Adverse Events
A Global Perspective

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Emerging Importance of Global Thinking

The phrase, “the ever-shrinking planet,” used to seem like a hollow cliché. Then, when the recent financial crisis hit, we discovered just how real that phrase had actually become. Now, we watch as the latest news from Spain and Greece has yet another seismic impact on our portfolios, and our lives. We need to understand, in detail, how their governments and economies work, and what factors are most likely to influence them in the future. We have had to develop a global mindset.

Medical science, of course, could well be the most international of all human endeavors. Penicillin was invented in London, by accident, in 1928. The concept of “triage” was introduced in the trenches of World War I by French doctors attempting to optimize the use of terribly scarce resources. Conversely, many of today’s most effective medicines are products of relentless time and effort in Swiss and U.S. pharmaceutical companies.

There are many ways we can learn from one another—including sharing knowledge through vehicles like the cover article for this issue of Physician Insurer. The article is actually three stories. The topic that they all focus on is a complex and difficult one: disclosure of adverse events in the healthcare setting. Our three authors detail how disclosure is accomplished in the U.K. (Paul Nisselle), Canada (Gordon Wallace), and the Netherlands (Harry Henschen). We thank them for their insightful and thought-provoking contributions to this ever-evolving magazine.

What they describe can help all of us, both domestic and international PIAA member companies, to reflect on our current procedures for disclosure, think about how we might fine-tune those procedures, and thereby help both healthcare providers and patients while, hopefully, reducing litigation, as well.

These stories remind us of the emerging importance of global thinking. For example, like it or not, the Patient Protection and Affordable Care Act is apparently here to stay. As its implementation continues in the ensuing months, we may need to look to the procedures and systems that have worked in other countries to help us in making the ACA workable. It seems likely that huge numbers of patients will be entering the U.S. healthcare system. This healthcare system will be straining at the edges to try and meet the needs of these new patients. If countries like the U.K. can accommodate their entire population within the National Health Service, perhaps there are some lessons we can learn, as all of us here in the U.S. prepare to shoulder this impending burden.

Whether or not the new inrush of 30 to 50 million patients, and the consequent strain on U.S. healthcare, will lead to more unhappy patients and more medical liability claims is not yet known. Admittedly, the MPL business is governed largely by local factors and local issues. But that doesn’t mean that we can’t reach across the oceans and around the world for inventive answers that could help resolve these issues.

The PIAA provides a unique forum for the sharing of novel approaches to problems. Now, you can take part in the discussion of global—and other—issues, too. You can join in on the conversation online in our new PIAA Idea and Information Exchange. Just visit the Internet site, https://connect.piaa.us. If you join with your colleagues in our discussion forums, you just might find answers to some of those questions you’d thought were unanswerable.
Up Front
1 The President Comments
4 Observer: Notable News and Trends

Departments
6 Think Excellence, Not Difference
Eric Margenstern on Marketing/Communications
10 Personal Take
Kevin M. Bingham
Getting Better All the Time: The Decade-long Improvement in Patient Safety. Part Three in a four-part series
16 Case and Comment
Kevin M. Miller and Michael J. Mersot
22 Legislative Update
By the Numbers
Stephen J. Koca and Richard B. Lord

Features
24 Cover story: Disclosure in Adverse Events: A Global Perspective
• U.K. Perspective—Dr Paul Nisselle
• Canadian Perspective—Gordon Wallace, MD
• Perspective from the Netherlands—Harry Henschen
• Alternative Perspective—Victor R. Cotton, MD, JD
34 Feature: Using Municipal Securities to Enhance Earnings
Tim Senechalle
38 Feature: Early Detection—Is It Really Too Expensive?
Gregory M. Jackson, MD
42 Feature: The MPL Industry Unpaid-Claim Reserve—The Whole May Be Greater than the Sum of the Parts
Charles W. Mitchell and Shaun Cullinane

General opinion in the Netherlands holds that when a doctor realizes he has made a mistake, it should be discussed as soon as possible with the patient, and the doctor should apologize for what has happened.
—Cover story

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MPL Claims Alleging ‘Under-triage’ Are on the Rise

"Under-triage," says Robert Dunn, MD, FACEP, "is basically delay in diagnosis." Dunn is chief of emergency medicine at St. John Hospital and Medical Center in Detroit, Michigan. He cautions providers, "It can result in serious liability.

Overcrowding, the expanding elderly population, and the overall increase in volume of patients, can mean a greater risk of under-triage, says Jonathan E. Siff, MD, MBA, FACEP, director of emergency informatics and assistant director of medical operations for the Department of Emergency Medicine at Metro Health Medical Center in Cleveland, Ohio.

He’s not optimistic that any of these concerns will be resolved any time soon. "I don’t see how it’s going to get better without a major focus on addressing the issues of overcrowding, and specialized triage nurse training for at-risk populations that EDs are likely to encounter," he adds. But he does offer a few strategies that can help reduce risk.

First off, EPs shouldn’t assume that every significant question was asked at triage. "Even some low-priority triage patients have a serious medical condition," Dunne says. "If you are stuck with a big volume, send someone out to the waiting room to eyeball folks."

He suggests that EPs "start from scratch" in taking a patient’s history. "Do not start with the triage chief complaint. The triage does not matter at all once you see the patient," he adds. EPs should document new information if this changes the patient’s triage level or acuity.

Second bit of advice: Providers should carefully document the changes that happened while the patient was in the ED, such as, “The patient arrived with stable vital signs and was in no distress. On repeat evaluation, patient now has tachycardia and chest pain.”

Third, if a patient turns out to have a more serious illness or injury, providers shouldn’t hesitate to move him to a higher acuity area in the ED. Finally, it’s important to remember that patients with common diseases may present uncommonly.

As long as the EP follows the standard of care, he can be wrong and still not lose a lawsuit, notes Siff. "But if you can’t justify why you did what you did, and you are trying to explain yourself three to five years later when a lawsuit comes up, it’s pretty tough if that explanation is not in the chart," he says.

Source: Advisen Healthcare News, July 1, 2012

Report Card on Insurance Regulation: the Top Five and Bottom Five States

Washington’s R Street Institute has issued a report card on the insurance-regulatory environments in each of the 50 states. The grades are based on 14 objective variables employed to assess the extent to which a state’s insurance regulation reflects “the principles of limited, effective, and efficient government.” And now: the top five.

The number one state was Vermont, with its grade of A+ (28 points). Vermont has the second highest number of domiciled insurance companies in the nation, behind only New York. It nonetheless does a good job of keeping up with its responsibilities to subject its domestic insurers to financial exams. Vermont is also notable for its low tax and fee burden.

Runners-up included Illinois, A (21 points); Ohio, A (19 points); Wyoming, A (17 points); and Idaho, A (11 points).

At the other end of the scale, the states with the worst state regulation, and the points they earned: California, D (19 points); Texas, D (-21 points); Massachusetts, D (-25 points); and Florida, F (-32 points).

Overall, the R Street Institute found a lot to like about the states’ regulation of insurance, commenting that, “Only one state, Florida, received a failing grade, falling more than two standard deviations below the mean. Nonetheless, even Florida had its strong points, including extensive anti-fraud enforcement, a low tax and fee burden, and a home owners’ insurance market that is not very concentrated.”

Source: The R Street Institute, June 6, 2012
Malpractice litigation “has been growing 10% each year, and now costs some $30 billion every year,” while the ACA “mentions the word ‘malpractice’ once,” notes the editorial page of the Culpeper Star-Exponent. The editors add, “One study showed that 93% of physicians do defensive medicine practices, estimated to cost between $100 billion and $178 billion per year.”

The fix? Here is the newspaper’s first solution: “For the past three decades, we have been using a perfect model for how to entirely cure that defensive medicine problem.” It’s the Vaccine Injury Compensation Program. Started in 1988, it has totally replaced vaccine-related suits. Like many MPL suits, the vaccine-related claims frequently involve tragically injured children—difficult not to sympathize with.

Since the claims are all no-fault, the only inquiry pertains to the amount of damages the patient has suffered, or will endure in the future. Because this approach is relatively simple and straightforward, all vaccine claims can be managed and adjudicated by just eight special masters in the U.S. Court of Federal Claims.

Despite the fact that there is no upward limit on an award for a vaccine-related injury, and the average award is $1,022,699, the Vaccine Trust Fund reportedly has billions in surplus; its cost is minimal and funding is pay-as-you-go.

The Star-Exponent sums up, “There is no reason why we can’t use the same doctor-pleasing, patient-friendly solution to end medical malpractice litigation.”

But wait, there’s more! The Culpeper paper also suggests another strategy, for lowering overall healthcare costs, based on the old supply-and-demand paradigm: “End the medical education monopoly.”

Medical schools are jointly accredited by the Association of American Medical Colleges and the American Medical Association, the paper points out, and they have accredited “only 129 medical colleges in the U.S.” This means that medical school admissions are, in all likelihood, unnecessarily restrictive, and students who have a solid MCAT score of 24 to 26 have only a 47.8% chance of actually getting accepted.

With more doctors, lower prices. Naturally.

Source: Culpeper Star-Exponent, June 19, 2012
The Pathway to Great Messaging

All great stories share consistent attributes that make them compelling. From fairytales to Martin Luther King’s “I Have a Dream” speech to the latest movie blockbuster, great stories have the same basic components.

We know breathing requires a working system of several integrated organs. In much the same way, great messaging requires a working system of fundamental components. At Morningstar Communications, we call these the Pathway to Great Messaging. It’s helpful to consider the Pathway in two parts: message content and message context. The first, content, consists of the “What?”, “So, What?”, and “Now, What?” The second, context, is built upon simple, listener-oriented, everyday language.

Message content
The first step, “What?” is deceptively easy. We’re great at listing all of the details about the subject of our messaging. We can talk for days about upholstery options and available colors when we’re selling a couch, or the level of liability coverage needed and what a policy covers when we’re selling insurance. The tricky part is turning this “What?” sales once again: this is where you tell prospective buyers to take the car and try it out for a couple of days. The “Now, What?” encourages a change in their attitude or behavior.

Answering the “Now What?” question is like putting a stamp on a letter; if you forget it, your message isn’t going anywhere.

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content by answering the three “What” questions, the next step is to put your message into a context that helps it succeed. Context is built with simple, listener-oriented messages delivered in everyday language.

**Message context**

First, speak simply. Use as few words as possible, and avoid jargon. You wouldn’t drive an extra 20 miles to work in the morning if you knew a faster route, so don’t use a long sentence when a short one will suffice. Customers appreciate messages that are direct and easy to understand.

After this, consider what your recipient needs to hear; this is the next step on the Pathway. We call this recipient orientation.

Americans tend to take a one-size-fits-all approach to messaging. We assume that each consumer is looking for the same features, and so we train our sales team to highlight a standard list of benefits and options when talking to a customer, forgetting that everyone has different needs. In reality, message construction is like a diamond. At the core, you have a chunk of pressurized coal—but what makes it beautiful are the many facets, perfectly cut to give it sparkle.

Messaging is the same. At the heart, there is just one story, but each audience has a different point of view that must be considered. Think of how different people view popcorn in the movie theater. Corporate executives are concerned with how much profit they can earn, theatergoers are concerned with how it tastes, and employees are concerned about how easy it is to pick up off the floor.

The key is to tell your audience what they need to hear, not what we want to tell them. When creating a message, try to forget what you’re excited about and, instead, focus on what matters most to your audience.

The final step on the Pathway is to use everyday language in your message. Be direct and easy to understand. Avoid corporate jargon or the latest buzz-words; use the language your audience uses in their everyday lives.

For instance, only the most tech-savvy people know what all of the specifications on the side of a computer box mean, so computer salesmen have to make it easier to understand for the rest of us. Instead of saying, “This computer has a 2.3GHz quad-core Intel Core i7 processor with 6MB L3 cache,” the salesman tells you that the computer is fast.

**The big picture**

It’s important to remember that each step on the Pathway is vital to creating great messaging. It’s like breathing. Air has to travel through our mouth, nose, trachea, and lungs in order to oxygenate our blood. Each organ plays a vital role in keeping us alive. The same is true for the Pathway to Great Messaging; each step is important in the process of breathing new life into the message of your organization.
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Getting Better All the Time: The Decade-long Improvement in Patient Safety

The big news on patient safety programs is about how well they have worked. In Part Three of this article, I describe the impressive results from dedicated medical-specialty societies like an Ob/Gyn group in Canada.

Back in early 2001, the Patient Safety Division of the Society of Obstetricians and Gynaecologists of Canada (SOGC), under the leadership of its Associate Executive Vice President Dr. J.K. Milne, embarked on a new campaign to improve patient safety in hospital obstetric units. In collaboration with the Healthcare Insurance Reciprocal of Canada (HIROC), Salus Global Corporation was formed, to bring to life what is known today as the MORE® (Managing Obstetrical Risk Efficiently) Program.

The MORE® Program is a three-year effort that fosters patient safety, professional development, and performance improvement for both caregivers and administrators in hospital obstetrics units. Its structure is based on the principles that underlie the concept of High Reliability Organizations (HROs), which stress safety as the ultimate priority, effective communication, and teamwork. Salus Global notes that, “Hierarchy disappears in an emergency,” adding that, “decisions about safety can be made at any level of the organization.”

Based on claims information—tracked for several of the hospitals insured by HIROC that work with the MORE® Program—a dramatic reduction in annual incurred losses has been achieved. In fact, HIROC’s tracking and analysis of MPL claims data for the participating hospitals shows that they’ve achieved double-digit percentage reductions in their ultimate obstetrics claims costs.

The August 2010 Journal of

Emergencies are prepared for—“rehearsed” as Salus puts it—and there is an emphasis on reflective learning. The program integrates evidence-based professional practice standards and guidelines with current and evolving patient safety concepts, principles, and tools.

The pilot phase of the program was launched in Ontario in July 2002. Its roster included 21 healthcare organizations located in three provinces comprising 33 hospitals with a total of 2,500 participants. In October 2004, after the initial success of the pilot program and its subsequent expansion to other provinces, Alberta’s Minister of Health and Wellness announced his support for implementation of the Program on a provincial basis.

In December 2007, the Quebec Ministry of Health and Social Services agreed to support the new provincial version of the MORE® Program. As of July 31, 2011, 260 hospitals had participated in the initiative, with more than 12,000 participants: nurses, obstetricians, family physicians, and midwives.
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Obstetrics and Gynaecology Canada featured an article, “Outcomes of the introduction of the MORE© program in Alberta,” a study by an independent third party, which helped confirm that the MORE© Program really does improve outcomes for both mothers and newborns in Canada. The program had significantly diminished severe morbidity among newborns, as measured by the rate of serious complications such as respiratory distress syndrome, sepsis, and severe intraventricular hemorrhage.

