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AMS

Insured Colleague

A Medical Liability Insurance Company

APPLIED MEDICO-LEGAL SOLUTIONS RISK RETENTION GROUP, INC.

AMS RRG President's Message

by Richard B. Welch

Richard B. Welch

2010 Highlights

AMS RRG ended 2010 the way it has ended every year: exceeding growth expectations, increasing profitability and growing capital surplus. In 2010, AMS RRG wrote over $33 million in gross written premium. We expanded our footprint by adding seven additional states. We are now in 48 states and the District of Columbia (go to **www.amsrrg.com** for a detailed map of Where We Do Business). Additionally, the following are key accomplishments:

- Second Consecutive Dividend – $.18 per share;
- Capital & Surplus Growth – over $1.6 million (net of dividend);
- Demotech, Inc. reaffirmed Financial Stability Rating® of A' (A Prime), *Unsurpassed*.

We also added a new attorney to our team in Dallas. We welcome Dena Mastrogiovanni and look forward to her contributions in the area of claims and litigation management.

2011 YTD

2011 has started extremely well. We wrote over $7.7 million in gross written premium, our highest first quarter premium volume ever. When compared with our competition, we continue to outperform, based on premium growth, profitability, and surplus growth (net of dividends). Claims and reserve development are well within our expectations and we continue to be conservative in our reserving philosophy.

Market Overview

Let me start by saying that the medical liability market shows no immediate signs of hardening (increases in premium). However, we are keeping a close eye on global events and reinsurance market rates, which can signal increases in the primary markets. An obvious reason for rate increases is the erosion of capital surplus at any level, but often it is at the top of the insurance pyramid that the trend begins. The following events over the last two years were significant losses to the reinsurance layer:

- Japan Earthquake/Tsunami
- New Zealand Earthquake
- Chile Earthquake
- Australian Floods
- Cyclone Yosi Australia

continued on page six

In This Issue

- **Head Off Malpractice Lawsuits by Disclosing Breast Density** *pg. 2*

  A 33-year-old female is seen by her family practice physician for a lump in her left breast. Her physician knows that she has severely dense tissue and fibrocystic disease, and recently had a negative mammogram.

- **Comprehensive Risk Resources for AMS RRG Members** *pg. 4*

  AMS RRG offers a wide array of custom programs for reducing risk. Our latest service is a partnership with the Medscape Reference, formerly eMedicine, to offer free, unlimited access to approved CME courses from our website.

- **Electronic Health Records: Risks and Rewards** *pg. 5*

  Over the next several years, all physicians, physician practices, clinics and hospitals will be switching to Electronic Health Records (EHR). While there has been much debate over whether this change is good, ultimately, the answer will be yes.

- **Dena Mastrogiovanni Joins AMS RRG's Claims/ Litigation Team** *pg. 6*

  AMS RRG's claims/litigation department in Dallas has hired attorney Dena Mastrogiovanni to work with Susan Martin on cases in Texas, Florida and other states in the Southeast.

Head Off Malpractice Lawsuits by Disclosing Breast Density

Breast Cancer A Growing Malpractice Risk

by Kathy Schilling, MD and Susan Martin, RN, JD

Susan Martin, Esq.

A 33-year-old female is seen by her family practice physician for a lump in her left breast. Her physician knows that she has severely dense tissue and fibrocystic disease, and recently had a negative mammogram. He performs a breast exam. He believes what she feels is normal breast tissue, and tells her that "we will watch it" and repeat a mammogram in six months. She returns in six months stating she can still feel the lump and that it feels different than the other tissue. He tells her that this is fibrous tissue but will repeat the mammogram. Results are negative, and he orders no further testing.

Approximately one year later, she returns and now states the lump is increasing in size. Her physician feels a large mass, orders appropriate needle biopsy, which returns with bad results, and the patient is diagnosed with advanced stage breast cancer. A lawsuit is filed and even the defense experts have a difficult time finding a defense for the physician. The case settles in the high six figures.

