Winter 2015 | Volume 014

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

With another year coming to a close, I want to take this opportunity to wish you a Happy Holiday Season! We have had a great year marked by continued growth and ongoing financial strength. As of the end of the third quarter, we had gross written premium of over $34 million and expect to end the year with approximately $49 to 50 million. We are focused on building our capital and surplus and as of the end of the third quarter, assets were greater than $140 million.

This year, we also saw very favorable retention rates, despite experiencing the effects of physician practice consolidation in the industry – the primary reason individuals or groups change insurers. And we continue to strengthen our growth and retention strategies and drive future business through the ongoing maturation and success of our Preferred Aesthetic™ program as well as our newly added Preferred Radiology and Imaging™ and Preferred Anesthesia and Pain Management™ programs.

As I mentioned in my last article, we anticipated a good reinsurance renewal process in 2015 and I am pleased to report we again saw improvement in our reinsurance terms, showing the commitment and support of our reinsurance partners. Overall, the reinsurance market continues to be fairly soft, with low catastrophic losses and access to capital contributing to the trend.

This year, we contracted with a new consulting actuary, Rusty Kuehn, FCAS, MAAA, CERA, CPCU, ARM, FCA, with Huggins Actuarial Services, Inc. Rusty brings many years of experience and a wealth of knowledge in MPL actuarial sciences to AMS RRG, and we are pleased to have him working with us.

The rating agency Demotech reaffirmed AMS RRG's rating of A' (the highest for an MPL RRG) in 2015. We also continued to participate in the PIAA, our trade organization, which represents MPL insurance companies throughout the United States. If you would like to receive information regarding the PIAA and/or Demotech and programs they offer, please contact Erika Wilson at ewilson@amsrrg.com. Erika can also subscribe you to our monthly e-blast, which provides claim trend updates and marketplace information.

As we enter our 14th year of business, it is important to reflect on the reasons for our success. While the quality of the underwriting process and our insureds are paramount to the success of AMS RRG, equally important are our employees, who have unparalleled experience and expertise in their respective roles and are committed to driving exceptional value for our members. In addition, a number of core competencies are critical to achieving our goals and differentiate AMS RRG in the market, including competitive pricing, return on investment, knowledge of the issues facing physicians today, and robust claims and risk management processes. Another less obvious benefit is the unlimited access to key management. This access, along with our physician involvement and leadership in everything from underwriting to claims management, are designed to promote open communication and provide useful information to you and your practice in today's changing healthcare delivery environment. Finally, AMS RRG enjoys a large geographic scope of service, with registration in 48 states and the District of Columbia.

Remember, if you have questions or concerns, please do not hesitate to contact us. Additionally, if we can be of assistance with anything regarding your policy or risk management program reviews, we are happy to help. We continue to differentiate ourselves from our competitors by providing unparalleled access to medical and legal professionals to assist you in managing and reducing risk. Again, I wish you a wonderful and safe Holiday Season!

In This Issue

A' Unsurpassed Financial Stability Rating® Demotech, Inc.

PIAA Member

Defensive Medicine Continues

By Steven Shapiro, MD, AMS RRG Chief Medical Officer


Steven Shapiro, MD

There is a fairly standard path from the provision of medical care to the initiation of a lawsuit. The first thing that has to happen is an error or a perceived error that leads to some form of damages. Once that occurs, those patients and families who perceived that their doctor was either unavailable, discounted their concerns, poorly delivered information or lacked an understanding of the patient and/or family's feelings were more likely to sue. To help combat the risk of litigation, many physicians practice defensive medicine, or medical care provided to patients purely to reduce the threat of a malpractice lawsuit.

Defensive medicine is a concept that has been talked about – and studied – for many years. In a 2005 article, JAMA reported that 93% of physicians in emergency medicine, neurosurgery, obstetrics/gynecology and radiology reported practicing defensive medicine. In the survey-based study conducted in Pennsylvania:

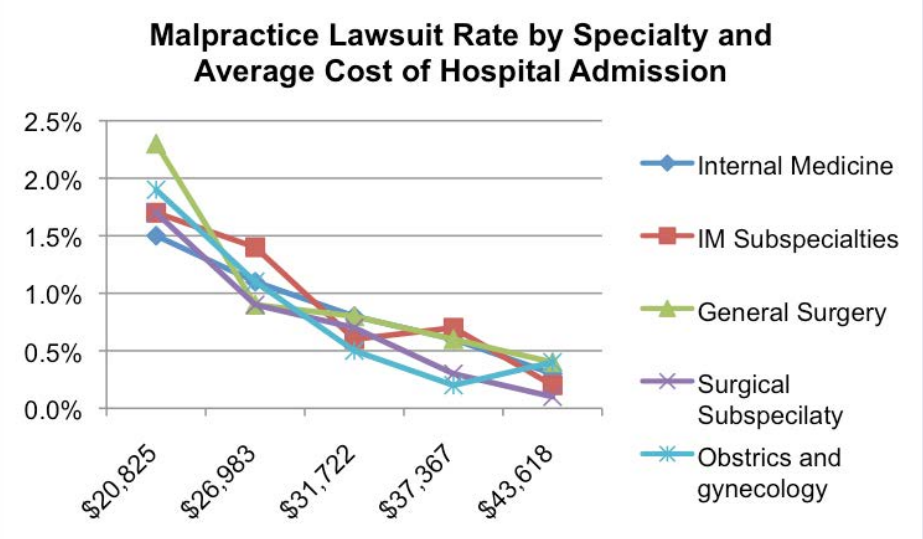
- 92% reported that they ordered tests, performed diagnostic procedures and referred patients for consultation to help avoid the risk of a medical malpractice lawsuit
- 43% reported using imaging technology in clinically unnecessary circumstances
- 42% reported they had taken steps to restrict their practice over the prior three years, including reducing procedures prone to complications and avoiding patients with complex medical problems

A new study, documented in a November 2015 article in The BMJ, led by Dr. Anupam Jena, an associate professor of health care policy at Harvard Medical School and an internist at Massachusetts General Hospital, assessed the impact of defensive medicine on the subsequent risk of malpractice claims. Data from "nearly all" admissions to acute care hospitals in Florida was collected for the years 2000 through 2009 and compared to the online malpractice data available for all physicians in Florida. The results, which included 24,637 physicians, 154,725 physician years, and approximately 19 million hospital discharges, revealed that 4,342 malpractice claims were made against physicians, with greater average spending by physicians associated with a reduced risk of incurring a claim. The chart at the bottom of this page shows the average malpractice rate for higher risk specialties based upon the average cost of each hospital stay.

The researchers also gave special attention to Cesarean deliveries due to ongoing concerns that many C-sections are preformed due to malpractice concerns. The data revealed that those physicians with the lowest C-section rates of 5.1% averaged a malpractice suit rate of 5.7%, while physicians in the highest quintile, averaging C-sections in 31.6% of all deliveries, had a malpractice suit rate of 2.7%, less than half of those in the lowest quintile.

In conclusion, Dr. Jena noted that, "A higher use of resources by U.S. physicians in acute care hospitals in Florida during 2000-2009 was associated with fewer malpractice claims." (BMJ 2015;351:h5786).

While most physicians feel they order unnecessary tests, procedures, studies and hospitalizations, does this type of care truly represent defensive medicine just because the number of lawsuits associated with higher levels of resource utilization are lower? There are clearly other factors considered by physicians and patients when making decisions about healthcare. Whether you call it comprehensive medicine or defensive medicine, one thing is clear: most physicians would rather order more tests, admit more patients and obtain more consultations than face the risk of more medical malpractice lawsuits.



Risk Mitigation for Radiologists

By Susan Martin, Esq., Executive Vice President, Litigation Management/Loss Control

Susan Martin, Esq.

Breast Cancer Poses Highest Risk

A 38-year-old female is seen by her primary care physician for a lump in her left breast. Her physician knows she has severely dense tissue and fibrocystic disease, and recently had a negative mammogram. He performs a breast exam. He believes what the patient feels is normal breast tissue, and tells her "we will watch it" and repeat the mammogram in six months. She returns in six months, stating she can still feel the lump and that it feels "different" than other tissue. Her physician orders another mammogram. The radiologist reports the mammogram again as negative, failing to address her cystic disease, dense breast tissue, or make any further recommendations on the report.

Approximately one year later, the physician feels a large mass in the patient's left breast, orders an ultrasound, and refers her to a surgeon for a needle biopsy. She is diagnosed with advanced stage breast cancer.