MORE© was also instrumental in achieving a significant reduction in third- and fourth-degree tears and the length of stay in hospital for mothers.3

So far, ten U.S. hospitals have adopted the MORE© program.

As the adoption of MORE© continues to expand, I look forward to hearing more about its impact on patient safety, and its ultimate impact in reducing claims from hospital obstetrical units across the United States.

Here is a link to the proud announcement of another new MORE© program—in Buffalo, New York, on May 16, 2012: http://buffalo.ynn.com/content/584497/-more-ob-program-at-sisters-hospital/.

Anesthesiology, too

Although obstetrics is probably the best-known example, there have been significant advancements in patient safety achieved by quite a number of specialties. The amazing journey in anesthesiology was highlighted in a June 21, 2005, Wall Street Journal article, “Heal thyself, once seen as risky, one group of doctors changes its ways.”4 Thanks to the work of the Anesthesia Patient Safety Foundation and the American Society of Anesthesiology, anesthesiologists have benefited from the wider application of pulse oximeters, capnographs, and the use of simulators that closely replicate real-life conditions with patients.

Since the early adoption of patient simulators by anesthesiologists in the late 1980s, several other specialties have followed suit. Today, simulators are increasingly used by hospital training programs

When the MORE© program was first conceived, we were convinced of the need for a patient safety program to improve childbirth outcomes for both mothers and newborns. We are delighted to have research that now clearly confirms the significant impact of our program when it is adopted by hospitals and their staff.”

—Dr. Ken Milne, President and CEO of Salus

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across the country, to help healthcare providers such as emergency room physicians, surgeons, and nurse practitioners fine-tune their communication skills, critical thinking abilities, and teamwork. This ultimately leads to better outcomes for patients.

In his book *Complications, A Surgeon’s Notes on an Imperfect Science*, Atul Gawande tell us that, “in surgery, as in anything else, skill and confidence are learned through experience—haltingly and humiliatingly. Like the tennis player and the oboist and the guy who fixes hard drives, we need practice to get good at what we do. There is one difference in medicine, though: it is people we practice upon.” Fortunately, the use of simulators is helping physicians across the country hone their skills before they operate on patients. Everyone benefits.

In Part Four of this series, Kevin M. Bingham talks about the proliferating power of checklists—surgical and otherwise.

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“MOREOB has brought a really different attitude toward communication throughout the whole staff. Now, we really are on the same level as everybody else. It is nice to be able to feel comfortable enough after something occurs to sit down as a team, and talk about what actually happened and what could have been better. I really enjoy MOREOB and I think it has brought a lot to our hospital setting.”

—Heather Fabian, RNC, St. Joseph’s Hospital Health Center in Syracuse

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potentially reputation-damaging litigation, if the plaintiff asserts that the casual phone call resulted in a provider-patient relationship.

**Estate of Kundert v. Illinois Valley Community Hospital**

The Illinois Appellate Court Third District recently shed some light on the genesis of the provider-patient relationship in Estate of Kundert v. Illinois Valley Community Hospital. In the case, the mother of an infant made a distressed late-night call to the hospital and described the symptoms exhibited by her son. She spoke with an unidentified individual, presumably a receptionist, who assured the young mother that she was overreacting to common symptoms that did not warrant emergency care. The hospital employee further told the mother that the facility could not accommodate her child that evening. Instead, the staff member recommended Tylenol and tepid baths to alleviate the symptoms.

When the symptoms did not disappear by the following morning, the mother took the child to her family physician, who, following an examination, arranged for immediate transport to the hospital for sepsis. The 6-week-old child underwent a lumbar puncture, and x-rays were taken, before he was transferred to a larger facility that was capable of providing a higher level of care. He ultimately died of bacterial meningitis.

The mother brought suit against the hospital, claiming that she had relied to her child’s detriment on the defective medical advice provided to her by hospital staff. The defendant hospital denied

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**Case and Comment**

**The Curbside Consult: Merely Advice, or a Provider-Patient Relationship?**

*It’s 1 a.m. when the doctor’s home phone rings. The caller may be a first-year resident, a colleague, or the local emergency department, but the question is always the same: “Can I just run this case by you for a moment?”*

Determination of what it takes to establish a provider-patient relationship is an essential element of risk management. In the medical profession, however, pinpointing the exact moment when an individual becomes a patient, not just a member of the general public, and therefore due a professional standard of care, may be difficult. Certainly, the practitioner has a medical professional’s duty to her office and surgical patients, but what of the “on call” specialist rendering a late-night telephone consult, or the colleague requesting an informal opinion? All too often, these physicians find themselves in the precarious position of being requested or required to give medical opinions and advice based on limited, and perhaps incomplete, information about a patient they’ve never met.

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liability for any outcome from the latenight phone call, claiming that no provider-patient relationship could have evolved from such a casual encounter. Ultimately, the trial court found that the circumstances were insufficient to give rise to a professional duty of care and dismissed the claim. The mother appealed.

The appellate court affirmed the dismissal. It explained that no professional duty arises unless and until the patient knowingly seeks care and the physician knowingly accepts. Upon an extensive survey of precedent on the provider-patient relationship, the court explained that the mere dispensing of advice, by itself, is insufficient to give rise to a professional duty of care. Important, yet non-exhaustive, factors to consider are: whether the physician examined the patient or was asked to do so, whether she analyzed or recommended tests, made arrangements for follow-up care, or billed for the encounter. In Kundert, the mere act of giving advice to a potential patient did not meet the requisite threshold.

That is not to say, however, that the provider-patient relationship requires an in-person examination. As recognized in the decision, under certain circumstances a duty may arise based on a phone call only. For example, in Adams v. Via Christi Medical Center, a Kansas case, a physician was held liable for advice given during a brief evening phone call. In this case, a mother called her family physician at around 9 p.m. to report her teenage pregnant daughter’s abdominal pain. The doctor did not instruct her to seek emergency attention, but did agree to see her in his office the following day. The patient suffered cardiac arrest and died before morning. Finding a provider-patient relationship sufficient to establish a duty of care, the Kansas court affirmed a $2 million jury verdict against the physician.

Similarly, in Bovara v. St. Francis Hospital, an Illinois appellate court found that consulting cardiologists owed a patient a duty, even though they had never examined the patient or had any plans to perform a physical examination. In this case, a treating physician consulted with two interventionist cardiologists to ask if his patient was a candidate for angioplasty. The consultants reviewed an angiogram and decided that the proce-

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The procedure was appropriate. Aside from examining the test results and discussing the case with the primary physician, they had no involvement in the patient's care; they did not even bill for their time. Nevertheless, the appellate court found that this level of involvement did result in a provider-patient relationship sufficient to require a professional standard of care.

The implications for practitioners
As recognized by the court in *Kundert*, the medical profession, by its very nature, is a collegial and collaborative endeavor. Patients benefit from interaction and discourse between medical providers. Practitioners, though, should engage in such activity with full knowledge that well-intentioned advice could result in a claim of medical malpractice. Learning from *Kundert* and the prior Illinois precedent, we note that a very important factor in determining the existence of the provider-patient relationship is the acceptance or declination of further examination. That is not to say that the analysis of the depth of the consultant's involvement is not important. Questions of whether the consultant saw the patient's chart or labs, interpreted radiology scans, or billed the patient are always factors in determining the issue of whether there was in fact a provider-patient relationship. But an informal consult, although benign on its own, may almost certainly result in liability if punctuated by an offer to examine the patient at a later date, even if no specific appointment is made.

Scheduled “on call” specialists are thrust into a particularly difficult situation, because they are required to provide critical and potentially life-saving guidance based on limited information. The physician is often asked to interpret test results based only on the caller’s recitation of them, yet such a detailed analysis may very well transform the encounter into a potential liability case. The duty may ultimately turn on whether or not the specialist agrees or suggests that he will follow up with the patient.

While we do not suggest that physicians should compromise patient care or refuse to engage in medical discourse and collaboration out of fear of the potential legal ramifications, the physician should be keenly aware that such involvement may come under scrutiny in later litigation. The risk is measured on a blurred sliding scale, with theoretical academic discussion on one end and actual intent to treat the patient, either immediately or in the future, on the other. Where no such intent is harbored, the professional is well advised to make that clear. The risk of litigation cannot be eliminated, but placing explicit bounds on the advice that is given will greatly improve the odds of beating the claim.

References
Doctor’s Orders:

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A New PIAA Committee—and an Expanded Focus on Government Relations

This fall will bring a dramatic, but subtle, change to the PIAA: a reconfiguration of one of the organization’s longstanding advisory committees. It’s dramatic because we’ll be opening up new opportunities for many PIAA companies to work with the Association, but subtle because the change will in fact only enhance what we’ve been doing for many years.

The change stems from the new PIAA Strategic Plan, which calls for a “restructuring” of the Legislative Oversight Committee, to increase PIAA members’ involvement in the Association’s interactions with government. To meet this goal, the Legislative Oversight Committee will become the Government Relations Committee (GRC)—and, in the process, assume a new structure, new members, and a slightly revised role.

Structure
Unlike all of the other PIAA advisory committees, the new GRC will adopt a subcommittee structure, to oversee the multiple elements of government that it will monitor. The three subcommittees will be Federal Legislative, Federal Administrative, and State Legislative. The Federal Legislative Subcommittee will concentrate on the activities of Congress, while the Federal Administrative Subcommittee will focus its attention on the departments and agencies in Washington, D.C., that produce regulations, guidelines, and other procedural directives. The State Legislative Subcommittee will keep track of what’s happening in state legislatures—anything of particular interest to medical professional liability (MPL) insurers.

With this new structure, the PIAA will be able to maintain its traditional emphasis on Congressional actions, while, at the same time, ramping up its attention to federal regulations (an area of increasing relevance to MPL insurers) and the issues currently before state legislatures—an ongoing concern for our individual member companies.

In light of the tasks that will be assigned to the subcommittees, the GRC itself will no longer be directly involved in government policy-making. Instead, it will oversee the work of each of the subcommittees. In this way, it will help coordinate PIAA policy across the full spectrum of government relations, ensuring consistency and coordination across the broad range of issues important to PIAA members.

Membership
Like other PIAA committees and sections, the GRC will be comprised of six to 14 individuals, all of whom represent PIAA regular member companies. Those who serve on the committee will be selected as individuals, and not necessarily as company representatives. So, when someone’s term on the committee ends, his seat will not necessarily be filled by an individual from the same company. For many years, this has been the practice for PIAA committees and sections. It ensures that individuals from the newer members of the PIAA can have a chance to work on a committee, over time. Each individual selected will serve a one-year term on the committee, but may be re-nominated each succeeding year without limits.

In a departure from the committee “norm,” however, the members of the new subcommittees will not necessarily be members of the GRC. Subcommittee membership will be open to those who want to concentrate on some particular aspect of government relations, without having to serve in the broader oversight role assigned to the full committee. In addition, the subcommittees may have

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some members who want to serve on the committee but can’t, because there aren’t any vacancies, or because they’d prefer to get some additional experience before they take on the full roster of committee responsibilities. Like the GRC, subcommittee membership will be capped, to ensure that it can do its work efficiently.

In another twist unique to the GRC, membership on both the committee and its subcommittees will be reviewed regularly, to check to see that its membership accurately represents the interests of all the PIAA members. Characteristics such as company size, location, and type of operating structure will be considered, to ensure that the totality of the PIAA’s membership is represented. This doesn’t mean that we’ll have membership quotas—only that many factors are going to be considered in determining how best to fill the limited number of committee and subcommittee slots.

Role
For many years, the Legislative Oversight Committee focused primarily on bills that were working their way through Congress, and federal legislation will still be a significant part of what the GRC works on. The new subcommittee structure will substantially expand the committee’s role, however, making possible a new focus on regulatory and state legislative issues; the GRC will benefit from the additional expertise provided by the expanded number of members needed to fulfill this role.

As I mentioned before, each of the subcommittees will have a highly specific responsibility. Here are a few details:

- **Federal Legislative.** This subcommittee will review, analyze, and make recommendations on the PIAA’s position on bills and resolutions pending before Congress. It may also provide information for legislative hearings, draft new legislative initiatives, or monitor political activities.

- **Federal Administrative.** Similarly, this subcommittee will review, analyze, and make recommendations on the PIAA’s position in regard to regulations, guidelines, and similar documents that are issued by the federal regulatory and administrative bodies—including the Centers for Medicare & Medicaid Services, the National Practitioner Data Bank, and the new Federal Insurance Office.

- **State Legislative.** Monitoring and notifying PIAA members about state legislative activities that are relevant to a significant number of PIAA companies will be this subcommittee’s primary role. It will also advise the PIAA on how best to help member companies, if asked, to lobby effectively for state-level tort reform.

Relying on the work of the subcommittees, the full committee will be able to assume a more traditional oversight role, including the review of the recommendations submitted by a subcommittee, before these recommendations are forwarded to the PIAA Board of Directors. Each recommendation from the committee will have had two rounds of review, so they will have been analyzed fully by a broad representation of PIAA member companies before they are adopted as policy.

What lies ahead
In the coming weeks, we will create the committee and subcommittee rosters, and there will be organizational meetings, to get each entity up and running. We hope to have the entire GRC structure operating smoothly very soon, so the groups can handle any new developments that emerge this autumn, and certainly well before the new year, when state and federal legislative deliberations will begin again in earnest (there are always new regulations, of course). Meanwhile, we encourage member companies with a particular interest in government relations to contact the PIAA: ask us questions, or suggest some candidates for the GRC and its new subcommittees.

Footnote
1. State regulatory matters, including issues related to the National Association of Insurance Commissioners, will continue to be monitored by the PIAA Regulatory Affairs Committee. For more information about that committee’s work, please contact the PIAA.

Hinderberger Commended for Service to PIAA

Philip R. Hinderberger, Esq., the longtime Chair of the Legislative Oversight Committee, concluded his time on the Committee in July. Hinderberger served as senior vice president, general counsel, and corporate secretary of NORCAL Mutual Insurance Company from 1991 until his recent retirement. When he joined NORCAL, the board gave him a special assignment: to lead efforts to preserve California’s Medical Injury Compensation Act (MICRA) and to assist in the enactment of similar measures in other states and at the federal level. Hinderberger is a principal contributor to H.R. 5, the “Protecting Access to Healthcare Act,” the federal medical professional liability (MPL) legislation currently pending in Congress. His annual report on the benefits of MPL reform, “Medical Liability Report Card,” has been extensively referenced in the media and legislative reports. At his final meeting as Chair, the Committee unanimously approved a motion to thank him for his efforts and commend him for his outstanding leadership. The PIAA thanks him as well and wishes him the best in his future endeavors.
Disclosure in Adverse Events: A Global Perspective
O liver Wendell Holmes reflected the culture of his era when advising a group of new medical graduates in 1871 that, “Your patient has no more right to all the truth than he has to all the medicine in your saddlebags.”