Breast cancer cases continue to be a huge area of risk for women's health practitioners, including OB/GYN, family practice and internal medical physicians. Approximately 50% of the breast cancer claims involve one of those specialties, with radiologists and pathologists representing the other 50%. Since these cases usually involve young women, many with young children, the indemnity payouts are high. If the cancer is not caught early and the patient has a poor prognosis, the loss of income from her capacity to work, and the loss of companionship, love, and household services to her husband and children, can be overwhelming. Jurors see these cases as "tragic" and plaintiff's evidence will show that there are better technologies for women who present with complaints of a change in breast tissue, rather than simply relying on a mammogram.

Practice Tips for Lowering Risk

Although a failure to diagnose is the most common allegation, inappropriate readings of mammograms, failure to refer patient to a breast surgeon, and failure to perform MRIs, ultrasounds and/or other diagnostics are also claimed. The Physician Insurers Association of American (PIAA) Data Sharing Reports show that the most common and expensive diagnosis resulting in claims against physicians is breast cancer.

Some common tips for practitioners:

- Document findings of *any* changes in breast tissue, including any lump in the breast, and order appropriate tissue diagnostics, *even with a negative mammogram.*
- Order needle biopsy, MRI or further studies as needed to evaluate any changes.
- If needed, refer the patient to a breast surgeon for more invasive procedures. Document the referral and inform the patient of the necessity of follow-up.
- Review all tests and procedures and inform the patient of the results, what further should be done and why.
- Repeating exams and procedures, and closely following the patient, are key to keeping the patient informed about the progress of any new developments. Document your conversations with the patient.

Many breast cancer cases turn on the communications with the physicians. "I tried to tell him that the lump in my left breast felt different, but he didn't believe me." If the patient feels a palpable mass, even if the physician cannot palpate any mass, it is in the physician's best interest to get the diagnostics done. Many times, the patient is right and, with a more rapid diagnosis, lives can be saved and lawsuits prevented.

Breast Density and Disclosure

Radiologists are always looking to head off potential malpractice lawsuits – especially in breast cancer. One area of breast imaging that has been getting more attention in recent years is breast density.

Breast density refers to the amount of active tissue in a woman's breast. It's a big deal because the more active tissue a woman has, the more likely she is to contract breast cancer. And having dense breast tissue also makes it more difficult to spot a cancer within the breast, which can lead to cancers being detected later at a more advanced stage.

In 2009, the state of Connecticut made it mandatory for radiologists to inform women if they have dense breast tissue. They must also let patients know that they might want to consider other imaging modalities, such as ultrasound or MRI, in addition to a mammogram. While ultrasounds and MRI aren't recommended for screening instead of mammograms, they can be used in addition to mammograms in certain groups of women to find more cancers.

Seven other states are also mulling legislation that is similar to Connecticut's bill and a federal bill has been proposed as well.

Women are also becoming savvier when it comes to breast density. Some activists are encouraging women to ask their doctors if they have dense breasts.

This all adds up to potential legal risks for breast imaging facilities.

If a woman with dense breasts only has a mammogram and isn't referred on for other imaging, and a cancer is found at a later stage, a lawsuit for delayed diagnosis could result, says **Gerald Kolb, JD,** vice president of business development for Volpara, a breast density software company.

A physician might counter that claim by saying that he or she followed the current standard of care, which is a mammogram only, says Kolb. "But one of the first things that lawyers learn, and that doctors should learn, is that standards of care are not set by doctors, they are set by juries."

Taking Action

At Boca Raton Regional Medical Center in Boca Raton, FL, women know their breast density before they leave with their mammogram results, says **Kathy Schilling, MD,** its medical director of breast imaging and intervention.

Density is considered one component of a three-step breast cancer assessment.

- Has the patient had a recent breast exam?
- What is the patient's risk of breast cancer based on an assessment?
- What is the patient's breast density?

Asking these questions allows physicians to open a discussion with women about their potential risk factors and the necessity to consult with an advanced care practitioner.

"We're actually training our technologists on what the added risks are related to high breast density," says Schilling. "We are letting them know that they are going to be having questions from their patients about density."

Physicians at the facility also sometimes perform bilateral ultrasounds on women that have dense tissue.

Because there is no payment available for a screening ultrasound, they must bill them as a diagnostic service, at a low rate considering the time taken to perform the exam.

