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While I was driving on the Clara Barton Parkway alongside the Potomac River the other day, headed to a meeting in downtown Washington, D.C., I was reminded of the pivotal role that nurses and other non-physician caregivers play in our evolving healthcare system. Clara Barton, I’m sure you’ll recall, founded the Red Cross. She was a true pioneer in the field of nursing.

Ever since Clara Barton’s day, nurses and other allied health professionals have remained central to the health of our patients and healthcare delivery system. Traditionally, they have served as coordinators of care, on hospital floors and in physicians’ offices. With dramatic changes in the marketplace and the advent of the Patient Protection and Affordable Care Act (ACA), patients in the U.S. healthcare system will probably be relying on them even more in the future. New strategies aimed at improving patient handoffs also depend largely on nurses for such processes as ensuring follow-up visits with primary care physicians after a hospital stay.

And now, individuals with a degree in nursing can choose from a wide range of options, such as nurse practitioner, nurse anesthetist, critical care nurse, nurse midwife, and physician assistant. Similar trends are notable in the international community. In the U.K., for example, there are nurse-led services that provide 24-hour health advice by telephone, and walk-in centers, which treat minor illness and injury.

The ACA will deliver millions of new people into our already taxed healthcare delivery system. How will it absorb these new patients? Moreover, what does this influx of patients mean for the medical professional liability (MPL) insurance industry? MPL thought leaders—professionals from PIAA member companies—will be challenged in finding smart new ways to deal with the emerging areas of liability that arise from the newly reconfigured healthcare delivery system.

Two articles in this quarter’s issue of Physician Insurer magazine address these kinds of issues. Jeff Dougherty, in his article, “Good Nurse, Poor Deponent,” sheds light on the perplexing fact that the personal and professional qualities that make people good nurses can sometimes make them poor deponents, thereby transforming one of healthcare’s most valued assets into one of its biggest (potential) legal liabilities. As nurses begin to play a more prominent role in healthcare, understanding how this dynamic works may prove critical to avoiding losses in the courtroom.

In two other articles, Mike Hollenbach and Bob Allen discuss the ramifications of the ACA for MPL carriers from two vantage points—one, a high-level perspective that examines a host of variables that may be material for MPL insurers, and the other, a consideration of the underwriting implications that will likely result from the latest round of merger and acquisition activity between physicians and hospitals.

These articles address only a few of the new realities in our healthcare system post-ACA. There are, of course, many other challenges. Everything from reimbursement policies for healthcare providers and institutions, to finding ways to reign in burgeoning costs while advancing patient safety, to pressing for federal MPL reform that will establish a fairer and more efficient medical liability system, will need to be examined.

The trends rolling forward in the healthcare system and marketplace seem predicated on forces that include the ACA, but are not completely dependent on it. We will see more hospitalists and an expanded role for non-physician health professionals. It is likely that the emerging healthcare liability landscape will create or reveal new unanticipated liabilities. We at the PIAA are already hard at work, studying federal and state issues, developing educational sessions for workshops and meetings, devising a new slate of webinars—and listening carefully to you, doing everything we can to help you succeed in these changing times.
One of the biggest gifts a deponent can give plaintiff’s counsel is an answer that goes beyond the question—an all too common occurrence—or a response to a question that hasn’t actually been asked. Quite often, nurses are vulnerable in this regard. —Cover story

Cover story: Good Nurse, Poor Deponent: How to Fix This Problem
By Jeffrey Dougherty

Professional Guidelines and Performance Measures: Do They Constitute the Standard of Care?
By Ruth Ryan

Definitive Ruling, Uncertain Consequences
By Michael Hollenbach

An Uncertain Diagnosis: Growth Opportunities from the ACA?
By Bob Allen
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In an encouraging attempt to rouse Madison County from its near-annual spot on the top-ten list of “Judicial Hellholes,” a grassroots group has been working to unseat four county judges up for “retention.” The group, which calls itself Citizens for Judicial Integrity (CFJI), is bound and determined to oust Chief Judge Ann Callis and Judges Barbara Crowder, Dave Hylla, and John Knight. Each was compelled to stand for what is known in Illinois as a “retention” vote on Election Day, and thus needed to win at least 60% of the votes cast to retain their respective seats on the bench. CFJI chairman Phillip Chapman had said that Madison County would clearly be better off without them. Dubbed a “Judicial Hellhole” once again in 2011, Madison County, Chapman contends, has a court environment that drives away doctors, as well as businesses.

“Callis, Crowder, Hylla, and Knight were elected in 2006 promising reform,” Chapman explained in a news release. “Among the factors leading to Madison County’s poor reputation [as a Judicial Hellhole] is the number of asbestos lawsuits and the contributions made by plaintiffs’ lawyers specializing in asbestos litigation to the judges’ elections campaigns. “Interestingly,” Chapman continued, “the number of asbestos cases went from 325 in 2006 to 953 in 2011! This is an increase of 265%!”

On a flier distributed by volunteers throughout Madison County, the CFJI urged a “No” vote for the four judges seeking retention. Claiming the county’s lawsuit-embracing environment helps “drive away businesses, doctors [and] jobs,” it argued that when the region’s plaintiffs “lawyers prosper, [the] economy suffers.”

The same source (the Madison/St. Clair Record) also reported on the outcome of a local MPL claim. An Edwardsville, Wisconsin, woman claimed that doctors failed to properly monitor her recently deceased husband while performing a knee replacement surgery on him. His wife, Darlene Kombrink, claimed that the staff at defendant Anderson Hospital negligently failed to properly install a machine intended to monitor the neurological status of her husband during the operation, the suit states. Because of the staff’s actions at the hospital, the suit alleged, Melvin Kombrink incurred medical costs, suffered disfigurement and disability, and lost his normal life, the complaint says. Now, here comes the surprise—amount of non-economic damages sought by the plaintiff—$50,000. It would seem that plaintiffs of Madison County are, at least for now, satisfied with impressively modest sums.

Source: Madison/St. Clair Record, October 1, 2012

The ACA Wars, on a New Front
New questions about health exchange expenditures on public relations

On September 29, Senator Chuck Grassley (R-IA) and Representative Fred Upton (R-MI) sent a joint letter to HHS Secretary Kathleen Sebelius, objecting to the use of government funds to promote California’s Health Benefit Exchange through entertainment media. Specifically, Ogilvy Public Relations Worldwide had won a $900,000 contract to promote California’s exchange. It’s anticipated that roughly 4.4 million Californians will be using the exchange by the end of 2016, with registration opening for the first time in October 2013.

Here’s a sample of what Ogilvy had to offer: ‘A number of popular television programs and personalities such as ‘Grey’s Anatomy,’ ‘Modern Family,’ ‘The Biggest Loser,’ ‘Dr. Oz,’ and others will be approached and pitched to incorporate story lines or mentions of healthcare reform that would reinforce campaign messages.’

And then it gets better: “In addition, we would explore approaching select reality television producers to create a new reality television program revealing the trials and tribulations of families living without medical coverage.” There’s no explicit angle on patient safety, or MPL claims and lawsuits, as of yet, but if the trial bar is watching (as they surely will), that can’t be far behind.

Source: California Healthline, October 1, 2012
Of course, we all see those somehow ominous television ads from lawyers casting about for a net of new medical malpractice clients. But consider this. In any sector where there are scads of money in play, the attorneys involved are highly exposed to lawsuits that claim dereliction of duty. And thus it comes as no surprise: a new survey by the American Bar Association finds that real estate lawyers are getting hit with malpractice suits at a rate greater than lawyers in any other practice area.

This is a first for the real estate lawyers, their debut in the number-one position in the ABA’s latest analysis, for the years 2008–2011, with a compilation of 53,000 claims.

Personal injury lawyers (MPL is one subcategory here) who lead the pack.

“No there are a lot of projects out there where either the tenants went out of business or the appraised values of the centers dropped precipitously,” said Bill Phillips, who represents shopping center developers and is co-chairman of the real estate group at Taft, Stettinius & Hollister in Cleveland, attempting to explain the increase in lawsuits. The specific law-firm activity most likely to generate malpractice claims was “preparation, filing, and transmission of documents.” In the number-two slot was “advice.”

Some 10,772 malpractice claims were filed against real estate lawyers in the bar association’s study, which covers the years 2008–2011. That’s an impressive 2,512 more than second-place personal-injury practice racked up. Family law practice came in third in this and the prior four-year study.

The report cautions against broad conclusions, given the relativity inherent in any ranking like this: “We must question whether Real Estate’s first-place finish is actually due solely to an increase in real estate-related claims, or can be attributed to a decline in alleged malpractice by personal injury practitioners.”

Source: Bloomberg BNA, September 12, 2012.

Real Estate Malpractice Claims Now Top ABA’s List
Think Excellence, Not Difference

The Four Levels of LinkedIn

Networking is much more than collecting as many business cards as you can. I define networking as “building and strengthening relationships with no predetermined end in mind, which becomes a win-win for both people.” No one person, by herself, is as smart as all of us, combined, which is why it is essential to network—whether you’re trying to promote your business or establish key connections.

I often share my philosophy about networking at speaking engagements: “The only thing you own in life is your reputation and your relationships … everything else is transitory.” You exercise sole control over your presence and how that defines your relationships—whether with family, friends, or co-workers. The same thing holds for personal branding online. LinkedIn serves as your 24/7 online resume, and you never know who’s going to come knocking on your door. So you need to monitor your online presence, and learn how to utilize LinkedIn to grow your networks. Unlike platforms such as Facebook and Twitter, LinkedIn provides a more formal opportunity to display your professionalism.

Although face-to-face networking trumps all other kinds of connections, and will never be replaced, LinkedIn is currently the primary tool for building professional and personal brands online. There are four levels of activation that need to be mastered to form purposeful relationships in the LinkedIn environment: “Rolodex,” endorsed referrals, personal brand building, and engagement.

Rolodex

Rolodexes were common before the twenty-first century. For those who may not remember, they were small, rotating filing devices that people used to store their contact information. Then technology advanced, and Rolodexes began to fade away. Now, computerized databases allow easy updates to your contacts and resources. With LinkedIn, rather than having to worry about updating a Rolodex or database, a person of interest changes his or her own information, then it filters through the online networks. People keep track of themselves, and you keep track of them at your convenience.

On this surface level, LinkedIn serves as a comprehensive database of your professional connections. Your connections can find new information about you, and vice versa. It is essential to keep your online profile updated, because you never know when you might cross paths with a potential business partner.

Take action:

When building your list of connections, don’t use the automatic message generated by LinkedIn that says, “I’d like to add you to my professional network on LinkedIn.” Instead, personalize your request. After you’re connected, send a brief message as a thank you. Here’s an example: “I am glad we are linked up! See you soon.”

Endorsed referrals

Referrals are a great way to establish credibility on LinkedIn, but they are frequently misused or overused. It’s similar to contacting references in the hiring process: you want endorsements only from people who have worked with you and can attest to your skills. Be strategic and selective about the individuals you
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ask to give you an endorsement, and also
about the people you write a reference for.
This will translate to a profile that seems
genuine and honest. It’s not who you
know. It’s who knows you.

Take action: Tell the professional
who you’ve asked for a recommendation
to highlight your X, Y, and Z traits. It will
serve as a guide for your referee; they will
appreciate it, and you’ll be more likely to
get your desired result.

Personal brand building
Your LinkedIn profile is always up and
running. You never know when a future
prospect might be looking at your profile,
so it is important to be a dedicated user.

Establish your prominence within the
industry by posting articles relevant to
your field of work. Always add some com-
ments showing your own knowledge and
insights about the articles you post. It’s also
important to show something of your per-
sonality and use your own voice in your
verbal expressions. You’ll become a trusted
resource to your connections, and demon-
strate that you’re a thought leader.

Original content is always the best
when it comes to establishing credibility.
If you don’t have that kind of time avail-
able, then you can easily post a relevant
article and sprinkle your perspective in
an introductory note. This is a manage-
able way to get your point across, in just a
minimum of time.

Take action: Stay current (and
dependable) by posting at least twice a
week. It doesn’t have to be original, just
insightful. Still, you should aim for origi-
inal content at least once per month.

Engagement
Now that you’ve moved beyond the basic
level of LinkedIn, it’s time to consider the
highest level: dialogue. Don’t forget that
social networking is a two-way street—it
is essential to engage with your connec-
tions on LinkedIn.