Fast-forward 135 years, and Professor Lucian Leape, adjunct professor, was very firm in saying, in a presentation on open disclosure at an international forum in Barcelona in 2007, that, “Pretending that nothing happened, or telling about it in incomplete ways, is lying.”

The paternalistic, “doctor knows best” model that was both the doctor's and the patient's preference for centuries has been overtaken by a more balanced doctor-patient relationship. Narrow, legalistic concepts such as “informed consent” are expanding into broader relationship concepts such as “shared decision making.”

While there has been a focus on the importance of giving and sharing information with patients when treatment decisions are being made, more recently, the concept of an “information continuum” is being adopted, one that crosses all phases of the doctor-patient relationship, that is, before, during, and after treatment. Providing information at each phase of care reflects the ethical duty to respect a patient's autonomy and that, of course, includes when things go wrong.

In the U.K., the principle of openness in healthcare is now firmly embraced.

What the regulators say
The regulator of medical practice in the U.K., the General Medical Council, has stated in its document Good Medical Practice.

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SECOND QUARTER 2012

Practice (2006) that:

If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.

In the U.K., the Health Bill 2008-09 (which came into force in October 2009) requires that all organs of the National Health Service (NHS) observe the dictates of the NHS Constitution, one of which is:

The NHS commits when mistakes happen to acknowledge them, apologise, explain what went wrong and put things right.

The NHS added:

With the introduction of this bill, it is clear that within the NHS there is a clear commitment to the principles of open disclosure. Most importantly for those of you working in the NHS where part or all of your work is covered by indemnities provided by the NHS Litigation Authority (NHSLA), a letter from the NHSLA to all chief executives of all NHS bodies and endorsed by the GMC, all professional indemnity associations in the United Kingdom and the royal college of nursing explains the position of the NHSLA with regards to transparencies/open disclosure.

The NHSLA’s position was:

Patients and their relatives increasingly ask for detailed explanations of what led to an adverse outcome…. The NHSLA is keen to encourage both clinicians and NHS bodies to supply appropriate information whether informally, formally or through mediation.

The NHSLA also strongly supported early apologies to patients injured in the course of receiving healthcare. To the extent that doctors (and others) feared that an apology could jeopardize their access to indemnity, the NHSLA added:

It is most important to patients that they and their relatives receive a meaningful apology. . . . We encourage this and stress that apologies do not constitute an admission of liability…. it is not our policy to dispute any payment, under any scheme, solely on the grounds of such an apology.

This policy had already been expressed in the U.K.’s Compensation Act (2006), which included a clause stating: An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty.

MPS supports openness

MPS strongly supports a culture of openness. In our experience,
many complaints arise from poor communication. The doctor-patient relationship is based on trust, and this requires honesty and integrity on the part of the doctor when things go wrong. After the facts have been established, a genuine apology accompanied by a full explanation and a plan for resolving the problem is often well received.

A wall of silence after an adverse incident can provoke formal complaints and legal action. Open and honest communication is not always easy if emotions are running high, but if the matter is handled sensitively and professionally, patients will often be more accepting of the incident—and grateful for the honesty. Contrary to popular belief, apologies tend to prevent formal complaints, rather than the opposite.

Further detail of MPS’s strong advocacy of openness can be obtained by accessing our booklet “A Culture of Openness—An MPS Perspective” at www.medicalprotection.org/uk/booklets/a-culture-of-openness.

In recent years, there has been considerable focus on how best to communicate with patients following unexpected clinical outcomes and adverse events. In Canada, disclosure of adverse events to patients is seen as part of the relationship of trust between patients and healthcare professionals. Disclosure is considered an ethical and professional obligation by all medical regulatory licensing authorities (Colleges), even when formal policies are not available. Although specific legislation may not exist in each jurisdiction, disclosure may be seen as a legal duty in all of the provinces and territories.

Guidelines for disclosure

The Canadian Patient Safety Institute (CPSI) published the Canadian Disclosure Guidelines in 2008 and revised the document in 2011. Patient representatives and many professional healthcare groups, including the CMPA, contributed to these guidelines.

Accreditation Canada requires that organizations implement a formal and transparent policy, including process and training, for disclosure of harm from healthcare delivery. The policy should include support mechanisms for patients, family, and care or service providers. The Canadian Disclosure Guidelines have been widely adopted to meet these accreditation requirements.

The CMPA provides practical advice and training to physicians, based on the Canadian Disclosure Guidelines.

Terminology

The first version of the Canadian Disclosure Guidelines used the term “adverse event” to describe harm from healthcare delivery. Using this broad definition, adverse events most frequently result from recognized complications—the inherent risks of investigations and treatments. Others could result from failures in the system of care or issues in provider performance, including errors.

In the 2011 revision of the guidelines, the CPSI promotes the use of the term, “patient safety incident,” based on the World Health Organization International Classification of Patient Safety (WHO-ICPS). Organizations are considering the implications of adopting this new terminology and framework, which emphasize the context in which an “incident” can occur. This may be helpful in moving away from the simplistic perspective, in which adverse events are looked upon as an error made by a single provider at the “sharp end” of care.

The use of the term “error” itself has also led to some debate on the reasons for harm and delayed communication with patients and families. In fact, the CPSI Guidelines recommend the term “error” be used carefully, as it may be misunderstood, especially prior to full analysis, and imply that care provided was substandard or negligent.

The Guidelines also distinguish between disclosing an incident to a patient and reporting an incident to an organization.

Disclosure of Harm in Canada—An Update

By Gordon Wallace, MD, FRCPC

In recent years, there has been considerable focus on how best to communicate with patients following unexpected clinical outcomes and adverse events. In Canada, disclosure of adverse events to patients is seen as part of the relationship of trust between patients and healthcare professionals. Disclosure is considered an ethical and professional obligation by all medical regulatory licensing authorities (Colleges), even when formal policies are not available. Although specific legislation may not exist in each jurisdiction, disclosure may be seen as a legal duty in all of the provinces and territories.

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The Guidelines also distinguish between disclosing an incident to a patient and reporting an incident to an organization.
Just culture of patient safety
The Canadian Disclosure Guidelines emphasize the importance of building a “just culture” in healthcare organizations, to facilitate reporting and correction of vulnerabilities before patient harm occurs. Such a workplace culture emphasizes appropriate professional accountability. However, providers are not held responsible for system failures over which they have little or no control. There is growing recognition that the creation of a just culture is necessary to facilitate disclosure and a learning environment. Committed leadership is important for setting the tone of the culture. The creation of a just culture and how to approach disclosure are now embedded in many Canadian patient safety education programs.4

Many healthcare institutions and quality agencies understand, and are beginning to implement, the principles and appropriate accountabilities of a just culture. However, much more education within institutions and community facilities, as well as of the public and media, is required.

The disclosure process
Based on the Canadian Disclosure Guidelines, the CMPA booklet, Communicating with Your Patient about Harm: Disclosure of Adverse Events5 is used widely. It provides practical suggestions on how to meet the clinical, information, and emotional needs of patients and families who have experienced unexpected clinical outcomes. Early disclosure and ongoing discussions are suggested, including advice on who should be involved, how best to formulate an apology, and a summary checklist of the important steps.6

Quality improvement protection legislation in Canada reflects the public policy objective of encouraging participation by providers. To varying degrees, legislation in each province or territory protects quality improvement information deliberations, records, and documents from being disclosed in legal proceedings. New facts discovered during the review, and any measures being implemented to limit the likelihood of recurrence of similar events, are intended to be provided to the patient.

Apology legislation
Apology legislation is in place in eight of ten provinces and one of three territories. The legislation protects an apology from being used in civil litigation and, depending on the wording, in other forums as well. It typically provides that an apology does not constitute an admission of fault or liability. This legislative protection has not been challenged in court, to date.

Training in disclosure
Based on accreditation requirements, disclosure training in hospitals is relatively widespread, but generally less so in community practices. Although other training programs exist, the CMPA provides much of the training to physicians. CMPA members are encouraged to obtain telephone advice on disclosure from CMPA medical officers.

Disclosure training is increasingly taught in medical schools and residency training programs.7 The CMPA Good Practices Guide for trainees, which will be published in late 2012, contains relevant educational resources for students and teachers.

Frequency and impact of disclosure
There is little formal research about the impact of the Canadian Disclosure Guidelines on disclosure. Most healthcare institutions would likely conclude that they have made progress in reporting and disclosing harmful events to patients over the last several years. Calls to the CMPA for advice have increased.

Early offers of compensation are generally not linked to disclosure in Canada, as negligence has not been proven. The courts have the responsibility to make such determinations.

Provider support
Although concerted efforts must be directed at patient and family support, there is increasing recognition that providers involved in adverse events may also have clinical, emotional, and information needs. These aspects of care are less well addressed. The CMPA Good Practices Guide contains important information on coping strategies for physicians.

References
2. Accreditation Canada provides organizations with an external peer review process to assess and improve services.
4. For example, the Patient Safety Education Program (PSEP-Canada) and Patient Safety Officer Course from CPSI.
In the Netherlands, during the last ten years there's been increasing interest in communication, and the provision of information, in the context of the physician-patient relationship. Many complaints and claims result from incomplete or incorrect information, research has shown. Patients are very sensitive about communication, and they tend to be more unsatisfied, and complain more, about this subject than about any other shortcomings and disappointments in their medical treatment. It is my sense that patients complain more about the manner in which physicians deal with the mistakes they have made than about the mistakes themselves.

General opinion in the Netherlands holds that when a doctor realizes he has made a mistake, it should be discussed as soon as possible with the patient, and the doctor should apologize for what has happened. A transparent and open attitude helps prevent complaints and claims. It is our experience that patients understand that a physician is human and can therefore make a mistake. But hiding information, or just giving patients that idea, increases the likelihood of problems. Physicians also have a legal obligation in our country to inform the patient about a bad outcome, because this frankness is helpful in preventing, or reducing, the damage caused by the mistake.

So it is worthwhile for physicians and other healthcare practitioners to invest some time and effort in improving this kind of communication.

Policy language

Regularly, there are disputes about the influence of the specific language in the medical professional liability (MPL) policy in deterring physicians from open disclosure.

This is, however, only a persistent misunderstanding, as you find when you investigate the actual intent of the clause, as cited below.

**Article 7: The insured physician shall omit everything that might affect the insurer's interests in the claim.**

There are, even now, still some physicians in the Netherlands who interpret this clause as a ban against informing the patient when something goes wrong during treatment. This supposition was not unreasonable in the past: a Dutch judge had ruled that when a physician admitted that something went wrong during treatment, the physician was negligent, unless he could prove the opposite.

However, during the last few years, it has become clear that open disclosure to a patient cannot be considered a violation of Article 7, and that physicians are in fact allowed to furnish open disclosure, in the patient's interest. The intention of the clause is to keep physicians and other healthcare providers from accepting liability during disclosure, or providing any sort of guarantee that a mistake will lead to compensation.

Survey of patients’ experience

In May 2008, a remarkable report was published under the aegis of a Dutch institution, the Ombudsman. (This serves as an impartial and independent complaint-resolution mechanism to supplement traditional means of seeking redress.)

In this report, the Ombudsman criticized not only the way that MPL insurance claims were handled, but also the way in which patients were dealt with after medical errors had occurred. The report made clear that 45% of patients felt that the acknowledgment of an error is more important to them than compensation for damages. Another conclusion pertained to their low opinion of the way that patients' complaints were handled: Only 13% were satisfied with that.

The report generated a good deal of publicity, and even in the Dutch parliament, the Dutch Minister of Health was asked about the findings in the report. The minister took the report very seriously, and he appealed to all of the parties involved in MPL to assume full responsibility for improving patients’ rights.

**A Perspective from the Netherlands**

**How to Deal with Adverse Events—the Dutch Perspective**

*By Harry Henschen*

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**Harry Henschen** is with VvAA groep, Utrecht, Netherlands.
Code of Conduct

The result, in 2010, was the creation of a Code of Conduct for medical incidents. Responsible for its drafting were the Dutch Association of Insurers, the Royal Association of Physicians, the Dutch Patient and Consumers Federation, and other important stakeholders like the Dutch bar (in an advisory role).

The first part of the code discusses the phase during which an adequate reaction from a physician can help stop misunderstandings about an unnecessary complaint, or claims can be prevented, and an escalation in mistrust in the patient-physician relationship can be avoided. Open disclosure is an important issue during that phase. The code recommends that the physician:

■ Contact the patient within 24 hours after the discovery of the incident
■ Take all the necessary measures to reduce negative consequences for the patient
■ Analyze how the incident could have happened and take the necessary steps as soon as possible to ensure that it won’t happen again.

Significantly, the code makes a clear distinction between “fault” and a “complication.” A “complication” is defined as an unintentional outcome, one that can be considered inherent to the particular medical procedure that was performed. In that case, liability is not an issue.

On the other hand, admitting to having made a mistake cannot be considered an acceptance of civil liability. This requires further, and more thorough, investigation, according to current law.

Conclusion

The importance of disclosure after adverse events has, for a long time, been a neglected topic in our country. The report of the Dutch Ombudsman and, as a result of that, the new Code of Conduct on medical incidents, has greatly stimulated discussion of this subject. Now, there is a common understanding about the necessity and importance of transparent communication whenever there is an adverse outcome after a medical treatment. This attitude will help physicians and patients realize that complaints and claims are risks that are simply inherent in the everyday work of the medical profession.

The Other Side of Apology

By Victor R. Cotton, MD, JD

Disclosing medical errors to affected patients and apologizing for those errors has recently emerged as a potential solution to the medical professional liability (MPL) problem. The approach is built on the premise that patients who receive honest explanations and apologies are less likely to sue, and it has gained considerable acceptance in the risk management community.

However, the idea that seriously injured patients, many of whom face major financial burdens, will simply forgive and forget about the errors that crippled them is counterintuitive. And, most clinicians remain skeptical, if not fearful, of the practice.

This article will evaluate the scientific literature behind disclosing errors, analyze the situations where it has allegedly been successful, and then examine why more physicians are not implementing this practice.

The ideal world

If we lived in an ideal world where the legal system functioned perfectly, every person who had been injured by medical negligence would file a lawsuit and be guaranteed to receive proper compensation. In addition, because the system was perfect, persons who had not been injured by negligence would never sue, and there would be no frivolous or non-meritorious lawsuits. In this ideal world, every injured patient would sue, and every lawsuit would have merit.