While their policy was based on optimizing patient care, and not legal risks, Schilling says she couldn't rule out legal action in this area in the future.

"Some women do feel angry that when they aren't told that [density] is a risk factor. We're trying to get ahead of the game," she says.

Kolb says this is the right approach.

A facility can cover itself from malpractice risk in this area by taking a few simple steps, says Kolb.

- Develop criteria to identify women with dense breast tissue that will require notification.
- Inform the patient or, at the very least, her physician if she has high breast density.
- Be prepared to discuss additional imaging options with patients and, if necessary, to refer them to other sites if you don't offer the imaging procedures at your own facility.

"The first time one of these cases does get to a jury, then we're going to have a cascade of cases," says Kolb. As of 2008, the evidence was there to show that women with high breast density would benefit from an ultrasound in addition to a mammogram. Facilities that were not informing patients about their density at that point might have some element of exposure, says Kolb.

Ten years of research points to the additional benefit of ultrasound with dense breasted patients.

It's better to be informing patients about this issue now before it is required than to wait and expose your facility to legal risks in the meantime.

For any questions regarding risk issues, please contact Steve Shapiro, MD or Susan Martin, RN, JD.

Comprehensive Risk Resources for AMS RRG Members

AMS RRG offers a wide array of custom programs for reducing risk. Our latest service is a partnership with the Medscape Reference, formerly eMedicine, to offer free, unlimited access to approved CME courses from our website. Medscape gives physicians access to more than 6,300 disease and condition articles covering over 30 specialties, each worth up to 2.5 hours of Category I CME credit.

Other risk management strategies we provide members include

- On-site practice evaluations and self-audit surveys for specific specialties
- Tele-risk consulting with our Chief Medical Officer and Executive Vice President of Litigation Management/Loss Control
- 24/7 access to web-based tools and assistance with consent forms, refusal of care forms and follow-up methodologies
- Newsletters articles on risk management and claims avoidance strategies
- Risk management updates on specialty practice areas

To learn more about any of these services, please call Susan Martin at 866-520-6896, or visit **www.amsrrg.com.**

Insured Colleague Program

Risk Management Update

AMS

A Medical Liability Insurance Company

Date:
April 27, 2009

Topic:
Emergency Medicine

Author:
Steve Shapiro, MD
Chief Medical Officer

"An essential element in maintaining safe operations in high risk environments with this 'on-call' organizational architecture is to understand how to bring called-in practitioners up to speed quickly during escalating situations."[1]

While these cautionary words are from an article about Space Shuttle Mission Control, shift changes in virtually every field – including medicine – can have potentially disastrous consequences. For example:

1. **1988 Piper Alpha disaster**. An off-shore oil platform in the North Sea exploded, resulting in a fire that caused 167 deaths.[2] An engineer coming off duty neglected to inform his replacement that the "A-pump" could not be used under any circumstances as the safety valve had been removed for maintenance. When the B-pump failed, the on-call engineer did not see the written note that had been left and started the A-pump.
2. **1991 US Continental Express Flight 2574.** The Embraer aircraft crashed in a cornfield outside Eagle Lake, Texas, killing all 14 people on board. "Departures from approved procedures included failures to solicit and give proper shift-change turnover reports, failures to use maintenance work cards as approved, failures to complete required maintenance/inspection shift turnover forms, and a breach in the integrity of the quality control."[3]
3. **1995 amputation of the wrong leg of Willie King in Tampa, Florida.** During the handoff update, the surgery pool nurse did not tell the surgery shift nurse that the incorrect leg had been input by the clerk for amputation.

Handoffs in the Emergency Room between physicians who are on-duty and those coming to replace them are particularly risky because of the following characteristics common to EDs throughout the country:

1. The Emergency Room is composed of many interconnected parts and stakeholders who are all constantly in motion.
2. The event-driven care of acutely ill patients competes with the care of those that are less ill but may have some significant, potential long-term consequences.
3. Care is increasingly time-pressured as Emergency Rooms face increasing patient volume, particularly from the uninsured.