Perhaps you’ve joined groups that
are in some way related to organizations
you’ve been involved in. That’s a good
start, but you should also take five min-
utes to filter through the message board
and leave a comment or two. Start conver-
sations, and make your connections
worthwhile.

Take action: You will notice the
more you share your opinions with other
people about their posts, the more feed-
back you’ll receive on your own posts.

Everyone has a digital presence, even
people who don’t participate in social
media. We need to take good care of our
reputation online and provide the nurtur-
ing it warrants, by regularly engaging and
influencing our connections there and
beyond. Your LinkedIn profile is a mirror
of your character in person. Both need to
be proactively managed, so you make a
favorable impression with your profes-
sional persona.

Try this experiment: Google your
first and last names. You’ll find that
your LinkedIn profile is one of the
first that pops
up. Is this how
you want to
be seen?

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organizations across the world have lever-
aged the concept of checklists to help
make healthcare safer. A visit to the web-
sites of the Society of Thoracic Surgeons,2
the Association of periOperative
Registered Nurses,3 or the World Health
Organization (WHO)4 illustrates just how
far checklists have come. Figure 1 displays
the surgical checklist developed by the
WHO and the World Alliance for Patient
Safety. The one-page checklist comes
with a 28-page implementation manual
that breaks down surgical operations
into three phases: sign in, time out,
and sign out.

The use of checklists by hospitals
and physicians has gained widespread
application since 2002. Dr. Atul Gawande,
a leader in promoting checklists, is the
author of the 2009 book
The Checklist
Manifesto: How to Get Things Right
5 and
the December 7, 2007,
New Y orker
article
"The Checklist."6 Intensive care units
(ICUs), Gawande said, insert 5 million
lines into patients each year, and national
statistics showed that, after ten days, 4%
related what had
been achieved by
using a simple
decision-rule
method, at
Chicago’s Cook
County Hospital,
to improve triage
of patients who
came to the emer-
gency room with
a possible heart
attack. The
method, present-
ed in JAMA as a
one-page flow chart, combined three bits of
information—heart failure, low blood
pressure, and chest pain—to classify each
patient’s risk as one of four categories:
high, moderate, low, or very low. The
results indicated that using a clinical-deci-
sion rule had a favorable impact on triage
decisions, improving efficiency without
compromising the safety of patients.

Since that groundbreaking article,
physicians, hospitals, and patient safety
of those lines became infected. Through
a simple example, he describes how a
simple five-step checklist implemented
by Johns Hopkins Hospital was used to
reduce central line infections. The
demonstrated success of this program,
and the impact it has had all across the
country (e.g., infection rates dropping
by 6% at Michigan’s ICUs), illustrates
the power of checklists in improving
patient safety.

As an actuary, I’ve been excited to see the
inventiveness and diversity of risk manage-
ment programs and environmental, health,
and safety initiatives on behalf of patient
safety. These programs have succeeded,
impressively. In the last article in this
series, I describe the surprising results, and
widespread applications, of checklists—a
strategy borrowed from the aviation indus-
try—for improving the safety of surgery
and other complex medical procedures.

In July 2002, JAMA published a report,
“Impact of a Clinical Decision Rule on
Hospital Triage of Patients with
Suspected Acute Cardiac Ischemia in
the Emergency Department.”7 The report
Kevin M. Bingham, ACAS, MAAA, is a
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Conclusion
The above examples barely scratch the surface in the full story of the evolution we’ve seen in patient safety over the past decade. But even this brief discussion is enough to suggest strongly that the actuarial profession’s compilation of claims data is becoming ever more meager because of the combined efforts of hospitals, medical associations, MPL carriers, physicians, nurses, and patient safety organizations.

In a perfect world, actuaries focused solely on the analysis of MPL claims would no longer be needed: every healthcare error would be prevented. However, until that day comes, working with ever smaller data sets is a step in the right direction. Because, when all is said and done, less data for us means safer patient outcomes for everyone.

Figure 1 Surgical Safety Checklist

Some Closing Remarks, on the Future of Patient Safety Initiatives—A Question for the Author

Dana Murphy, Editor, Physician Insurer:
Kevin, what are your final thoughts on the future of patient safety initiatives?

Kevin Bingham: Dana, as my four-part series highlights, we’ve made tremendous progress in advancing patient safety. That being said, I believe that the patient safety journey is more like a marathon, with an occasional sprint now and then, when we’re lucky enough to identify a new opportunity for strategic risk reduction.

For all of the programs I discussed in my series, I see a bright future. Many will expand across the country. Some will evolve further, as innovative physicians, hospitals, and risk managers add new refinement to them. And some efforts will inspire patients themselves, as well as their healthcare providers, to look at procedures and treatments in new ways, which will, together, lead to the next wave of success stories in patient safety.

I also believe there are many future stories about patient safety that have yet to be told. I am particularly excited about the increasing use of advanced analytics to solve healthcare problems. With the implementation of electronic medical records, the collation of patient complaint information, advancements in the tracking and capture of root cause analyses, and the routine collection of survey results on patient satisfaction, the amount of data available for predicting outcomes is expanding daily. I truly believe we can leverage
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Patrick.Tuohy@primeadvisors.com
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analytics to shift our focus from looking out the rearview mirror (i.e., after the events) to looking out through the windshield of the “patient safety car” (i.e., before the events have a chance to happen).

Atul Gawande’s recent New Yorker article, “Big Med,” related a number of stories about how the healthcare industry can leverage lessons that have been learned in other industries. From Brigham and Women’s Hospital effort to standardize joint-replacement surgery, to Steward Health Care System’s use of an ICU command center to monitor and treat patients, efficiencies gained by leveraging economies of scale are helping hospitals to improve the consistency and safety of healthcare. This might well be the next “best seller” in the field of patient safety.

Now, toss in the benefits of some other emerging trends:

- Leveraging social media
- A more informed healthcare consumer
- Price transparency
- The growing influence of patient safety organizations
- Medical professional liability insurance company loss prevention and loss mitigation efforts
- Healthcare reform shifting the focus of primary care physicians, multi-specialty groups, and hospitals from paying for numbers of procedures to paying for healthier outcomes.

With all that in play, I believe that Parts Five through Eight of my series will write themselves.

Some Closing Remarks

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Legislation limiting the amount of damages in personal injury cases, and whether it survives constitutional muster, has long been the subject of debate on the floor of state legislatures and in courtrooms across the nation. Many states have enacted such limiting statutes, or “caps,” in the context of personal injury litigation involving alleged medical negligence or malpractice.

Proponents of caps in medical professional liability (MPL) awards argue that they inject predictability into the underwriting process and prevent the “runaway” award, resulting in lower premiums for MPL insurance. The ultimate benefit of the cap is availability of affordable insurance coverage for practitioners and facilities and, in turn, availability of and accessibility to insured medical care for the nation’s populace. Opponents generally object to the constitutionality of cap laws—specifically, as to the state’s alleged inability to establish a rational basis or link between the laws’ intended purpose and their effect that would be sufficient to overcome an alleged discriminatory effect on those injured victims for whom redress of their injuries results in a verdict award exceeding the subject limitation. Notwithstanding the jury’s assessment and award of damages, the award is reduced by operation of law to comply with the state’s cap. In the case of seriously injured victims, this “by-law reduction” of the damages effectively overturns the fact finder’s damages determination and has the potential to significantly reduce the plaintiff’s recovery.

Consequently, cap laws are repeatedly challenged by victim’s rights advocacy groups and trial lawyers.

**Louisiana’s cap is constitutional**

Louisiana’s MPL damages cap is found at La. R.S. 40:1299.42. Louisiana’s cap was adopted in 1975 and remains relatively unchanged since its inception. Unlike many other states, Louisiana’s cap is a “total damages cap,” meaning that the total amount recoverable for injury to or death of any one patient is $500,000, exclusive of future medical care and related benefits, plus judicial interest. Louisiana’s cap is a tiered payment system, with the first tier being that each responsible individual healthcare provider is liable for payment of $100,000 plus judicial interest. The second payment tier finds the Louisiana Patient’s Compensation Fund being responsible for any additional remaining sums up to the $500,000 limitation of liability plus judicial interest maximum allowed recovery. The Louisiana Patient’s Compensation Fund is also responsible to reimburse the plaintiff for necessary expenditures on future medical care and related benefits, assuming that the trier of fact, judge or jury, expressly finds that the plaintiff is in need of such future care.

Like most caps, Louisiana’s was enacted in response to an MPL insurance
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crisis occurring in the state. The rising cost of MPL insurance was said to be driving practitioners either out of practice in Louisiana entirely, out of the more risky practice specialties, or into a practice setting devoid of professional liability insurance coverage. The perceived ramifications of such a result—a shortage of available healthcare for Louisiana citizens or uninsured practitioners, should a claim arise—garnered the attention of the state legislature. In response, La. R.S. 40:1299.42 was passed and ultimately signed into law, limiting the total exposure for MPL awards. This in turn brought predictability to the insurance underwriting equation, and made it possible for MPL companies to continue writing affordable coverage. Since its inception, Louisiana’s cap, like many others, has come under constitutional scrutiny.

The most recent attack to be addressed by the Louisiana Supreme Court, Oliver v. Magnolia Clinic, involved a seriously injured child whose permanent and disabling injuries were alleged to have been sustained as a result of a nurse practitioner’s failure to diagnose neuroblastoma, a form of childhood cancer, correctly and in a timely manner. A jury determined that the nurse practitioner was negligent in her care and treatment of the child and returned a total verdict in excess of $10.2 million. Following the trial, plaintiffs sought to have the damages cap declared unconstitutional, a finding that would have resulted in a judgment being entered against the nurse practitioner and her insurer for the full amount of the jury’s award. The defendant and the State of Louisiana defended the constitutionality of the law, ultimately prevailing, after post-trial motions. The trial judge then issued a judgment recognizing the cap and reducing the damages award commensurate with the state’s cap.

Plaintiffs appealed to the Court of Appeal for the Third Circuit of Louisiana, arguing primarily that the cap violates both the state and federal constitutions. In sum, plaintiffs argued that the cap deprives the victim of his right, via the state's constitution, to an adequate remedy at law and that the cap violates the Equal Protection Clause by arbitrarily and
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capriciously discriminating on the basis of physical condition. The cap, according to plaintiffs, created two classes of injured persons: one class whose injuries are sufficiently severe that complete redress for those injuries exceeds the cap, and the other whose less severe injuries do not support an award that exceeds the cap. The result of this is that those severely injured persons are left without complete compensation, while those less severely injured obtain a full recovery. On remand from the Louisiana Supreme Court for the purpose of an en banc determination of the issue, a majority of the Third Circuit agreed with the plaintiffs, reversed the lower court and found the cap to be unconstitutional. In so doing the majority held:

We reject the positions of the [defendants] and find . . . that the MMA’s [Louisiana Medical Malpractice Act] cap on general damage awards unconstitutionally disadvantages and discriminates against [plaintiffs], victims of [defendant’s] malpractice, because of the severity of [the patient’s] physical condition when compared to other malpractice victims who receive full recovery for their injuries . . . .

We must declare the MMA’s cap, when used to limit this group of healthcare providers’ general liability for damages caused to severely or catastrophically injured victims, not only discriminatory . . . but that its application, in these instances, violates the Equal Protection Clause of Article I, Section 3 of the Louisiana Constitution and the right to an adequate remedy guaranteed in Article I, Section 22 of the Louisiana Constitution.

The state and the defendant sought writs of certiorari to the Louisiana Supreme Court, seeking a ruling that Louisiana’s cap is constitutional, and a reinstatement of the trial court’s judgment. The Court granted certiorari and began its analysis with a reminder that lower courts of the state are bound to follow its last pronouncement of law on an issue. The Court then directed attention to its 1992 decision in Butler v. Flint-Goodridge Hospital, in which it last definitively answered the question of the cap’s constitutionality. The Court then outlined the constitutional analysis.
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underpinning issue:

We noted in Butler that the right of malpractice victims to sue for damages is not a fundamental constitutional right. Accordingly, in enacting medical malpractice legislation which limits a plaintiff’s monetary recovery, the State must articulate a rational basis for the discriminatory treatment reasonably related to the interest the government seeks to advance. This rational basis standard, however, shifts to a higher standard if the legislature creates a separate or suspect classification. The separate statutory classification [created by the Louisiana medical malpractice damages cap] discriminates on the basis of physical condition. As noted above, in order to prove such discrimination is not arbitrary, capricious, or unreasonable, a legitimate state objective substantially furthered by the discrimination must be advanced.