In such a world, apologizing for medical errors might be a viable strategy: If every injured patient is 100% likely to sue and equally certain to receive an equitable compensation, there is little to lose by asking for forgiveness. And, if even a few patients decide to forgive and forget, the savings could be substantial.

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The real world

While this “ideal world” scenario is intriguing, most physicians practice medicine in the “real world.” And, in the real world, 84% of lawsuits are filed by patients who did not suffer medical negligence. 1, 2 Because these persons were not victims of medical errors, they would not be targeted for disclosure or apology (since there is no error to disclose, and therefore nothing for which to apologize), and their decision to file a lawsuit would therefore be unaffected.

The other 16% of litigants (who actually did suffer errors) could be targeted for an apology. And, if we assume that half of them subsequently decide not to sue (an optimistic assumption), the total number of lawsuits would fall by 8% (one-half of 16%). Compared with the dramatic decrease in lawsuits that often results from legislative tort reform (40% to 60%), this is a relatively minor reduction.

Of course, one could argue that the apologies eliminated half of the meritorious, and therefore more costly, lawsuits. While this argument is theoretically true, our legal system does not function with such precision. Brennan found that the likelihood of a plaintiff receiving money, along with the amount of money that he receives, is dependent only upon his degree of injury, and not whether he actually suffered medical negligence. 3 So, in this scenario, the 8% of lawsuits eliminated would reduce the overall cost by only a proportionate 8%. And, to achieve even this result, half of the injured patients must agree to forgive and forget.

The significant risk

In contrast to its limited potential benefit, the disclosure-and-apology strategy carries with it a significant number of risks. In the “ideal world” example, 100% of patients who were injured by medical negligence filed lawsuits. However, in the real world, only 2% of these patients do so.1, 2 This means that the vast majority of patients who are injured by medical negligence do not presently sue. While it is likely that there are multiple reasons for this phenomenon, a primary one is that most of these patients are unaware that they suffered an error, and therefore do not know that they have a viable claim for medical malpractice. 4

Because there is no established method for distinguishing the 2% of injured patients who will sue from the 98% who will not, apologies would have to be given to all of them. This would be a very labor-intensive and precarious undertaking. To be successful in reducing the number of lawsuits, the approach would have to persuade the 2% not to sue, without triggering an appreciable number of the other 98% to sue.

The improbability of succeeding against these odds has been demonstrated in simulated scenarios, where 27%–44% of patients who were told of a medical error indicated that they would sue (compared with the 2% who do so now). 5, 6 And, despite the hope that injured patients will forgive and forget, Wu found that, once aware of an error, neither expressions of empathy or apology had any effect on the patient’s desire to sue. 5

The net result is that full implementation of disclosure and apology can be projected to increase the number of injured patients who file lawsuits by more than tenfold (from 2% to 27%–44%). In addition, because the errors will have been admitted, few of these cases will be defensible. The resulting financial impact would be devastating. Even with optimistic assumptions, a Harvard study concluded that the question was not whether disclosing errors would increase MPL costs, but rather, how great the increase would be. 6

The alleged success stories

Despite the improbable math, it is frequently said that apology programs have been proven to reduce the number of lawsuits at the VA hospital in Lexington, Kentucky, and at the University of Michigan. However, these statements are not consistent with the study results that were published in the scientific literature.

According to the paper originally published in the Annals of Internal Medicine, beginning in 1987, the Lexington VA investigated every bad outcome (of which it was made aware) and informed the patient of the result. 7 In the event of a medical error, the involved persons would apologize and explain what was being done to fix the problem. Over the next 12 years, the policy resulted in an increase in the number of legal cases, and the facility rose to the top quartile among its VA peers (even though it was one of the smaller facilities). But, the facility was able to negotiate reasonable settlements in most cases and realized a slight overall savings, primarily because of a decrease in attorney hours.
Unfortunately, there are some essentials for a rigorous study that the authors did not report: a standardized methodology for the apology, the number of cases in which the strategy was employed, or the results of those particular cases. And, there was no control group. In addition, the results were favorably influenced by several phenomena that are unique to the VA system. The VA patient population consists mostly of older men of limited means, who have finite expectations, deep ties to the Armed Services, and low levels of litigiousness. The level of legal exposure is further reduced by the Federal Tort Claims Act, which protects government physicians from personal liability and mandates that a patient first proceed through an administrative process before he can gain the right to sue. But, even with this unique patient population and extensive legal protection, the number of claims increased.

Many proponents of apologies cite the University of Michigan as another success in the apology movement. However, a recent analysis of the University’s data (also published in the *Annals of Internal Medicine*) revealed that in fact the number of lawsuits there began to drop after the State of Michigan enacted extensive tort reform. The University then capitalized on tort reform and further reduced the number of lawsuits by changing the way it handled pending legal claims (settling many of them before a lawsuit could be filed). Finally, several years into the process, the University implemented an apology program. Given the many variables in play, the *Annals* paper concluded that a causal relationship between the apology program and the decrease in lawsuits could not be established.

In addition to the increased risk of a lawsuit, disclosing errors to patients is fraught with multiple other problems. Spokesmen for the apology movement claim that patients “want to know” about medical errors, but this is an overly general statement, which assumes that all patients have the same desire. In fact, each patient is unique, and one study found that up to 24% of them do not want to know about errors. To override these patients’ wishes by informing them anyway directly violates the tenets of “patient-centered care” upon which disclosure and apology is supposedly based.

In addition, forcing this information on unwilling patients has potentially serious health consequences. A patient’s mental outlook has been shown to affect his clinical outcome; optimistic patients have better outcomes. As a result, to the extent that it compromises the patient’s outlook and confidence, informing patients of errors may also compromise his prognosis.

Disclosing errors outside of protected settings (e.g., patient safety organizations, peer-review proceedings) also poses significant risks for the clinician. In addition to the risk of being sued for malpractice, physicians who commit errors are regularly disciplined by state boards of medicine and sanctioned by hospitals. They also face the risk of criminal prosecution; this happened recently to a Wisconsin nurse, after her error caused a patient’s death. Although most states have passed some version of a medical apology law, most of these laws cover only expressions of sympathy (and not admissions of fault), and provide no protection in an administrative (board of medicine) or criminal proceeding.

In addition to the legal and professional
risks, disclosing errors also poses a remote but nevertheless real safety concern for clinicians. In 2010, a surgeon at The Johns Hopkins Hospital was shot by a patient's family member who was distraught by bad news about his mother's condition. A JAMA article several months later outlined the significant problem of patient violence against healthcare providers.15

Although this risk receives little attention from apology advocates, it is very real for physicians, many of whom have hospital security with them when they are breaking bad news to certain patients. Disclosing that a healthcare provider may have been responsible for the bad outcome will increase the inherent risk in these situations and inevitably put physicians and nurses in harm's way. This isn't just ethically problematic; it will also likely result in liability for those who create these situations.

The outside influences
Because the vast majority of patients who suffer medical errors are not aware of the mistake and thus do not know that they have a viable legal claim, trial lawyers have repeatedly advocated for the disclosure of medical errors. During the legislative battle over tort reform in 2005, then-Senator Obama proposed the National Medical Error Disclosure and Compensation (“MEDIC”) Act, a bill that championed disclosure and apology for medical errors as an alternative to the Republican calls for limits on non-economic damages.16

Although that initiative failed, most of the Affordable Care Act money that was earmarked for studying MPL subsequently went to disclosure and apology programs. And, in Pennsylvania, trial lawyers were successful in obtaining legislation that requires hospitals to provide written notice to any patient who experiences an unanticipated outcome.17

In contrast to trial lawyers, those who practice medicine are anchored by the principle of primum non nocere (“first, do no harm”). This principle demands that any change in the interaction between doctor and patient must first be proven to offer more benefit than risk. Unfortunately, because it poses a substantial risk to both doctor and patient, and offers little to no established benefit (other than to trial lawyers), disclosure and apology are not properly within the practice of medicine.

Conclusion
The concept of disclosure and apology purports to reduce legal risk by improving the interaction between doctor and patient in the wake of a medical error. However, only 2% of patients who suffer medical errors eventually file a claim, which suggests that there is actually little room for improvement. How physicians have managed to produce this phenomenal record has not been established. However, it is likely related to the lessons learned during 4,000 years of empathizing with the sick and comforting the dying. And, physicians are understandably reluctant to transform the nature of these interactions simply to conform to a counterintuitive and unproven idea.18

Caveat: I would like to emphasize, however, that I fully support reporting medical errors to Patient Safety Organizations and other peer-review groups, in a location where the facts of the case can be discussed beyond the reach of trial lawyers.

References
9. FTCA 28 U.S.C. §1346(b), §1402(b), §2401(b), and §§2671-2680.
Using Municipal Securities to Enhance Earnings

“Economic conditions...are likely to warrant exceptionally low levels for the federal funds rate at least through late 2014.” —April 25th Federal Open Market Committee Meeting Statement

With interest rates at or near record low levels, and those that rely on fixed income struggling with historically low yields, investors and their advisors are more focused than ever on ways to maximize income and preserve the value of a dollar earned. This includes expanding traditional core portfolios to new asset types: lower-quality bonds, emerging market debt, dividend-focused equities, and alternative assets, among others.

For property/casualty insurers, a more subtle method of income enhancement is based on an understanding of the tax code, the insurer’s operating forecasts, and its exposure to the municipal bond market. According to SNL Financial data (through December 31, 2011), medical professional liability (MPL) companies held an average 13% of their invested assets in municipal bonds—general obligations of states and local governments or revenue-backed bonds supported by water, sewer, highways, or other projects (Table 1).

While insurance companies typically take a long-term...
approach to investing reserve and surplus funds, there are periodic opportunities to take a more active approach in working with the tax-exempt municipal portion of an insurer’s portfolio. This can result in higher after-tax yield and lead to new opportunities for capital appreciation. In this article, we discuss some key principles for municipal bond investing that should be used by MPL carriers and their investment teams. Adhering to these principles will yield greater risk-adjusted income for the enterprise.

Dynamic tax analysis
In recent years, rating agencies and regulators have put greater emphasis on the risk management procedures in place at financial institutions. As a result, carriers are expanding their traditional one-to two-year budget forecast to include a more dynamic probability-weighted operating forecast with base case, best case, and stress case estimates—attempting to capture the impact of tail events on capitalization levels.

These forecasts can be incredibly valuable when they are included in the investment decision-making process as an insurer’s profit expectations, and potential for unforeseen losses or adverse reserve development will determine the entity’s tax liability and its ability to utilize tax-free income.

As the investment strategy is developed and refined, the investment policy should identify a maximum allocation to municipal bonds that is the result of such a dynamic forecast model. Insurance companies that fail to link potential future-period operating performance and investment performance face the following risks: Alternative Minimum Tax (AMT) liability for marginally profitable companies with heavy allocations to municipals, or, conversely, in the event of poor underwriting performance a carrier may find itself wholly unprofitable—with no tax liability and a portfolio of low-yield municipal bonds. Investment advisors with expertise in insurance tax are best suited to deliver an optimal solution.

Traditional relative valuations
Just as a medical practitioner evaluates symptoms and performs tests before making a diagnosis, a corporate investor or its advisor must understand the typical patterns in the municipal market to successfully implement an active tax-advantaged strategy. Traditionally, the after-tax income advantage of a municipal bond, relative to a comparable-maturity taxable bond, is limited in short maturities because new issuance is limited and there is a heavy demand from individual investors. Recent market data

<table>
<thead>
<tr>
<th>Table 1 Municipal Bond Allocations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Largest Allocation to Municipal Bonds (% of Cash &amp; Invested Assets)</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>1 Health Care Indemnity Inc. Hudson Specialty</td>
</tr>
<tr>
<td>2 Insurance Co. MO Professionals Mutual Ins Co.</td>
</tr>
<tr>
<td>3 Mutual Ins Co. Prof Underwriters Liability Ins Co.</td>
</tr>
<tr>
<td>4 Medical Mutual Ins Co. of NC</td>
</tr>
<tr>
<td>5 West Virginia Mutual Ins Co.</td>
</tr>
<tr>
<td>6 Kansas Medical Mutual Ins Co.</td>
</tr>
<tr>
<td>7 MMIC Insurance Inc.</td>
</tr>
<tr>
<td>8 OMS National Insurance Co. RRG</td>
</tr>
<tr>
<td>9 Ophthalmic Mutual Ins Co. RRG</td>
</tr>
<tr>
<td>10 Mutual Insurance Co. of AZ</td>
</tr>
<tr>
<td>11 MedAmerica Mutual RRG Inc.</td>
</tr>
<tr>
<td>12 Central PA Physicians RRG Inc.</td>
</tr>
<tr>
<td>13 MHA Insurance Co. CA Healthcare Ins Co. Inc.</td>
</tr>
<tr>
<td>14 MCA Inc.</td>
</tr>
<tr>
<td>15 CA RRG</td>
</tr>
</tbody>
</table>

Source: SNL Financial Medical Professional Liability companies with Cash and Invested Assets > $50 million.
shows 3-year tax-exempt municipals earning a tax-adjusted yield of approximately 0.65%, slightly above the 0.40% yield on 3-year Treasury notes. Conversely, demand for longer maturity municipal bonds comes from institutional investors, including insurance companies. For bonds with maturities beyond seven years, the typical yield relationship relative to taxable bonds is compelling, as the slope of the municipal yield curve exceeds that of the Treasury curve (Figure 1). An example of this relationship is evident in tax-exempt municipals with 15 years to maturity, which currently yield approximately 3.4% on a tax-adjusted basis versus roughly 2.0% in Treasuries.

Performance amid rising interest rates
Exposure to the sector can also provide for diversification from the interest-rate risk embedded within an insurer’s core taxable fixed-income portfolios. Many investors have expressed concern about the prevailing level of rates and the long-term consequences of Federal Reserve policy. Historical performance in the municipal market suggests that, on average, municipal yield changes exhibit a correlation of approximately 70% to yield changes in the Treasury market. While this suggests that tax-exempts may underperform in falling-interest-rate environments, it also indicates outperformance for the sector, should rates begin to climb.

Trading opportunities
While Municipal yields tend to exhibit mean reversion characteristics, municipal bond performance also shows some degree of seasonality, which can lead to opportunities. Interest income and principal repayments are sizable in January-February and July-August, leaving retail investors and mutual fund managers with large cash balances for reinvestment. Expectations are for as much as $120 billion of reinvestment flows during the summer months ahead, well above the expected new-issue supply. This demand usually results in outperformance in the sector as cash is redeployed, driving prices higher. March and April are generally weak performance periods, as individual investors prepare for tax deadlines and sell bonds to raise cash.