[1] Shift Changes, Updates and the on-call Architecture in Space Shuttle mission Control
[2] http://en.wikipedia.org/wiki/Piper_Alpha
[3] http://www2.hf.faa.gov/opsManual/assets/pdfs/HFOM_Maint_Org.pdf

For more information, call 1.866.461.1221 or visit www.amsrrg.com.

Applied Medico-Legal Solutions Risk Retention Group, Inc.

Electronic Health Records *continued from page five*

Physicians will also need to familiarize themselves with the key concepts of the federal e-discovery rule to understand how EHR information may be used in litigation in the future. The American Health Information Management Association advises the following:

- **Early attention to e-discovery.** Attorneys representing physicians must be aware of (and able to discuss) all potentially relevant information, electronic and paper, early in the litigation process. These include pretrial conferences, preservation, form of production, and assertion of privilege.
- **Duty to disclose.** The legal obligation to disclose relevant information and records extends to all electronically stored information. If the information is relevant to the claim or the defense of it, it must be retained and disclosed regardless of format.
- **Preservation.** The party must take steps to preserve information that would be automatically destroyed or overwritten by an information system once it receives notice of litigation, or can reasonably anticipate such notice.
- **Accessibility.** The e-discovery rule recognizes that not all electronic information is reasonably accessible and may be costly to produce (such as information on back-up tapes). It provides a mechanism to balance cost and burden versus value of the information produced.
- **Native file format and metadata.** This is the information in an EHR that is normally not printed out. All parties in any lawsuit will be entitled to the metadata that includes other information such as date and time stamps, access logs, and other audit data.
- **Sanctions and safe harbors.** Failure to disclose or produce relevant information can result in sanctions. There are exceptions if information was lost as a result of good faith practices, including normal destruction processes that occurred prior to knowledge of impending litigation. However, if relevant information was destroyed once there was knowledge of impending litigation, sanctions could be applied.

Overall, EHRs can and will be helpful in the delivery of healthcare. But there are likely to be significant growing pains and dramatic software improvements as errors are detected and repaired. As you implement an EHR program, you can help improve the systems by submitting – anonymously – any errors in your use of the technology at **www.ehrevent.org.** The site is designed to improve patient safety and reduce professional liability, and also contains links to other EHR resources.

For more information about Electronic Medical Records or the information in this article, please contact Dr. Shapiro at 800-367-1337.

Electronic Health Records: Risks and Rewards

By Steven Shapiro, MD, AMS RRG Chief Medical Officer

Steven Shapiro, MD

Over the next several years, all physicians, physician practices, clinics and hospitals will be switching to Electronic Health Records (EHR). While there has been much debate over whether this change is good, ultimately, the answer will be yes. It will, however, be important for physicians and providers to understand that, while some problems will be solved as EHRs become more prevalent, others will appear.

Physicians will be faced with many options when it comes to selecting an EHR. The most important consideration is to choose a system that has been designed to meet the needs and capabilities of the physician and/or provider using it. However, no matter how good the design, all systems will present users with numerous opportunities for mistakes, slips and associated unintended consequences.

All of us in the real world of private practice have developed our own tricks and devices to help reduce "errors." Now, we will have to learn a new set of tools to help decrease the "well-documented spike" in errors that typically occurs during the implementation of an EHR program. What can go wrong? Below are some examples:

- While selecting the correct choice, your pen slips down to the next selection as you pull it away, resulting in a change from "qd" to "qid" dosing. It is important to note as well that Amoxapine, a tricyclic antidepressant, shows up right ahead of amoxicillin in many EHR programs.
- Another physician ignored a warning box that suggested Rocky Mountain Spotted Fever should be ruled out. The physician did not remember clicking to ignore this warning for a patient who subsequently had RMSF.
- Will the EHR cause an increase in screening lab work? Will the screening be more appropriate because the computer suggested it? Does clinical opinion matter or can all care follow a simple algorithm?
- A member of the Florida Board of Medicine requested that the Board issue a statewide warning that all physicians review the default settings of their EHR program following an incident in which an OB-GYN missed an abnormal Pap smear and blamed the EHR. While the physician received a $20,000 fine, risk management review and 100 hours of community service, the EHR program was replaced.
- The Archives of Internal Medicine published a report which revealed that, of 17 measures of quality assessed, EHRs made no difference in 14. In two areas, better quality was associated with the use of electronic records, while worse quality was found in one area. For this study, a survey of 1.8 billion physician visits (18% of which involved an EHR program) in 2003 and 2004 was used.
- While an EHR may improve the delivery of care for a practice that is already run well, it could also exacerbate any problems that exist in a practice that already has process issues.
- If the design of the EHR program does not match the needs of the user, you can blame it on the software, the clinic, the technology or the healthcare culture. But the patient will blame it on you. This can cause unhappy patients and frustrated doctors, damaging your practice.
- All notes entered into an EHR are time-stamped. If a note is entered late, i.e. an operative note or office note, it will be obvious.
- If other healthcare providers (i.e. residents, mid-level providers, or even nurses) are entering data into an EHR under your name, you must be careful not to sign off on the entries without verifying their accuracy.
- If a hybrid system is used where a written record is generated and scanned into the system, you will need to save the written record as it may still contain information that did not make it into the EHR.
- Protection of patient confidentiality, restricted access and hardware and/or software problems will all become more of an issue in the future.
- Lack of time synchronization between various electronic charting systems can indicate that a child was born before a C-section was performed.
- Relying on an electronic capture of physiological data, an anesthesia care team failed to document 90 minutes of vital sign data.
- An emergency room physician documented patient care four hours after actual treatment, but the system recorded the entry as occurring at the time of treatment.
- During the discovery process for a malpractice claim, the record printed by the EHR contained information that was not actually available at the time the physician saw the patient.
- A progress note that had been dictated into the wrong patient's chart was not corrected as the system did not require a physician verification of the dictation.

continued on page four

AMS RRG, INC.
23 Route 31 North
Suite A-10
Pennington, NJ 08534

A Medical Liability Insurance Company

Upcoming Events

ACEP (American College of Emergency Physicians)
Scientific Assembly 2011
October 15 – October 16, 2011
San Francisco, CA

President's Message *continued from front page*

These events equate to roughly $60 billion of losses in the reinsurance market layer. Given the size of the losses, all eyes are on the upcoming windstorm season. Although these types of events do not directly affect the medical liability market, they do impact the overall property and casualty markets. Ultimately, this causes rate increases and reallocations of capital and surplus. Again, it appears as though rates will stay at the current levels for the foreseeable future.

Moreover, as this soft market continues, we believe many of our competitors will face increased pressures to:

- Increase reserves as reserve inadequacies are becoming more prevalent;
- Be aggressive on premium pricing; moreover, writing business at a loss to gain market share;
- Merge or sell;
- Exit the market.

For many carriers, operating costs continue to rise as a percentage of revenue because of the pricing pressures and decreases in premium volume. Having a company like AMS RRG, with strong reserves and capital, ensures ongoing viability. Add to that the ability to continue to grow premium and be profitable, and AMS RRG is in an enviable position.

Finally, as we are now into our 9th year of business, it is only fitting to say "Thank You" to all of our Insured Colleagues! We are very pleased to continue to provide value to you through competitive rates, ongoing risk/claims management support and shareholder dividends. And, as always, please feel free to contact us any time with any comments, concerns or ideas. We really do appreciate your partnership!

Dena Mastrogiovanni Joins AMS RRG's Claims/Litigation Team

AMS RRG's claims/litigation department in Dallas has hired attorney Dena Mastrogiovanni to work with Susan Martin on cases in Texas, Florida and other states in the Southeast.

With many years experience representing physicians in medical negligence cases, Dena understands physician practices and is well respected among other defense counsel in the area.

Most recently, Dena ran a trial practice in the area of defense of healthcare liability claims for nursing homes and physicians. She focused on complex litigation issues, evaluation, analysis, and communication of risk issues and professional liability claims to aid clients in decision-making regarding their exposure. Previously, she was an attorney with Schell Cooley LLP in Dallas with a heavy practice in medical malpractice litigation for many physician groups and hospitals (including Texas Oncology, EmCare, Sheridan Physician Services, Tenet Hospitals, and Texas Health Resources hospitals).

Welcome Dena!