In conducting this weight and balance, the Court then reiterated and reaffirmed its previous reasoning, as first detailed in Butler:

Both now and then, malpractice claims exceeding the cap’s monetary limit would effectively increase the probability that health care providers would not have medical malpractice insurance sufficient to pay for these uncapped damages. The result would be an underfunded, perhaps insolvent system of recovery for malpractice victims. Any discrimination resulting from the cap, while unfortunate, substantially furthers a legitimate state interest, making the “imperfect balance” “reasonable.”

Finding that the same justification exists today, the Court again upheld the cap and reinstated the trial court’s judgment.

Although the Louisiana Supreme Court’s rulings have consistently upheld the constitutionality of the cap, an increase in the amount of the cap is most certainly in Louisiana’s foreseeable future. For many years, the Louisiana plaintiff’s bar has sought unsuccessfully to invalidate Louisiana’s MPL damages cap. In recent years, however, there has been a growing belief, at least in my opinion, now on both sides of the medical liability bar, that the cap should be adjusted to account for modern-day economic changes. In the most recent Louisiana Legislative session, HB 105[1] was introduced, seemingly to do just that. Although the bill was not brought up for an up-or-down vote, it was sent to the Louisiana Law Institute’s Civil Law Committee for review and comment. I believe that those on all sides of the issue—victims’ advocacy groups, the plaintiff and defense bars, healthcare professionals and executives, and the MPL insurance industry—should make a concerted effort to arrive at a consensus on a workable cap value adjustment or risk having no input in the process, should the legislature decide to adhere to the Court’s “suggestion” without outside input.

Footnotes
1. La. R.S. 40:1299.42(B) provides, in pertinent part: “(1) The total amount recoverable for all malpractice claims for injuries to or death of a patient, exclusive of future medical care and related benefits as provided in R.S. 40:1299.43, shall not exceed five hundred thousand dollars plus interest and cost.”
2. The act was amended in 1984 to remove future medical care and related benefits from being within its coverage. Future Medical Care and Related Benefits See La. R.S. 40:1299.43.
3. Certain states’ limitations draw a distinction between economic and non-economic damages, limiting only non-economic damages. Generally, non-economic damages, which include items such as pain and suffering, are impossible of calculation and are for the most part left up to the judge’s or jury’s great discretion in fixing an award. It is this category of damages where most often the “runaway” award occurs. On the other hand, economic damages, which include medical expenses, are based on actual calculation presented by the par-
ties. The ability to calculate these items greatly removes the potential for "runaway" awards so often the focus of retrospective public scrutiny. New Mexico, Indiana, Nebraska and Virginia also have a "total damages cap."

4. A State-created and administered fund funded by the payment of yearly surcharges on those individuals and facilities who wish to participate and obtain the benefits of the Louisiana Medical Malpractice Act La.R.S. 40:1299.41 et seq. including, among other benefits, the limitation on damages discussed herein.

5. Future medical care and related benefits in sum "means all reasonable medical, surgical, hospitalization, physical rehabilitation, and custodial services and includes drugs, prosthetic devices, and other similar materials reasonably necessary in the provision of such services, incurred after the date of the injury"… See La. R.S. 40:1299.43 B(1)(a) and (b).

6. Oliver v. Magnolia Clinic, 11-2132 (La. 3/13/12), 85 So.3d 39.

7. The Louisiana Supreme Court issued a per curiam opinion on May 22, 2012 wherein it deferred to consider the merits of the constitutionality challenge and instead remanded the case to the appeals court with instructions to reconsider its ruling of unconstitutionality in light of the Court's ruling and analysis in Oliver v. Magnolia Clinic, 11-2132 (La. 3/13/12), 85 So.3d 39.

8. $6,000,000.00 in general damages, $629,728.24 in past medical expenses, and $3,358,828.00 in future medical expenses. The jury also awarded the patient's father $33,000.00 for loss of consortium and the patient's mother $200,000.00 for loss of consortium.

9. Plaintiffs also alleged that nurse practitioners as a specialty were not expressly included within the scope of the Medical Malpractice Act's coverage. Thus, the MMA did not apply to the case in any regard. The Louisiana Supreme Court ultimately resolved this issue, finding that nurse practitioners were covered by the Act. This issue is not germane to this article.

10. Challenges raised in other states have found success on the argument that a damages cap deprives a party of his constitutional right to trial by jury. Washington, Pennsylvania, Illinois, Ohio, Delaware, and Florida are such forums. Louisiana differs in that its constitution does not grant an individual a right to trial by jury in civil cases; in Louisiana, trial by jury in a civil case is conferred only by statute. The other arguments generally asserted are based on a separation of powers argument on the ground that the pre-determination of claim value by the legislative branch impermissibly invades the judicial branch's power to adjudicate controversies.

11. Three judges dissented from the majority decision, finding the cap to be constitutional, for the reasons previously assigned by the Louisiana Supreme Court in Butler v. Flint-Goodridge Hospital, 607 So.2d 517 (La.1992).


13. The Butler court also noted: "As an offset to the Act's $500,000 limitation, Louisiana now offers those most severely injured … three benefits: (1) greater likelihood that the offending physician or other health care provider has malpractice insurance; (2) greater assurance of collection from a solvent fund; and (3) payment of all medical care and related benefits." In the Court's opinion, these benefits constituted a reasonable alternative remedy that furthers the state purpose of compensating victims. "Compensation and full medical care for those grossly injured by medical malpractice are legitimate social interests, which are furthered by the malpractice legislation."

14. The proposed amendment would raise the total amount recoverable from $500,000 to $750,000—limiting its applicability to non-economic damages only—and provide for yearly adjustments of the limitation by reference to the change, up or down, in the Consumer Price Index for all Urban Consumers.
Are you aware of the long list of legislative initiatives on which the PIAA is working in the U.S. Congress? In 2012, we saw our preferred federal package of tort reforms—H.R. 5, the Help, Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act—pass in the U.S. House of Representatives, twice. Then, a newer bill, the Good Samaritan Health Professionals Act, was approved by the House as well, thereby getting us one step closer to protecting healthcare providers from meritless lawsuits when they provide volunteer services to disaster victims. In addition, we won new support for legislation that would prevent the inappropriate application of federal health guidelines in establishing standards of care in a medical professional liability (MPL) lawsuit. We also supported legislation to reform the Medicare Secondary Payer process—a bill that was approved by the House Energy & Commerce Committee shortly before this issue of Physician Insurer went to press.

PIAA members’ interests go beyond Congress, though, and thus the PIAA has also focused on state legislative activity. Efforts to enact state-level tort reform have diminished over the last decade (thanks largely to the success so many states have had in enacting some types of reforms); however, other issues critical to the success of MPL insurers are still being considered. These may differ dramatically from the issues before Congress, but they are no less important. With 2012 now drawing to a close, let’s take a look at some of the bills that were deliberated in state legislatures, keeping a particular focus on the issues that are likely to persist in 2013.

**Phantom damages**

The issue of “phantom damages” (i.e., when plaintiffs are allowed to collect the full amount of billed healthcare expenses, rather than the lesser amount that providers actually accepted as payment) garnered significant attention when it came before the California legislature in August. As the state’s legislative session for 2012 wound down, trial lawyers advanced a bill (SB 1528) intended to overturn a recent state Supreme Court decision on damage awards. The ruling, *Howell v. Hamilton Meats*, stated that plaintiffs could collect economic damages based only on the amount that was actually paid (or which they would pay in the future)—concluding that economic damages should not include money meant to compensate someone for a loss he’d never actually incurred. SB 1528 would have created a “right” for plaintiffs to collect damages based on what they had been billed, and thus paved the way for awards far in excess of actual losses. More important for plaintiff attorneys, the bill would allow them to collect higher contingency fees. After they’d surreptitiously slipped the bill through the Senate, the personal injury bar made an all-out effort to push it through the Assembly. Countering with an impressive advocacy effort, supporters of MICRA pointed out that the bill would drive up MPL costs and decrease access to care, exposing the bill as little more than a vehicle for increasing the income of plaintiff’s attorneys. In the end, the California Assembly rejected the bill by a vote of 43–13, with 24 members abstaining.

Several other states addressed this issue. Unlike California, however, they did not need to stave off an attempt to increase damage awards. Instead, they merely wanted to define economic damages in legislative language, to prevent the kind of manipulation to damage awards that personal injury lawyers had hoped to achieve. While Tennessee, New Hampshire, South Dakota, and Florida, among others, all considered such bills, none were enacted. Expect this to be a big issue in 2013, as plaintiff lawyers continue to use “phantom damages” as a vehicle for increasing overall damage awards, especially in states that have already capped non-economic damages.

**Litigation lending**

One issue that hasn’t yet been addressed at the federal level, but has been considered by several states, is litigation lending. This is the practice wherein third parties loan funds to individuals to help them pursue personal...
injury claims. Companies that engage in this practice have managed to avoid banking regulations by claiming that these payments are not loans, since they do not have to be repaid if the “borrower” fails to win his case. Because they are unregulated, these companies charge exorbitant interest rates (though they may not tell consumers about them) and require full repayment even if the award is far less than the amount owed.

In an effort to legitimate this practice, a trade association representing the lenders has been pursuing legislation in several states to “regulate” their members’ practices. Unfortunately, the laws they propose would provide only a veneer of regulation, while the lenders’ questionable practices continue unabated.

Fortunately, state legislators seem able to recognize these legislative proposals for what they are. In 2012, both Indiana and Nevada defeated bills that would have legitimized third-party funding of lawsuits. Taking action one step further, Oklahoma introduced legislation to ban the practice of lawsuit lending outright, while Arizona legislators pursued a bill to cap the interest rates that may be charged for such loans. While neither bill passed, it is gratifying to find that states are able to see through the sham regulatory bills proposed by these lenders, and are, at least, pursuing effective action to curtail their most egregious practices.

Patient compensation systems

A new advocacy group is promoting the concept of a “patient compensation system,” modeled after the workers’ compensation system. Their proposal would provide a “patient advocate” for every patient who claimed an adverse outcome, engage a medical review department to research the facts in every claim, and use an independent review panel to assess the validity of the claim (on a no-fault basis, rather than a negligence basis). Damages would be determined by a compensation department using a pre-established fee schedule, for both economic and non-economic damages, based on the type and severity of injury, with any final determination eligible for appeal to an administrative law judge. Finally, this scheme would use a quality-improvement department to make patient safety recommendations, based on an analysis of the medicine involved in the underlying claim.

All this, proponents claim, would be achieved at substantially less cost than the current MPL system. The analysis behind their numbers, however, has not been publicly exposed to scrutiny, and many of the assumptions they make about patients’ and physicians’ response to this new system are dubious, at best.

The first target for enacting this sort of system was Florida, but the bill, SB 1588, died in committee. More recently, advocates of a workers’ comp type scheme have focused on Georgia. They have been presenting the concept to medical groups and selling it as a no-risk alternative to MPL reform. Expect to see this proposal reappear in one or both of these states in 2013.

Early offers

New Hampshire became the first state to adopt an “early offer” program—as developed by former University of Virginia law professor Jeffrey O’Connell — when the legislature overrode a veto by Governor John Lynch (D) at the end of June. The new law includes strong financial incentives for the physician/insurer to make an offer within 90 days of notification of a claim, and for the claimant to accept a reasonable offer.

Among other things, the law requires that the offer include full compensation for economic losses, as well as capped “additional” damages (ranging from $2,100 to $140,000, depending on the severity of the injury). Claimants are encouraged to accept the offer by a requirement that they meet a higher standard of proof if they opt to decline. When an “early offer” agreement cannot be achieved in a case, it can still be heard in court. While the language of the legislation makes the program “voluntary,” it is not clear if it is in fact voluntary for both parties, or just for the plaintiff. The full ramifications of this law may not be known for several years, but don’t be surprised if other states consider this approach in upcoming legislative sessions.