Investors who can exploit these relationships, and anticipate the ebbs and flows of heavy new issuance, stand to generate tidy profits. Last fall, new issuance approached $35 billion per month and led to a rare opportunity for investors to purchase municipal bonds at extremely attractive yields. With 10-year Treasuries yielding approximately 2.0%, 10-year tax-exempt municipal bonds traded with tax-adjusted yields of nearly 3.7% (Figure 2). Even non-taxable investors were drawn to the sector, as nominal (actual yields without any tax adjustment) municipal yields exceeding 2.5% approached 130% of Treasury yields. By mid-January, the seasonal demand pattern brought yields back to normalized levels with 10-year tax-exempts offering approximately 90% of comparable Treasury yields, and rewarding investors who seized the opportunity.

Emphasis on quality and liquidity
Historically, municipal defaults have been rare, and generally isolated to bonds that are supported by revenue streams such as healthcare projects or stadium complexes. For example, today’s challenges facing states and local governments are unique, long-term, and the marketplace now differentiates issuers of high-quality from those with sizable structural issues or weak revenue streams. Chicago’s recent general obligation bond offering due in 2022 is priced to yield 2.64%, which is approximately 80 basis points wider than trading levels for the highest-quality issuers, such as Maryland or North Carolina.

An investor’s ability to implement an effective trading strat-
egy requires timely and efficient execution of trades, particularly when reducing exposure through sales. Liquidity must be managed at the point of purchase with a disciplined approach to security selection, in order to minimize trading friction when a sale opportunity subsequently materializes. Impediments to liquidity include low-coupon bonds, the presence of call features, trade size, and, of particular importance, the credit quality of the issuer.

Quality can be controlled by focusing on general obligations from issuers that have exhibited economic resilience during downturns and government entities that have shown the strong fiscal discipline needed to enact timely and recurring budget measures to restore long-term structural budget balance. Within the revenue segment, bonds that are supported by essential services with strong credit metrics to cover debt service generally carry a low risk profile.

**Asset class to consider**

Many MPL companies are operating profitably and growing, two conditions likely to justify strategic exposure to tax-exempt securities beyond the levels they held at December 31, 2011. While some companies are structured as reciprocals, associations, or risk retention groups and have unique tax positions, the municipal market offers value to all bond buyers, in different ways, at differing points in time. Insurers combing the marketplace for alternatives to traditional government, corporate, and mortgage sectors should not overlook the after-tax income, return, and diversification advantages of adding tax-exempt Municipal securities to the mix.

**Footnote**

1. AAA tax-exempt municipal yields have been tax-adjusted using 1.4577 factor.

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In determining which screening and preventive measures to provide to their patients, doctors are clearly on the horns of a dilemma. To limit screening to what is actually prescribed by agencies like the U.S. Preventive Services Task Force (USPSTF), which, while valid for statistical purposes for large populations, are of scant relevance to individuals, can have dire consequences for patients. Missing a diagnosis of colon cancer, because a colonoscopy was not performed with sufficient frequency, can mean severe illness or death. And that in turn can trigger a medical professional liability (MPL) claim.

Not detecting disease early in its progression can mean sizable payouts for medical errors, delay in diagnosis, and delay in treatment, the three most common reasons for MPL claims.

In 2010, cancer was the second highest cause of death, after cardiovascular events and conditions. The top four sites linked with cancer mortality in men were lung and bronchus (29%), prostate (11%), colon and rectum (9%), and pancreas (6%). Among women, the leading anatomic sites leading to cancer deaths were lung and bronchus (26%), breast (15%), colon and rectum (9%), pancreas (7%), and ovary (5%).

In fact, the guidelines on cancer screening from the USPSTF seem badly out of alignment with these statistics. They specify:

- Lung cancer—no screening
- Breast cancer—biennial screening only, starting at age 50, and no screening after age 75
- Prostate cancer—screening is no longer recommended
- Colon cancer—still recommends screening colonoscopy, but has extended the frequency from five to ten years. There are indications that the task force is moving away from recommending colonoscopies at all, in asymptomatic individuals.
- No screening ever for these potentially lethal conditions, either—pancreatic cancer, ovarian cancer, and liver cancer, and leukemias.

USPSTF recommends against self-exams for skin or breast cancers in all individuals and testicular exams in adolescent and adult males. As part of promoting awareness, physicians have always taught patients to examine themselves, because it afforded the chance of finding something early.

But statistics from the National Cancer Institute indicate that screening can be of great value, especially if data on the epidemiology of particular conditions is used in considering whether to screen individual patients for these diseases. For example, the median age to contract colon cancer is 70 years, leaving half to occur before this age. The American Association of Colon and Rectal Surgeons states on their website that 90% of these cases occur in patients over age 40. Another important risk factor is race: African-Americans tend to have a higher incidence of colon cancer than other races. These considerations make you wonder when screening really should begin.

Similarly, the data on breast cancer point up errors in the USPSTF approach. If only biennial screening is done, commencing only at age 50, the cancers that occur in ages 40 to 45 (incidence of 1 in 217) and 45 to 50 (incidence, 1 in 93) will be missed.

Remember, it was because of these statistics that society developed campaigns to teach doctors and patients awareness and to
develop technologies which made early detection possible. These efforts, by and large, have been successful and cancer death rates have trended downward as a result. Is a study necessary to show that by abandoning these protocols we will not revisit the death rates that made them necessary in the first place? Will juries understand the redefinition of the standard of care based on calculations using pure cost denominators? 

Costs

Screening tests can be expensive. But bowing to pressures to cut healthcare costs across the board, simply by reducing services, is the wrong approach. We should be looking to reduce the cost of the services. All costs can be negotiated and services can be made more affordable. The best way to contain costs is to make sure people are healthy, by striving to prevent all that is preventable while intercepting diseases that are not preventable early enough to treat them successfully. This would significantly cut costs resulting from diseases that are predictable and modifiable and could allow people to live longer and more productive lives.

In my practice, I focus on prevention by doing comprehensive physical examinations and various screening tests to determine how healthy my patients really are. Some come in every year, others every 18 months to two years, depending on their age and health issues. The idea is to position ourselves at reasonable intervals sufficient to prevent the little that is preventable and intercept, as early as possible, all that is not.

Let's say that a patient comes in at age 30 and then has comprehensive physicals every 18 months until age 60. That would be 20 physicals at approximately $2,000 each, or $40,000. If you add in another $5,000 for preventive or interceptive treatment for anything that comes up, since most serious diseases—like cancer—if detected early, can be easily prevented or managed.

That’s a grand total of $45,000.

We can compare that with the price of chemotherapy. Chemo for breast cancer can run $80,000, and that would come after surgery, hospitalization, imaging, and other specialists, which might add up to $150,000 or more.

Read the fine print

In January of last year, the Center for Medicare & Medicaid Services (CMS) announced a new benefit, courtesy of the Patient Protection and Affordable Care Act: an “Annual Wellness Visit” (AWV). Purportedly, its intent was to provide: 

"The best way to contain costs is to make sure people are healthy, by striving to prevent all that is preventable while intercepting diseases that are not preventable early enough to treat them successfully."

"Read the fine print"
Early Detection

Figure 1 Reality Check Annual Physical Checklist

<table>
<thead>
<tr>
<th>Test</th>
<th>Cost</th>
<th>Frequency</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete history</td>
<td>$95–$175</td>
<td>Every 14–18 mos. (Regular reasonable intervals)</td>
<td>Starting at birth</td>
</tr>
<tr>
<td>• Including a thorough review of your history (medical, surgical, familial, and personal)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A review and update of immunizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical examination, including:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A complete skin assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Rectal exam after age 25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete bloodwork, including:</td>
<td>$110–$950</td>
<td>Every 14-18 mos.</td>
<td>From childhood on</td>
</tr>
<tr>
<td>• Complete blood count</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Blood chemistries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Thyroid</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Lipid profile</td>
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<td></td>
<td></td>
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<tr>
<td>• C-reactive protein and Vit. D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PSA (after age 39)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td>$17–$45</td>
<td>Every 1-2 years</td>
<td>Start at age 25</td>
</tr>
<tr>
<td>EKG and chest x-ray (2 views)</td>
<td>$40–$125 (each)</td>
<td>Every 1-2 years</td>
<td></td>
</tr>
<tr>
<td>Bone density test</td>
<td>$125–$900</td>
<td>Every 1-2 years</td>
<td>Women 50-55 depending on onset of menopause and 60 for men. Well before osteoporosis has developed.</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy*</td>
<td>$125–</td>
<td>Every 4 years</td>
<td>35</td>
</tr>
<tr>
<td>Full colonoscopy</td>
<td>$600–$1000</td>
<td>Every 4-5 years, depending on risk factors or signs of bone loss</td>
<td>45 Especially helpful in people who smoke or have cardiovascular risk factors.</td>
</tr>
<tr>
<td>Cardiac stress test and echocardiography</td>
<td>$300–900</td>
<td>Every 5-7 years or annually in high-risk patients</td>
<td>60 Especially helpful in people who smoke or have cardiovascular risk factors.</td>
</tr>
<tr>
<td>Echocardiography in all athletes in competitive sports at age 15 or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patients who have a family history of sudden cardiac death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Young patients who have had several episodes of syncope (fainting)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patients who experience an abnormal blood pressure response with exercise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patients who have a history of arrhythmia with a fast heart rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patients with severe symptoms and poor heart function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultra-fast CT scan of chest, abdomen, and coronary arteries with calcium scoring</td>
<td>$906–$1,200</td>
<td>Every 2 years</td>
<td>35 Especially helpful in people who smoke or have cardiovascular risk factors.</td>
</tr>
<tr>
<td>Advanced lipid test (NAP) or Berkeley Profile</td>
<td>$110</td>
<td>Every 3 years, annually under treatment</td>
<td>35 Especially helpful in people who smoke or have cardiovascular risk factors.</td>
</tr>
<tr>
<td>For Women Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap smear &amp; pelvic exam</td>
<td>$120</td>
<td>Annually</td>
<td>At onset of sexual activity</td>
</tr>
<tr>
<td>Digital mammogram and sonogram (if needed)</td>
<td>$115 each</td>
<td>Annually every 1-2 years</td>
<td></td>
</tr>
<tr>
<td>Pelvic sonogram</td>
<td>$90–125</td>
<td>Annually, depending on sexual activity and number of sexual contacts</td>
<td>35</td>
</tr>
<tr>
<td>Human papilloma virus (HPV) test</td>
<td>$115</td>
<td>Annually, depending on sexual activity and number of sexual contacts</td>
<td>25</td>
</tr>
<tr>
<td>For Men Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate-specific antigen (PSA) test</td>
<td>$95–$110</td>
<td>Annually, Age 25</td>
<td></td>
</tr>
</tbody>
</table>

Personalized Prevention Plan Services (PPPS) at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update a personalized prevention plan. This new benefit will provide an ongoing focus on prevention that can be adapted as a beneficiary’s health needs change over time.

The goals of the visit stress the fact that this is an individualized assessment, specifying the:

Provision of personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks, and promote self-management and wellness.

The need for screening, as a general principle, is underscored in beneficiary materials disseminated by CMS about the AWV. The CMS brochure for the program requires “the establishment of a written screening schedule, such as a checklist for the next 5 to 10 years.” But then, the program specifies the screening schedule that should be used: “Based on recommendations of the United States Preventive Task Force” [emphasis added].

So: the AWV doesn’t really represent progress in regard to the guidelines to be used in screening for potentially lethal illnesses. If we follow the AWV instructions, many lung, colon, prostate, and breast cancers are going to be missed, to cite just the top examples. It is obviously not possible to have effective early detection and treatment, if screenings are done late or not at all. Those that are reimbursable by Medicare are limited to those included in the USPSTF roster. How preventative is this exam?

In contrast, Figure 1 shows a checklist that I use in my practice.

Emerging risks

There are new risks in the healthcare landscape, whose import is not yet known, for physicians and their MPL insurers. The first of these falls under the rubric of capitated models for care, which seek to reward physicians for limiting all of the procedures—screening and otherwise—that they may need to perform on patients to optimize costs. These include some of the newer models, such as accountable care organizations and medical homes, but also the old standbys like HMOs, all of which are licensed by USPSTF recommendations to provide less care. Capitation perverts the moral sense of the medical community because it diverts physicians away from core values, toward concern mostly about financial viability.

Also of concern is the current devolution of care to physician extenders like physician assistants, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives. These providers pay a fraction of what the physicians pay yet their risk and claims are just as high. Not enough is known about what will happen to claims as this trend develops, but we must be mindful: there is a possibility that premiums could be insufficient to justify
reserves that were set up on these cases.

New revenue-producing concepts, such as aesthetics (noninvasive cosmetic procedures, for instance), pain management, and surgical procedures are becoming more common, and they are frequently performed by individuals with minimal, or no, training in what they are doing. How these innovations in practice patterns will impact claims is largely unknown, at this point.

**Strategy**

How can physicians and MPL companies best cope with this radically fluctuating environment? Here are some suggestions.

First, try to stay up to date on trends in healthcare, and the relative likelihood that they will balloon into something that will impact your business in a substantial way. Then, explore options for providing coverage: low limits, deductibles, shared- or single-limit options, and aggregates.

Re-underwrite physician extenders, since renewals of extender policies are otherwise automatic. Check for changes in location, responsibilities, or employment—every time a change is reported.

Strongly encourage all of the surgical specialties and every staff member working in anesthesia to perform perioperative evaluations of individual patients, since this is when many adverse events occur. A more complete database enables physicians to know more about patients and allows risks to be visible and more calculable.

Use a “teaching questionnaire.” Most questionnaires consist of checkboxes designed to assist the underwriter in evaluating the risk. A sentence or two about why we are asking questions can teach the applicant something about risks associated with their practice. These forms can be designed to benefit the applicant while still assisting the underwriter and can provide a powerful risk management tool at no extra cost to our companies.

**Conclusion**

Well, then, is early detection actually too expensive? Compared with the myriad costs associated with late detection and delay in treatment of serious conditions, to say nothing of the emotional and financial consequences of an MPL lawsuit, it is clearly a bargain. Underwriters in MPL companies need to keep this simple fact in mind.
The medical professional liability (MPL) insurance industry has seen lower overall claim costs, driven by a recent decline in the number of MPL claims. The unexpected magnitude and duration of the decline in claim frequency have precipitated a favorable runoff in unpaid-claim reserves, since 2005.

Some industry observers believe that there continues to be an industry-wide redundancy in unpaid claim reserves at this point. For one, A.M. Best has projected an industry-wide redundancy of $3.0 billion on a statutory basis (i.e., relative to the undiscounted reserve requirement) as of December 31, 2011. However, we would urge caution when translating this apparent redundancy, which shows up at the industry-wide level, down to the level of individual companies.

