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President, Brian Atchinson

What does it mean to be a national insurance trade association in 2012? For the PIAA, it means that we must take careful stock of the current and impending changes in the delivery of healthcare. Then, we drill down to make informed assessments of the likely impact of these changes for our members, our stakeholders, and the medical professional liability (MPL) industry as a whole. And we take a close look at how we operate, and even our reason for existing in the first place. We examine the services we provide, the information we share, and our role and interactions with policymakers, the public, and the media.

Guided by the Association's Strategic Planning Committee and your Board of Directors, we have embarked on a deliberate process for developing and implementing revitalized strategic initiatives for the PIAA.

Central to any strategic planning endeavor is research. So, we have done in-depth interviews with PIAA members, leadership, stakeholders, and staff to identify the issues and areas of service that matter most to you. Armed with this information, we have reassessed our priorities accordingly. It is clear that we must understand your needs before we can build a successful foundation for our future strategic framework.

It is important that we continue to move forward, building on the strong foundation and history of more than 30 years that have embedded the core values that reflect our members.

We will never stop advocating for federal MPL reform and other important legislative initiatives—while also defending against legislative threats that may be advanced by others. To ensure your interests are well represented with respect to the federal government and its agencies, the PIAA will maintain an active program of engagement on the issues and activities that can impact your company.

We will take advantage of new tools and methods to ensure that our voice as the leader of MPL insurers is unified, understood, and, when necessary, strident. We will strategically deploy our expertise, and offer it in new and unique ways. And we will leverage in new and innovative ways the valuable information available from the PIAA Data Sharing Project.

Not since the years that witnessed the formation of many of your companies have we confronted so many profound questions about the future of PIAA, MPL insurers, and those who deliver healthcare. But be assured that the PIAA will stand behind you as we work together to find ways to strengthen the impact of your voice and ensure your continued success in this industry that is so vital to America’s healthcare.

We will invite your feedback regularly. It will serve as a barometer for our effectiveness. Then, we will continually recalibrate and refocus our energies and resources as necessary to ensure our work is consistent with your needs and priorities. I strongly believe that as long as we are standing still, we are in fact losing ground.

I am excited about the challenges and opportunities that await us in the months ahead. I will be giving you regular updates on our progress.

PIAA at the Crossroads

It is important that we continue to move forward, building on the strong foundation and history of more than 30 years that have embedded the core values that reflect our members.
It's an imperfect science, but a science nonetheless. And we have seen the results.

—Cover story

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2012 First Quarter
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When it comes to advancing the interests of medical professional liability (MPL) companies, there is no more ardent supporter than the PIAA. Your association has worked tirelessly for you and your physicians over the last 12 months, on Capitol Hill, inside federal agencies, in MPL research, on risk abatement and patient safety, and in many other ways.

As I reflect on 2011, I am proud of what we have accomplished—and eager for the organization to enter new, uncharted territory.

Providing you with high-quality education was a key goal during the past year. I’m pleased to report that our meetings and workshops—covering an expanded range of disciplines—were well attended and highly rated by attendees. As the only organization that provides professional advancement and networking just for MPL specialists, we will continue to deliver on what you have identified as a top priority.

The inaugural PIAA Medical Liability Conference (formerly the “Annual Meeting”) proved to be the year’s premier MPL industry event. For this year’s conference, we have lined up an unparalleled slate of speakers and sessions, so be sure to register early for this “can’t miss” event in Washington, D.C., on May 9–12.

Through its Data Sharing Project, PIAA has advanced the safe practice of medicine. The broadening of this database—several new companies began contributing data in 2011—bolstered its scope and statistical power. In addition, the Data Sharing Advisory Committee convened regularly to discuss possible enhancements to the project’s research agenda. And as a result of the efforts of this committee, the PIAA has entered into a collaborative study with the Rand Institute for Civil Justice to examine tort reform and the factors that led to crises in the MPL insurance market in prior years. We look forward to sharing with you the results of this work.

This year, a new member benefit was launched: the PIAA Expert Witness Database. This tool was developed exclusively for member companies and their attorneys to assist in defending claims. I urge you to invest in this important technology, which will help expose so-called “experts” who offer junk science in the courtroom, instead of helping to bring the truth to light.

In August, we welcomed a new President and CEO—Brian Atchinson—to the PIAA. Brian is a seasoned and versatile leader, and we will benefit greatly from his enthusiasm, energy, and many years of experience in the insurance industry.

We continue to beat the drum for federal MPL reform. The PIAA Political Action Committee can be a singularly effective method for communicating our message on MPL reform to lawmakers—but only with your help. I ask that you allow the PIAAPAC to solicit contributions from your executive staff and board members, and also for your company’s direct support. Please mark your calendar for Wednesday, May 9, in Washington, D.C.,

James L. Weidner is Chief Executive Officer of the Cooperative of American Physicians, Inc., and Chair of the PIAA Board of Directors.

Continued on page 6
For nearly a century, Thuillez, Ford, Gold, Butler & Young, LLP has been the law firm doctors, hospitals and nursing homes have called to their defense.

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Continued from page 4

when we will host a special fundraising event for the PIAAPAC.

Physician involvement on the PIAA Board and in our committees is a critical component of the association’s governance. For this reason, we will launch a new program this year to identify and train healthcare providers for board and committee service in the association. The program will consist of educational modules, roundtable discussions, focus group participation, and speaking assignments. Details will be coming soon on an orientation event.

My time as PIAA Board Chair will end in May (term limits, after all!), but as I look ahead, I am truly excited about the future. The PIAA Board of Directors, under the guidance of a consultant and in concert with the PIAA staff, is developing and implementing a three-year strategic plan. This plan will help guide the association’s work in identifying key priorities, making critical decisions, and undertaking the initiatives that will help ensure the continued success of the companies that make up the PIAA. I look forward to providing you with an update before I leave office.

The PIAA operates as a lithe, cost-conscious organization. We make every effort to stretch each of your dues dollars. Your continued support and commitment are crucial to the delivery of the benefits that I have noted here—and many more. This year, come to the meetings, participate in the webinars, and take full advantage of the many resources that the PIAA has to offer. The PIAA is an indispensable force in protecting physicians—so let’s work together for its success.
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According to a recent article in the New York Times, a poll shows that half of technicians running bypass machines admit to texting during the operation, and 55% admit to talking on their cell phones during the procedure. “You walk around the hospital, and what you see is not funny,” said Dr. Peter J. Papadakos, an anesthesiologist who is the director of critical care at the University of Rochester Medical Center in upstate New York. He has observed nurses, doctors, and other staff members who are glued to their phones, computers, and iPads. “You justify carrying devices around the hospital to do medical records,” he said. “But you can surf the Internet or do Facebook, and sometimes, for whatever reason, Facebook is more tempting. My gut feeling is that lives are in danger.”

Already, there have been medical professional liability (MPL) claims with personal use of gadgets at the center of the allegations. Scott J. Eldredge, an MPL lawyer in Denver, represented a patient who was left partly paralyzed after surgery. The neurosurgeon was distracted during the operation, using a wireless headset to talk on his cell phone, Eldredge said. “He was making personal calls,” Mr. Eldredge asserted, at least ten of them to family and business associates, according to phone records.

Surgeons: A Reason to Tweet
Social media for education?

Some hospitals are limiting the use of social media, worried about possible legal ramifications. But the University of Buffalo has a different take on the matter. The instructors there are encouraging wider use of social media.

The basic theory here is that social media in fact comprise a highly effective channel for accelerating and enhancing the flow of information needed for optimal medical training.

In an article featured in the Bulletin of the American College of Surgeons, two surgeons, eager tweeters themselves, note that, “A lot of the training consists of passing on information, lessons learned, and wisdom to the next generation. Twitter allows us to dramatically scale up our ability to do this.” Philip L. Glick, MD, vice chairman and professor of the school’s Department of Surgery and also professor of pediatrics and Ob/Gyn, comments, “When I post something on Twitter, all the pediatric surgeons, trainees, and colleagues in the country and the world can see it instantly.”

Glick thinks that surgeons will find social media an excellent tool for graduate and continuing medical education as well, because what surgeons do is essentially visual. “Social media allows us to take digitized audio and video content of procedures, edit it into pieces that have some sharing value, and share it,” he says.

But Glick also cautions that jumping into the social media waters requires homework beforehand: extensive planning and institutional guidelines. But soon, medical professionals can consult the American College of Surgeons and the American Medical Association for assistance. Both are working on guidelines for the responsible use of social media to communicate with patients.

And for patients, the operating room may be the next new site for tweeting. For instance, an epilepsy patient allowed Aurora Health Care’s social media manager to tweet throughout his brain-surgery operation.

We note here, post script, that a search on Twitter for “Philip Glick” yielded zero results. It will be difficult to use Twitter effectively, absent some sort of delimited search criteria. The word “surgery” yields only an endless index of celebrities’ current surgical dilemmas.

Source: University of Buffalo, press release, October 3, 2011

I

n 2011, West Virginia held the uncoveted rank of number three in the roster of Judicial Hellholes from the American Tort Reform Foundation (ATRF). It has been on the list every year since it was initiated in 2002. This is its second year in the number-three slot.

Now, West Virginia Supreme Court Justice Brent Benjamin responds. And what he has to say is surprisingly positive.

He notes that it is easy to dismiss the report, and comments that, while it may be biased, the state can learn from the report. “I think that it’s important that we do take a look at it,” he observes, “and see what they’re saying, because it’s too easy to be dismissive sometimes, and I think some of the things that are in the report are important for us to look at.”

The entry on West Virginia from the ATRF notes that there seems to be no right of appeal in West Virginia. Benjamin says that this statement is not entirely true. “Every petition that comes to us gets a full analysis,” he notes. “What they don’t always get is oral argument to every case that comes before it.”

Benjamin points out that another common critique of West Virginia’s court system is the lack of a middle-level court, but even that debate has two sides. “States that are known as big business states or that draw business in, like Delaware and Nevada, don’t have middle-level appellate courts,” he points out, “so the argument is not really just about ‘if we build it, they will come.’”


New research shows that in 2007, West Virginia had the highest outpatient antibiotic use per capita: 1,222 dispensed antibiotic prescriptions per 1,000 people. This is more than two times the amount prescribed in Alaska, with only 546 dispensed antibiotic prescriptions per 1,000 citizens.

There is in fact a pocket of states, mostly in the South, where residents use significantly more antibiotics: Alabama, Kentucky, Louisiana, Mississippi, Tennessee, and West Virginia.

William Schaffner, chair of the Department of Preventive Medicine at Vanderbilt University School of Medicine, says that doctors in states with lower-than-average rates are not prescribing antibiotics enough, and the consequence could be untreated infections. And the upshot of excessive prescribing of antibiotics, he says, could be bacterial resistance to these agents. Observers find it troubling that use of broad-spectrum antibiotics in particular, such as the fluoroquinolones, is on the rise.

The effort to limit prescription of antibiotics to instances where an affecting organism has been positively identified has gone on for many years now. Nonetheless, the American Medical Association will enter the fray one more time, with a new educational program this year, to educate health professionals and the public on appropriate use of prescription drugs, including antibiotics.

Source: American Medical News, December 5, 2011

Going Viral among MPL Lawyers: Lax Regulations for Cosmetic Surgery

Content about the relative dearth of regulations on in-office cosmetic surgery appeared on an astonishing number of MPL lawyer blogs in early January 2012. So perhaps MPL companies should be aware of it, too.

USA Today ran a story, “States lax in regulating cosmetic surgery,” on December 28, 2011. By the end of the day, the article had been picked up by MPL attorneys all across the country. A typical entry is quoted here, with apologies for the somewhat awkward syntax:

“One of the dangers that have come along with surgeons branching off into areas in which they are inexperienced or untrained is that these physicians will market ‘cheap’ alternatives to many of the procedures offered by more practiced physicians. Even spas have offered liposuction procedures along with other beauty treatments without sufficient safety procedures implemented.