Additional reforms

Other states tackled MPL issues, too, during 2012. Notably, Massachusetts enacted a comprehensive bill that requires a six-month “cooling off” period between the notification of an intent to sue and the actual filing of an MPL lawsuit, protects apologies/expressions of sympathy from being used in court, reduces the prejudgment interest rate for MPL suits, and increases (to $100,000) the liability limitation for “nonprofit organization[s] providing health care.”

While less successful than Massachusetts, the other states attempting MPL reform will likely address these same issues in the new year. Apology laws and caps on non-economic damages, just to name two, were on legislators’ agendas in several states, and will undoubtedly be there again in 2013.

A unique bill that failed to gain momentum, but certainly illustrates an interesting concept, addresses the calculation of appropriate non-economic damages. In New Hampshire, HB 1180 spelled out matters that may not be considered by a jury in determining these damages. Specifically, the bill would prevent a jury from considering evidence of the defendant’s wrongdoing, the defendant’s wealth, or any other evidence offered with the intent of punishing the defendant rather than compensating the plaintiff. This proposal failed to emerge from committee, but it highlighted a potential issue for helping juries understand the difference between non-economic and punitive damages, and the role each plays in our judicial system. This type of legislation may emerge in other states in the future.

Looking ahead

As we contemplated all that happened in 2012, began looking forward to 2013, and considered the likelihood that states will tackle a whole host of MPL-related issues, the PIAA recognized that we needed to do more to help our members keep abreast of what is happening in other states, and how it might affect them. In this regard, we have created a State Legislative Activity forum within the new PIAA online Idea and Information Exchange. There, PIAA members can share breaking news on important actions in state legislatures.

You may use the forum to tell other PIAA members about how you’ve tackled legislative issues like the ones they’re facing, discuss bills pending before your legislature, or simply check up on the hot issues in other parts of the country. With your help, we can make the State Legislative Activity forum a valuable tool for every PIAA member. To register, visit the Member Center in the PIAA website (www.piaa.us), or go to https://connect.piaa.us to log in. We look forward to hearing from you there.
Unfortunately, much of what it takes to make people good nurses tends to make them poor deponents, transforming one of healthcare's greatest and valued assets into one of its biggest legal liabilities. Left unchecked, this may lead to unnecessary loss of both leverage and money to the opposition.

Here, I highlight some of the most common aspects of the nursing profession that create the greatest pitfalls for nurses in the deposition.

1. Nurses must have answers—always.

Professionally: Patients routinely ask nurses about their condition, treatment, and prognosis. And nurses either must have the answers, or find the answers. Physicians also rely on nurses' assessments to develop the treatment plan. It would be professional suicide for a nurse to simply say, "I don't remember" or "I don't know" in response to an inquiry from a physician about a particular patient, or to a patient's inquiry about his current medical condition. Moreover, nurses must respond quickly, which means that they frequently anticipate questions from patients or physicians, and then respond before the patients or the physicians have finished asking the questions. Professionally, this is a necessary skill set, and it promotes efficiency in the work setting.

In the deposition: Because nurses must have all the answers in their professional daily lives, it makes their job in the deposition extremely difficult. They feel compelled to provide an answer to every question, even if they do not know the answer. Thus, when they are asked a question during a deposition and they don't know the answer, or if the answer is outside their area of expertise, they tend to speculate, hypothesize, or guess—all of which can prove catastrophic in this setting. In addition, feeling compelled to have answers on the spot is extremely problematic in the context of a deposition. When the nurse thinks she knows what is being asked by plaintiff's counsel, she starts to formulate her response before the question is even on the table, sometimes answering a question from opposing counsel before it is asked.

The result: The nurse's authentic, but incorrect, guesses and hypotheses are now part of the court record, and the nurse, the defendant, and the other deponents are now held to, and compared with, the "truths" of her testimony. When a nurse anticipates the question in a deposition, her attention is split between the question being asked and her formulation of a response, causing her to make critical mistakes—either agreeing with something untrue, guessing and getting it wrong, admitting to something that did not happen, or adopting counsel's terminology and elevating the severity of the occurrence at issue (and the list goes on).
Inconsistencies between her testimony and the testimony of the other deponents (and sometimes the actual facts) create more hurdles for the defense team to overcome, and ultimately increase plaintiff’s leverage, either in settlement negotiations or at trial.

2. Nurses volunteer information.  
**Professionally:** Whether the question comes from a physician about a patient’s vital signs and current response to a treatment plan, or from a patient or a patient’s family member about his medications, treatment, or prognosis, nurses must make sure their responses include sufficient detail to ensure total clarity and understanding. This is done for efficiency, which is crucially important in the medical setting, where time is a precious commodity, not to be wasted. In this regard, it is better for a nurse to err on the side of providing more, rather than less, detail in her responses and communications. The informed consent requirement, something that nurses deal with every day, illustrates the point. For example, no matter how remote the possibility of a negative side effect for a given procedure, nurses must operate under the standard that “more information is better.” This good nursing practice ensures that the patient understands virtually all the risks associated with a particular procedure before it is performed. Professionally, this is good nursing practice.

In the deposition: One of the biggest gifts a deponent can give plaintiff’s counsel is an answer that goes beyond the question—an all too common occurrence—or provides an answer to a question that has not been asked. Nurses frequently fall prey to this vulnerability because, as competent and efficient health professionals, they are accustomed to providing detailed explanations to doctors, patients, and patients’ families. In the deposition, a nurse falsely believes that providing full and complete answers with plenty of detail will be an efficient way to “tell the story,” get the “whole truth” out, and convince everyone (hospital administrators, fellow nurses, and even plaintiff’s counsel) that she did nothing wrong. She also hopes that this “efficiency” will help end the deposition quickly.

The result: Volunteering unsolicited information in the deposition simply gives plaintiff’s counsel more ammunition, more questions to ask, and more areas of inquiry. It opens up pathways for plaintiff’s counsel to probe, prod, and pry. Providing detailed answers ultimately produces unanticipated (and unwelcome) “surprises” to defense counsel and takes nurses out of their areas of expertise, spheres of experience, and knowledge base, into unfamiliar territory. The likelihood of more speculation, guesses, and errors increases. The deposition tends to last longer, thereby increasing the witness’s frustration, decreasing her confidence, and ultimately, making her look and feel incompetent. In turn, the nurse’s anxiety elevates, her concentration wanes, and plaintiff’s counsel’s job becomes easier, and defense counsel’s job becomes more difficult.

3. Nurses form opinions.  
**Professionally:** Nurses must form opinions about their patients every day, including responses to treatment, improvement or deterioration of patients’ conditions, and the efficacy of prescribed medications. In practice, nurses’ opinions can be centrally important to the physicians, who rely on nurses’ assessments because they are on the forefront of care. Even though it is outside their realm of responsibility and qualifications, nurses frequently have opinions about the many aspects of the treatment plan (including the selection and dosage of medications)—opinions that they and physicians know are often correct.

In the deposition: Plaintiffs’ attorneys know that nurses have opinions about medical care and treatment, and it is easy for them to elicit these opinions in the deposition. Plaintiffs’ attorneys are also keenly aware that nurses have opinions about the quality of care provided by other nurses, which is not always flattering. When asked for their opinions in the deposition, nurses often feel compelled to respond, because they do have opinions, and they feel it would be a violation of the oath they just took (to tell the truth) not to give their truthful opinions. What the nurses do not realize is that in the legal context, an opinion is more than just an “opinion,” and anything outside their area of training and qualifications or their actual involvement in the care of the patient is off-limits.

The result: Plaintiff’s counsel, via leading questions, will lead the nurse to a point where her opinion will either necessarily
support plaintiff’s position, will contradict the conduct of the medical professionals in the case, or will trap her into agreeing with something she does not actually believe. In addition, pointing the finger, even subtly, at other nurses or medical professionals does not take the heat off the deposed nurse, as she might hope. In contrast, she will likely be compelled to testify at trial, which otherwise might have been avoided. Ultimately, opinions that fall outside a nurse’s expertise, training, and sphere of experience, and that are critical of other parties, only serve to make the defense of the case more challenging, and the nurse’s job in the deposition more difficult.

3. Nurses defer to authority.

Professionally: Even though nurses are on the frontline of patient care, they recognize that the medical decisions, diagnoses, and treatment plans are the responsibility of the physician—the authority—in the patient-care hierarchy. In their profession, nurses must defer to this ultimate authority for the medical care of the patients. And, although nurses might have opinions that differ from those in authority, they typically do not challenge the physicians, nor do they attempt to override the physician’s opinions and medical judgment.

In the deposition: In the legal arena, it is the lawyers who are seen as the authority figure, particularly in a deposition, where no higher authority (i.e., a judge) is present. Because a plaintiff’s lawyer can sound commanding, act in an authoritative manner, and sound “physician like” in his questioning, he, in effect, takes the place of the physician in a nurse’s mind. A nurse is likely to have a difficult time respectfully disagreeing with the attorney (authority), even when all of her training and experience tell her that what the plaintiff’s attorney is saying is incorrect. In addition, during questioning, when this authority figure applies pressure, raises his voice, becomes aggressive, quotes hospital’s

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Key Things to Remember When Working with Nurses

- **Avoid last-minute preparation.** Nurses sometimes require more than one training session for optimal performance in the deposition. If training is put off to the last minute, some of the most important behavioral and attitudinal changes will not take place because time simply runs out.

- **Do not rely on social evaluations.** Many nurses thrive in the work setting and in social environments, including informal discussions of their case. However, possessing a good skill set in social and professional situations can often work against a nurse in a deposition. A communication assessment, tailored for the psycho-legal context wherein depositions occur, is vital to accurately identify potential problem areas and to effectively address them before they manifest themselves in the deposition.

- **Provide emotional support.** It is important to support nurse deponents emotionally. Ask your nurse how she is “holding up emotionally,” give her “permission” to vent her negative feelings, and remain open to listening to her concerns and fears.

- **Establish trust.** Many nurses will be wary of anything or anyone associated with the litigation process, including defense counsel. It is important to emphasize to nurse witnesses that you are there to help them, you care about them, and you are going to provide them with the necessary tools to navigate the deposition safely.

- **Reassure nurses.** A pervasive belief among nurses who are deposed is that they are at risk of losing their jobs, their licenses, their reputations, and possibly even their livelihoods. It is important to address these concerns and to eliminate inaccurate beliefs and assumptions with nurses as early as possible in the litigation process.

- **Distinguish charting from causation.** Plaintiff’s counsel will always find something “incomplete” in the charting. Nurses are exceedingly vulnerable in this regard during depositions; they need to embrace the concept that patient care trumps charting, and that something “missing” from the chart is not a cause of the patient’s harm.

- **Teach the standard of care.** Nurses might mistakenly believe that something less than perfection is a breach in the standard of care. For example, nurses commonly believe that a bad outcome, a missing chart entry, or a deviation from hospital policies are all per se breaches in the standard of care. So nurses need to be taught what “the standard of care” actually means in the legal context, how it applies to the care they provided, and how plaintiff’s counsel will attempt to use it in the deposition. Nurses must be forewarned, so they can identify and handle all of the various types of standard-of-care questions they may face in a deposition.
policies and procedures, and tells the nurse that she violated the standard of care, the nurse will frequently acquiesce. The plaintiff’s attorney takes advantage of the dynamic in play between physicians and nurses in the medical arena, and he uses it to manipulate nurses in the deposition. The tactics plaintiffs’ attorneys use to intimidate nurses are not much different in appearance and feel from the demeanor and tone employed occasionally by some physicians.

The result: Sometimes, even when a nurse has been prepared by defense counsel, has practiced answering adversarial leading questions, and seems to be in line with the defense themes, she will falter in the deposition. This is because many nurses do not have the communication tools, preparation, or “permission” to respectfully disagree with plaintiff’s counsel in the deposition. In the end, nurses who do not believe they violated the standard of care might admit to standard-of-care violations, because they do not know how to disagree with “the authority” in the right way and without appearing argumentative or becoming defensive.

Prevention
An investment in a prevention program is the key to successful nurse depositions. A qualified witness trainer who is well-versed in the emotional, psychological, and cognitive struggles nurses face in the adversarial legal arena should be included as a vital member of the litigation team. This trainer understands the science of legal communication and trial psychology and has an intimate understanding of the underlying reasons nurses struggle in the deposition. Then, nurses’ challenges in the setting of a deposition can be assessed, addressed, and resolved—and catastrophes averted.