In theory, the industry-wide reserve clearly does equal the sum of the individual-company reserves. However, when you take into account the statistical properties and inherent risk in company-level claims experience, the whole may in fact be greater than the sum of its parts.

This is so because the statistical properties of unpaid-claim liabilities at the company level, where reserving decisions are made, differ from those of the industry as a whole. Favorable reserve developments should not lead to a conclusion that reserves are being set too high. This article shows that if individual companies set reasonable claim reserves, we may still find that the industry’s total reserve will develop favorably more often than not.

Estimating the unpaid-claim liability: technical considerations

Future unpaid claim liabilities are uncertain and must be estimated. The selected reserve is an amount that represents one point estimate on an unknown statistical distribution of possible outcomes. There is no specific point estimate that represents the...
perfect (exactly accurate) amount to use as the unpaid claim liability reserve.

An actuary may project a specific point estimate directly, without attempting the more challenging task of estimating the probability distribution of outcomes. However, in order to understand the nature of MPL reserves and put context to what is meant by a “reasonable” reserve level, we do need to think in terms of the probability distribution. The fact that not all actuaries use stochastic reserving models does not eliminate the need for this discussion.

A probability distribution represents the stochastic (random) variability in the final cost of unpaid-claim liabilities. However, it is important to note that the true, underlying probability distribution can never be known with certainty. The actuary needs to assume a model, and then make a series of assumptions, to estimate the mathematical parameters of that model. In addition to random variability of unpaid-claim liabilities (or process risk), these assumptions introduce both parameter and model risk.

These risks are especially high for MPL, because claim costs are extremely variable and exhibit a probability distribution that is highly skewed to the right side of the curve (Figure 2). The shape of this distribution represents the asymmetrical nature of the risk that MPL insurers face. A bad year generated by large claims, a higher number of claims, or both, has the potential to be much worse than expected. However, the improvement seen in a good year will likely be of a lesser magnitude. In other words, when claim experience goes bad, it can be very bad, but there is a limit on how good it can get.

Suppose Figure 2 represents the model for the unpaid-claim-liability distribution of an MPL insurer. From this assumed distribution, we now need to select the point estimate to book. The “mode” of the distribution is the most likely outcome, and it is represented by the highest point on the curve. Even though this is the most probable outcome, few actuaries would argue that it represents a reasonable reserve amount for a liability whose distribution is skewed. In this sort of distribution, the mode is less than the 50th percentile (or “median”), which implies that there is a greater than 50% chance that the actual liabilities will exceed the mode estimate.

The median is the point estimate within the distribution where there is a 50% chance that the actual claim liabilities will come in lower, and a 50% chance that they will come in higher. One could argue that this is a reasonable amount to carry on the balance sheet. However, the median number does not account for the fact that the expected average size of an adverse reserve development is greater than the expected average size of a favorable development. If a company uses the median amount as its reserve, then the expected value of the reserve development would be adverse. From this perspective, the median represents an estimate that may be biased on the low side.

The fact that the expected value (or “mean”) exceeds the 50th percentile is typical of this type of asymmetrical distribution. The mean is weighted in such a way that it takes into account the potential size of the reserve development, in addition to its probability, so the mean may be a more appropriate number to book for a skewed distribution. If the mean of the distribution is used, then the expected reserve development is $0.

However, reserving to the estimated mean may be more precarious for some companies than for others. The mean for the unpaid-claim liability of a larger MPL insurer might actually correspond to the 55th percentile. This implies that if the company books to the mean, there is a 55% chance that the reserves will be adequate and a 45% chance that the reserves will prove to be inadequate. For a smaller company, or one that has more variable claim costs, the expected value might in fact correspond to the 65th percentile. If this company uses the mean estimate for setting its reserves, it will have a 65% chance of having adequate reserves and a 35% chance of inadequate reserves.

In short, estimating the unpaid-claim liability and establishing the reserve is not an exact science with a single, precise answer. This is why actuaries say that there is a range of reasonable esti-
mates that can be used for establishing the liability reserve.

The industry compounding effect
What might be a prudent approach to reserving by individual companies can compound to produce an apparent reserve redundancy at the industry level. This is because claim costs, and thus reserve developments, are only partially correlated across MPL writers. Various factors influence each company’s claim costs differently. In addition to random chance, these might include changes in the legal environment, loss control and litigation strategies, excess policy limits claims, or clash claim exposures, to name a few. Favorable claim-cost developments for one company might be offset by adverse developments that impact another. Likewise, improving claim-cost conditions in one state might be offset by deteriorating costs in another. This implies that the aggregated industry-wide distribution of unpaid-claim costs is actually “narrower” than the sum of the individual company distributions.

Let’s assume that, when companies book reserves, they are targeting the mean unpaid-claim liability as the most reasonable reserve amount. As we have shown, the mean for a skewed distribution falls at a probability level that is greater than the 50th percentile. For the sake of discussion, assume that, on average, for MPL specialty writers the mean corresponds to the 55th percentile. However, the actual probability distribution is unknown, so the mean has to be estimated. Any bias in the estimation of the mean would alter the location of the number of the booked reserve on the actual, but unknown, probability distribution. In highly variable and skewed lines such as MPL insurance, there is a greater likelihood that the estimated mean will exceed the actual mean. For the sake of discussion, let’s assume that the actual mean would correspond to the 55th percentile, while the estimated mean would fall on the 60th percentile.

Now watch what happens. When these 60th percentile reserves are aggregated across all companies, the reserve level for the whole industry ends up at a much higher probability level—perhaps, the 85th percentile. This implies that industry reserves would be adequate 85 times out of 100, and would fall short only 15 times out of 100. This might seem excessively conservative, but in fact, it is not. It is simply a reflection of the asymmetrical nature of the unpaid-claim liabilities, combined with the diversification effect that occurs when the individual company estimates are added up.

The compounding effect is demonstrated in Figures 3 and 4. Figure 3 presents a typical claim-liability distribution of an MPL insurance company. As discussed, it is wide and highly skewed, reflecting a wide range of possible outcomes and the potential for extremely adverse results. The section outlined in red represents what might be considered a reasonable range of estimates to use as the liability reserve.

Figure 4 displays a hypothetical industry distribution of unpaid-claim liabilities. It reflects the aggregation of all the company distributions that look like those in Figure 3. A comparison of the figures shows that the industry-wide distribution becomes narrower and less skewed. If, for example, we assume that all of the companies establish their reserves at the 60th percentile level, and we then sum those reserves, the industry booked reserve ends up at a much higher probability level. Depending on the assumed correlation between companies, the aggregate of company reserves set at the 60th percentile might correspond to the 85th percentile on the industry-wide probability distribution.

It is important to note that the red bars in Figure 4 represent the sum of the reasonable range endpoints of the individual company reserves. They do not represent what might be considered a reasonable range for the industry when examined as a whole. For example, suppose we consider the 50th percentile to be the low end of the reasonable range for the individual companies. This is below the mean because of the skewed distributions. If all companies were to book the 50th percentile estimate, then the industry reserve level would be at a much lower percentile, perhaps the 40th percentile. This would produce an industry reserve that will more
likely develop adversely than favorably. With this knowledge, we might once again question whether the 50th percentile estimate is an appropriate reserve for an MPL writer.

**Two significant reserve risks**

An increase in claim frequency poses a significant risk to the adequacy of the claim reserves. As discussed, the recent industry buildup in claim reserves came about because of the prudently cautious acceptance of the decline in claims frequency.

Alternatively, an unanticipated rise in claim frequency can deteriorate claim reserve adequacy. While it is not likely that we will see claim frequency return to the levels seen at the beginning of this century, early evidence suggests that the low point may have already been reached.

Higher than expected inflation in claim costs, another substantial risk, prompted the reserve increases between 2000 and 2004 depicted in Figure 1. The combination of an increase in claim frequency and higher than expected claim-cost inflation can have a devastating impact on the unpaid-claim liabilities of a company.

**Conclusion**

While it may be more likely that MPL industry reserve levels will run off favorably than adversely, this statement cannot be used as evidence that the reserve level in the industry is unreasonably high or, more particularly, that any one company’s reserves are unreasonable.

The industry-wide number for reserves is in some respects an artificial notion. As noted before, reserves must be set at the company level, where estimates of the unpaid-claim liabilities are highly uncertain. The asymmetrical nature of the unpaid-claim-liability distribution quite naturally leads to a prudent approach in setting liability reserves by individual companies. When added together, these can compound into an industry-wide reserve redundancy—when in fact, the company-level reserves are not unreasonably high.

**References**

1. “Medical Professional Liability Outperforms, But Is This Sustainable?”, May 1, 2012, Best’s Special Report, A.M. Best Company, Inc.
3. Process risk: Uncertainty that arises from the random nature of insured loss events, assuming that the distribution of possible outcomes is known. Parameter risk: Uncertainty that arises from the selection of parameters within a modeled distribution, assuming that the form of the distribution is known. Model risk: The chance that the modeled distribution does not accurately describe the distribution of possible outcomes.
Don’t Miss the PIAA Fall Workshops!

September 12-14, 2012
Technology, Human Resources, and Finance Workshop
Caesars Palace
Las Vegas, Nevada

Sessions include:
- Keynote: The State of Social Marketing in the MPL Insurance Industry — A keynote presentation offering practical information on social media platforms. Do physicians and hospital staff use social media and will they listen to MPL insurance companies on these channels? Learn how to get started, apply and deploy social media wisely.
- Human Resources: The Future of Talent: A New Frontier for HR — The demographic makeup of our workforce is changing rapidly, and managing talent is more challenging than ever. Do we have the talent we need to compete and succeed in a competitive global marketplace? Will we have the talent that is necessary to thrive in the future? The speaker will lead a thought-provoking discussion on the changing nature of talent and the framework for managing it now and into the future.
- Information Technology: Current IT Defense Strategies — A look at all too real risks to IT security that threaten PIAA companies and their customers. Learn how malicious attacks are created, find out how to take the best steps to avoid becoming a victim and minimize exposure, loss, and liability. Strategies for lessening employee risk and strengthening security controls will be discussed.
- Finance: At the Crossroads—Opportunities for Insurance Companies in the Current Market Environment — How to minimize risk and maximize reward in the current business and investment environment. Given the inextricable link among insurance risk, capital market risk, and the resulting effect on asset allocation, the presenters will highlight the many ways that insurance products have influenced investment strategy over the past several years, providing insight on how current insurance and capital market trends could affect investment strategy in the future.

October 3-5, 2012
Underwriting Workshop
Four Seasons Hotel
Austin, Texas

Sessions include:
- Pain Medicine: Today’s Practice and Tomorrow’s Future — Several modalities are available today for the treatment of pain, including interventions, such as nerve blocks, and medications. Learn what is coming on line in treatment modalities, how a physician fine-tunes medication management to avoid addiction, and how to identify the red flags that signal drug-seeking behavior. This session will also consider the role of physician extenders in pain medicine, the risks and exposures inherent in the specialty of pain medicine, and what a physician can do to minimize them.
- Coverage Approaches for Hospital Physicians/Groups — Many PIAA companies have noted rapid changes in where today’s physicians practice. The changes run the gamut, from a handful of physicians moving to a five-bed hospital, to a large physician group joining a 500-bed hospital or a national hospital chain. What is the impact of these developments for MPL insurers? This session will also address the issues inherent in physician purchasing groups, hospital designated physician programs, and the newly emergent issues for hospital CEOs.
- Latest Trends in Bariatric Surgery — Bariatric surgery presents significant liability risk to MPL insurers, and it is important for underwriters to understand this specialty and the procedures commonly performed in order to appropriately evaluate the risks. The speaker will discuss the changes in bariatric surgery that have occurred over the past several years, describe the current status of the specialty, and provide some insights as to what the future may hold.

November 7-9, 2012
Claims/Risk Management Workshop
The Broadmoor
Colorado Springs, Colorado

Sessions include:
- Claims: Defending Cancer Claims — Cancer claims continue to represent a high percentage of the total reported claims. Will new medical research and treatment options begin to change this dynamic? This session will focus on cutting-edge treatments and studies in the field of oncology and lead to a discussion on how this will impact the defense of cancer claims. Join an in-depth review and discussion of this fascinating area of medicine.
- Risk Management: What an Oncologist Would Tell a Primary Care Physician about Cancer Screening and Cancer Diagnosis — Does cancer screening really save lives? How cost-effective are mammograms? Different organizations provide different recommendations for screening, so how do we deal with this divergence in guidance? Learn about the particular patient-specific and disease-related factors that can lead to a delay in the diagnosis of cancer and how a primary care physician can best avoid a delay in diagnosis.
- Claims: Effective Case Resolution Strategies — This interactive session is designed to give attendees an opportunity to hear about various case resolution strategies that have proven successful and to share the strategies that have worked for them. Come prepared to discuss your creative approaches to case resolution and enjoy a spirited discussion with your professional colleagues about this essential topic.
- Risk Management: Invoking Medical Students and Residents in Patient Safety and Medico-Legal Risk Management — Medical schools are increasingly recognizing the need to teach their students the science of patient safety and approaches to reducing medico-legal risk. This session provides an overview of the possible themes and teaching approaches to include in a risk management curriculum, and includes a look at programs for teaching students, residents and recently graduated physicians best approaches to medico-legal risk management and the provision of safer care.

To view the complete agendas for any of these workshops, or to register online, go to www.piaa.us.
since the late 1990s, a cycle generally familiar to the insurance industry has been playing out in the medical professional liability (MPL) market. During the late 1990s and early 2000s, insurers’ costs increased rapidly. By 2001, after a bit of a lag, insurers started increasing their pricing. Then, between approximately 2003 and 2007, claim frequency dropped significantly for a number of reasons—patient safety initiatives, tort reform, public sentiment, and others. Meanwhile, net earned premiums continued to rise, peaking in 2006 (Figure 1).

While this was occurring, insurers continued to increase rates, in an effort to correct prior rate inadequacies. As a result, reserves built up, allowing insurers to ease up on premium prices. This set in motion a wave of declining prices, in a fiercely competitive market that continues to this day. The results, in terms of policy writing and profits, have been phenomenal on a calendar-year basis.

However, the price war has escalated to the point where reserve releases have become the primary undergirding of profits. Today’s stellar financials are possible only because insurers are still reaping the benefits of the earlier high prices, at the cost of reserves, which have been steadily declining in the most recent years. As of 2010–2011, many analysts began to worry about how long the reliance on reserve releases could continue before the industry would have to increase premiums. On the surface, it might appear that the tide has not yet turned; data from 2011 still indicate a continuing positive financial performance on a calendar-year basis. However, one can see that prior-year reserve releases reduced the underwriting combined ratio by more than 20%, slightly less so than in 2010, but still a significant boon to results (Figure 2).