Thus patients may leave a state where plastic surgery is fully regulated to have a procedure performed in other states where statutes might not be in place to protect the patient.”

This was excerpted from the blog of a law practice in Dayton, Ohio. You might want to check out their website, below, if only for the fearsome tiger that looms large on the home page.

Think Excellence, Not Difference

Building the Future, Honoring the Past

Corporate sustainability is a widely discussed topic in today's world, with varying ideas about what it takes for a company to prosper in 2012. I believe sustainability is achieved by establishing a core set of values that will stand the test of time, and helps in navigating through an industry's naturally occurring ups and downs. It is also important to practice bifocal vision—that is, keeping one eye on the horizon, while also watching each next step.

In that spirit, Morningstar Communications hosted an event in our hometown of Kansas City with representatives from longstanding community leaders, to share their insights on what is essential for lasting success. Here is a summary of the learning and best practices we gleaned, which are applicable across all industries.

Sharing a century of knowledge
Fourteen-year-olds have limitless possibilities, as they embark on their journey into adulthood. They are starting high school, on the verge of driving for the first time, and look toward the future with optimism as they begin to make their way in the world. Like a precocious teenager, I share this teenage enthusiasm, as Morningstar Communications celebrated its 14th birthday in late 2011.

Last year, our team began brainstorming ways to commemorate this milestone. We looked with admiration to several organizations, which we have ongoing professional relationships with, that are more than 100 years old. We decided to celebrate by facilitating a thought-provoking panel discussion with top executives from six of these companies. Business professionals from across the region joined us. The executives shared their best advice on sustainability and offered insights into enduring business practices.

Our panel discussion revealed one common, unifying theme for continued longevity and success: it's all about the people. Panelists unanimously agreed it is essential to empower and engage employees, because they are the physical embodiment of an organization. No matter what the industry, employees are the lifeblood and driving force behind sustainability.

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Eric M. Morgenstern, APR, Fellow PRSA, is President and CEO of Morningstar Communications, Overland Park, Kansas. Eric is a regular contributor to Physician Insurer magazine and presenter at PIAA workshops.
### PIAA Marketing Workshop
March 28–30, 2012

**Sessions include:**
- **IBM Brand Experience**—IBM's resident expert in brand experience and strategic design, Lee Green, will reveal his brand-management principles, and relate how brand strategy has helped in modeling every experience of the diverse stakeholders involved in an enterprise, from clients to employees.
- **Physician Hospital Affiliation: Options and Issues**—Every day, more physicians decide to sell their practice to a hospital. What's motivating this decision—and what do hospitals gain from buying physician practices? Learn the answers to these questions and much more in this informative session.
- **State of the States**—Hear a discussion on current market conditions for MPL carriers. The panelists will address the challenges that marketing, sales, and communications professionals confront in the rapidly evolving healthcare environment, and will discuss strategies and tactics that PIAA carriers can use for sustaining their current success.
- **Repackaging Your Marketing Message for Today's MPL Buyer via Social Media**—Learn how to repackage your current marketing copy for today's social media-powered digital world. Find out how a noted social media consultant adapts traditional B2B marketing materials to create a full suite of pieces that make the most of the power of the new social media, tailored to each of the major social media networks.

### PIAA Dental Workshop
March 28–30, 2012

**Sessions include:**
- **Day One Focus: Managing Complications in the Dental Office**—In the first day of the workshop, four sessions will each focus on a specific high-risk area in the dental/oral surgical setting. They will investigate the clinical/medical aspects of the various potential complications or issues, present cases based on high-award claims that pertained to one of these issues, and then offer risk-management recommendations and risk-mitigation strategies you can use to avoid future claims and enhance patient safety.
- **Claims Trends in Dentistry/Oral Surgery**—This session will provide an overview of the dental professional liability insurance marketplace, as seen through the eyes of a leading industry actuary. The speaker will use data compiled from PIAA carriers and other insurers as the basis for an analysis and discussion of claims trends, including both frequency and severity.
- **The Risks of Social Media in the Dental Office**—Electronic medical records, websites, blogs, and social networking sites are the latest phenomena in communications for dentistry. This session will explore the liability issues that may arise in using the newer electronic and web-based communication media. The presenter will also recommend approaches to developing effective risk management protocols.

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**Watch your mail for a registration brochure!**

**Online Meeting Registration Available!** Visit [www.piaa.us](http://www.piaa.us) to register for the Marketing Workshop or the Dental Workshop. Visit our website to learn more about these one-of-a-kind workshops, and the many other outstanding PIAA educational opportunities.
Continued from page 10

The panelists identified some additional elements for longevity, including adhering to core values, maintaining flexibility to adapt and remain relevant, and living up to the brand promise. I hope you enjoy the following “pearls” of wisdom we captured at our event, “Sharing a Century of Knowledge.”

“Pearls” of wisdom
Bill Berkley, president and CEO of Tension Corporation, a global leader in producing envelope products and packaging solutions, said quality of service and innovation are central to Tension’s success. After 125 years in business, the culture of innovation that exists within Tension is a way of life. “We have more patents than anyone in our industry, and we got there not by having a research and development department, but by working with our customer base—working on what our needs are and what our customers’ needs are,” Berkley said. Tension Corporation continues to prosper by asking customers what would help them, and then taking that information to its production team to create viable solutions. This is how they develop new products and services. “Customers may know what their issues are, but not the possibilities,” Berkley said. “So we come up with things they may not have even conceived of.”

Mark Hinderks, managing partner at Stinson Morrison Hecker, an AmLaw 200 firm specializing in corporate, transaction, and litigation legal services, said a merger provided the opportunity to reshape the entire company culture and guide a transition from an entitlement-based to a performance-based culture. “We instituted a rigid culture of self-evaluation at all levels—a more entrepreneurial culture in which we could hold all partners and constituents accountable,” Hinderks said. “We have to attract and hold on to our clients by treating them well and providing excellent client service.”

Steve Doyal, senior vice president of 2012 PIAA Medical Liability Conference Sneak Preview

MPL Financial Trends: Today’s Perspective
James D. Hurley, ACAS, MAAA, Consulting Actuary, Towers Watson, Hope Maxwell, Managing Director, IFC&E Services, LLC

The aggregate financial results for PIAA member companies have improved over the last few years. What are the key drivers behind this improvement, and how did 2011 stack up in comparison? The speakers will focus on the salient trends noted on company balance sheets, income statements, and premium over the past ten years. The most important aspects of industry performance will be highlighted, and there will be a review of the principal factors that affect MPL carriers’ ratings and financial strength. Participants will learn how to utilize the key ratios on income statements and balance sheets to compare their company’s financial performance with that of the combined PIAA member company results.

Don’t miss the 2012 PIAA Medical Liability Conference, May 9-12 in Washington, D.C. Visit www.piaa.us for the complete agenda or to register.

We have to attract and hold on to our clients by treating them well and providing excellent client service.

Julie Quirin, CEO of Saint Luke’s Hospital, said people should be held in high regard and valued. “Saint Luke’s has an employee engagement team open to anyone. Nearly 50 people come to each meeting to share ideas and opportunities to improve our culture and work environment,” Quirin said. “We believe culture eats strategy for lunch.”

Reinhard Mabry, president and CEO of Alphapointe Association for the Blind, a nonprofit organization that offers rehabilitation services, education, and employment opportunities for the visually impaired, said an organization must continually adapt to remain relevant. Mabry said products and services need to change over time, and companies need to look to the community for inspiration. “Our focus is to remain relevant to our community and those we serve,” he said.

Bob Kipp of Hallmark Cards, representing the city of Kansas City, Missouri, summed up the discussion with this insight: “The closest person to the CEO should be the HR person. Only by doing that can you perpetuate, and make real, the fact that people are the most important aspect of the organization.”

While there isn’t a cookie-cutter solution for bringing success and longevity to all businesses, the common factor in all industries is people. Keeping people not only engaged, but enriched, is an overarching concern that is crucial for lasting success. I hope this knowledge resonates with you as it did me and will help you reach your next milestone, no matter how many candles light up your cake.
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Getting Better All the Time:
The Decade-long Improvement in Patient Safety

In the past decade, tremendous innovation and passion have been focused on improving patient safety. As an actuary, I’ve been excited to watch the sheer diversity of risk management programs and environmental, health, and safety initiatives. The big news is how well these programs have worked.

As an actuary who specializes in medical professional liability (MPL) coverage, I’ve observed a significant decline in claims since the turn of the twenty-first century. For some companies, claim frequency has dropped by almost half in the last ten years—an astonishing decline.

But actuaries, senior executives, and risk professionals struggle even today to articulate all the drivers of the decline. That said, it is common knowledge that a plethora of factors has led to the overall decline in claim frequency. In Part One of this article, I describe the fruitful work done by the apology movement and the “saving lives” campaigns.

Starting at a macro level, I believe that national and local media have helped people appreciate just how hard their doctors have had to struggle, just to survive. We’ve all seen, up close, the passion doctors evince in helping their patients, thereby reminding all of us about their deep concern for our well-being. At the same time, patient safety organizations, medical associations, and hospitals have done a tremendous job in getting the word out about how hard physicians and hospitals have worked to make healthcare a safer experience.

Another key factor, of course, is tort reform. Granted, claims frequency has declined in states that haven’t had tort reform, along with those that have. But there is little doubt that tort reform campaigns have helped to shed light on the challenges physicians have been facing all across the country—financial and otherwise.

There is nothing like the sight of doctors marching on your state capital, news stories about how much physician reimbursements have declined, and scary stories of counties across the country where there is zero access to Ob/Gyns, to make people appreciate the daily struggles of physicians.

And the list of endeavors that have had a measurable impact on patient safety goes on: electronic medical records, computerized physician order entry, risk management programs, mandatory check lists, Joint Commission national safety goals, insights gained from data sharing projects, patient safety alerts, enhanced educational training, and so on.

A complete discussion of every item on this list would fill an entire book. In this series, though, I highlight for you a few examples of advancements in patient safety, which have helped shape a sea change in U.S. healthcare.

Continued on page 16
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The power of an apology
Doug Wojcieszak, the founder of Sorry Works!, knows the importance of good customer service—and treating patients and families with respect after an adverse event. Sorry Works!, founded in 2004, has grown to more than 4,000 members nationwide, with the website receiving more than 4 million hits. Stories about Sorry Works! efforts have been published in *Time*, *The National Review*, *National Law Journal*, and American Medical Association publications.

Sorry Works! is a three-step disclosure process: (1) initial disclosure/initial apology expressing empathy, (2) investigation, and (3) resolution. If an investigation shows an error caused an adverse event, the disclosure team schedules a meeting with the patient, family, and their attorney to: (1) apologize or say “I’m sorry,” (2) admit fault, and (3) explain what happened and outline the steps that will be taken to prevent it from happening again, and (4) compensate.

If, on the other hand, the investigation reveals that there was no error, the disclosure team still meets with the patient, the family, and their attorney. In this meeting, the investigation will be explained, records opened and shared, and questions answered. The key is effective and open communication, all aimed at informing patients, reducing anger, and diminishing the likelihood of litigation.

A quick visit to the Sorry Works! website will tell you about the expanding ranks of apology programs at major institutions such as the Lexington Veterans Administration hospital, University of Michigan, University of Illinois Medical Center, Stanford University and Harvard teaching hospitals, Minneapolis Children’s, Catholic Healthcare West hospitals, Catholic Health Initiatives, and Physicians Liability Insurance Company (PLICO). Doug has made it his life’s mission to share the power of apologizing to patients, and there is no doubt in my mind that Sorry Works! has helped get the word out.

A leader in the apology movement, among MPL carriers, is COPIC, which founded its 3Rs Program in October 2000. The 3Rs Program stands for (1) Recognize the patient injury, (2) Respond quickly after the event, and (3) Resolve unanticipated events. Integral to the program are the goals of maintaining the physician/patient relationship; encouraging open/honest communication, with disclosure of any unexpected medical outcomes; encouraging expressions of
concern, including an apology when appropriate; meeting patients’ emotional and physical needs at crucial times; and reducing litigation expenses.