For related information, see www.courtroomsciences.com.
Professional Guidelines and Performance Measures: Do They Constitute the Standard of Care?

Three actual events: what is the common error?

- A cardiologist practicing in a large urban hospital received a form letter signed by the physician chairman of his hospital’s Quality Review Committee. Referring to an instance when the cardiologist’s care of his patient failed to satisfy a Joint Commission core measure, the letter asked him to explain why he had “violated the standard of care.”

- A general surgeon employed by a free-standing ambulatory surgery center was informed by his facility administrator that a certain NSQIP measure (National Surgical Quality Improvement Program) was the “standard of care,” and that he would be judged in accordance with that standard in a court of law, if he violated it in an individual patient’s case.

- A national medical specialty organization posted its practice guidelines on its website, referring to them prominently as “Standards of Care” on the top of each page of the guideline section.

Standard of care versus guidelines

On all three of these occasions, the parties involved misused the term “standard of care,” erroneously equating it with professional guidelines or performance measures. In fact, “standard of care” is a legal term. It defines the professional duty the physician owes to the patient. A “breach in the standard of care” defines negligence or medical professional liability (MPL). For this reason, the term should be limited to the legal setting.

Twenty years ago, the American Medical Association warned about this alarming trend by physicians and hospitals—wrongly equating the standard of care with professional guidelines.

The misuse of this term has persisted, and has been expanded to include hospital quality improvement initiatives.
and performance measures such as NSQIP and The Joint Commission's core measures. Like the cardiologist and the general surgeon in the three examples described above, physicians who do not follow the performance measure in an individual case may be labeled as “violating the standard of care,” thereby handing a gift to plaintiff attorneys.

What is a professional guideline?
Unlike the standard of care, which is determined by a judge in a court of law, professional guidelines are written by physicians and promulgated by medical specialty organizations.

Physicians and their defense attorneys should know that guidelines are a tool, an aid to the physicians’ decision-making—not a substitute for it. Guidelines are not intended to apply to all patients under all circumstances.

Many organizations have embedded this principle within the introduction to their guidelines. Here are some examples.

The American College of Chest Physicians—from the preamble to the 2008 ACCP Guidelines:

No clinician, and nobody charged with evaluating a clinician’s actions, should attempt to apply our recommendations in rote or blanket fashion…. Clinicians…should not construe these guidelines as absolute…. Even Grade 1A recommendations will not apply to all circumstances and all patients.

The American Geriatric Society—from the AGS Beers 2012 criteria for prescribing to the elderly:

This list is not meant to supersede clinical judgment or an individual patient’s values and needs. Prescribing and managing disease conditions should be individualized and involve shared decision-making.

The American College of Obstetricians and Gynecologists—in its “Practice Bulletin” on prevention of thromboembolism, ACOG states that its guidelines:

…should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on needs of the individual patient, resources and limitations unique to the institution or type of practice.

The American College of Radiology—from the Preamble to the ACR guidelines:

The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. …All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of these guidelines is to assist practitioners in achieving this objective.

In a court of law, the standard of care refers to the community standard, the reasonable and average care available, not the best possible care in any location. It’s not determined with the benefit of hindsight—it’s based on the information available to the physician at the time the care was rendered. The standard of care at issue in a particular case is provided in testimony by an expert witness, and is then decided on by judge and jury. The law recognizes that there may be more than one standard of care, just as there may be more than one text or authority on a subject. The law recognizes that perfection is not the standard of care, and that a bad outcome is not always due to a breach in the standard of care.

So the concept “standard of care” is actually multi-dimensional, but it should not be confused with professional guidelines and performance measures (Table 1). Physicians, healthcare organizations, and PIAA member companies would do well to declare a moratorium on the use of the term “standard of care,” unless they are referring to an actual claim.

This misuse of the term “standard of care” has served to add fuel to another false equation: implicating guidelines as “cookbook medicine.” In this view, guidelines are erroneously depicted as heavy-handed mandates imposed on patients and physicians, intended to apply to all cases.

Equating guidelines and standards of care has one more ill effect: it contributes to a culture of blame in healthcare. Physicians have been conditioned to expect a punitive approach

<table>
<thead>
<tr>
<th>Table 1 Standards of Care vs. Professional Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard of Care</strong></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Legal term</td>
</tr>
<tr>
<td>Applies only to a single case</td>
</tr>
<tr>
<td>Determined by expert witness testimony, judge, and jury</td>
</tr>
<tr>
<td>Static: applied to one fixed case at one fixed point in time</td>
</tr>
<tr>
<td>Determined after the fact</td>
</tr>
<tr>
<td>Applied by a court of law</td>
</tr>
</tbody>
</table>

This misuse of the term “standard of care” has served to add fuel to another false equation: implicating guidelines as “cookbook medicine.” In this view, guidelines are erroneously depicted as heavy-handed mandates imposed on patients and physicians, intended to apply to all cases.

Equating guidelines and standards of care has one more ill effect: it contributes to a culture of blame in healthcare. Physicians have been conditioned to expect a punitive approach.
to medical error, stemming in part from the actions of state boards and claims filed by plaintiff’s attorneys. Blame and punishment in medicine have the chilling and counterproductive effect of driving errors underground. This approach is premised on the notion that rooting out the bad apple will eliminate error.

In reality, no physician wants to make a harmful mistake. Medical errors are better understood and studied as pitfalls: what one person can fall into, so can others in the same circumstances. Solutions can be better identified and carried out when blame is removed and data is collected in a no-fault atmosphere, permitting lessons to be learned and pitfalls to be remedied.

Guidelines are not the same thing as evidence. They are created by many different organizations, and they are based on greater and lesser strengths of evidence. Some are based on data from published studies; others are based on expert consensus. The prudent physician will consider the source of the guidelines and the strength of the evidence supporting it. (Table 2).

Guidelines are not the same as outcomes. Guidelines may be drawn up from data suggesting that a certain measure might improve outcomes. For example, studies have found that the frail elderly at risk for falls are deficient in vitamin D. So, high doses of vitamin D were recommended and prescribed. But subsequent studies showed that high-dose vitamin D really doesn’t diminish the number of falls, so it is no longer recommended.

Guidelines are a work in progress. Some guidelines eventually pass into standard practice (hand-washing before seeing a new patient, for example), some are modified (universal venous thromboembolism—VTE—prophylaxis), and some are discarded over time (the requirement for face-to-face notification of HIV/AIDS test results).

### Table 2 Professional Guidelines and Clinical Pathways

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Promulgated or adopted by</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Guidelines</td>
<td>Evidence-based recommendations for care, usually related to diagnosis or procedure</td>
<td>Medical specialty organizations</td>
<td>ACOG bulletins, ACR imaging guidelines, AGS/Beers prescribing criteria</td>
</tr>
<tr>
<td>Clinical Pathways</td>
<td>Standardized order forms and anticipated sequences of care for a particular procedure or condition</td>
<td>Institutions, facilities</td>
<td>Labor and delivery clinical pathway, chemotherapy protocol</td>
</tr>
<tr>
<td>Performance Measures</td>
<td>Baseline measurement of frequency of desired care that is then targeted and tracked for improvement</td>
<td>Promulgated by accreditors, government agencies</td>
<td>Joint Commission core measures, CMS Conditions of Participation, NSQIP measures</td>
</tr>
</tbody>
</table>

What about clinical pathways and performance measures?

Many clinical pathways or performance measures are based on data from peer-reviewed studies and professional guidelines. They may consist of hypotheses, derived from the data, not yet shown conclusively to improve outcomes. They may be drawn up by medical specialty organizations, accreditation bodies, and government agencies. They are adopted by facilities and institutions. Some are unilaterally imposed by payers, a sore spot for physicians, especially when the supporting evidence is little to none. One example of these unilateral requirements is the designation of patient falls and other occurrences as “Never Events.”

The oxymoronically named “Never Events” are the exception; it is usually not expected that there will be compliance with performance measures 100% of the time, because they don’t apply to all patients. For some people, beta blockers after a heart attack are contraindicated. For some women, elective delivery prior to 39 weeks’ gestation is appropriate and necessary. And there are patients with bleeding disorders who cannot tolerate VTE prophylaxis, and others who just won’t comply with instructions to use compression stockings after orthopedic surgery. The most that can be anticipated for these measures is improvement, not perfection.
Like guidelines, clinical pathways and performance measures are a work in progress. When data shows that certain performance measures don't improve outcomes, they are discarded and new measures take their place. Some measures are associated with very good compliance and very good outcomes, and these pass into common practice or standard practice.

From evidence to standard practice
Evidence takes a long time to work its way into common practice—on average, 17 years. The proper goal of guidelines and performance measures is the improvement of patient outcomes, based on the best evidence. Some guidelines have improved patient outcomes, have been validated time and again, and have become common or standard practice. The physician who routinely treats his or her patients contrary to those guidelines, without any documented rationale for doing so, may be difficult to defend in a claim of malpractice.

When guidelines collide
Cancer screening is one example of the current controversy in regard to guidelines, especially for prostate specific antigen testing. There are conflicting recommendations from the U.S. Preventive Services Task Force, the American Cancer Society, the American Urological Association, and other groups.

Physicians may consider their patients well served if they mention their own preference among the various guidelines in conferring with a patient, offer their recommendations, elicit the patient's views, and partner with the patient to arrive at a shared decision.

Another example of warring guidelines: the recommendations on VTE prophylaxis after hip and knee replacement. The American College of Chest Physicians and the American Academy of Orthopedic Surgeons have conflicting recommendations, though they are now working to make their recommendations more compatible. To complicate matters, the Joint Commission required hospitals to have policies on VTE prophylaxis, and the Centers for Medicare & Medicaid Services now require hospitals to have policies on VTE prophylaxis, though they are now working to make their recommendations more compatible. Physicians should look for the most current guidelines adopted by their own medical specialty organization and those of your own facility or institution.

Which guidelines?
How can a physician sort his way through the proliferating, and even conflicting, guidelines and find the best ones with the strongest evidence? As a first check, physicians should look for the most current guidelines adopted by their own medical specialty organizations, and also look for the recommendations adopted by their own hospital or institution. If there are no guidelines provided by one's specialty organization, physicians should look for the most reputable source with the most relevance to their practice. There is also a website, www.guidelines.gov, a free searchable database of practice guidelines. It includes a ranking, according to the relative strength of evidence, for each guideline.

The guidelines.gov website is maintained by the Agency for Healthcare Research and Quality. The user types in a desired topic such as "pediatric sinusitis," and a list of guidelines appears. The user can select the most recent (and most applicable) one that is based on the strongest evidence.

Summary of risk management suggestions
Now, here is a recap of the recommendations in this article.

■ “Standard of care” is a legal term. Don’t use it to refer to professional guidelines.
■ Guidelines are an aid to, not a substitute for, the physician’s decision-making.
■ Guidelines are a work in progress; anticipate an evolutionary process.
■ Be aware of the guidelines promulgated by your own medical specialty organization and those of your own facility or institution.
■ Weigh the strength of evidence that stands behind the guidelines. When you depart from them, it’s a good idea to document your rationale for doing so.
■ Let the record show that you were aware of the relevant guidelines, that you took into account the individual circumstances and preferences of your patient, and that your treatment decisions were guided by what was best for your patient.

References
3. American Geriatric Society. From the AGS Beers 2012 criteria.
4. American College of Obstetricians and Gynecologists: “Practice Bulletin” on prevention of DVT and PE.
8. Streiff MB, Haut ER. The CMS ruling on venous thromboembolism after total knee or hip arthroplasty; weighing risks and benefits. JAMA. 2009;301(10):1063-1065.
Definitive Ruling, Uncertain Consequences

In June 28, 2012, the U.S. Supreme Court upheld, in the main, the Patient Protection and Affordable Care Act (the Act). Now, although the Court has made a firm decision on the essential legality of the ACA, a host of issues pertaining to medical professional liability remain unresolved. The most successful MPL insurers will be those that best anticipate, and react to, the changes in the MPL environment that do occur.

