’t even reached consensus on the meaning of “evidence-based.” Second, the stated purposes of CPGs vary. Some purport to define “optimal” care or best practices, while others claim to describe “standard” care. These are different concepts.

Tort law requires that the defendant provide only “standard” care; any evidence of care that was of higher quality is irrelevant and actually ought to be inadmissible.

Moreover, there is little evidence that providers actually abide by CPGs, or can afford to. Hence, the relevance of CPGs is questionable. Nor is there much evidence that adherence results in better outcomes, so causation is not established, either.

IML: What are your thoughts about the requirement in Texas that telemedicine patients must establish an in-person relationship with a physician prior to a telemedicine visit?

McMenamin: I respectfully suggest that Texas paints with a brush too broad for the picture it is trying to create. That picture ought to be nuanced, as disease itself is nuanced. Some patients should not be evaluated at a distance without the in-person baseline that Texas demands. Ideally, in fact, some patients ought not to be evaluated telemedically at all. But some can be diagnosed and treated via telemedicine in a manner fully consistent with good clinical practice, and Texas fails to recognize that.

IML: A recent study in JAMA Internal Medicine, “Variation in Quality of Urgent Health Care Provided During Commercial Virtual Visits” (April 4, 2016) indicated that “significant variation in quality was found among companies providing virtual visits for management of common acute illnesses. More variation was found in performance for some conditions than for others, but no variation by mode of communication.” Do you find this result troubling?
McMenamin: It does concern me, to a degree, but of course variations in quality of care have doubtless been with us since before Hippocrates, and certainly before we began providing telemedical services. The writers did not examine variations in in-person care, but surely no one would deny they exist. There are variations in the services of butchers, bakers, and candlestick makers, not to mention lawyers, as well. Humans differ.

More important, I question the assumption that uniformity, even if possible, is always desirable. Considering the nearly infinite variety in human biology, I suggest we are obliged to make ample allowance for clinical judgment. But what approach did the authors take? To evaluate care, they expressly considered “adherence to guidelines of key management decisions.”

I do not share the authors’ assumption that adherence to the CPGs they selected necessarily correlates with quality care. Nor do I think there is much evidence to support such an assumption. They wrote: “The score [for each visit evaluated] was based on whether the physician’s key management decision agreed with the relevant guideline,” as though the CPGs selected for the study were the only ones available. Given the proliferation of CPGs, that may well not have been the case.

IML: What do you see as the chief risks in physicians using telemedicine? Do you think there are many we don’t yet know about?

McMenamin: There certainly could be unidentified risks, though I doubt they are numerous. Depending on one’s definition, telemedicine has been around for a few years, or many decades, or more than a century. But the technology evolves rapidly, and today’s widespread deployment of telemedicine is relatively new.

Our experience with its use on a wide scale is thus limited; by definition, our experience with the newest technologies is even more so. I often advise professionals seeking informed consent to advise the patient that there may be risks we cannot yet identify.

The biggest risk I see today is that some of the more enthusiastic practitioners might fail to bear in mind the limitations inherent in telemedicine. When applied to appropriate clinical problems, telemedicine can bring great benefit to the patient. If applied where it should not be, or without making allowances for its characteristics, the opposite is possible.

IML: First: encourage them to understand what telemedicine can do and cannot do, and to educate patients on these matters as well. The telephysician’s first task may well be to evaluate whether, given the apparent nature of the problem, distance care is suitable, and, if not, to refer the case.

Third, prod insureds to stay current with the literature, to keep up with the developments in this fast-changing field.

Fourth, as with in-person care, point out the value of a good “cyber side manner,” and build rapport with patients, despite the physical separation.

As with in-person care, encourage good documentation.

At the same time, discourage: advertising—if the insured must advertise, urge him to keep his representations factual, and participation with patients on social media. Encourage insureds, through their professional societies, to question the need for guidelines, and to prevent the creation of new ones, at least until such time as clinical efficacy can be demonstrated.

If we cannot eliminate CPGs, advise insureds and their professional associations to attempt to harmonize the existing ones, and to keep them updated. Advise those who write them to issue clear, tested disclaimers to discourage plaintiff’s counsel from using them against the profession. Shape the law to make (or keep) CPGs inadmissible. And, of course, watch for developments in the law, and apply the lessons learned.

References
The medical professional liability system presents constant challenges to healthcare providers and other industry stakeholders. Accurate, timely and quantitative information, from indicated loss reserves and funding estimates to the impact of proposed legislation, is vital. Our experts understand the inherent risks of delivering healthcare services in today’s litigious and ever-evolving environment.