Since the program’s inception, COPIC has published success stories and case studies that highlight the impact of the 3Rs Program. In a recent conversation with COPIC representatives, I found that they have, at this point, worked on more than 2,200 cases where patients received reimbursements for out-of-pocket medical expenses and/or recognition of loss of time through the program. Patients are never asked to waive their rights to formal legal action, and no determination of negligence is ever made as part of the program. So it is impressive that only 3.4% of the patients who receive reimbursements via the 3Rs Program ever proceed to formal claims or suits; and only 0.4% of the 2,200-plus patients who were reimbursed have had additional payments via the tort system.

In June 2007, the New England Journal of Medicine showcased COPIC’s 3Rs Program as a leader in a national transformation in healthcare providers’ communications with patients on unanticipated outcomes. The article called COPIC’s 3Rs Program “the best-known private-sector disclosure program.” For the back story on COPIC’s program, see the Fourth Quarter 2007 issue of Physician Insurer, “Recognize, respond, resolve—a successful approach to disclosure.” This is a must-read if you are thinking about expanding the scope of your apology program.

**Saving Lives campaigns**

In December 2004, the Institute for Healthcare Improvement (IHI) announced a new 18-month collaboration with hospitals across the country. The ambitious goal of the project was to save 100,000 lives. Its six key interventions were:

1. Deploying rapid-response teams, at the first sign of patient decline
2. Preventing adverse drug events through medical reconciliation
3. Preventing central line infections
4. Preventing surgical site infections
5. Preventing ventilator-associated pneumonia

According to results published on IHI’s
website, the 3,000 hospitals participating in the campaign saved more than 122,000 lives.

Building on the initial success of the 100,000 lives campaign, and adding 1,000 new hospitals, the IHI expanded its program in December 2006, announcing a 24-month campaign now targeted at saving 5 million lives. Expanding beyond the list of six original interventions, the IHI targeted six more steps (e.g., preventing pressure ulcers, reducing surgical errors, preventing harm from high-alert medicines). The IHI has yet to disclose the actual number of lives saved from the 5 million lives campaign. But there is evidence that the institute’s efforts have paid off for the hospitals and healthcare professionals responsible for delivering quality care.

In Part Two of this series, we’ll look at patient-safety alerts, and some of the patient-safety initiatives medical specialties have come up with, to find out how they complement the other initiatives now in play.

References
1. Sorry Works!, http://www.sorryworks.net/

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2012 PIAA Medical Liability Conference
Sneak Preview

Ian Morrison, PhD, Healthcare Futurist, Author

The full impact of the Patient Protection and Affordable Care Act won’t be felt until 2014 and beyond, but in the meantime, healthcare stakeholders will have to deal with “Life in the Gap,” before the new provisions are in force. At the same time, everyone involved in healthcare will need to prepare for the emerging reality of healthcare reform, and try to determine what “Life in the Game” will be like in a reformed system.

Even now, the healthcare marketplace is changing rapidly (in part, in anticipation of reform), with increasing consolidation of delivery into ever-larger organized systems of care. This change will have a profound impact on the medical professional liability (MPL) insurance marketplace as well.

This presentation will focus on the political, economic, and strategic context of change in healthcare, describe the possible scenarios we face, and examine how the various actors are preparing for the future. It will identify the leadership challenges and opportunities that lie ahead, and will provide strategic insights for initiatives MPL insurance organizations can take to ensure that they flourish in the future. Don’t miss the 2012 PIAA Medical Liability Conference, May 9-12 in Washington, D.C. Visit www.piaa.us for the complete agenda and to register.
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Case and Comment

Breaking New Ground for a Nondisclosure-of-Risks Claim

As claimants and their attorneys continue to contrive creative liability theories, the lines separating distinct types of medical professional liability (MPL) claims from one another are at risk of becoming blurred. One prominent example of this tactic: cases in which a patient tries to conjure a negligent nondisclosure-of-risk claim from what is really nothing more than a garden-variety negligent treatment claim. A recent decision by the Minnesota Court of Appeals reaffirms that distinction, and it also illustrates the fundamental difference between these two kinds of claims.

Kingsley v. Pinto, 2011 WL 1743840 (Minn.App.) is the latest in a line of cases that illustrate the difference between negligent treatment and negligent failure to disclose the risks and alternatives associated with treatment.

The plaintiff in Kingsley was a woman with a longstanding history of back pain, including two previous lumbar fusion surgeries that had been performed by the defendant. As time passed, her back pain became debilitating, and she was diagnosed by the defendant as having severe degenerative disc disease.

To treat this condition, Dr. Pinto—an orthopedic spine surgeon—offered Kingsley the option of another spine surgery. This time, he proposed fusing her spine from a point high in her mid-back all the way down to her sacrum (from T3-S1, incorporating the previously fused segments of her lumbar spine). The patient elected to proceed with this surgery. Unfortunately, she was unable to move her legs upon waking up after surgery. While she has retained sensation in both legs, she has no motor function and is now considered paraplegic.

Kingsley brought suit against Dr. Pinto, alleging in her complaint that her paraplegia resulted from negligence in the performance of her spine surgery. Specifically, the plaintiff and her experts claimed that the standard of care required the use of intraoperative neuromonitoring (IONM) during the procedure performed by Dr. Pinto; that use of IONM would have alerted the surgical team to compromise of the patient’s spinal cord during this nine-hour operation; and that awareness of cord compromise would have permitted the surgical team to implement measures (primarily the administration of steroids) that would have improved her outcome. Dr. Pinto and the defense experts asserted that IONM is not the standard of care for this kind of surgery; that it would not have revealed the type of cord compromise the plaintiff experienced; and that even if it had been detected intraoperatively, cord compromise of the type experienced by the plaintiff—anterior cord vascular compromise—could not have been reversed once it had occurred.

The trial testimony of Kingsley’s experts established that they had no criticism of Dr. Pinto’s performance of this complex, multi-level spinal fusion surgery. Rather, their criticism was that the failure to employ IONM was a deviation from the requisite standard of surgical care, and that this deviation was a proximate cause of the plaintiff’s paraplegia. Although expert testimony to support the claim was dubious at best, Kingsley also sought to have the jury instructed on her theory that Dr. Pinto had negligently failed to disclose to her that IONM was an option that could be employed during her operation.

The trial court, concluding that using IONM during surgery was not actually an alternative treatment but, rather, just another method of monitoring a patient’s condition intraoperatively, denied Kingsley’s request for a negligent disclosure of risk claim.

Continued on page 22
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nondisclosure instruction and submitted the case to the jury solely on the negligent treatment claim. The jury concluded that Dr. Pinto was not negligent, and Kingsley appealed.

**Court of Appeals affirms**

The Minnesota Court of Appeals affirmed the jury's verdict, agreeing with Dr. Pinto that IONM is nothing more than a component of surgical treatment, not a treatment in and of itself. The law does not impose upon a surgeon the duty to disclose to a patient a plethora of details about how surgery will be done, what instruments will be used, how the patient's condition will be monitored, etc. Rather, the surgeon's duty is to disclose to a patient the recommended treatment for the patient's condition, any recognized alternatives to that treatment, and the significant risks and complications associated with treatment. *Cornfeldt v. Torgen*, 262 N.W.2d 684, 699 (Minn. 1977).

Although no “bright-line” rule can be formulated to address all potential situations arising in the context of obtaining consent for medical treatment, courts should construe the notion of treatment alternatives very narrowly. That is to say, for example, while a surgeon would generally be obligated to disclose that a certain procedure could be done either laparoscopically, or “open” through a larger incision and under direct vision, the surgeon's duty does not extend to disclosing the existence of the multitude of other alternatives from which the surgeon might choose in carrying out a procedure. A surgeon is not obligated to have a discussion with a patient about the type of padding, retractors, anesthetic agents, instruments, suture material, etc., that will be used in an operation. Such information is nothing that is generally going to have an impact on the “reasonable person's” decision whether to consent to surgery.

The law has long recognized this objective, “reasonable person” standard as the proper standard to be used by juries in determining what information a physician or surgeon must disclose. That principle presumably arises out of knowledge that patients who've experienced an undesired outcome of treatment are likely to proclaim that they'd have made a different choice if only they had been told...
about this or that—even though no reasonable person, without the benefit of hindsight, would have done the same.

The *Kingsley* court relied on previous decisions of Minnesota appellate courts in holding that use of intraoperative neuromonitoring during Kingsley’s surgery wasn’t an alternative treatment; rather, it was a means of obtaining information about the patient’s condition, which would be analogous to the monitoring of blood pressure, heart rate, or other vital signs. In *Kalsbeck v. Westview Clinic*, 375 N.W. 2d 861 (Minn.App. 1985), a negligent nondisclosure-of-risk claim could not be pursued in instances where the allegation was that the patient should have been informed that various laboratory tests and hospitalization were available in addition to antibiotic therapy he was receiving.

Similarly, in *Madsen v. Park Nicollet Med. Ctr.*, 431 N.W.2d 855 (Minn. 1988), a negligent nondisclosure-of-risk theory was not available to a pregnant patient in a case where the appropriate treatment was monitoring of her condition, and she alleged that inpatient monitoring and outpatient monitoring were alternative treatments about which she should have been specifically informed. The *Madsen* court recognized that the only distinction between what the plaintiff had argued were “alternative treatments” pertained to the practice setting where the treatment occurred—and not the essential nature of the treatment itself.

The fallacy of arguing that an informed consent claim can be made whenever negligent treatment is also alleged is that, in most such instances, what the patient is really alleging is that the physician owed a duty to disclose the risk that he or she might be negligent. What patient would consent to negligent treatment, after all? But no such duty to disclose the possibility of negligence has ever been imposed on physicians under the common law.

If the use of IONM was the standard of care for Kingsley’s surgery, Dr. Pinto was obligated to employ it irrespective of whether he told her he was going to do so. His failure to utilize IONM would have been negligence, and the jury could have reached that conclusion had the testimony supported such a result. But Dr. Pinto was not obligated to tell Ms. Kingsley about the availability of this technology. His only obligation was to do what the standard of care required.

*Kingsley* had degenerative disc disease. The alternatives available to her were, in the simplest of terms, either to have surgery or to try and get along without it. When surgery was discussed, Dr. Pinto had the obligation to advise his patient of risks attendant to that surgery, including the risk of spinal cord injury, which could result in paralysis. This case reaffirms that it was not Dr. Pinto’s duty—not is it the duty of any surgeon—to engage the patient in a discussion about the specifics of how a particular surgical procedure will be carried out.

**Conclusion**

In an effort to put one more liability theory before a jury, some plaintiff’s attorneys have tried to argue that a negligent treatment claim includes a negligent nondisclosure-of-risk claim. Rarely will that, in fact, be the case, and it is important for the defense to recognize the distinction illustrated by *Kingsley*. The duty of disclosure is a duty to disclose alternative treatments and the associated risks; it is not a mandate to discuss the myriad technical details of a procedure. Once the procedure is undertaken, however, the technical details must be executed in accordance with the standard of care.
The 2012 election cycle has been underway for quite some time. If you aren’t a fan of politics, you may be getting annoyed by now. News programs are flooded with political discussion and commentary, early primary states are being overwhelmed with political advertising, and it seems as if there are at least two debates between the Republican presidential candidates every week.

Whatever your views on politics, by the end of this year change will have come once again to Washington, D.C.—and that change will likely impact the future of medical professional liability (MPL) insurers.

Early analyses suggest that this election will be different from the last three. We will not likely see yet another “wave” election, where one party completely overwhelms the other. Some pundits are suggesting that control of the U.S. House of Representatives is in play, although there is no consensus on that among political analysts. The U.S. Senate is certainly up for grabs, although many observers are now questioning the certainty of a GOP takeover (based on the number of Democratic seats in play). The race for the White House, and the impact of that race on “down ballot” contests, is certainly up in the air, with some indicators favoring President Obama’s re-election and others suggesting victory for the Republican nominee (whomever that may be).