The bad news, then, is much the same as it was one year ago: on a policy-year basis, there is reason to believe that current pricing, geared to the competitive market but likely inadequate to sustain ongoing profits, will not work much longer. Figure 3 shows how underwriting combined ratios for the industry would look if prior policy-year reserve releases were backed out of the equation. An increase in this ratio in 2009 has remained through 2011, but it is not sustainable in today’s investment environment, unless it is buoyed by reserve releases.

While the loss experience is immature for this calculation, given the fiercely competitive pricing environment, it is likely that these results are more indicative of the actual current results and not of further reserve building that could be released in the future. In other words, the clock may be ticking as to how long reserve releases can buoy calendar-year financial results.

A few factors in the equation
Between 2003 and 2007, claim frequency within the MPL industry dropped by about one-half. We are already beginning to see signs of moderate frequency increases, and it is conceivable that a steeper upturn could suddenly take place, with claim losses increasing significantly in a short period of time. Past history shows a pattern of

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recurring market cycles; it is unlikely that the current holding pattern will persist indefinitely, and the next turn of the cycle will almost certainly be upward.

Meanwhile, since medical costs are a significant portion of total claim costs, the cost of individual claims has been rising in tandem with the steep inflation of healthcare costs. Combine this factor with a significant uptick in claim frequency, and the obvious result would be a strong adverse pressure on insurer financials.

Provider consolidation. A second piece of the puzzle is the trend, in recent years, whereby more and more physicians leave private practice and join large groups or take employment in hospitals. The ultimate effect of this trend on the MPL industry is not yet clear, but as physicians become hospital employees, they are more likely to join their hospital’s insurance program than to continue purchasing their own private MPL coverage. The same is true of providers who consolidate their small practices by forming accountable care organizations (ACOs) and other larger-scale provider institutions. That means a decrease in the number of policies physician insurers will be writing.
Declining premiums. Figure 1 shows a steady decline in net earned premiums from 2006 through 2011. The most obvious explanation of this decline is the ongoing softness of the market—premium price cuts amid stiff competition—but that may not be the only explanation. Other possibilities are that:

- Provider consolidation and the resulting loss of policies may already be exerting a significant effect on these overall statistics. As more physicians join hospital self-insurance programs or other alternative risk vehicles, their exposure and the related premium may not be included in statutory insurance financials.
- Increases in deductible or self-insured levels among MPL purchasers may also be decreasing the total premiums paid.

Whatever the actual configuration of factors, the trend toward decreased premiums is a warning signal about the sustainability of current price levels, especially in an environment of claims cost inflation.

Possible effect of healthcare reform

As far as MPL is concerned, little has changed since last year as a direct result of the Patient Protection and Affordable Care Act (PPACA) of 2010. The main impact of the reform legislation awaits its full implementation in 2014.

In a nutshell, if the reform is implemented as called for in the legislation, achieving the goal of a healthier nation could cause healthcare costs to ease somewhat over the long term, because more people will presumably receive regular care and preventive care, and fewer will be requiring higher-cost treatment. The medium-term effect, however, will almost certainly be an increase in the utilization of medical services and, compared with the current situation, a potentially higher proportion of less-healthy participants. This, in turn, could raise the number of MPL claims, putting pressure on loss ratios—just when industry financials may already be entering a difficult period within the market cycle.

Conclusions

Last year, we predicted that “the reserve releases may continue for only another three to four years, declining each year, if the current cycle unfolds similar to the previous one …” Financial performance results from 2011 have not changed our thinking about this.

Insurers need to pay close attention to both calendar- and policy-year results, and to reassess pricing carefully in tune with cost trends. There will be continued pressure to keep premiums low in a market that remains soft, but adequate pricing demands a consciousness that current policies may not be making money. If insurers continue to keep premiums low in order to get more business in the door, it is more than likely that, someday in the not-so-distant future, they will have to raise their prices hastily, and that could turn the market hard in a hurry.

Reference

Mary-Lou Nesbitt is Head of Governmental & External Relations, Medical Defence Union, London. She recently traveled to the PIAA offices as part of the Association’s professionals exchange program in which the staff of international member companies are welcomed to Washington, D.C., to meet with PIAA staff, learn about MPL insurance from the perspective of the PIAA, and exchange ideas about best practices. She spoke with Physician Insurer about some of the important differences—and some surprising similarities—between the MPL sector in the U.K. versus the U.S.

**PI:** Can you help me understand the kinds of assistance the MDU provides?

**Nesbitt:** We are a members’ organization, and we assist doctors with anything that can go wrong medico-legally. More than 100 years ago, liability wasn’t an issue. Doctors weren’t sued very often, because of their status in society.

When we started, we provided assistance on “a discretionary basis.” Because we’re a mutual organization, doctors who are members own the company—like many PIAA companies. Their subscription provided them with the right to seek assistance, with an expectation that their request will be considered but no right for it to be provided. This included advice about claims and indemnity assistance with claims, as well as criminal allegations and disciplinary matters, actually one of the most likely problems that will occur for a doctor in the U.K.

Then, there came a time when the medico-legal climate changed in the U.K. Claims were increasing in frequency and size and we thought members needed more certainty.

**PI:** So the MDU saw the need for an insurance product?

**Nesbitt:** Yes, we decided in 2000 that the way the medico-legal climate was developing, it wasn’t fair for doctors not to have a piece of paper—a guarantee—that there would be assistance. So we gave them an insurance policy, initially through Zurich and now underwritten by SCOR UK Company Limited and by International Insurance Company of Hannover Limited.

The insurance policy provides coverage limits of £10 million (individual) and £10 million (in the aggregate). If a doctor gets a claim that for a higher amount, he can ask for our assistance on a discretionary basis, i.e., claims made, and the discretionary wraparound is on an occurrence basis.

Our members comprise more than 50% of doctors in the U.K. in primary and secondary care, and more than 30% of dentists, overall.

**PI:** How do specialists obtain coverage?

**Nesbitt:** In the late 1980s, indemnity had become very expensive for obstetricians. There were quite a few large claims against them. Before then, MDU and the other

Just because you’re not personally mentioned on a claim, it doesn’t mean the claim doesn’t have any personal repercussions.
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Nesbitt: Not at all—although the indemnity is paid for, through the NHS, by the state, it is funded through the Clinical Negligence Scheme for Trusts, which is run by the Litigation Authority. And if you're a trust, and you're indemnified by the state, you pay them an annual sum. There are three levels of managing risk, each linked to a different level of payment. If you manage your risk to the required standard, and you can prove to them that you do, you pay less than other trusts that are not as successful.

So there is an incentive. There is also clinicians' personal sense of responsibility, and the ethical requirements of medicine.

Just because you're not personally mentioned on a claim, it doesn't mean the claim doesn't have any personal repercussions. Although you do feel it more keenly if you're named yourself, I'm sure.

PI: I read that the Bolam test is the defense that's used in many cases. True?

Nesbitt: Yes, the Bolam test means that you're not judged by an absolute standard, but by the standard of a responsible body of your peers.

PI: But then I read on the MDU website about the multiple guidelines in the U.K.—local, national, from the Royal Colleges, NHS screening programs. How does a court decide which one is germane?

Nesbitt: You don't have to follow all guidelines slavishly. What you must do—and ethically must do—is use your own judgment about your patient's best interests. In practice, the Bolam standard means you don't have to do what every clinician would do, nor do you have to do what the guidelines say. You have to be able to justify that what you've done is in your patient's interests.

According to the Bolam test, what you've done must be considered reasonable by a responsible group of your peers. There may be three or four different schools of thought, but as long as you can prove that there is a legitimate school of thought that would have done the same thing in the same circumstances, that would be considered acceptable by the court.

PI: Are juries involved in these cases?

Nesbitt: No, we don't have them. These cases are determined by a judge. But very, very few cases go to trial, because it's not something we want to do. It's very harrowing for our members.

It was one of the interesting differences that I discovered in talking with one of the U.S. mutual insurers I met earlier this week. They said that many of their members feel they don't really get value for money if they didn't get their day in court.

Generally, our members' view is that they don't want all the attendant publicity. But overall, our settlement rates are very similar to those of the PIAA insurers. Seventy percent of their cases are discontinued or go away, and 30% are settled. And that is about what we have.

PI: Then what is the impetus for tort reform there?

Nesbitt: The cost of the claims. It's the special damages that matter here—not the general damages, which are up to a point preordained—that involve the cost of future care. If there is a brain-damaged infant, with a long life expectancy, for example, you can see awards that number in the millions.

Or there may be a loss-of-earnings claim. If you have someone who is a high earner prove that he has a normal, or even longer, life expectancy,
that could be quite expensive, too.

I think there's quite an interesting element here. Because we're talking about what the state pays for. We have a very anachronistic law in the U.K., the Law Reform Act of 1948, issued when the NHS was founded. Essentially, when a defendant has to pay damages for future care, that care must be funded privately—defendants can't fund it to be provided privately. That care will be funded by the NHS when the defendant is sued in their own right. So they are understandably rather wary about a change. But in the current economic climate, you ask yourself, is this the right use of the state's money? This means that money from state funds (billions of pounds sterling) that could otherwise be used to care for NHS patients, will go out of the NHS and into the private sector. That can't be right. There are better ways of spending it—actually providing healthcare for a lot more people.

PI: Are there any limits—caps—on awards in the U.K.?

Nesbitt: No.

PI: Is there anything you've discovered about our system, during your visit, that you couldn't have known beforehand?

Nesbitt: I actually did expect things to be quite different, because your healthcare is delivered in a different way. But one thing I found quite interesting—and it's happening in the U.K. as well—is that claimants are now suing other healthcare professionals, not just doctors.

In the U.K., we provide indemnity to primary care teams through our general practitioner members if they have a group scheme. That policy provides vicarious liability for the nurses and others in the practice. Usually, it's the general practitioner who is sued. But what we're seeing now is that nurses are identified in claims and sued in their own right. So we are encouraging nurses to take out indemnity. I understand that this is happening here too. That was quite an interesting parallel.

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Nesbitt: We've been talking about it for some time, but there is a very strong lobby from claimants. You can understand them, because what they want to know is that they can get care, when they want it. They think they're better able to do that in the private sector.

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Nesbitt: I actually did expect things to be quite different, because your healthcare is delivered in a different way. But one thing I found quite interesting—and it's happening in the U.K. as well—is that claimants are now suing other healthcare professionals, not just doctors.

In the U.K., we provide indemnity to primary care teams through our general practitioner members if they have a group scheme. That policy provides vicarious liability for the nurses and others in the practice. Usually, it's the general practitioner who is sued. But what we're seeing now is that nurses are identified in claims and sued in their own right. So we are encouraging nurses to take out indemnity. I understand that this is happening here too. That was quite an interesting parallel.

Our members comprise more than 50% of doctors in the U.K. in primary and secondary care, and more than 30% of dentists, overall.

Nesbitt: We've been talking about it for some time, but there is a very strong lobby from claimants. You can understand them, because what they want to know is that they can get care, when they want it. They think they're better able to do that in the private sector.

So they are understandably rather wary about a change. But in the current economic climate, you ask yourself, is this the right use of the state's money? This means that money from state funds (billions of pounds sterling) that could otherwise be used to care for NHS patients, will go out of the NHS and into the private sector. That can't be right. There are better ways of spending it—actually providing healthcare for a lot more people.

PI: Are there any limits—caps—on awards in the U.K.?

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For 27 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.

Strength in numbers.
Your participation in the DSP permits greater statistical power—and better information for patient safety.
To learn more about participating in the DSP, please contact P. Divya Parikh, dparikh@piaa.us.
The capital of the U.S. provided an ideal backdrop for the 2012 Medical Liability Conference, presented by the Physician Insurers Association of America. This year’s conference once again reflected the Association’s focus and commitment to providing the information and expertise deemed vital for thriving in the ever-changing world of MPL insurance.

This year’s attendees corroborated the consensus of last year’s participants, who said that the conference provides the essentials—in areas such as finance, claims management, government and regulatory policy, innovations in legal procedure, and more—needed to stay up-to-date in every area of importance to the MPL industry participants.

Washington, D.C., itself provided a beautiful setting, in picture-perfect spring weather, for learning more about the PIAAPAC, finding out what’s happening on The Hill and in the various agencies, and as a source for presenters from federal government departments.

The conference was informative and substantial. Attendees left the meeting with a clearer perspective on the present and future of the MPL business, and with specific strategies for meeting the challenges of a healthcare system, and national economy, in the midst of unprecedented change.

For the 2013 Medical Liability Conference, in Palm Desert, California, the PIAA will continue to develop the content, to best meet the needs of its ever-expanding membership.
Keynote Session: Ian Morrison, PhD

Healthcare must make the transition from the “first curve” to the “second”—and it won’t be easy

Noted healthcare futurist Ian Morrison led off the conference presentations with a talk that was sweeping in scope and eye-opening in important new insights. His presentation, “Healthcare Reform: What Does It Mean for MPL and Medicine?” elucidated the multiple forces now converging to effect dramatic change in the U.S. healthcare system, such as the movement of physicians from private practice to employment by hospitals.

Like many industries in the past, U.S. healthcare, and more specifically its hospitals, will be compelled to reinvent their business model—to shift from a “first curve” (volume-based) to a “second curve” (value-based) economics. Morrison cited IBM as an example of a company that has proved nimble in shifting from the manufacture of adding machines to mainframes, and then PCs and the Internet, to a point where the company is now serving principally as a consulting firm.

Although the 1990s saw a similar movement toward physician employment in managed care entities, and that ended badly, we now have well-established metrics for quality and safety, as well as integrated information systems and payer-provider networks, which will lead to the development of new core competencies, such as the creation of accountable governance and leadership. In short, Morrison said, these recent changes are likely to endure.

Morrison took note of healthcare’s place within the broad U.S. economy. “The old economy is over,” he said, “and its meltdown has impacted healthcare.” Seven million people lost their jobs and their health coverage, and the credit crunch slowed capital investment by healthcare systems. Even those with coverage were likely to be in high-deductible plans, and the volume of health services provided has shrunk. At present, the system is out of alignment: the biggest hospitals are looking for further growth, across the continuum of care and with core offerings. But consumers say that they prefer these plans, and those with closed networks, because of lower cost.

Similar forces are impacting MPL. As physicians transition to hospital employment, more of these institutions will self-insure for MPL coverage; 72% of them do already. The standardization of healthcare via protocols, patient safety initiatives, and electronic health records will likely lead to fewer claims, Morrison predicts. Nevertheless, he said, economic and policy wonks don’t seem to see that tort reform is vital to containing the overall costs of the U.S. healthcare system, helping to make it affordable once again.