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For the astute investor, the changing market landscape offers a unique investment opportunity. In this article, we take a deeper look into money market funds, and discuss how the new regulations will impact the asset class moving forward.

A brief history of money market funds
The mere mention of money market funds likely conjures up images of the financial crisis of 2007-2008. It was during the early innings of this upheaval that the largely unknown Reserve Primary Fund became the first money fund ever to “break the buck,” meaning that its net asset value (NAV) dropped below $1.00 per share. In doing so, the Reserve fund violated the fundamental premise of a money market fund, namely, that a dollar invested is a dollar returned at maturity, plus interest.

The subsequent torrent of withdrawals from money market funds fanned the already burning flames of the subprime mortgage crisis, precipitating the decline of firms like Lehman Brothers and Bear Stearns. As a result, the Securities and Exchange Commission implemented a series of regulatory changes, with the goal of making money market funds safer, and less vulnerable to future market turmoil. While some of these changes were implemented back in 2010, the more substantial changes have just recently taken effect. Two of the most important changes are discussed in more detail below.

The first change to money market funds concerns only what are known as “prime funds,” which invest in a variety of short-term debt, including commercial paper, CDs, and floating rate bonds. The new rules require prime funds to migrate from a stable $1.00 NAV to a value that floats with the value of the underlying assets (floating NAV), similar to a mutual fund. This rule will also apply to municipal and tax-exempt money market funds. In contrast, “government funds,” which must invest 99.5% of their assets in government securities, were exempted from this regulation and will continue to have a fixed value of $1.00 per share.

The second change gives all prime funds the ability to prevent investors from making withdrawals or imposing liquidity fees during periods of extreme volatility. These fees and restrictions (often referred to as “gating”) occur in stages, and are designed to protect against large outflows over a short time peri-
The first fee is triggered if weekly liquid assets fall below 10% of total assets, and can result in a liquidity fee of 1%. If the value of weekly liquid assets declines below 30% of the total assets, a liquidity fee of up to 2% may be charged. In addition, redemptions may be suspended in this scenario for up to 10 days within a 90-day period.

These changes have altered the fundamental purpose of a money market fund, which had historically offered the stability of a fixed NAV along with the promise of some incremental yield. With a floating NAV, and the potential for liquidity fees and gates, prime money market funds are now more akin to a short-duration mutual fund than a savings account.

As one might expect, the near-term implication of these new changes has been a rotation out of prime funds into government funds that will maintain a stable NAV. As Figure 1 illustrates, $1 trillion dollars has moved from prime funds to government funds.
flown out of prime money market funds, and into government money market funds.

The move out of prime funds and the resulting decline in demand for short-term financial paper is a fundamental shift that is not likely to be reversed. Because prime funds were one of the largest holders of short-term financial debt, demand for commercial paper and CDs has dropped off considerably. This has forced banks to pay significantly higher rates for short-term funding, which is reflected in the noticeable increase in the LIBOR rate. Three-month LIBOR has increased by approximately 25 basis points since the end of the second quarter. This makes floating-rate debt, much of which has coupons that reset at regular intervals based on a spread to LIBOR, much more attractive.

Prime funds have also been forced to sell large amounts of short-term debt to meet redemptions. This has caused the yields offered on short-maturity bonds to increase (recall that for bonds, prices and yields move inversely to one another). As of October 2016, high-quality corporate bonds that mature in one year offer yields of around 1.00%, roughly double the 0.55% yield of 1 year Treasuries. Short-dated tax-exempt municipal bonds also offer value, with pretax yields anywhere from 0.70% to 1.00% (tax equivalent yields of 1.00% to 1.45%, if you are able to capitalize on the tax preference).

The market dislocations that occurred as a result of the new money market regulations offer an attractive investment opportunity for investors looking to increase yield in high-quality short-maturity assets. Short-dated, high-quality corporate debt, municipal debt, and floating rate debt whose coupons reset off of LIBOR all offer compelling yields and attractive relative value. Some money has begun to flow into these asset classes over the past few weeks, as investors begin to identify and capitalize on this opportunity.

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Having an employed actuary or actuarial staff may not be optimal for smaller insurance programs. Careful consideration of the way in which a company utilizes actuaries, in conjunction with the compensation structure for the actuaries, will help the company get the maximum value for its actuarial dollars.

There are many advantages to having an in-house actuarial staff, including these:
- In-house staff can provide actuarial advice with a company-focused perspective
- The company will be better able to control the actuarial processes and budget
- In-house staff can help with managing external actuarial projects
- They can serve as a liaison to facilitate communication between consultants and management.