Expectations on MPL
A key philosophical underpinning of the Act is access to healthcare for all, or nearly all. The Congressional Budget Office (CBO) estimated an additional 32 million people will obtain health insurance thanks to the Act. The influx of new insureds will result in greater utilization of healthcare services. Greater utilization, all things being equal, results in greater claims frequency. If the number of insureds were to grow by the anticipated 13%, one might logically assume that claims frequency will increase by a similar percentage in 2014, when the mandatory insurance provisions take effect.

However, all things will not be equal. Let’s look at some of the variables that could affect liability.

Increased access to healthcare. The premise that the new insureds are new entrants to the healthcare system is imprecise. These new insureds currently are consumers of healthcare via the emergency room. With the benefit of insurance, they more often will receive care from a primary care physician or clinic providing regular and preventive care. More treatment provided before an illness becomes acute may mitigate the anticipated increase in the number and severity of claims from this population segment.

Further, the projection of an additional 32 million insureds is inexact. This projection is based upon the individual mandate and more generous Medicaid eligibility. Even with the mandate, it is unclear how many currently uninsured will purchase health insurance. Failure

Michael Hollenbach is Executive Vice President, BMS Intermediaries.
to do so will result in the tax/penalty, but usually the tax/penalty will be less than the cost of the insurance, even for those eligible for the premium subsidies provided by the Act. Thus, there will be economic incentives, particularly among the young and healthy, to simply pay the tax rather than purchase the health insurance.

The Supreme Court also left the door open for the states to opt out of the Medicaid expansion, and some may do so, potentially reducing the number of new insureds.

Many areas of the country already have shortages of doctors and other providers. The influx of new insureds may result in a disproportionately high increase in claims if an already stressed provider population takes on a greater number of patients. In addition, the increased numerical strain on healthcare providers is likely to result in greater use of mid-level providers, such as physician assistants and nurse practitioners, and an increase in convenience-oriented clinics such as CVS’s Minute Clinic and in workplace clinical care. This trend has been underway for some time now but should accelerate due to the Act. The impact on liability from increased mid-level care and greater use of clinics remains to be determined.

Reimbursement changes. Conventional wisdom holds that “you get what you pay for”: Lower provider reimbursements will result in poorer-quality care and more adverse claims experience.

The goal of the Act is to “bend the cost curve” downward. In a letter of July 24 to House Speaker John Boehner, the CBO stated that the impact of repealing the Act would reduce spending by the same amount by an estimated $713 billion from 2013 through 2022, implying that the impact of repealing the Act will reduce spending by the same amount. Most of these reductions result from payments to providers less but expect the same services as before, a reduction in healthcare quality and an increase in liability, at least initially, seems a logical outcome.

However, a material part of the savings is anticipated to come from the implementation of outcome-based compensation. Integrated delivery through entities such as accountable care organizations (ACOs), or groups of providers such as hospitals and physicians, is encouraged. ACOs make providers jointly accountable for the care of their patients, with financial incentives for providers to both lower costs and meet quality, evidence-based benchmarks focused on prevention and managing chronic disease. The introduction of quality-care financial incentives should generate higher-quality care and a reduction in liability claims. Further, pursuing lower costs through evidence-based care may reduce utilization of inefficient procedures, with some corresponding reduction in the number of MPL claims.

Electronic medical records. Both the Affordable Care Act and the 2009 stimulus act encourage greater use of electronic medical records (EMRs). The aim is to improve care by giving medical providers immediate access to important patient information, help control costs by eliminating unnecessary and duplicative tests and procedures, and allow both greater coordination and measurement of care. It seems self-evident that the achievement of these goals should improve the quality of healthcare and thereby reduce liability for MPL in the aggregate, yet an electronic record of the care given to a specific patient may simply leave a roadmap for demonstrating provider negligence. Furthermore, use of EMRs creates new potential claim exposures resulting from issues such as data breach and technological mishaps.

Impact on physician insurers

Two principal consequences emerge regarding the MPL insurance landscape following the Supremes’ ruling on the Act.

Pricing uncertainty. As noted above, there are a slew of factors that could impact MPL liability in uncertain ways (Table 1).

Claims payment is the insurance product. For a long-tail line of business such as MPL, determining the cost of product in normal times is difficult enough. Our best pricing tool, the actuarial process, relies on extrapolation based on loss trends that have already taken place. Since loss trends change over time, our actuary friends often find themselves trying to catch up to the correct answer.

With greater than usual uncertainty looming...
over the future of liability trends, carriers will need to be more diligent and nimble than ever in assessing loss trends and pricing business accordingly. The best, if imperfect, approach probably remains to monitor loss trends frequently, assess them critically, and react appropriately (quickly, but not so quickly as to mistake momentary data blips for trends).

Meeting the needs of insureds. The changing healthcare landscape after the affirmation of most of the Act probably will accelerate the ongoing trend toward greater consolidation within the provider community. The nature of healthcare insureds is likely to change, and their liability insurers will want to be able to respond to their customers' new needs.

As physicians join hospital staffs, there will be pressure on physician insurers to develop or expand their ability to insure the hospital risk or lose a chance at insuring the consolidated exposure including their prior insured physicians. Many carriers have or are in process of expanding this capability, oftentimes with the help of reinsurers or other partners.

However, to borrow from Mark Twain, for a number of reasons, reports of the demise of the physician insurer may have been greatly exaggerated. It is reasonable to expect that there will always be a meaningful minority of doctors who prefer to work independently. Further, the acquisition of physician practices by hospitals is still a fairly specific geographic phenomenon and may not progress to a full national trend. In addition, there will be hospitals that do not wish to take on the risk and tie up the capital necessary to insure an influx of newly acquired physicians. Nonetheless, in the new world of integrated healthcare, it is reasonable to expect that the successful physician insurer will have evolved into a more multi-dimensional entity, with the capability to insure more integrated, institutional risks, or maintained a targeted physician focus, based on a particular brand, geography, sponsorship, specialty focus, or other niche.

A number of physicians who remain independent are likely to join ACOs or other integrated delivery vehicles. The focus of ACOs under the Act, for now, is on Shared Savings Program under fee-for-service Medicare. However, the Centers for Medicare & Medicaid Services has initiated the Pioneer program for private providers and health plans. Under the Pioneer Model, more risk taking by providers and, ultimately, a population-based, or capitated, payment

"Lower provider reimbursements will result in poorer-quality care and more adverse claims experience."
system is expected to develop. With such a model, participating providers will receive not only incentive payments for cost savings and quality care; they will also receive a fixed per patient compensation. The providers assume the risk that the costs of care will exceed the payments received.

Physician insurers who wish to write business beyond targeted niche areas will soon need to prepare for the possible blossoming of the ACO model. Taking a wait-and-see approach could put these carriers at a competitive disadvantage, without sufficient time to catch up to a market ready to meet the needs of ACOs and their provider participants. The traditional physician insurer will want to continue to insure the ACO physician participants, but it is likely that some of the larger, commercial insurers expected to vie for insure ACOs will seek to bundle the sale of coverages for both the ACO and the provider participants. Should this transpire, at least as a defensive measure, the physician insurer will need to be able to offer ACO coverage (Table 2).

**Conclusion**

The Supreme Court has ruled on and, for the most part, upheld the Patient Protection and Affordable Care Act. Notwithstanding this definitive ruling, many unknowns about the future evolution of the healthcare system and its fallout on MPL trends remain. Increased provider consolidation and integration of care seem likely. Physician insurers will need to maintain vigilance in monitoring the liability consequences of these changes and react accordingly, while positioning themselves in the marketplace with the necessary client focus, and an appropriate selection of products to remain insurers of choice for their changing customer base.

**Footnotes**

1. The frequency of claims is measured by comparing the number of claims to the number of providers with MPL insurance.
5. AON Hospital and Physician Professional Liability 2011 Benchmark Analysis.

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**Table 2 Coverages ACOs May Need**

<table>
<thead>
<tr>
<th>Potential ACO Coverages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Professional Liability</td>
<td>Cyber Liability</td>
</tr>
<tr>
<td>Directors &amp; Officers Liability</td>
<td>Fiduciary Liability</td>
</tr>
<tr>
<td>Managed Care E&amp;O Liability</td>
<td>Billing E&amp;O Liability</td>
</tr>
<tr>
<td>General Liability</td>
<td>Provider Stop Loss</td>
</tr>
<tr>
<td>Employment Practices Liability</td>
<td></td>
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</tbody>
</table>

For related information, see www.bmsgroup.com.
The healthcare industry has been evolving and preparing for the Patient Protection and Affordable Care Act (ACA) since it was enacted, in March 2010. What companies have done varies by region and type of provider. The ACA will mean changes in MPL underwriting . . . maybe.

We have watched as our clients' businesses have been transformed, through merger and acquisition (M&A) activity, the creation of new entities, and IT investments. As liability insurers, it is our responsibility to assess the impact of the Act on our insureds and on our own businesses. As this historic development continues to unfold, insurers must prepare for wide-reaching underwriting implications, through 2014, the final date when the major provisions of the phased-in Act become law.

Some experts have recently focused on the purchase of physician groups by hospitals. We tend to hear a good deal about the cons of this trend, but very little about the new opportunities. As an example, let's say a 200-bed hospital in the Northeast partnered with a PIAA insurer to cover all of its employed physicians. Because they have included joint-defense language in their contract, the parties are comfortable with their approach to settling cases with multiple defendants. Through this innovation, the insurer has gained as new clients physicians who had been out of the MPL insurance market for years.

Another aspect of acquisition activity seldom discussed is that it is not one-sided; these transactions have underwriting implications. There is M&A activity among physician groups that receives very little publicity. As noted in The Health Care M&A Report by Irvin Levin Associates, the value of M&A activity for hospitals was just slightly above the value of transactions for physician groups (Table 1). We do not have space here to discuss all of the reasons for these acquisitions, so let us focus on the consequences for underwriting.

Bob Allen is Senior Vice President, Medical Professional Liability, Torus Insurance Holdings Ltd.
M&A among physician groups

Contrary to popular belief, there has been M&A activity among physician groups. In specialties heavily hit by Medicare cuts (e.g., cardiology and radiology), we are seeing physicians aggregate into large groups; from multi-specialty groups to single-specialty groups, there is acquisition activity among physicians. The concern in regard to underwriting is the lack of planning for the integration of new physicians into group insurance programs. In some cases, the new physicians are not completing individual applications for coverage. In others, risk management and patient safety appear to be an afterthought, making it very difficult to predict the future frequency or severity of claims.

The hospitals that acquire physician groups confront comparable concerns; adding new doctors to their roster of employees sometimes brings unexpected underwriting issues. A recurring topic of debate is the available limit for an extended-reporting period. The average hospital carries higher limits than the average physician group. So, should the hospital ask the physician group to purchase tail coverage with limits comparable to those of the hospital? If the physician group historically purchased $1 million per claim, should an underwriter be willing to offer tail coverage with $5 million per claim?

Hospitals will argue that even in an asset-only purchase, a successor can be held liable for historical operations, often referred to as successor liability. We understand the hospital’s rationale for wanting higher limits for the acquisition, but underwriters have to determine whether they should accept this type of risk.

Table 1 The Healthcare M&A Market, Second Quarter, 2012

<table>
<thead>
<tr>
<th>Sector</th>
<th>Dollar Amount Second Quarter 2012</th>
<th>Percent of Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technology (Pharma, Biotech, Devices) Subtotal</td>
<td>$38,130,729,000</td>
<td>62%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>$4,533,000,000</td>
<td>7%</td>
</tr>
<tr>
<td>Physician Medical Groups</td>
<td>$4,222,817,000</td>
<td>7%</td>
</tr>
<tr>
<td>Long-term Care</td>
<td>$1,889,081,000</td>
<td>3%</td>
</tr>
<tr>
<td>Managed Care</td>
<td>$730,000,000</td>
<td>1%</td>
</tr>
<tr>
<td>Other Services</td>
<td>$11,699,590,000</td>
<td>18%</td>
</tr>
<tr>
<td>Services Subtotal</td>
<td>$23,074,488,000</td>
<td>38%</td>
</tr>
<tr>
<td>Total Healthcare</td>
<td>$61,205,217,000</td>
<td>100%</td>
</tr>
</tbody>
</table>


Hospitals acquiring hospitals

The increase in the numbers of hospitals acquiring hospitals has prompted a surge in requests to segregate and/or remove past liabilities. Unfortunately, the combination of claims-made coverage, large deductibles, trust funds, and encumbered limits makes for an underwriting morass.