With all this in mind, the Physician Insurers Association of America Political Action Committee (PIAAPAC) has been very active this political season, and is preparing for even more outreach as the elections draw closer. We are carefully reviewing all of the federal races, with an eye out for opportunities to support our friends and oppose our adversaries.

2012 goals
PIAAPAC’s primary goal for 2012 is to help elect congressional candidates who share the PIAA’s views on the U.S. legal system and on government regulation of the insurance industry. While tort reform is clearly a leading issue in considering whom to support, a candidate’s views on antitrust reform or patient safety programs may also influence the PAC’s decisions regarding financial support. Other factors considered are the candidate’s commitment to insurance industry issues, the candidate’s ability to influence the legislative process if elected, and the competitiveness of their race.

After reviewing these factors, the PAC Board of Directors decides how it will allocate the PAC’s limited campaign dollars. It is important to note that PIAAPAC is a voluntary, nonpartisan political organization, and, as such, every effort is made to support a bipartisan slate of candidates.

How the PAC raises funds
To be recognized as a serious participant in the political process, PIAAPAC needs money—plain and simple. Regrettably, the campaign finance laws make it exceptionally difficult for a relatively small trade association like the PIAA to raise PAC funds. Like other similar organizations, we cannot collect funds from corporate entities and we are also banned from

Continued on page 26

Michael C. Stinson is Director of Government Relations at the Physician Insurers Association of America; mstinson@piaa.us.
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Continued from page 24
taking donations from the general public.
To raise money, we must contact each of
our member companies annually, to (1)
get their permission to ask for contribu-
tions from the individuals that the law
allows us to solicit, or (2) confirm the
names of the persons we are allowed to
solicit if the company has previously given
us permission to do so. Under federal
campaign law, individuals who can legally
be solicited make up what is known as the
“restricted class” or “eligible class,” which
consists of salaried executive and admin-
istrative personnel of the PIAA and its
member companies.
If a member company has granted
us permission, we still have to go back to
those companies to get the names and
addresses of every individual in the eligi-
ble class for that company. It is illegal for
us to seek a contribution from anyone
until both of these conditions have been
met. Clearly, this process is time-consum-
ing and cumbersome for our companies,
with this same solicitation process,
with the law provides us no other alternative. Making
matters worse, the American Association
for Justice (AAJ) does not have to contend
with this same solicitation process,
because the rules are different for associa-
tions that have individuals, rather than
companies, as members. Annually, the

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AAJ raises more money than PIAAPAC—by a margin of 200 to 1.

**Does the PAC help?**
The fundraising process is difficult—so is it worth it? The answer is a resounding “Yes!” For starters, money generates attention. The political fundraising process is a key tool to ensure elected officials are aware of who we are and what we do. Furthermore, the PAC is the only political entity in Washington, D.C., that is solely committed to the interests of provider-directed MPL insurers. Without it, our message would surely get lost among all the other political organizations advocating on other healthcare issues.

Especially now, with so many competitive races for the U.S. House and Senate underway, maintaining a viable and effective PAC is essential to any organization’s lobbying efforts. The PIAA, through its PAC, remains committed to playing a significant role in the legislative process, for our members and the healthcare providers they insure.

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**2012 PIAA Medical Liability Conference Sneak Preview**

**Finding Success in the New Healthcare Marketplace**

In this session, prominent executives in the insurance and healthcare industries will provide their perspectives on the evolving changes in the healthcare marketplace, the likely impact of these changes on individual and small-group physician practices, and the resulting impact on MPL carriers. They will also offer some innovative strategies for achieving success in the new marketplace.

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*First Quarter 2012 Physician Insurer*
Patient Safety Initiatives May Help Reduce Claims
There is general consensus in the medical professional liability (MPL) industry that the annual number of new reported claims has been trending downward for most of the past decade. Whether this is an enduring change, or just part of a traditional cycle in a notoriously cyclical industry, remains to be seen. But the trend is sufficiently apparent to warrant analysis. What factors are driving it?

Some experts trace the trend in part to what can be broadly described as a national patient safety initiative credited with reducing many categories of adverse events over the past two decades. The Rand Institute for Civil Justice released a study last year that showed “a highly significant correlation between the frequency of adverse events and malpractice claims.”

An important player in the patient safety initiative has been the MPL industry itself, in providing risk management and continuing medical education (CME) programs that have become a pervasive part of the professional life of today’s physician.

“Some of the most successful patient safety initiatives have come from the risk management activities of professional liability companies,” wrote Barry M. Manuel, MD, and co-authors in a December 2010 article from the federal Agency for Healthcare Research and Quality. “[They are] uniquely positioned to analyze and trend large data sets…”

“The MPL industry has an advantage in creating such programs because of its bird’s-eye view of why doctors become involved in lawsuits,” says Paul Gabel, vice president of claims for NORCAL Mutual Insurance Company. “From initial complaint to final resolution, malpractice claims have a singularly long life, sometimes stretching to five years or more. But an insurer with decades of closed claims data can accommodate this trait and tease out trends—not only in primary causes of claims, but also in associated issues that might otherwise go unnoticed for years.”

Issues and associated issues

Why does one doctor miss a diagnosis and become involved in an MPL lawsuit, while another doctor misses the same diagnosis without suffering the same fate? Often, it comes down to whether there were associated issues that somehow exacerbated the situation. They might include a problem with follow-up or a failure to properly document a discussion of risk with the patient. Whatever they were,
the associated issues joined the primary issue to provoke an action against the physician.

One of the key functions of effective risk management and CME programs is to identify associated issues that most often contribute to patient harm, lawsuits, and indemnity payments.

The NORCAL Group, which includes NORCAL Mutual, PMSLIC, and Medicus insurance companies, identifies high-risk associated issues in two ways.

First, risk management and claims specialists continually evaluate closed claims to see why doctors are being sued. If a

## Measuring Risk Management Impact

There was in fact a documented and published case of achieving a measurable reduction in both quantity and severity of claims through a risk management program in the Baltimore-Washington, D.C., area, several years ago. MedStar, a network of seven nonprofit hospitals, launched a combination of new protocols and new technology to improve its obstetric performance. In the two-and-a-half years after implementation (January 2005 through June 2007), improvements were achieved, as compared with what was projected to happen if no changes were made.

<table>
<thead>
<tr>
<th>Loss Period</th>
<th>Expected Frequency</th>
<th>Actual Frequency</th>
<th>Expected Severity</th>
<th>Actual Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/05-6/30/05</td>
<td>1-4 claims</td>
<td>1 claim</td>
<td>0.6M to 2.8M</td>
<td>0.9M</td>
</tr>
<tr>
<td>7/1/05-6/30/06</td>
<td>2-8 claims</td>
<td>3 claims</td>
<td>1.2M to 5.6M</td>
<td>0.07M</td>
</tr>
<tr>
<td>7/1/06-6/30/07</td>
<td>1-5 claims</td>
<td>0 claims</td>
<td>0.75M to 3.5M</td>
<td>0$</td>
</tr>
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</table>


## What Do Paid Claims Tell Us About Patient Safety?

The annual percentage of closed claims that are closed with the payment of a settlement or jury award indicates how well physicians are meeting the standard of care in the eyes of the courts. If physicians are steadily improving, the percentage should shrink—which it is. The PIAA database for all specialties combined for 1985–2010 shows the percentage of paid claims at 30 or higher for the first nine years (1985–1993). For the next five years (1994–1998) it dropped below 30%, but then crept up again for four years (1999–2002). Beginning with 2003, there has been an eight-year run of less than 30% paid claims per year, including a record low of 24.10 in 2005.

### The Shrinking Rate of Indemnity Payments

The annual percentage of closed claims that were closed without a settlement or jury award, 1985–2010, all specialties combined.

<table>
<thead>
<tr>
<th>Above 30%</th>
<th>Below 30%</th>
<th>Above 30%</th>
<th>Below 30%</th>
</tr>
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<tbody>
<tr>
<td>1986 — 33.72</td>
<td>1995 — 27.86</td>
<td>2000 — 33.38</td>
<td>2004 — 25.05</td>
</tr>
<tr>
<td>1992 — 33.93</td>
<td></td>
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<tr>
<td>1993 — 30.68</td>
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settlement or jury award was paid, the company determines why. The analysis is nuanced, revealing not just primary causes but also the associated issues involved. With three decades’ worth of data, the companies are able to track trends over time, including emerging trends.

“This is one of the values an insurer can bring to the physician,” says Gabel. “We have a unique view of risk factors that can be of great value to the practitioner.”

Second, the NORCAL Group pays close attention to the onsite risk assessments conducted by its risk management department. To screen certain applicants and as a service to policyholders, the companies send specialists to selected physician offices and hospitals to identify risk issues. Segments of data from the subsequent reports are analyzed in the aggregate to identify both primary issues and associated issues. The findings from closed-claims analysis are several years old, but data from onsite assessments is current.

Looking for the overlap
To see how the most important closed-claims associated issues align with the most important risk-assessment associated issues, the NORCAL Group recently compared the two types of data for a two-year period, July 2009 through June 2011. Table 1 shows the top ten associated issues from closed claims, while Table 2 shows the top ten associated issues from 175 risk assessments conducted during the period.

Based on the overlap, the NORCAL Group identified four main areas in which physicians can take action to effectively minimize risk:
- Managing follow-up processes
- Generating documentation
- Managing medications
- Communicating with other healthcare providers.

“Not surprisingly, these four risk areas tend to be vulnerable to the seismic changes now under way in healthcare,” says Dustin Shaver, NORCAL vice president of risk management, “including the growing roles of allied health professionals and hospitalists, the transition from paper charts to electronic health record (EHR) systems, and an acceleration toward medical group expansion and network health-delivery organizations.”

Accordingly, the risk management and CME programs in the NORCAL Group emphasize documentation, follow-up, and communication. Because EHR systems are so relevant to all three areas, the companies have a program devoted to promulgating best practices for selecting, purchasing, and implementing an EHR system. Called EHR Tools, the online cache of articles consistently reinforces the theme that such systems are only as patient-safe and risk-reducing as the people who develop and use them.

In the case of medication management, the main issues discovered in the office assessments had to do with the distribution of sample drugs and the management of chronic pain. As an example of how this kind of analysis yields relevant CME materials, the January 2012 issues of Claims Rx and Consult, monthly risk management publications of the NORCAL Group, will address “The Risks Associated with Chronic Pain Management.” The 12-page article will include detailed accounts of two lawsuits, the first on an allegation that involved the prescribing of opioids to a patient at risk for misusing medications, the second on an allegation that an accidental methadone overdose was the proximate cause of injury.

“Physicians like these articles because the cases give enough detail to let you fully appreciate what happened,” says Patricia Dailey, MD, an anesthesiologist at Mills-Peninsula Medical Center in Burlingame, California. A PIAA Risk Management

### Table 1 Top ten associated issues in NORCAL Group closed claims, July 2009–June 2011

1. Problem with history, examination, or work-up.
2. Error associated with interpretation or communication of radiology results.
3. Communication problem between healthcare providers.
5. Informed consent issues.
6. Problem with medical records.
7. Failure to follow up on tests.
8. Vicarious liability.
9. Problem with a medical or surgical device.
10. Inadequate facility or equipment.

### Table 2 Top ten associated issues in NORCAL Group risk assessments, July 2009–June 2011

1. Handling of after-hours telephone calls (including documentation and communication with covering physicians).
2. Distribution of sample medications.
3. Reporting test and consult results to patients.
4. Use of therapeutic agreements with chronic pain patients.
5. Follow-up processes after hospital discharge.
6. Follow-up processes for return office visits.
7. Documentation of allergies.
9. Legibility of documentation.
10. Authentication of medical record entries.
Section member and Board member for the NORCAL Group of companies, Dailey has seen many clinical and systemic improvements in her specialty during 20 years of practice.