Likewise, there are many reasons why you should hire actuarial consultants. They may include:
- The desire to have an actuarial opinion from an independent actuary
- The need for short-term work capacity
- An insufficient or inconsistent volume of work to hire an internal actuarial staff
- A desire to access industry expertise and the broader experience of consulting actuaries.

Companies can use any one of several fee structures when utilizing actuarial services. These might include:
- In-house salaried actuary
- Time and expense billing
- Time and expense with a cap on fees for a specific assignment
- Fixed fee.

Careful consideration of your actuarial needs, combined with the most appropriate fee structure, will help to control costs and maximize the value of your actuarial budget.

In-house salaried actuarial staff
Having an in-house actuary or actuarial staff is advantageous because the interests of the in-house employees are aligned with the company. The in-house actuary will be more closely focused on working efficiently and effectively to accomplish his company’s objectives. An in-house actuary can provide company-focused insight and interpretation of actuarial analyses. For larger companies that want to utilize independent actuarial consultants, an employed actuary can serve as an intermediary between the outside consultants and company management. The employed actuary can help estimate and negotiate the cost and scope of projects, provide a source of internal actuarial peer review, or can provide a company-focused perspective of the results of the analyses.

The principal disadvantage of hiring internal actuarial staff is that there is a threshold volume of work required to justify the cost of full-time employment. Therefore, this might not be feasible for smaller insurance companies or self-insured programs. Additionally, the qualifications and expertise of actuaries is such that recruiting and retaining an actuarial staff best suited for your company can be challenging.

Time and expense billing
Paying consultants on a strictly time-and-expense basis can have some advantages. For example, if a company uses an outside consulting firm on an ongoing basis, a time and expense fee structure will incentivize the consulting firm to provide detailed work and responsive service. This is particularly advantageous when an actuarial firm is providing ongoing...
services for a variety of projects. This fee basis reduces the need to continually negotiate budgets as new projects are initiated or the scopes of projects expand.

However, there are also some possible disadvantages to paying time and expense on an ongoing basis without careful monitoring of the bills. For example, an unlimited time-and-expense budget does not incentivize the consulting firm to be cost-efficient. Rather, this will encourage the consultant to assume that more analysis is always better. That can lead to an unintended expansion in the scope of an assignment, with more analysis or projection methods than what is actually necessary, or more layers of review than are optimal. For example, when deciding whether to refine or expand an analysis, the consultant might be biased in favor of doing more work because of the additional billings involved. In many circumstances, applying additional methods or adding new analyses will not add significant value to the analysis in terms of the accuracy of the estimates or providing better predictive diagnostics.

When regularly updating a periodic analysis, you might expect that efficiencies mean that less time was required to complete the updates. However, consultants are incentivized to increase billings over time. An unrestrained time-and-expense budget may result in higher bills without a corresponding increase in value to the company.

Time-and-expense fee structures will motivate more detailed analysis, higher quality work, and focused attention. However, it would be wise to discuss an appropriate budget at the start of each project. Then, it is important to monitor the scope of each analysis and the charges on bills over time in order to evaluate the need and the marginal value of additional analysis.

**Time and expense with a project cap**

In many circumstances, consultants are willing to cap the total charges for a project. This has advantages for the client, in that it holds the project’s costs to the amount specified in the budget. It motivates the consulting firm to do the work efficiently as they do not want to accrue time charges above the cap, charges for which they will not be paid.

For this type of fee structure to work for both parties, they will need to have the scope of the assignment specified in a way that minimizes miscommunication in terms of what is expected. For example, a company may wish to have a cap on the charges related to the annual actuarial statement of opinion. This would incentivize the consulting firm to efficiently provide the services.
needed to issue the statement of opinion and comply with actuarial standards and regulation requirements. In this case, the scope and requirements are well defined because they are specified by standards and regulations.

This type of fee structure is less appropriate for open-ended or innovative analyses in which the scope is more difficult to define and the amount of work is hard to estimate. In some instances, a larger project might be broken down into segments for which a scope and budget can be more easily defined. A cap on each would help the client control and monitor costs on an incremental basis and make it possible to adjust the budget as the project unfolds.

Project billing caps may also be beneficial to the hiring company for first-time analyses that are expected to be updated on a regular basis. A cap will mitigate the higher cost of first-time analyses that are driven by the initial setup of projection files and a steep initial learning curve. Consultants are often willing to cap the total charges below the

expected time-and-expense cost of the analysis, in the hope of establishing a long-term client relationship.

Fixed fee
Hiring a consulting firm on a fixed-fee basis for an assignment entails both advantages and disadvantages, depending on the priorities of the assignment. Much like a cap on time-and-expense fees, a fixed-fee structure will provide a specific budget for company management. It also motivates the consulting firm to perform the analysis quickly and efficiently. However, the consultant may also be motivated to keep the time-and-expense charges below budget, and thereby increase the profit of the assignment.