The hospitals that are being acquired are asking to purchase unlimited extended reporting periods (ERPs). This request is often the easiest to provide at the expiring of terms and conditions. It becomes complicated when these facilities request ERPs with a $0 deductible after years of deductibles of $50,000, $100,000, or $250,000. If adverse losses justified a large deductible, should underwriters be willing to assume the incurred but not reported (IBNR) losses on a first-dollar basis?

Requests to remove all liabilities through a loss portfolio transfer (LPT) are becoming all too common. An LPT is a financial transaction in which existing case reserves (within the trust) are assumed and ultimately paid by a (re)insurer. The assumption of known liabilities rarely qualifies as a significant risk transfer (i.e., insurance), and the “premium” associated with these transactions is best accounted for as a “deposit,” similar to a loan (see Statement 113 of the Financial Accounting Standards Board). Sadly, very few underwriters understand the financial implications of these transactions; most merely focus on the top line.

When an ERP’s limits are relatively small (or exhausted), plaintiff’s attorneys have another avenue to pursue—successor liability. Since most targeted acquisitions are financially troubled, buyers frequently want to limit the transaction to the company’s assets. Buyers attempt to avoid any assumption of past liabilities, but attorneys may argue that:

- The acquired entity is simply a continuation of the old company’s operations.
- The transaction was entered fraudulently, to avoid liabilities.
- The transaction resulted in a merger of the two entities.
- The purchasing entity, via express or implied provisions, has agreed to assume the financial obligations of the company it bought.

When one of these four conditions exists, the successor may be held liable for the prior acts of the acquired entity. Some organizations have been able to successfully fight cases alleging liability as a corporate successor (see Craig v. Oakwood Hospital and Robbins v. Physicians for Women’s Health), but the uncertainty of
the outcome in post-acquisition litigation has led to new requests for coverage. As underwriters, intermediaries, and insureds we need to ask ourselves: Should we develop coverage that insures buyers for the prior acts of their acquisitions?

The ACA seems to have accelerated adjustments to MPL underwriting approaches, but this is not the first time government action has led changes in the healthcare industry and the underwriting community. Do you remember HIPAA? In 1996, HIPAA was passed; we questioned how electronic medical records (EMRs) could have the same protections as paper records. Shortly after that, we wondered whether a breach in patient health information (PHI) should be covered under general liability, professional liability, or some brand new type of coverage. In 2004, President Bush began promoting the nation's transition to EMRs. Fast-forward to the present—we now have two laws that support digital health information: the Health Information Technology for Economic and Clinical Health Act (HITECH) and, of course, the ACA.

Through the past 15 years, we have watched the growing importance of PHI, especially with electronic records. During the same period, carriers have tailored standalone policies for “cyberliability” (also known as HIPAA compliance coverage). In some cases, insurers have incorporated this risk into their MPL policies with little or no additional premium. How the breaches are covered is not important. The point here is that underwriters shift and adapt to the specific regulatory activity that has an impact on their insureds. In fact, when you stop to think about it, our industries are in a circular and constant state of metamorphosis. Healthcare providers who can access capital are able to invest in EMR software. Those who are unable to make this type of investment must consider themselves candidates to be acquired. A patient's right to privacy existed well before HIPAA became a regulation. Similarly, the theory of successor liability existed before the ACA and the recent trend in acquisitions. How healthcare providers and insurers respond to our evolving situations is what will dictate our success or failure.

Conclusion: an expanded market

Acquisitions of physicians and hospitals are driving a need for specialized risk and insurance products. These policies will need to address both historical and prospective liabilities. As long as we do our research, we should look at the ACA as an opportunity for MPL organizations to grow.

References

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Sessions include:

- Hospital/Physician Affiliation – Will the Trend Continue? — More physicians want to work for hospitals or become part of a large multi-specialty group. This session will explain the dynamics underlying the decision-making process, and discuss how these preferences influence the selection of a physician’s MPL insurance. You will learn how PIAA member companies can best respond to this growing trend.

- Creating Social Media Prose: What Is Different and What Is Not? — What is different about writing social media content? Traditional media is essentially a monologue, with the content pushed out. In contrast, social media is primarily created to build a community, to foster a dialogue, and to draw a targeted audience into your company’s orbit. This session offers a hands-on, practical approach to writing material for social media.

- The Education of Tomorrow’s Physician: What They Learn Today and How It Will Affect Their Decisions Tomorrow — During the long years spent in learning how to be a physician, the last thing on a student’s mind is MPL insurance. Yet, one of the first priorities on completion of residency is how to protect that investment. Through a panel discussion and Q&A, this session explores the challenges and opportunities of teaching and communicating with medical students and residents, and provides insights about how they prefer to work with their MPL company.

PIAA MARKETING WORKSHOP
April 10-12, 2013

Sessions include:

- Zap the Gap — Dental practices need to create a multi-generational team that is effective and productive. Unless that happens, a practice puts future growth and sustainability at risk. This program outlines the dominant generational forces in the workplace and how each generation’s “generational signposts” drive motivation, influence loyalty, and assist in delivery of customer service.

- Dental Trends Aren’t Very Interesting, Until They Get Really Interesting! — The most important trends that now affect dentistry are revealed in this session. The speakers will explain “Baby Boomer” demographics and shifting patterns of care as well as the evolving trend towards group practice.

- Generational Claims: Examining New Exposures — This session will explore a typical claim from the vantage point of three generations of professionals: young practitioner, mid-level practitioner, and experienced practitioner. The claims used in the case studies presented will come from Dental Section member companies, and each will include an overview of the claim and a discussion of its key aspects.

- Generational Claims: Risk Management Tips and Techniques — In a follow-up to the previous session on generational claims, a risk manager will analyze the risk management elements involved in “generational” issues and offer tips, techniques, and insights for enhancing patient safety and mitigating loss.

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Most observers of the medical professional liability (MPL) insurance space would be forgiven for thinking that the past few years have seen nothing but good news for the sector. The perception is that both practitioners and insurers alike are reaping the rewards of a benign claims period and an industry that has risk-managed its way to stability and prosperity. And there is some truth in that.

Willis Re, in their 2011 Publication *The Medical Record*, announced that MPL had been the “star performer of the P&C Sector,” with all aspects of the industry seeing a better rating environment in the early years of the past decade, despite some extremely challenging preceding years. At that time, there was a crisis in access to MPL insurance: in some states and in some classes, physicians were unable to purchase coverage, given the tort and claims pressures those areas were facing.

**A revolution of healthcare risk management**

The one thing that drives tort reform, however, is public outcry, and when hospitals close ERs, or cancel surgeries, as a consequence of the actions of plaintiff lawyers, tort reform follows. Sure enough, in many states, reform did follow and, as a result, the plaintiff’s bar in those states weakened and instead, turned its attention to product liability cases, nursing home, and auto accidents. So, as tort reform was enacted, coinciding with a hardening insurance market, healthcare providers (particularly hospitals) commenced a new revolution of healthcare risk management.

In an incredibly short period of time—under a decade—risk had moved from a somewhat esoteric subject to the number-one position on hospital radars, for executive compensation, mission statements, and advertising; it was the final part of the perfect storm of rate, reform, and risk.

Claims frequency is static or falling

Fast forward to 2012: to say that we are still in a good place is undeniable. Frequency levels in MPL claims are essentially static, and in some areas, may have dropped. This has been good news for physicians and hospital captives, which tend to mop up the more modest claims. The excellent results of the

*Ian Thompson* is Senior Vice-President, Hiscox Bermuda.

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**Physicians Need to Take Stock of Their Insurance Limits (but Beware the Rise of the Super-Loss)**

If insurers underwrite the wrong geography, the wrong attachment, or maybe just get unlucky, the results can be catastrophic.
MPL sector are testament to this, and for every hospital captive looking to drop its actuarial confidence level, there are ten more that are overfunded. The low level of loss also brings predictability. Without wishing to get too deeply into the actuarial view, let me say that at this point, the law of large numbers takes over—more losses make trends easier to spot, so primary MPL insurance has benefited from stability and profitability.

While claims frequency has ebbed of late, however, the value of individual claims has, year after year, gone the other way, meaning that an “as before” renewal actually translates as a price reduction.

**Physicians demanding bigger limits**
Excess insurance is by contrast more volatile, less predictable, and more of a big bet. If insurers underwrite the wrong geography, the wrong attachment, or maybe just get unlucky, the results can be catastrophic, and while the market results do not indicate this has happened, the swings are wider and more damaging. Historically, the excess market has been focused on hospitals, but in recent years we have seen more and more physicians demand bigger limits than the $1 million/$3 million staple that we are all so familiar with.

This is absolutely reasonable in my view. Many physicians rightly take home big paychecks and need to protect their assets and credibility if the unexpected occurs. The traditional market of MPL companies, however, has generally been reluctant to take physicians down this path; the $1 million/$3 million limits have served the insurers well, are manageable, and mean they rarely end up as the deep pocket in a lawsuit. But the math doesn’t support this approach as a good deal for the physician.

While I understand all the good reasons for controlling the limit—that the ultimate physician loss can be heavily influenced by the limit available—when the first physician-owned carriers were founded, in the 1970s, $1 million was $1 million. Taking into account monetary inflation, that $1 million would today be almost $4 million. Medical inflation compounds this, and a $1 million loss in 1977 would be worth close on $6 million in 2012. That is why, if I were in some physicians’ circumstances, I would be nervous carrying $1 million of vertical limit: it just isn’t enough.

**Seize the opportunity**
In many ways, this is the sort of opportunity that the MPL sector craves at the moment. With a dwindling base of physician and
physician group buyers who are being bought up by the larger hospitals at an alarming pace, maybe this is the answer to the question of how to fill the holes in income and give their client base the products they are looking for. After the widespread consolidation, the mutual arguments for conservatism are less relevant, and MPL companies’ balance sheets can largely support vertical loss.

There is a balance to be struck, however, when it comes to choosing the right limit; not enough and the client is exposed, too much and we could see rampant claims inflation, which may already have started to show itself. In March 2012, Hiscox Bermuda announced loss figures recorded from recent hospital and large-physician-group risk submissions, and supplemented by publicly available information. One of the main conclusions was a concern that the bigger so-called “super-losses” are getting larger, and also becoming more frequent. While this conclusion was based on only a handful of super-losses, and is not yet conclusive evidence of a genuine trend, it has sparked further debate, fuelled by more recent super-losses such as the $74 million verdict against a physician in San Luis Obispo, California (April 2012).

As well as showing an unusual prevalence of really large verdicts, which may or may not be appealed down to lower amounts, Hiscox’s findings also revealed that losses above $5 million are increasing at a concerning rate. In 2000, losses above $5 million represented 0.25% of all losses, while that figure has risen to 0.7% today, and it is projected to reach 1% of losses by 2014. That represents a significant change.

Beware batch coverage

In addition, a relatively new dynamic that could compound the problem is an insurance industry that has thrown batch coverage around like rice at a wedding. Vertical losses alone can be damaging, but I think most insurers know what they are dealing with. Batch coverage—the ability to group losses together under a single common aggregating cause, and attachment—may be the catalyst that recreates the problems of the late 1990s. It has the potential to really create a hole.

Be wary

Physicians too need to be wary. On the one hand, I would advocate more vertical physician purchase. A structure that has basically remained unchanged since 1977 may eventually implode, as courts say that the dollars available are not only insufficient but also unfair to injured parties. This opens up all sorts of issues with the potential for excess-policy-limit verdicts. The answer is simple then: buy coverage with a higher limit. Now might be the time to acknowledge a vertical limit of $2 million or $3 million as the standard for individual physicians. There is a balance to be struck, though; if doctors buy too much coverage, it could further drive the trend for super-losses.
What’s a good strategy for defending against crazy, inflated claims advanced by injured parties through life care plans? Several members of the Claims and Litigation Management Alliance offer suggestions.