Is “accountable care” the wave of the future? Morrison thinks it is, but notes that a recent survey of healthcare executives found them evenly split as to whether they are “interested” (25%), “somewhat interested” (37%), or “not at all interested” (21%) in joining an ACO. But there will certainly be increased consolidation in some form, with integrated medical staffs dedicated to high performance, performance management across the continuum of care, integrated HIT solutions, and a business model sufficient to sustain it all.

Focus on a Session

“The Impact of Accountable Care Organizations on Healthcare and MPL”

Among the presenters at this session was Paul Greve, JD, RPLU, with the Willis Health Care Practice. Amid all of the rush toward transformation in healthcare, Greve sees some notable risks, including joint-venture partner risk (with the accompanying loss of control) and economic credentialing/network exclusion (with the potential for assertions of antitrust).

There will be continued growth in the ranks of allied health professionals and long-term care facilities, he said, but declines in the numbers of hospitals and physician groups. As the numbers of ACOs increase, the new entities will need to have agreements in place as to how MPL claims will be treated. Another requirement is a template agreement for hospitals and health systems, as well as for their professional liability carriers. There should be a carefully coordinate joint defense, with no finger pointing. The right to consent to settle should go to the economic buyer, Greve advises, and every member of the claims staff should understand who controls the claim.

Risk management measures for providers should include online courses, careful management of critical test results and telemedicine, and the application of claims data for quality.
improvement purposes.

Finally, Greve asked a fundamental question, “Is the sky falling?” He answered with a reassuring, “No.” After all, many of the uninsured patients are already in the system, via one venue or another. Also, many of the factors now in play will mean that claims will not be as attractive to the trial bar, as healthcare systems get larger and care becomes more standardized

In regard to the emerging area of telemedicine, Greve said that this could become a new area of business for PIAA companies—providing guidance on the management of telemedicine risks. In addition, these companies have a “goldmine of data,” of great value to healthcare systems, which can help them manage physician risk and quality. What’s needed, though, is a more collaborative mindset, viewing hospital executives as partners in a joint venture.

In another presentation in this session, Robert E. White, President, The Doctors Company – FPIC, noted that even as the new ACOs are beginning to take shape, there really is no one model for what they will eventually look like. But most or all of them will need services that PIAA companies can provide: coverage for MPL risk, general liability insurance, excess medical stop loss coverage, errors and omissions policies, and directors and officers coverage.

James W. Saxton, Esq., Chair, Healthcare Litigation Group, Stevens & Lee, told attendees that PIAA companies are uniquely positioned to help doctors take specific steps that can really make a difference, for example, helping them understand the new use of data, and how to protect it under peer review. They can introduce tools for physicians that will help them in navigating their new environment, with its new metrics.

Chad C. Karls, Principal and Consulting Actuary, Milliman, explained that an ACO is just like managed care—except that it’s not, because the world has changed. Now, we have market changes such as the increased demand for healthcare in a shrinking supply, and technological innovations like EMRs and patient screening protocols. Karls provided systematic instructions for rating an ACO’s exposures. Insurers will need to assess elements such as degree of provider integration, organizational structure, the risk-sharing arrangement, the quality-of-care metrics, the mix of patient population, plus basics such as location, financial strength, and quality of management.

Focus on a session

“Financial Strategies for MPL Carriers: One Size Does Not Fit All”

Joel E. Strauch, CPA, Senior Vice President, PIMCO, provided a detailed picture of the current economy, and of the optimal role of fixed-income assets for the current market. Overall, he said, PIMCO envisions a 1% to 2% global growth rate, as deleveraging continues to happen in Europe, although it has subsided in the U.S. Inflationary pressures will continue to build, and policy deadlocks will postpone needed structural reforms. Three major forces, Strauch cautioned, will persist, hindering expansion of the economy: indebtedness, wealth destruction (diminishing household net worth), and mortgage credit availability. Businesses, too, are being challenged: configured for pre-recession higher sales, they will have to downsize to survive in the new economy.

But Strauch notes some favorable indicators as well. Private-sector leveraging has advanced, and inventories are
growing slowly relative to output. This may boost production, income, and spending. Also, household payment obligations are at their lowest point since 1994.

A new economic climate, Strauch believes, should dictate a new investment strategy for PIAA companies. Investing based on “mean reversion” is less compelling; investing based on benchmarks and correlation assumptions will be challenged; and tail hedging will be potentially more important. He also provided an “appendix” to his presentation, detailing how a company would invest with PIMCO in this “new normal” economy.

But there was also a bit of contrarian thinking. To James E. Bachman, PhD, Vice President, General Re-New England Asset Management, Inc., the “one size fits all” premise might just be perfectly acceptable. MPL companies in the U.S. tend to show remarkably similar investment policies and patterns. They all have to deal with the same sorts of tradeoffs in formulating their investment policy. One thing is certain: Given sufficient time, rates will rise. But that may not come until 2014. MPL companies will need to make certain tradeoffs in determining investment policy going forward: shortening duration sacrifices current income but reduces the temporal loss of value. While rising rates drive increased income, there is a concomitant depreciation of value. Stress tests, Bachman said, indicate that MPL companies have ample liquidity, to avoid forced sale of investments.

Doug Clark, Chief Portfolio Strategist, Prime Advisors, Inc., provided an in-depth analysis of the role of duration in selecting and retaining portfolio assets. There are some common themes of investors regarding duration. These include market fears (volatility, market aversion), rising interest rates (concerns about inflation, and questions about the sustainability of the market), and operational concerns (a desire to hold cash, or a change in the business). He noted that PIAA companies that rely on yield will, in any event, face a dilemma, since it is unlikely that the yield of the prior three years can be repeated, and underwriting results are not likely to be as good as they were in the past.

Focus on a session
“Finding Success in the New Healthcare Marketplace”

Larry L. Smith, JD, Vice President, Corporate Risk Management, MedStar Health, pointed out the limitations of the current healthcare system—and the drivers that will shortly bring about its complete transformation. Notable for MPL carriers among the recent trends is the wholesale employment of physicians by healthcare systems. In 2009, 57% of physician practices were owned by healthcare systems; that number is projected to rise to 77% by 2013.

Echoing a theme of other presenters, he told attendees about some new services that MPL companies can provide, in light of the evolving market. Healthcare systems will need tail coverage for the physicians they are hiring, he said. There will also be greater exposure in their insurance captives given the new risks they take on in swelling the ranks of salaried doctors. Captives will need to pay more attention to the task of underwriting.

There may well be something of a culture shock for newly hired physicians. They may find their new hospital-provided coverage deficient—or at least very different—from the insur...
Physicians are likely to be concerned about the insurer’s propensity to fight a claim versus settling, and on what is reported to the National Practitioner Data Bank. The health system, on the other hand, is more concerned about its bottom-line results, and its own reputation.

PIAA companies also house data on claims for the physician market that can serve as a rich store of expertise for healthcare systems. They can also help these systems address new actuarial puzzles. For example, is a new-hire doctor really an additional exposure?

Tim Kenesey, President and CEO, Medical Protective, and Chairman, Princeton Insurance, spoke on the tendency in the U.S., for several decades, to deliver healthcare in a siloed fashion. Companies that sold MPL coverage usually focused on a particular silo—state-based MPL companies for physicians and surgeons, multi-line commercial insurers for healthcare systems. Most of the PIAA companies have concentrated on one, or just a few, states, and sold one, or just a few, products.

But the siloed approach to care is breaking down, as physicians become employees, and providers across the continuum of care begin to join hospitals. Kenesey pointed out that, in light of these developments, the siloed marketing of MPL companies will not be able to be effective, in two to three years. Right now, they are buoyed by a “huge tailwind” comprised of low frequency and severity, healthy balance sheets, and excess surplus. This rosy view may continue—or the industry may in due time be penalized for its “self-inflicted roller coasters” from aggressive pricing and not fully appreciating new risks.

William Munier, MD, Director, Center for Quality Improvement & Patient Safety, Agency for Healthcare Research and Quality, pointed to a new focus for MPL reform in the federal government. In prior years, reform advocates focused principally on caps. Now, the main thrust of the Agency’s program is on medical liability and patient safety. AHRQ’s Partnership for Patients campaign has as it goals a 40% decrease in hospital-acquired conditions and a 20% drop in hospital readmissions. By advancing patient safety, fostering better communication with patients, and finding ways to ensure that patients are compensated for medical injuries in a fair and timely manner, AHRQ believes that liability premiums can be reduced.
Make your plans now to attend next year’s Medical Liability Conference, at the JW Marriott Desert Springs, in Palm Desert, California.

The Peter Sweetland Award
Edward J. Amsler Receives the 2012 Peter Sweetland Award of Excellence

Edward J. Amsler was named as the 2012 Peter Sweetland Award of Excellence recipient at the Medical Liability Conference for his significant contributions and dedication to the MPL insurance industry and the PIAA.

Amsler, an insurance executive and attorney, has spent more than 40 years representing the interests of physicians, hospitals, and other healthcare providers. He has served as Vice President of Medical Liability Mutual Insurance Company (MLMIC) for more than 25 years, joining the company in 1984. He also serves as the President of Donald J. Fager & Associates, MLMIC’s administrative services provider, a position he has held since 2004, and is a partner in the law firm of Fager and Amsler, LLP.

Active for many years in the MPL insurance community, his list of appointments is extensive. His service to the PIAA includes serving as both a member and chair of the Board of Directors and on the Association’s Audit Committee, Membership and Bylaws Committee, Nominating Committee, and International Section.

He has been an outspoken advocate on behalf of the medical profession, as well as an active supporter of tort reform, initially as a litigator, and more recently before insurance regulators and state and federal legislators. He is a member of the Board of the New Yorkers for Civil Justice Reform, and Medical Defense Lawyers Association.

“We are honored to present Ed with this award,” said PIAA President Brian K. Atchinson. “His hard work and dedication to the MPL insurance industry, as well as to the healthcare providers they insure and their patients. Gingrey, an ob-gyn, has long been a champion of federal tort reform, serving as lead sponsor of H.R. 5, Help Efficient, Affordable, Low-cost, Timely Healthcare Act, since 2005, as well as the Provider Shield Act, meant to prevent new medical guidelines in the wake of the Affordable Care Act. PIAA Chair Theodore J. Clarke, MD (left above) and immediate past PIAA Chair, James L. Weidner (right above), presented Congressman Gingrey with the award at a brief ceremony in the U.S. Capitol.

Gingrey Receives First Annual PIAA Legislative Leadership Award

Congressman Phil Gingrey (R-GA) was presented with the first annual PIAA Legislative Leadership Award at the 2012 Medical Liability Conference. The award honors a U.S. Senator or Member of Congress who exemplifies outstanding service to the Association and the industry are inspiring and we thank him for his many years of service.”

The Peter Sweetland Award of Excellence, established in 1993 by the Association’s Board of Directors, was created in honor of Peter Sweetland, one of the PIAA’s chief architects and ardent supporters. The Peter Sweetland Award of Excellence recognizes an individual who has provided great service to the industry and to the PIAA, and epitomizes the high ideals and ethics that Peter Sweetland stood for.

2013 PIAA Medical Liability Conference • May 15–17, 2013 • Palm Desert, California

Make your plans now to attend next year’s Medical Liability Conference, at the JW Marriott Desert Springs, in Palm Desert, California.
Everyone Benefits by Sharing Information

By Eric R. Anderson

Trade associations serve as great stores of knowledge. Take the PIAA as an example. The membership of the Association boasts some of the most experienced and nimble minds that the medical professional liability (MPL) industry has to offer. Yet, despite this collective brain trust, we may also not always be aware of exactly what we do know.

Consider: You’re an underwriting professional, and you work for an MPL insurer. A policyholder calls you, asking for information about new areas of exposure for physicians as a result of the passage of the Affordable Care Act (ACA). You know that the PIAA and your fellow members have plenty of expert information about the ACA. But where is it? How do you find it? Who do you call?

The situation is complicated by the fact that knowledge about the ACA resides in many forms. Some experts at PIAA have been following ACA developments since the original bill was introduced. A best-practices paper was written to document one expert’s opinions. Several academicians have written journal articles about the impact of the ACA on the delivery of healthcare. But how can you be sure, even if you do find one or two sources of expertise, that you’ve done more than just scratch the surface of what’s actually out there?

That’s the kind of problem that hundreds of companies confront—many times, every day—and it’s a primary reason why the PIAA created a proprietary knowledge sharing vehicle called the Idea and Information Exchange. This new online tool, available exclusively to members through the PIAA website, will help all of the member companies take advantage of an invaluable asset—the collective expertise of these companies.

This sort of “knowledge management” may sound like just another trendy business idea. But in fact, this concept has been used recently, with great success, by a broad diversity of organizations, in both public and private sectors.

The PIAA Idea and Information Exchange is something like a library: it provides a repository for written documents on a given subject. But it also provides a platform for disseminating, to the entire PIAA community, the knowledge that is stored inside people’s heads—through real-time discussion forums. Quite possibly, this type of knowledge is the most valuable of all. It is discussed within a particular context; it is frequently in-depth and up-to-the-minute, and therefore more valuable for decision-making.

If all of this seems a bit abstract, you can experience it first-hand by visiting https://connect.piaa.us. The welcome page describes the groups you can take part in. These reflect the diversity of interests of MPL professionals.

The Idea and Information Exchange gives everyone in the PIAA community another vehicle for building a culture that is truly collaborative, innovative, and knowledge-sharing. But it won’t be successful without your support. Promoting this new Exchange among your peers, and adding your voice to the discussion groups, will be critical to the successful maturation of the knowledge network.

Don’t forget that your contributions will help in transforming the PIAA, and your company, into organizations that are fully prepared to compete successfully in the 21st century.

Note: Workshop attendance is restricted to Board members and employees of PIAA member companies and their subsidiaries.

For more information, call the PIAA Meetings Department at 301.947.3000. You can also visit our website at www.piaa.us.
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October 2–3, 2012
Four Seasons Hotel
Austin, Texas

Your staffers will learn the essentials—what every team member needs to know—about the medical professional liability enterprise. The presentations will cover the diverse departments, and types of work, that make up a successful MPL company.

Introduction to MPLI is designed for:
- PIAA company employees in the first years of their insurance careers
- Longer-term professionals who have not yet worked with the full range of insurance processes
- Physicians or other directors new to the insurer governance processes
- PIAA affiliate member employees who want to learn more about the companies they service

Program topics include:
- Claims administration
- Underwriting
- Risk management and patient safety
- Rate-making and reserves
- Understanding reinsurance

To see the complete agenda, or to download a registration form, visit our website at www.piaa.us.

Register before August 31, 2012 to qualify for the discounted rate!