The key to making a fixed-fee arrangement beneficial to both parties is to establish a sound estimate of the scope and cost of the project when establishing the fixed fee. Setting the fixed fee consistent with the expected cost of the project incentivizes the consultant to perform the analysis quickly and efficiently, and it ensures that the client is getting the full value of their investment. Consultants may also use fixed-fee arrangements to sell analyses on a value-based basis in order to increase profits. For example, if a consulting firm is performing similar analyses for a number of clients, based primarily on broader industry information, there are overlapping tasks in compiling and developing the industry support or projection templates. Fixed-fee arrangements can be used to spread the costs of those common tasks more evenly across multiple similar projects. It may also allow the consultant to benefit from the cost savings of utilizing common industry statistics across multiple clients.

Under a pure time-and-expense arrangement, the time charges for the clients that get their analysis first may be disproportionately high. Clients who receive subsequent client analyses would benefit from a cost savings from the industry-level work previously performed. With a fixed-fee arrangement, the fees related to shared industry information can be allocated more evenly across the various industry-based projects.

The consulting firm can benefit by establishing a reasonable fixed fee that takes into account the value of their industry information and analyses. In this way, the consulting firm is incentivized to produce high-quality industry benchmarks and analyses that are beneficial to multiple clients.

Conclusion
Depending on a company’s operating philosophy in terms of actuarial services, careful consideration of the scope, objectives, and fee structure for required actuarial work can help lower costs and at the same time optimize the value of the actuarial budget. Matching the actuarial needs with the best fee structures will help establish and sustain a long-term, mutually beneficial relationship between management and its actuaries.

Freed from the hypnotic power of our screens, we can once again engage with other human beings and pool our knowledge and expertise in satisfying and productive ways. Ultimately, that can’t help but benefit our patients. —New England Journal of Medicine, October 13, 2016
The term “patient engagement” has emerged as a hot topic in healthcare circles. It is used to describe a form of collaboration wherein patients and healthcare professionals work together to improve population health. But “patient engagement” can also refer to everything from website access to a patient’s record to social media strategies for improving health, from tracking key patient data with wearable devices to programs for patients that let them actively participate in enhancing their own health and wellness.

Clearly, then, patient engagement means different things to different people.

And, according to recent survey results published in NEJM Catalyst, a new wave of patient engagement strategies may be on the horizon, as digital communication tools become more common. In a poll of more than 350 healthcare professionals, 69% said their practice utilizes patient engagement tools. These survey results seem to indicate decisively that we have finally (officially) arrived at the so-called era of patient-centered care. And that seems to make sense. The influx of new digital patient-provider communication tools has been prolific. Patient portal access has surged in recent years, while the use of tools such as secure e-mail has become extremely popular.

But is all this enough? Despite this apparently fortuitous start for patient engagement strategies, could it be that in fact we’ve only scratched the surface with patient engagement? That could well be the case. According to the same survey, only 14% of respondents said patient engagement had a significantly positive impact on the quality of care, and only 9% believed that it lowers the cost of care. Moreover, 34% stated that their patient engagement strategies had only a moderate impact on the quality of care.

According to Kevin Volpp, MD, PhD, University of Pennsylvania, and Namita S. Mohta, MD, Brigham and Women’s Hospital, the administrators of the survey, “Survey respondents clearly think the best is yet to come—Patient Engagement 2.0. ”

“Many survey respondents comment that we need to engage patients outside the exam room with frequent, creative interactions that do not have to always include their physicians,” stated Volpp and Mohta.

These are thought-provoking comments. However, I think the key word here is “interactions.” Of course, it goes without saying that it’s crucial for patients to participate in improving their own health and sustaining wellness, because it likely leads to lower costs and better outcomes. Making technology, digital tools, and other new advances in health monitoring available to patients is a step in the right direction. But true involvement necessitates a more personal sort of interaction—either guidance from physicians or from someone acting as a proxy for them.

So, as I see it, there are two elements in the equation. The patient must be willing and able to participate in his care, and someone must facilitate these “interactions” to encourage that participation.

Could this role of “interactor” be played by the MPL/HPL community? I think it could. Given the depth of their experience in patient communication, PIAA member companies are uniquely qualified to assist in this process. This could well be a win-win situation for everyone involved—MPL/HPL insurers, healthcare professionals, and patients, too, because a patient’s greater engagement in healthcare will most certainly contribute to something we all strive for: healthier patients.
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