“I think the onsite risk assessments are particularly important today because they often reveal structural or systemic issues that may be hard for the providers to see, because the problems are simply part of the environment in which care is delivered,” Dailey says.

Dailey can bear witness to patient safety practices that were first introduced as risk management tools but then evolved into widespread practice. She cites capnography as an example. Monitoring of carbon dioxide was once mainly used in the operating room, but today it is viewed as an important tool in other parts of the hospital, including the gastrointestinal suite, emergency department, and cardiology suite.

“If you have a patient under sedation, especially with obstructive sleep apnea, you need to watch the CO2 level,” she says.

The challenge of measuring impact

Trying to causally connect risk management and CME programs with a downward trend in both claims and paid claims is like trying to prove that virtue is its own reward—probable, but not quite provable. Many other factors affect claims activity, including tort reform, improved training, the use of drugs with fewer adverse side effects, and access to the legal system.

Still, the efficacy of such programs is more than a matter of faith in the MPL industry.

“Ideally, the risk management and underwriting functions work together to screen applicants, underwrite to the standard of care, effect systemic and behavioral change when possible, and protect the policyholder body as a whole from preventable risk,” says Gabel. “It’s an imperfect science, but a science nonetheless. And we have seen the results.”

For more information, see www.norcalmutual.com

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Medical Interactive Community
On October 20, 2011, the Centers for Medicare & Medicaid Services (CMS) released its “Final Rule Provisions for Accountable Care Organizations” under the Medicare Shared Savings Program (MSSP).

The MSSP promotes the formation and operation of accountable care organizations (ACOs) to serve Medicare fee-for-service beneficiaries. According to CMS, this program is intended to encourage providers of services and suppliers (e.g., physicians, hospitals, and others involved in patient care) to join together and create a new type of healthcare entity, an ACO. The ACO must agree to be held accountable for improving the health and experience of care for individuals and improving the health of populations, while reducing the rate of growth in healthcare spending.

Dana Switzer, CPCU, ARM, is Senior Vice President, Unit Manager, at Lockton Companies.
ACO RISKS

- Hospitals employing ACO professionals
- Other Medicare providers and suppliers, as determined by the Secretary of Health and Human Services.

In addition, certain critical-access hospitals, federally qualified health centers, and rural health clinics may be eligible to participate independently in the MSSP. These providers may become ACOs and be used for purposes of assigning patients to the ACO. In recognition of the fact that these facilities may not have access to the capital needed to fund an ACO infrastructure, Medicare established the Advance Payment Model. The model is open to two types of organizations only: ACOs that do not include any inpatient facilities and have less than $50 million in total annual revenue; and ACOs in which the only inpatient facilities are critical-access hospitals and/or Medicare low-volume rural hospitals and have less than $80 million in total annual revenue.

Organizations such as skilled nursing centers, home health agencies, and hospices may participate in an ACO, but they may not be used for purposes of assigning patients to the ACO. An ACO must agree to accept responsibility for at least 5,000 Medicare fee-for-service beneficiaries to be eligible to participate in the MSSP. The ACO must complete an application providing the information requested by CMS, including a full description of how the ACO plans to deliver high-quality care and, at the same time, dampen the increases in expenditures for the beneficiaries it serves. If the application is approved, the ACO must sign an agreement with CMS to participate in the MSSP, for a period of at least three years.

In addition to the MSSP, Medicare offered the opportunity to participate in the Pioneer ACO Model, designed for healthcare organizations and providers that are already experienced in coordinating care for patients across multiple care settings. It will allow these provider groups to move more rapidly from a shared-savings payment model to a population-based payment model, e.g., capitation. On December 19, 2011 CMS published its list of the 32 organizations selected to participate in the Pioneer ACO Model.

Through the CMS regulations, ACOs have an opportunity to provide high-quality, evidence-based healthcare to Medicare enrollees, while eliminating waste and reducing excessive costs. To the extent that an ACO is successful in capitalizing on this opportunity, its members will share in the savings achieved.

As is often the case, however, opportunity is accompanied by challenge: the challenge to “get it right” in order to achieve maximum savings, to change care delivery and improve patient safety, and to avoid running afoul of regulations that were designed to protect the healthcare consumer. An organization will be challenged to correctly structure or modify its insurance and risk-financing programs in response to the risks presented. This article focuses on several areas of risk considered key to formation and implementation of the ACO model.

Structure and governance

An ACO must be a legal entity that is capable of receiving and distributing shared savings, repaying shared losses, and reporting quality performance data. It must have its own governing body, separate from those of its participants. This means that the ACO’s board members cannot be “absorbed” into an existing directors and officers liability policy.

If an ACO consists of more than one large organization, e.g., a health plan and a health system or a hospital and large multispecialty physician group, there may be conflicts with respect to which organization will control the purchase of insurance. If both organizations retain significant liability risk through a self-insurance trust or captive insurer, will the ACO be able to retain similar risk?

As a legal entity, the ACO may own or lease property or office space in its own name and employ workers under a separate Federal Employer Identification Number, all of which will require a separate purchase of insurance. Liability insurance will be required in order to address the indemnification assumed in lease agreements and professional services contracts.

Several government agencies, including the Internal Revenue Service, Federal Trade Commission, and U.S. Department of Justice’s Antitrust Division, have provided guidance for ACOs formed under the MSSP. While this guidance will be helpful in the formation of Medicare ACOs, it may not be as applicable to commercial ACOs, leaving them with more uncertainty regarding regulatory risk.

Many hospitals and health systems have ramped up their acquisition of physician practices in preparation for providing the full continuum of care to ACO beneficiaries. These acquisitions may result in more intense government scrutiny with respect to market share. Hospitals frequently find themselves assuming responsibility for physicians’ prior liability exposures, purchasing an extended reporting endorsement from the physician’s insurer, or absorbing the risk into the hospital’s own risk-financing program. As the hospital’s number of ratable exposure units increases, its medical professional liability (MPL) premium and/or self-insurance funding may increase substantially.

Electronic health records

ACOs must meet 33 quality measures established by CMS in order to receive productivity bonuses under the MSSP. Implementation of electronic health records (EHRs) will be a fundamental component of any ACO, enabling the organization...
and its participants to share clinical data and provide results, quickly and accurately. Underwriters generally agree that EHRs will improve quality and patient safety over time. Some liability insurers, however, believe that claims will rise during the adjustment period, as providers work out the kinks in these new systems. Providers may be open to more errors and system breakdowns in the early stages of EHR implementation. In addition, it may be easier than ever for plaintiff attorneys to obtain the records they need for building their case against a provider.

A *New York Times* article, December 15, 2011, revealed a new phenomenon, a consequence of the explosion of technology in the healthcare setting: the distracted professional. According to the article, physicians and hospital staff are increasingly using hospital computers and their own smart phones for personal business—instead of tending to the patient. The article cites an MPL settlement involving a neurosurgeon who allegedly made at least ten personal phone calls while performing surgery.

**Privacy protection and cyber-liability**

The number of healthcare data breaches continues to outpace those reported in other vertically integrated business—including banking and government. The Second Annual Benchmark Study on Patient Privacy and Data Security conducted by the Ponemon Institute and sponsored by ID Experts found that, despite generally greater compliance with HIPAA and the Health Information Technology for Economic and Clinical Health Act, healthcare data breaches are on the rise—eroding patient privacy, contributing to medical identity theft, and costing billions annually.

Healthcare organizations seem particularly prone to internal problems, including malicious theft and unintentional loss of storage devices containing treasure troves of database information.

Earlier this year, the Department of Health and Human Services (HHS) imposed its first-ever civil monetary penalty on a covered entity for violating the privacy rule of the HIPAA. HHS ordered Cignet Health of Prince George’s County, Maryland, to pay $4.3 million for violating the rights of 41 patients in denying them access to their medical records when requested.

It will be critical for the ACO and its participants to have robust data security and compliance programs, along with properly structured privacy protection and cyber-liability insurance.

**Changing delivery models**

The CMS final rule requires that the ACO have procedures and processes that will promote evidence-based medicine, engagement of beneficiaries in their care, and coordination of care.

CMS expects that ACOs will invest continually in the workforce and in team-based care. To assure program transparency, the final rule requires that ACOs issue public reports on certain aspects of their performance and operations, and that CMS publish public reports on certain quality-related data.

ACOs may find themselves taking on more financial risk as the concept matures, not unlike the capitation models so prevalent in the 1990s. Smaller ACOs may entrust all of their business operations to an outside consulting or management firm. Managed care errors and omissions and stop-loss insurance may be needed to address the financial, credentialing, network management, and utilization review exposures presented by such arrangements.

ACOs are required to have systems for identifying and developing care plans for high-risk individuals. They must promote evidence-based medicine and “medical homes,” i.e., coordination of care across all providers. Demonstrating evidence-based medicine will require meticulous documentation, as well as more sophisticated processes and procedures. In time, it may become more difficult to defend lawsuits alleging deviation from the standard of care.

The medical home concept will require more collaboration between members of the care team, such as case managers and home health providers. And medical homes will need to include systems for ensuring the timely and accurate sharing of information among all participants.

Patient-centered care is encouraged, putting the beneficiary and family at the center of every aspect of care. Informed consent may give way to “informed choice”; providers will need to document the fact that the patient and his family refused available alternatives of the treatment chosen.

It’s too soon to predict how these changes in care delivery will impact medical liability litigation. The frequency of lawsuits could increase as plaintiff attorneys test new theories in litigation against ACO organizations and professionals.

**Conclusion**

There was a well-worn phrase during the infancy of managed care: “When you’ve seen one HMO, you’ve seen one HMO.” The same phrase could apply to ACOs. Recognizing that each ACO will be unique in its structure, governance, relationships, and delivery model is essential when evaluating its risk-financing needs. ACOs will be well served by involving their insurers and brokers early on in the planning stages, thereby ensuring a risk-financing program that is tailored to their unique risks.
The healthcare industry is in the midst of a prolonged transition period, and hospital systems are putting top priority on preparing for a new business model. Healthcare organizations of the future will be defined by their ability to deliver high-quality care as efficiently as possible. As a result, health system consolidation and service integration are increasingly included in systems’ strategic plans. Larger, integrated healthcare organizations will need to provide a broad range of coordinated medical services, while reducing expenses through economies of scale.

For many types of systems, the integration of hospital and physician services is a major part of this trend toward consolidation. From the perspective of medical professional liability (MPL) coverage, this integration is associated with financial savings. Many integrated hospital-physician systems are self-insuring the combined employed-physician and hospital professional liabilities. Combining insurance programs and retaining the risk may reduce overall insur-

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ance costs, but it leaves the system with new challenges: greater risk and a more complicated administrative structure.

Physician integration on the rise

The employment of physicians by healthcare organizations has accelerated in recent years. Figures 1 and 2 show that the number of employed surgeons is growing by more than 12% per year, while the number of non-surgeons is increasing by more than 7% per year. In the near term, the number of employed physicians is expected to continue to grow. Provisions of the healthcare reform act are prompting healthcare systems to integrate and pursue all possible efficiencies.

Unlike physicians, healthcare systems do not have a readily accessible marketplace for primary (or first-dollar) hospital MPL insurance coverage. Hospital self-insurance for MPL is a well-established institution for most systems. Faced with a rapidly expanding exposure from employed physicians, hospital risk managers and financial officers can opt to (1) maintain the newly employed physicians’ commercial coverage or (2) assimilate the physicians into the system’s self-insurance program.

Most healthcare systems choose to self-insure their employed-physician exposures. A survey of benchmark participants indicated that 73% of risk managers have decided to retain their employed-physician exposures within the hospital’s self-insurance program. This decision represents a classic risk-versus-reward insurance decision.

The reward

The Aon/ASHRM (American Society of Hospital Risk Managers) benchmark study provided an analysis of self-insured (i.e., hospital-insured) employed-physician loss rates. Not surprisingly, the loss rates follow a historical pattern that is very similar to that of the hospital MPL results. As Figure 3 shows, the loss rates bottomed out in accident-year 2006 and have increased modestly since then. For accident-year 2011, the analysis suggests an annual loss rate of $6,410 per Class 1 (internal medicine–no surgery) physician.