I respond by utilizing reduced life expectancy, collateral sources, and then (wait for it) the Affordable Care Act! In 2014 the plaintiff can get health coverage with no exceptions for pre-existing conditions. Then, the question becomes, what are the premiums, co-pays, and deductibles? Using every source possible and having a full cost analysis of the life care are steps that should be taken in all cases. Compile a line-by-line analysis of all treatments, items, equipment, etc. The big question, though, is, “Are you negotiating or at trial?” If negotiating, you can use any and all resources available to you. Take advantage of everything at your disposal! — Daniel Goodmann, CSSC, Managing Director—Structured Settlements, Mesirow Financial

When I sit down with my own life care planner, I start by asking for an analysis of what the plaintiff and his/her family would do if they received no money from the lawsuit. What resources would be available—what alternative care and treatment would they pursue? From there, I have them gradually work their way up to the next level of what they would do if they had some money (and I choose the amount). How

The Claims and Litigation Management Alliance is a collaborative organization that promotes and furthers the highest standards of claims and litigation management and brings together the thought leaders in both industries.
would they spend it? Then, I can usually land on a level of care and cost that works with my defense strategy and one that a jury would view as likely. At the same time, I do as Daniel Goodmann suggests; I also challenge the individual pieces and assumptions of the plaintiff’s plan through my own medical experts, or by utilizing favorable testimony from the plaintiff’s medical providers or medical records.

— John Trimble, Lewis Wagner, LLP

On occasion, you find an accurate life care plan. But usually, they are reserved for the catastrophic cases. What I think you are referring to is the simple injury case that then includes huge "boardable" damages. For these cases, I like to do a few things:

1. Compare the treatment being suggested with treatment that is already performed. Most times, you will find that the treatment suggested in the plan was never suggested by a treating doctor or has been rejected by the patient (injections are the most common in this category).
2. Compare the cost with costs that have already been incurred or to a multiple of the Medicare payment.
3. Look at the medications suggested. You will probably find redundant medications and incredibly inflated costs.
4. Calling a life care planner for a non-catastrophic case is likely to backfire. Instead, I ask my CME to comment on future expenses and the life care plan. That way, as the trial continues, you have that ammunition and can play it as loud or as soft as the case requires.
5. Finally, having information about the planner can be very effective. In South Florida, we have a well-known doctor who writes plans all the time. He includes everything, including morphine pumps, for the simplest of injuries. Bringing out the fact that he always includes these treatments has been very effective. In fact, I recently had the plaintiff’s economist chuckle when I asked him if it was common for the good doctor to include the morphine pump. — Thomas Berger, Boyd & Jenerette, PA

Another idea is to call in a structured settlement consultant. They generally have resources who can assist in tailoring the plan to what is truly required. The consultant can then tell you the cost of the care, reduced to present value. Additionally, they have experience working with "special needs trusts," often used to fund care over and above what is provided by Medicaid, or develop Medicare set-asides should the plaintiff qualify for Social Security benefits. Through medical underwriting, which provides "rated age" quotes, they can provide lifetime income replacement benefits, which the plaintiff can never outlive, at a premium discount. Finally, if the Affordable Care Act remains in place, they may be able to quote plans that can purchase lifetime healthcare benefits with no payment caps, for those with pre-existing conditions, starting in 2014. — Carolyn Finch, Markel Corporation.

“Compile a line-by-line analysis of all treatments, items, equipment, etc.”

“I challenge the individual pieces and assumptions of the plaintiff’s plan through my own medical experts.”

“Calling a life care planner for a non-catastrophic case is likely to backfire.”

“Call in a structured settlement consultant. They generally have resources who can assist in tailoring the plan to what is truly required.”
In investigations after alleged malpractice, medical practices and healthcare organizations (HCOs) will have to demonstrate clinical and technical due diligence in how they have managed the transition to electronic health records (EHRs) and in how they use them. Indeed, practices will be subject to inspection of information that is not available in the paper chart and a heightened level of scrutiny from those charged with evaluating the sequence of patient care events as they occurred, and when they occurred.

The difference between supporting the defense of a claim and undermining the defense (or even contributing to the problem) will rest on how rigorously EHRs have been deployed and used.

**EHR transition**

In many cases, EHR transitions lack clinical analysis and other considerations.

Typically, the transition process is poorly designed and even more inadequately documented. Unfortunately, many EHR transitions focus overwhelmingly on the technology, and the easiest path to EHR deployment, rather than on preserving the patient medical record and a seamless segue of patient care to the EHR. For example, a number of vendor “best practices” treat the paper record as superfluous in the EHR environment.

**Defense issue** – If the paper records contained information that was relevant to patient care or provided context to the patient’s situation and the paper chart was not available or was available but unreadable in the EHR, then the inability to access the patient record may have compromised the clinical care decision.

**Mitigation strategy** – A clinical decision should be documented about the disposition of the paper chart and/or some way found to make the relevant paper-based information available through the EHR. If a scanning process is used, the scanning procedure should be documented and include a step to verify the quality of the scanned images.

**Initial patient information**

EHRs need complete patient information to properly trigger the system’s care advisories. For example, some pediatric practices do not enter immunization history, to save time and money, but then have to contend with frequent and multiple warnings about missing immunizations.

Similarly, failure to enter a patient’s surgical history into the EHR may prevent the physician from reviewing the context of patient care and prevent the system from warning about an overdue checkup (e.g., checking on a hip replacement).

**Defense issue** – False warnings undermine confidence in
Many EHR systems compile patient notes using entry screens, and then produce reports and other documents through a separate process that may change or interpret the information on the entry screens.

the system, and staff and doctors tend to ignore the inessential inappropriate advisories. If there is important information missing, such that the system fails to trigger clinical-decision-support rules, that may undercut a claim of appropriate care.

**Mitigation strategy** –
Physicians should document the information needed to properly begin using EHRs with patients, and enable EHR features and capabilities. A defined process, including quality assurance procedures, should be designed to gather appropriate information for each patient. Initial entry of patient information should be performed by an appropriate clinical staff member.

**Clinical content**
Clinical content is the area of medicine-specific setups and checklists used to document patient care. Practices and healthcare organization typically buy EHRs for “out of the box” clinical content to meet their documentation needs. If the clinical content is not appropriate for the practice or HCO, then the providers will work around the EHR clinical content and undermine its full implementation. For example, patient issues may be noted in free-form text; as a result, their content will not be considered in determining the appropriate patient alerts or health maintenance items.

**Defense issue** – If the clinical content being used was never vetted for appropriateness and accuracy by the physicians, then the resulting notes are open to questions about their precision and the doctor’s ability to document care.

In a number of medical professional liability (MPL) situations, failure to understand clinical content and charting tools have led to inappropriate findings appearing in patient notes that undermine the efficacy of the entire clinical note and the physician’s decisions on care.

**Mitigation strategy** –
Doctors need to practice with the clinical content aspect of the EHR, using actual cases, to make sure that they understand the representations that are being recorded and how findings will be presented in the patient record and used within the EHR’s system. This process should be documented and used to evaluate any changes contemplated for the clinical content, as well as new vendor releases of clinical content and other EHR features. Additionally, physicians should verify the quality of EHR generated notes on a periodic basis.

**Printed EHR notes**
Many EHR systems compile patient notes using entry screens, and then produce reports and other documents through a separate process that may change or interpret the information on the entry screens. Indeed, many EHRs can print additional information that may not have even been entered for the patient.

**Defense issue** – Practices will have to prove that the printed documents and other products produced from the EHR properly reflect the information that is in the patient chart. This may be difficult, since patient note information may be replicated in the system, but not maintained. For example, a clinical summary that was presented to the patient through the patient portal may not reflect updated information added into the patient record since the clinical summary was produced.

**Mitigation strategy** –
Physicians need to review all of the printed documents used by the practice or HCO to verify that the correct information is appropriately presented. Additionally, procedures should be evaluated to assure that the patient and staff are using the correct document to guide patient activities and care.

**EHR workflow and messages**
In the absence of a paper chart, the EHR is used to record all interactions with and about patients. However, some EHRs consider messages as part of the patient medical record, while other EHRs do not. For example, a message with an instruction to staff on patient care may not necessarily be preserved in the EHR or considered part of the patient record in some systems.

Messages and their handling provide context for interpreting the sequence of events and care provided to the patient.

**Defense issue** – The defense may be unable to locate the supporting information about efforts to communicate and care for the patient. Missing messages will leave gaps in understanding the actions of the practice and even prevent the HCO from substantiating their assertions of due diligence and professionalism.

**Mitigation strategy** –
Messages and other care activ-
Medical practices and HCOs need to develop the proper procedures and processes to effectively and appropriately use the EHR they purchase.

Audit trails should be documented using features that will preserve the message in the patient chart. Staff and doctors need to be trained to use the appropriate features that will support documentation in the medical record. Equally important, the practice/HCO needs to review items outside of patient record to insure that clinical activities are not recorded in a manner that will not be saved. For example, the end-of-day process may include a review of messages to verify that important patient information was not omitted from the EHR chart.

**EHR audit trail**

Certified EHRs maintain an audit trail record of any changes, entries, and access to the patient medical record. In some cases, audit trails can be easily accessed from the patient record. In other cases, audit trails are accessed through a report.

**Defense issue** – Audit trails present a step-by-step guide to patient care activities. For example, doctors may sign off on tests after the tests are completed in a paper chart, but will need to appropriately sign off on orders before the patient is served via an EHR. Similarly, the EHR will present information on whether and when the doctor accessed and signed off on a message or reviewed an incoming document.

**Mitigation strategy** – Practices and HCOs need established standards of performance for clinical activities and efforts. EHR performance and standards should be checked on a daily basis. For example, signing of notes and responses to requests for prescription refills should be checked for completion and timeliness. Any problems should be addressed with the appropriate provider.

**Conclusion**

EHRs offer many opportunities for improving HCO operations and patient care. However, improper use, or lapses in EHR maintenance, will pose a wide array of problems that may lead to MPL issues and/or problems defending against such a claim. Medical practices and HCOs need to develop the proper procedures and processes to effectively and appropriately use the EHR they purchase. In this way, the practice or HCO can preserve a trail of information that reflects the due diligence and care provided to patients as a natural byproduct of their interaction with EHRs in support of patient care.

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Return of the Hawthorne Effect

BY ERIC R. ANDERSON

Workplace environments of all kinds have been studied for many years to try and find new ways to improve safety, productivity, and quality. One of the most famous is the Hawthorne study: when factory lighting conditions were modulated, worker productivity (apparently) changed in tandem.

In the healthcare field, a recent study by the Robert Wood Johnson Foundation examined acute-care hospitals to determine the relationship between selected characteristics of the nursing practice environment, nurse staffing levels, nurses’ practices in intercepting medication errors, and the consequent rates of medication errors that did not get detected.

The study findings reveal something that medical professional liability (MPL) risk managers may already know: nurses error-interception practices—for example, asking physicians to rewrite orders when they used ambiguous abbreviations, and ensuring that patients understand the specifics of a medication regimen, so that they can question unexplained variances—led to fewer medication errors.

These results illuminate the important role that nurses play in enhancing patient safety. And this fact has become even more important in the MPL industry, in light of the increasing numbers of nurses in healthcare and their expanding role in today’s integrated care environment.

But just as interesting to me is the fact that these findings supplement the increasing body of work which suggests that a supportive practice environment for nurses, as reflected in (for example) close teamwork between physicians and nurses; opportunities for nurses to participate in hospital- and unit-level decisions; continuing education opportunities; and administrators who are visible, accessible, and willing to listen to nurses’ concerns—is associated with better nursing care, overall, and better outcomes for patients.

So: what does this mean for MPL? It means that we need to teach healthcare administrators that it is of critical importance to promote programs that will promote a protective and supportive workplace environment for nurses. Whenever a nurse can intercept a medication error, it benefits the patient by diminishing the number of adverse outcomes—one of the philosophical cornerstones of the PIAA—and it may also reduce claims exposure and, ultimately, loss costs.

Now, back to Hawthorne. The investigators assumed that the outcome of their experiment—improved factory lighting increases worker productivity—was clear…until someone turned the lighting down to below the baseline level in the experiment, whereupon worker output increased still further. The moral of the story, called the Hawthorne effect, is that an external factor like lighting was less important than social interactions; and administrators who are visible, accessible, and willing to listen to nurses concerns—are is associated with better nursing care, overall, and better outcomes for patients.

Eric R. Anderson is Director of Public Relations and Marketing at the Physician Insurers Association of America; eanderon@piaa.us.

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