The 2011 projected loss rate for employed physicians is considerably lower than that contained in filed commercial premium rates for MPL coverage (Figure 4). A countrywide average (weighted by population) of the leading state carriers indicated an average filed rate of $15,808 for 2010 (more than two-and-a-half times the estimated loss rate for employed physicians in 2010). Clearly, an accurate comparison should include the considerable discounts that are applied to the filed rates. Assuming an average premium discount of 40% for 2010 rates, for example, the loss rate would be $6,100 for a commercial premium of $9,485. The perceived gap between commercial premiums and actual loss rates, both in the present and the past, would appear to support the case that a significant reward can be gained through self-insurance.

The risk

The risk involved in self-insuring employed physicians arises from the uncertain nature of the claims. This risk would seem clear to the risk-takers. If future MPL claims become more frequent or more severe than expected, the risk-taker may suffer a financial loss. A second risk is apparent if we look beyond the claims and consider the administration and underwriting of the insurance. For example, healthcare systems are faced with the negotiation and underwriting of tail and prior acts risks for physicians. Systems are also challenged by the maintenance of insured rosters and claim data for self-insurance.

Physician self-insurance involves making many—perhaps hundreds or thousands—of meaningful and individual obligations to employees. This is in contrast to the singular, and cor-
porate, hospital professional liability aspect of self-insurance, wherein one basic insurance obligation is made to the corporation (or to a group of facilities). Medical professional liability coverage for physicians has a more personal value, seemingly more like a benefit or type of compensation than behind-the-scenes corporate policy.

**Defining the obligation**

Prior acts and tail coverage are key elements that define the obligation made to physicians. For some surgical specialties, prior acts and tail coverage may be worth well more than $100,000.

A survey of benchmark participants found that most hospitals (64%) avoid the inclusion of prior acts coverage within their self-insurance obligations (Figure 5). Presumably, this is accomplished through the purchase of commercial tail coverage or through tail coverage provided by the physician's prior employer. Some hospitals (29%) insure employed physicians for prior acts only in specific circumstances.

Conversely, the majority of hospital systems (86%) do insure the tail liability for employed physicians (Figure 6). Some systems accomplish this by offering occurrence rather than claims-made coverage. Occurrence coverage responds to all events occurring during the coverage period, regardless of the claim report date. This effectively covers the physician’s tail liability but not the prior acts. Our survey indicates an emerging trend among hospitals, with more organizations moving toward occurrence coverage of their employed physicians.

**Maintaining useful data**

The individual nature of physician coverage adds further complication to the self-insurance process in the area of case reserving. For complicated claims, involving physician and hospital allegations, claims and loss reserves may be established on behalf of the physician, the hospital, or both.

Benchmark study participants reported using a variety of reserving philosophies when dealing with complex hospital-physician claims (Figure 7). Many systems (37%) set up a single claim file for such claims and designate the claim as a hospital liability file. A slightly more common approach (41%) was to set up two separate claim files, and to allocate reserves based on the
Consolidating claim reserves—coding the entire claim amount to one file—can result in the loss of important information. If the physician-related share of liability is not recorded separately, it may become impossible to maintain an accurate loss history (or “loss run”) specific to the physician liability coverage. This could have implications, should the hospital wish to discontinue self-insuring physicians and return to the commercial market. The lack of physician reserves also limits the organization’s ability to analyze the self-insurance financial results.

Unlike the case with prior acts and tail liability issues, the industry is not converging on a standard of practice for case reserving complex hospital-physician claims. The hospitals that opt to consolidate amounts into a single file may be missing an opportunity to collect key data.

**Future considerations**

Self-insurers of combined hospital-physician risks accept a higher level of risk and potential for volatility in their results. Risk theory illustrates that the accumulation of independent risks can lead to a more diverse and stable portfolio. However, hospital and physician liability are highly correlated risks. The two sets of exposures are influenced by the same underlying events and environmental factors. This implies that these risks will likely behave in a parallel, and not an offsetting, manner.

The healthcare industry benefitted from declines in MPL claim frequency through much of the 2000s. MPL insurers and self-insurers are currently reflecting these benefits in the form of reserve redundancies, dividend distributions, and lower funding and premium levels. The industry seems far removed from the MPL insurance crises of the past. However, despite the relative calm of the current environment, self-insurers of combined hospital and MPL liability should consider what might happen to a concentrated risk portfolio if adverse conditions ensue. Hospital and MPL insurance prices have, in the past, seen double-digit increases in annual trend rates. Long-range planning for these integrated programs should include careful consideration of how the combined portfolio of risks will react to deteriorating trends in claim frequency and severity.

**About the Study**

The 2011 “Aon/ASHRM Hospital and Physician Professional Liability Benchmark Study” is the 12th annual report compiled specifically for healthcare systems to address the cost of self-insured medical liability exposures. One hundred and seventeen healthcare organizations, representing more than 2,300 facilities, participated in the study. In this year’s study, Aon Risk Solutions reported on the impact the increasing numbers of employed physicians are having on the cost of risk. Systems provided rosters, claim data, and coverage parameters for more than 15,000 employed physicians.

The opinions expressed in this article are general in nature and are not intended to provide specific advice and you should consult with your risk and legal advisors to determine how they may apply to your specific circumstance.

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**Figure 5**  Survey Result: Offering Prior Acts Coverage to Employed Physicians?

- Yes, in many or all instances: 7%
- Yes, but only in selected instances: 25%
- Never: 64%

*Source: Aon Risk Solutions*

**Figure 6**  Survey Result: Offering Tail Liability Coverage to Employed Physicians?

- Yes, in many or all instances: 4%
- Yes, but only in selected instances: 19%
- Never: 86%

*Source: Aon Risk Solutions*

**Figure 7**  Survey Results: Case Reserving for Complex Hospital and Physician Liability Claims

- Multiple Case Reserves (50/50): 41%
- Multiple Case Reserves (Based on Responsibility): 4%
- One Case Reserve (Most Responsible Party): 37%
- One Case Reserve (Hospital): 19%

*Source: Aon Risk Solutions*
As is often the case, the most difficult part of writing an article is the first few words—the title. This article was no exception. Typically, since the author has only a few seconds to catch the reader’s attention, the objective of the title is to be descriptive and, perhaps, even catchy. Since you’ve read this far, maybe the five words above worked. Beyond the usual challenges with any title, this particular one proved especially difficult because some of the possible titles I came up with had already been used. “Defusing Defense Costs” was an early contender, until I discov-
ered that this was the title of a July 1988 Best’s Review article. Since I’m a big fan of alliteration, I next tried “Driving Down Defense Costs,” only to find that, that too, had already been used—this time, in a July 1999 Best’s Review article. In retrospect, though, the fact that these titles were already taken worked in my favor because, had I used them, I would have violated the first objective of a title: to be descriptive.

Managing defense costs is not a new concept, as evidenced by the generationally old articles noted above. Further, managing defense costs does not necessarily mean minimizing or defusing or even driving down defense costs. In order to better manage these costs, one first needs to understand them by gleaning insights into the defense cost data—hence, the title. Only with first having a better understanding of one’s defense costs can one be expected to better manage them.

If the topic of managing defense costs is at least a generation old, why would this publication allocate four pages to it when there are so many other issues facing the medical professional liability (MPL) industry? The answer, I believe, is twofold. First, while the MPL industry has enjoyed what is arguably its greatest financial success ever over the past several years, the one cost element that has increased at a noticeably higher rate than the others is the average defense cost per claim. The second reason for including this type of article now is that the proliferation of Web-based business transactions, along with advances in data mining and warehousing techniques, has made it possible to extract more granular and valuable insights from the detailed defense cost data than ever before. Armed with this information, one will be able to better manage the entire claims process, including the cost of defense.

Many articles have been written and presentations made regarding the MPL industry’s impressive financial results over the latter half of the past decade. The combination of rate increases in the early part of the 2000s, coupled with the unexpected and significant decline in claims frequency has been well documented here and in other industry publications. Frequently, the issue of claim severity has been assigned only a minor role in these discussions. Given the overall trends in claim severity during this period, this treatment seems appropriate, especially in light of the significant claim frequency decline. However, even though the overall trends in the average cost per claim have been manageable, when one deconstructs these overall trends into its components, the average indemnity per claim versus the average defense costs per claim, two distinct patterns emerge.

### Higher defense costs

Since the decline in claims frequency, we have observed a notice-

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or the actuary’s case development and/or incurred but not reported estimates. However, focusing on paid data can add to the volatility of the year-by-year indications and can be a lagging indicator of current trends given the claim settlement lag in MPL. Having said that, the overall conclusion based on this data, namely, that defense costs per claim have been trending at a noticeably higher rate than their counterpart indemnity costs, is consistent with our observations from the “actuarial data” we reviewed in the course of our analyses. Further, the overall differential in these rates of approximately 450 basis points is also consistent with our more technically “clean” analyses that were done using data from the claims departments.

It isn’t just the actuaries who’ve noted that defense costs are trending at a rate that is higher than expected. Many senior management teams have also noted this and have frequently attempted to answer the all-important question, why? Why are defense costs increasing? The discussion that ensues typically includes some reasonable and rational hypotheses: Expert witness fees are going up. The cases are medically and legally more complex. We need more experts per case. More motions are being filed. All of these suggestions seem plausible, and may in fact be contributing to the increased costs, but what is typically missing from these discussions is any comprehensive and systematic way to measure and quantify these hypotheses. The primary reason for this lack

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Or, send an e-mail to ginnye@piaa.us.
of quantitative ability is the dearth of detailed data that exists at most companies concerning defense costs.

**Extracting the details**

Defense costs in an MPL setting primarily take the form of attorney fees, expert witness fees, document retrieval and copying expenses (e.g., medical records, court reporters, etc.), and miscellaneous costs (e.g., surveillance, court animation, etc.)(Figure 3). Within each of these categories, the data can be broken down into more granular components. For example, the defense attorney fees are not only a multiple of the billing rate and the number of hours spent on the case; they are also a function of the distribution of the hours by type of legal professional working on the case—paralegal, associate, or partner.

Defense costs can also be assigned to a particular phase of the claim, which might be categorized as case assessment, discovery activities, pre-trial pleadings and motions, or trial preparation and trial. Likewise, within each of these phases of the claim, various events occur; witnesses are deposed, motions are filed, for example. Keeping track of the costs and associated activities at this sort of granular level can be difficult, if not overwhelming, for a particular claim, let alone for a company’s complete inventory of open claims, which can total several hundred or even thousands of claims, all at various stages of maturity.

While the task of monitoring an open claim inventory in a much more systematic and detailed manner may seem daunting, the good news is that the data to do it already exists, even if companies are not currently collecting or using this data. The bad news is that the data is not available in a neat and orderly package. The data I am referring to is the painstakingly detailed, line-by-line description of the services rendered by the defense attorney firms. Within this unstructured, text-based data lies a wealth of detailed information that can be extracted to better understand and ultimately better manage a company’s claims process.

**Benchmarking the costs**

Once this detailed data is collected, scrubbed, normalized, and stored in a data warehouse environment, management will have the ability to quickly and easily track and benchmark its open claims inventory on a variety of levels including at the invoice level, by defense firm, by the phase of the claim, etc. For example, Figure 4 displays the hypothetical costs by claim phase for a particular claim, versus those same statistics for all of the claims handled by the particular defense firm, as well as a benchmark using all claims closed since 2007.

Being able to monitor the open claims inventory in a detailed and real-time fashion, using the wealth of information that is contained in the defense attorney invoices, can enhance a company’s ability to better manage every aspect of its claims process, not just its defense costs.
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In Part One (Physician Insurer, Fourth Quarter 2011), T.C. Wilson discussed the basic elements of an "evolved" portfolio for a medical professional liability company. Minimizing tax payments, preserving capital, growing surplus, maximizing after-tax income, and/or achieving the highest after-tax book yield are still critical objectives. But, Wilson says, how your company attains these goals should have changed a while ago. With new pressure on income, companies need to consider a wider range of potential investments.

**Black swan events and the evolution chart**

By definition, “black swan” events are high-impact, hard-to-predict, and rare occurrences that lie beyond the realm of normal expectations.

Since there have been several such events over the last ten years, it might be worth considering a new metaphor as we continue to evolve. Regardless, insurers are facing new challenges, and it is time to step up and recognize that the world we live in today is a far cry from the one we knew yesterday.

Because income is a critical component of an insurer’s business model, we will start with a 15-year table that tracks the yield spreads of U.S. corporate and U.S. high-yield bonds prior to, during, and following a major, unforeseen event.

As you can see, after each major crisis (i.e., black swan event), there is a resulting contraction in yield spreads, indicating an opportunity for income-focused investors. Despite the downward trend in 10-year Treasury yields, the attractiveness of spread product (i.e., all non-government-related debt) should not be overlooked. Even as black swan events seem to occur with some regularity, the fixed-income markets have proved resilient, and credit spreads have recovered from crises.

It would seem that these supposedly “unexpected” events are here to stay, and as fiduciaries, you will need to take a hard look at the structure of your investments to ensure that the company’s portfolio is insulated.

Contrary to what many insurance executives and boards believe, expansion of assets (not contraction through simplification) has a better chance of protecting, and indeed improving, your portfolio in this most unpredictable and volatile period.

**Evolution chart revisited**

In the Fourth Quarter 2011 issue of Physician Insurer, we discussed the history of investments, and where we are today.
with new opportunities, themes, and strategies. Unfortunately, many insurance companies are still stuck in the early stages of the evolution spectrum. Investments should no longer take a back seat to underwriting in considering the overall profitability of the business. It is understandable that the process of evolution is growing at a rate that can best be described as dizzying, but to stay competitive in your market, you should consider going on the offensive.

With market volatility rising at an alarming rate, and the thirst for yield greater than ever, it would be imprudent for you, as fiduciaries for your companies’ assets and shareholders, to ignore today’s investment opportunities. Informed companies have embraced many of the strategies on the right side of the evolution spectrum, to complement their traditional investment-grade, fixed-income portfolios.

Where is the yield? It’s no secret that your investments have been getting squeezed as yields decline.
Insurance companies that still believe that high-quality, government-issued debt is the safest investment now face a very challenging investment and economic future. Bond yields, historically, have had long secular moves, punctuated by sharp cyclical corrections. After falling to record low levels, 10-year U.S. Treasury yields remain range-bound, as investors worry about employment and a still-lagging national economy.

Tactically (near-term), we do not see a significant move in long-term rates, but strategically, we are concerned about the price (in terms of higher yields) of current policies. The risk in moving out on the yield curve will not likely be rewarded.

Things are not much better on the short end of the curve for insurers. In the past, investors could earn a relatively attractive return on short-term, fixed-income investments. With the Fed’s commitment to holding the Federal Funds Rate at “exceptionally low levels through mid-2013,” return opportunities have dropped dramatically. The best thing about short-term fixed income vehicles is that they serve as a defensive investment and may counter an unexpected increase in yields/decline in bond prices resulting from a stronger than expected economic recovery or unanticipated inflation.

If there are limited opportunities on the long end of the curve and short-term maturities are yielding basically nothing, what is a company to do?

**Expanding your assets**

In fact, there are plenty of prudent opportunities to add yield over what Treasuries are paying these days. And not only yield, but total return as well can be achieved through exposure to asset classes not commonly used, but available, within your industry. Table 1 outlines a few of the asset classes that offer compelling yields, have attractive valuations, or can serve to complement a traditional, Neanderthal-type investment portfolio.

We strongly encourage you to look into each of these strategies and determine which are the best fit for your investment portfolio.

**Table 1** Yields for Some Alternative Investments

<table>
<thead>
<tr>
<th>Asset Class</th>
<th>Yield Range</th>
<th>Correlation to Intermediate Treasury</th>
</tr>
</thead>
<tbody>
<tr>
<td>High yield bonds</td>
<td>7-8%</td>
<td>-0.17</td>
</tr>
<tr>
<td>Bank loans</td>
<td>4-5%</td>
<td>-0.20</td>
</tr>
<tr>
<td>Dividend-paying stocks</td>
<td>3-4%</td>
<td>-0.20</td>
</tr>
<tr>
<td>Emerging markets debt</td>
<td>5-6%</td>
<td>0.23</td>
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<tr>
<td>Master limited partnerships</td>
<td>6-7%</td>
<td>0.50</td>
</tr>
<tr>
<td>REITs</td>
<td>4-7%</td>
<td>-0.08</td>
</tr>
<tr>
<td>Long duration IG corporates</td>
<td>6-7%</td>
<td>0.74</td>
</tr>
<tr>
<td>Non-agency RMBS</td>
<td>4-8%</td>
<td>-0.21</td>
</tr>
<tr>
<td>Commodities</td>
<td>6-7%</td>
<td>-0.08</td>
</tr>
<tr>
<td>Hedge funds— diversified</td>
<td>0%</td>
<td>-0.27</td>
</tr>
</tbody>
</table>

*Disclaimer: This table is provided for illustrative purposes only and is not indicative of any specific investments; individual investments may vary. Information has been gathered from sources that are believed to be reliable but its accuracy is not guaranteed. Past performance is no guarantee of future results.*

**Conclusion**

After a favorable period of combined ratios in 2009 and 2010, greater competition and negative premium growth are putting new pressure on an insurer’s investments to generate return. On the liability side, the volatility of losses has increased, so liquidity, duration extension, and surplus generation have become more critical objectives. As persistent low-interest rates continue to put a strain on investment income, the ongoing search for yield and total return will have to extend beyond outdated approaches. To accomplish this, find out more about each of the strategies on the right side of the evolution chart.

If you do, living with the black swan will become a considerably more tolerable relationship.

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Investing in fixed income securities involves certain risks such as market risk if sold prior to maturity and credit risk especially if investing in high yield bonds, which have lower ratings and are subject to greater volatility. All fixed income investments may be worth less than original cost upon redemption or maturity.
In our last interview, you mentioned that the uptick in stock market volatility in 2011 caused you to look at how the common stock investing practices of MPL-focused insurance companies had changed over the past three to five years. What were some of the findings from that study?

Larson: Between 2007 and 2010, we noticed very little change in the number of MPL-focused groups and companies that invested in common stock and only a slight increase in the percentage of cash and invested assets that was attributable to investments in common stock. From this it appears that the downturn in the financial markets in 2008 and 2009 had little impact on the long-term willingness of companies to invest in common stocks.

We did see some differences in the investment practices based on company size. We saw that companies with the largest cash and invested asset balances consistently invested in common stock, while those with the smallest cash and invested asset balances appeared to be less willing to invest in equities.

In the aggregate, MPL-focused groups and companies appeared to be less heavily invested in common stock when compared to an industry-wide sample of other companies with similar levels of policyholder’s surplus (PHS).

Finally, while common stock made up a slightly greater percentage of cash and invested assets at year-end 2010 than it did at year-end 2007, and the value of those holdings increased by roughly 14%, the value of PHS for the group also rose substantially over that time period—by 33%. So, as a result, the year-end 2010 common stock investment leverage, common stock holdings as a percentage of PHS, was actually lower than it was at year-end 2007.

PI: Have you looked at how the dramatic reduction in interest rates and U.S. Treasury yields over the past five years or so has impacted the fixed-income investment practices and overall investment yields of these same MPL-focused companies?

Larson: We haven’t published a formal analysis of these investments, like we did for the common stock. But we have looked at fixed-income investment data for a subset of PIAA companies. And we found some interesting things.

Within the typical fixed-income portfolio, we noted that, on average, U.S. Treasuries have made up only about 6% to 12% of the portfolio over the past ten years. This percentage has oscillated over time, reaching its low point in 2008, and then rebounding again in 2009 and 2010.

Note, however, that the magnitude of the move back into U.S. Treasuries in 2009
and 2010 was heavily influenced by the investment activity of one large company in that subset, which increased its U.S. Treasuries allocation from about 9% at year-end 2008 to roughly 25% at year-end 2010.

Nonetheless, while yields were on the way down in the 2008 to 2010 time period, we did clearly see an overall movement back into U.S. Treasuries, which was undoubtedly the result of the upheaval in the remainder of the market during this time period.

As far as the investment yields are concerned, the relatively low allocation in U.S. Treasuries meant that MPL companies' investment yields, overall, did not decrease nearly as quickly as the yields in U.S. Treasuries themselves.

As an example, if you look at the yield for the five-year U.S. Treasury, that dropped from about 4.5% in 2006 to less than 1% in 2011. At the same time, if you look at the overall investment yields of the MPL companies, that dropped by only about 1% during the same interval, from a little less than 4% in 2006 to a bit less than 3% in 2010.

Larson: I don't know if that, in isolation, would have done enough. If you recall Dave Spiegler’s comments from our last discussion [Physician Insurer, Fourth Quarter 2011, page 50], there have been some $6.1 billion in prior year reserve releases over the past four or five years, which has maybe masked, for some companies, the reality that the underlying incurred year loss ratios have been deteriorating.

Had the underlying deterioration in the loss ratios not been masked and had overall investment yields been dropping as fast as U.S. Treasury yields, there certainly would have been more focus on the profitability of the current business being written. With that being said, the most recent analysis shows that the 2010 business is still reasonably profitable. So, the market in general really hasn't been anywhere close to the “point of pain,” where they might have had to take corrective rate action.

PI: For a while, it seemed as if corporate bonds were very attractive to MPL companies. What happened with that trend?

Larson: One of the things that we noticed was that there was some movement elsewhere in the fixed-income portfolio in the recent past. Going back to late 2007 and into 2008, there was an increase in the allocation to...
municipal bonds at about the same time municipal bond yields spiked relative to those of U.S. Treasuries. Then in 2009–2010, there was a movement away from mortgage-backed securities and into corporate bonds, as, similarly, the yields on corporate bonds spiked relative to those of U.S. Treasuries. So, there was a fair amount of shifting between fixed-income sectors as companies went in search of higher yields.

Going back to the investment yield question for a moment, this shifting between sectors is a big reason that the drop in overall investment yields hasn’t been nearly as great as the drop in U.S. Treasury yields. The other thing to keep in mind, of course, is that MPL losses pay out over a very long period of time. If the asset durations are matched properly against the expected loss payoffs, the typical MPL company in 2009 and 2010 still had a lot of investment income being generated from bonds that were purchased several years back, when the yields were quite a bit higher.

Given that dynamic, we shouldn’t be too surprised to see investment yields come under even more pressure over the next several years as more and more of those older bonds mature and are replaced by investments in bonds at today’s much lower yields.

PI: In closing, I’d like to circle back to the investment practices issue for a moment. Is there anything else that you’ve noticed about the investment practices of some of the companies you’ve looked at that is of concern or interest?

Larson: The one thing that stood out for me when I looked at the data is this: diversification. We noticed some companies that had a significant portion (75% or more) of their overall fixed-income portfolio invested only in municipal bonds. Of course, those investment dollars are spread across a number of different securities, so there is diversification within that sector. Still, having that much of your fixed-income portfolio invested in one sector, like municipal bonds, seems a bit risky to me, especially when the value of that investment could, in many cases, be equal to or multiples of the PHS of the company. No matter how much surplus a company has, being too heavily concentrated in any one asset class or sector can be problematic.
For 26 years, the PIAA has maintained the Data Sharing Project (DSP), which is now the world’s largest independent medical professional liability research database. Storing detailed data on more than 260,000 closed medical and dental claims and suits, the database provides a rich resource for the investigation of the underlying causes and issues pertaining to medical professional liability claims. All DSP reports can be purchased online at www.piaa.us.

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These charts represent the average indemnity and expense payments reported for the ten-year period from 2001 to 2010. Data is provided in the 2011 Claim Trend Analysis report.
Attendee feedback indicates that all of the sessions were well received. A consistent observation about the program content has been that it not only adhered to a uniformly high standard; it also demonstrated the consistencies in medical professional liability (MPL) insurance, regardless of the delegate’s home country. While there are some jurisdictional differences, the issues are very much in common, across international borders. This level of commonality made the conference an ideal forum for exchanging ideas and experiences.

The opening session, “Trends in the Delivery of Healthcare and their Impact on Indemnity,” set the stage for the ongoing sharing of information, by prompting delegates to consider how
trends seen internationally might have an impact on their home markets.

Dr. Priya Singh’s presentation on the impact of women in medicine in the United Kingdom resonated with every attendee involved in medicine, because the increased demand for flexible working hours, more usually linked with female physicians, affects future workforce planning.

The issue of physician extenders, discussed by Dr. Jeff Varnell, struck a particular chord with Australian delegates, as the profession adjusts to the introduction of nurse practitioners, physician assistants, and independent midwives.

Many international delegates took part in the session that considered “The Australian Medical Indemnity Market.” Speakers addressed the recent past and possible future of an industry that has seen significant turmoil since the International Section Conference was last held in Australia in 2002.

For those who were more clinically inclined, the concurrent session, “Cerebral Palsy Workshop,” presented breakthrough research, by Dr. Suzanne Miller of the Monash Institute of Medical Research, which had not been previously presented in a public forum.

A topic that always seems to raise interest in the international MPL community is that of no-fault compensation. This meeting’s session, “No Fault Schemes—A Snapshot of International Experience,” was no exception. The presenters all described the mechanics and benefits of their national systems for no-fault resolution of claims, while not necessarily convincing those of their colleagues who still operate with a more traditional model of patient compensation. Nonetheless, this is a topic that continues to hold the interest of the industry. Some details on this session are provided below.

The conference keynote speaker was Dr. Gerald Hickson from Vanderbilt University Medical Center. His was one presentation in the session, “Handling the Physician Who Exhibits Disruptive Behavior.” It was extremely well received, particularly because the content illustrated that emphasis on teamwork and intervention can have a positive impact on disruptive colleagues. The session also featured presenters from Canada and Australia, and this format made possible a comparison of the differences in approach to managing troublesome members of the profession, which range from interpersonal communications to legislation.

Like the “No Fault” session, “Trends in International Tort Law” gave delegates insight into some significant issues in the application of tort law in various jurisdictions. Gaining an understanding into how other regions of the world are responding to issues of law can provide some early indication of possible future changes in home markets.

Schemes for Resolving Claims—Australia and Sweden

Australia: Concurrent Evidence

Alison Briscoe, National Director of Avant Law Pty Ltd, Australia, presented one approach to configuring an MPL system, termed “concurrent evidence” (CE). This scheme assists in overcoming adversarial bias, and also gives the court an opportunity to hear genuinely objective and informed expert evidence. It was established in response to a 1996 report that had noted some problems with the integrity of expert witnesses.

In essence, CE is a discussion, which is chaired by a judge and held among all the parties directly involved in the claim, including their attorneys and various experts. They identify the critical issues, and whenever possible, attempt to resolve them.

If there are issues that the parties cannot agree on, the judge serves as the chairperson for a more structured discussion. The experts provide their opinions, without any constraints by the attorneys, in a forum where they can respond directly to one another. The judge is not confined to one advisor; there may be many, and all are examined rigorously, in the context of a public forum.

Prior to the CE session, experts prepare their reports in the usual way. Then, there is a pre-trial, with a joint conference and joint report. As a next step, the parties draft an agenda for the court’s review.

In the session, the experts sit together and are sworn in one after another. There is just one microphone, which determines “who has the floor.” Each expert is asked to identify and explain the principal issues in the case. Each can comment on the other’s exposition and/or ask questions of each other.
Compared with the traditional procedure, for judges, the benefits of CE include:

- The impact of the parties’ attorneys is lessened.
- The capacity to decide which expert to accept is enhanced.
- The experts are accountable to one another.

For the expert witnesses, there are advantages, too. The element of any “contest” between them and the opposing attorney is removed, and whenever they wish to do so, they can expand their answers beyond a simple “yes” or “no.”

With CE, it may be easier to reach a settlement. But this scheme does require more intensive preparation, and coordination among all of the necessary parties may prove challenging. There is an inevitable loss of control, which may be troubling to some participants.

If queried about their satisfaction with CE, plaintiffs will probably offer an opinion that is colored by the results of the case. And while the prospects for settlement may be better, the overall cost for the proceeding may not be much lower than the traditional approach. For insurers, there is a question of company culture and philosophy: which is preferable, a win on the merits, or one that is achieved through the skill and strategy of the attorneys?

Sweden: A No-Fault System

Sweden may be a special case, in regard to MPL, since its expenditures are covered by the government. The costs involved in compensating for a brain-damaged baby are probably roughly the same as in other countries—but they come from different pockets. Insurers are the payers in the United States, Canada, and the United Kingdom, but in The Netherlands and Sweden, the social welfare system picks up the tab. Costs for healthcare because of the injury are paid by the same public system.

The presenter for Sweden was Kaj Essinger, Senior Advisor for LOF. He underscored the benefits of the Swedish approach to MPL, which has low numbers of claims and correspondingly low costs. He enticed the group with the repeated phrase, “If you had Swedish numbers…”

These are the key elements in the Swedish system for MPL claims, which is based on patients’ rights:

- In general, only avoidable injuries are compensated.
- There is no blame for doctors and nurses, or fears about reporting or disciplinary action, since claims should be used for learning.
- The doctor should help the patient with his claim.
- Claims are handled administratively (courts are only rarely involved), which saves both time and money.

Of some 11,000 MPL claims, only 20 (0.02%) had become court cases. Instead, the administrative procedure for claims requires only one claims handler. Transaction costs are low—20 times less expensive than in a court system. The key element here is the concept of the “avoidable injury,” which, because it obviates the whole issue of blame and direct causation, eliminates the need for court procedures.

Who gets the compensation money? In the U.S., only 28% goes to patients; the other 72% is consumed by lawyers’ fees and administrative costs. In Sweden, more than 80% is allocated to injured patients, and less than 20% goes for lawyers and administration.

There is tort law in effect, too. The payment is capped at $1.2 million, which compensates the patient for pain and suffering and also for any permanent disability. Since all of the claimant’s healthcare costs are covered by the government, this is actually a quite generous award. And there are very few high-dollar payments: more than 80% are less than $10,000.

Friday reception

The gala conference event was the Friday night reception and dinner, held at the legendary Melbourne Cricket Ground (MCG). In addition to cricket, the MCG is the home of Australian Rules Football (AFL). This was a quintessentially Melbourne-style event: the dinner speaker was Leigh Matthews, arguably the greatest AFL player in the last century. Mr. Matthews provided international guests with a witty and insightful description of this unique sport that is growing in popularity.

In addition, in conjunction with the gala reception, there
was fundraising component of the conference. Mont Blanc generously donated a variety of gifts to a raffle that raised funds for cerebral palsy research.

Thank you!
The PIAA would like to recognize the significant contributions and hard work of the 2011 International Conference Organizing Committee: Jonathan Burdon, MD, Avant Mutual Group; Andrew Miller, MD, MDA National; Claire Leonard, Medical Indemnity Insurance Association of Australia (MIIAA); Michael Halliday, MDA National; Michelle Finnegan, MDA National; and Kerry Ryan, Avant Mutual Group. The tireless efforts of these individuals helped ensure that the conference was a great success. In addition, the PIAA thanks John Gray, MD, CMPA, for his guidance and leadership as chair of the PIAA International Section.

The PIAA would also like to express its gratification to the sponsors of the conference for their generous and staunch support: Platinum Sponsor – TressCox Lawyers; Silver Sponsors – Willis Re and John W. Ball & Sons; Bronze Sponsors – Marsh and SCOR Global P&C, and Welcome Reception Sponsor – Mont Blanc.

Additional material and support was also provided by Maurice Blackburn, Finity Consulting Pty Limited; Clayton Utz, Berkley Re Australia; and Panetta McGrath. We thank these companies for their participation.

2014 International Conference
We look forward to the next PIAA International Conference in 2014. Watch for information on this global gathering of the leaders in medical liability and other PIAA International Section events at the 2012 PIAA Medical Liability Conference, May 9-12, in Washington, D.C., and on the PIAA website at www.piaa.us.

In Australia, a baby is born with cerebral palsy every 15 hours. While 95% of these cases occur either pre- or perinatally, there is no pre-birth test for this condition. It happens as a result of a lesion within the brain that arises during development; there is no known cure. There are some recognized risk factors, however. It has been linked with intrauterine growth restriction, intrauterine infection, asphyxia at birth, and preterm birth.

Suzanne Miller, MD, gave attendees an update on new treatments that target the mechanisms of injury that may lead to cerebral palsy. Dr. Miller is with the Neurodevelopment and Neuroprotection Group, The Richie Centre, Monash Institute of Medical Research in Australia.

Recently, it has also been suggested that cerebral palsy is linked with use of antibiotics. One study showed that, at age 7, cerebral palsy was more common among the children of women given erythromycin, co-amoxiclav (amoxicillin/clavulanic acid), or both during preterm labor, as compared with those who received placebo.

Hypothermia applied soon after birth may help some infants harmed by asphyxia at birth, but 47% of them still die or suffer neurological impairment. This is the most readily identifiable cause of cerebral palsy.

However, one agent shows real promise for ameliorating the impact of intrauterine growth restriction, as well as asphyxia at birth: melatonin. Animal studies with melatonin, in conditions that replicate human birth complications, are now under way. Results to date are very encouraging.
When It Comes to Technology, Anything Is Possible

BY ERIC R. ANDERSON

Here is a new twist on the delivery of medical care that would radically alter the landscape for patients, healthcare providers, and the medical professional liability industry alike: jettison doctors, and replace them with computers. There, I said it. However, before you fire off a letter to the editor, or, worse yet, throw away this magazine without reading another word, please note that this is not my idea. It’s the musing of a renowned Silicon Valley investor, Vinod Khosla.

Khosla, a venture capitalist and co-founder of Sun Microsystems, recently suggested that computers will, in our lifetime, likely evolve from providing diagnostic support and second opinions for doctors, to furnishing initial consultations and referrals. The cynic in me says that Khosla’s motivations are self-serving. Admittedly, though, he makes a compelling case in explaining why cyber-docs might in fact be feasible—and could even lead to a better healthcare system than the one we have now.

For example, he notes that computers can store vast amounts of data—much more than any human mind can remember and recall. Patient histories, drug interactions, and other key information could be accessed, processed, and assessed by computers to elucidate any correlations or trends with the past. A routine diagnosis that requires only a standard treatment could do—as easily as the best 20% of human doctors, according to Khosla. If you’ve ever had a chance to try Apple’s “Siri,” you may suddenly be thinking that there could be more reality than science fiction in Khosla’s prognostication.

The bottom line from my vantage point, though, is this: you can’t replace human interaction. Computers are limited by their built-in engineering architecture: they can only use deductive reasoning. People, however, commonly identify new medical issues, and develop unconventional treatments, through inductive reasoning—which requires human intervention. So, for the time being anyway, doctors are here to stay—which is good news for MPL carriers. Or is it?

If Khosla’s vision were realized, it could be the ultimate response in our battle over the broken medical liability system—let computers take the blame. Think about it. Who would the personal injury bar have to sue? Software developers? Microsoft? IBM?

Actually, on second thought, instead of exchanging computers for doctors, I propose that we use computers to replace judges, lawyers, and juries. If we did that, we’d rid the medical liability system of judges’ bad decisions, plaintiff’s melodrama and sympathy ploys, and compliant jurors, too.

This is all conjecture—but consider it the next time you use an iPhone, Blackberry, or some other high-tech device that’s become an integral part of your daily life. Maybe it’s not so far-fetched!
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