The patient files a lawsuit, naming the radiologist, the facility, and the primary care physician. When the radiologist reviews the mammogram, he now sees a very small area that is likely the original micro lesion he believes he just "missed" on the read. However, at the time and date he read the film, the radiologist did not have all of the information available now, such as the area of the mass and the ultimate outcome, which makes it much easier to identify the lesion.

Unfortunately, verdicts can be high in breast cancer cases due to large economics: younger ages of women, minor children at home, and empathy for families and the patient. 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. Simply relying on a mammogram, especially if the patient has dense breast tissue, is unlikely to appease a jury.

While mammography is better at picking up certain cancerous and pre-cancerous findings such as micro-calcifications, many studies have found that ultrasound is better at detecting cancers in women aged 45 or younger, in large part due to the density of the breast tissue that can reduce the sensitivity of a mammogram. And newer technology – automated breast ultrasound (ABUS) – provides a comprehensive ultrasound of the breast tissue similar to a CT scan while removing the dependency on skilled and experienced technicians, who can be challenging to find.

With available advances such as ultrasound, MRI, and 3D mammography (Digital Breast Tomosynthesis), which has been shown to reduce the false negative rate of mammography, particularly with dense breasts, the radiologist should employ a multifaceted approach incorporating other technologies when faced with a palpable finding.

In addition to diagnostic tools, the radiologist should follow a number of steps to manage breast cancer liability risks, including:

- Make clear recommendations in reporting on all mammograms.
- Obtain as much clinical information as possible (directly from the patient and the referring physician) to address clinical concerns.
- Pull earlier studies, if available, and make comparisons in reporting.
- Ensure the report is sent to appropriate physicians for patient follow up and a copy is sent to the patient, if the patient did not already receive a report at the facility.
- Follow the risk management strategies for reporting, staff education and equipment discussed below.

Liability from Unexpected Findings

Another high area of risk for radiologists arises from unexpected findings. For example, a radiologist reading films at the end of the day comes across a preoperative chest x-ray for a patient scheduled for knee surgery. The films are negative except for a possible nodule in the right upper lobe. The radiologist correctly identifies the finding and dictates in his report that comparison with previous films or a follow-up chest CT scan is indicated. There is no call made to the referring physician, an orthopedic surgeon, who claims to have never seen the report. Eighteen months later, the patient is diagnosed with inoperable stage IV lung cancer.

Radiologists are tasked with conveying critical information to a patient's caregiver in order to ensure appropriate and timely care. In the setting of a significant unexpected finding such as a lung nodule, the ACR (American College of Radiology) Guidelines require non-routine communication, which is generally person-to-person communication that should be documented in the medical record with the time, date and person notified. This step will ensure critical information has been communicated to the referring physician and reduce liability exposure for the radiologist. Critical results such as a dissection, pulmonary embolus, pneumothorax, and aortic dissection require immediate transfer of information between radiologist and the referring physician, which must also be documented in the medical record.

Risk Management Strategies for Radiologists

Most lawsuits against radiologists are diagnostic-related, such as reporting errors and misinterpretation of films or diagnostic studies, which may be due to poor quality of the films or the radiologist's inability to interpret them because of system problems. As a result, radiologists' liability can depend on a variety of factors, including the function of the hospital system, availability of state-of-the-art equipment, policies, and technician competence. To mitigate the impact of these factors, radiologists should adopt the following approaches:

- If film quality is suboptimal, report it as such and suggest repeat imaging, when feasible.
- Where appropriate, recommend follow up and/or comparison with outside studies, as needed.
- Obtain as much information as possible to support the radiographic findings.
- Ensure quality viewing conditions with up-to-date viewing boxes and/or digital viewing equipment.

continued on page 4

Risk Mitigation *continued from page 3*

- Partner with the hospital system for a superior reporting system such as PACS.
- Insist on highly-trained and skilled technicians in the radiology department.
- Consider overreads and quality assurance with peer review to improve patient quality of care.
- Keep current on the critical areas of evolution in radiology, such as radiation exposure from CT scanning, intravenous contrast administration, mammography, and ultrasound.
- For interventional radiologists, monitor patients closely with appropriate and necessary equipment, and get detailed informed consents regarding adverse events and recognized complications.

AMS RRG Claims and Risk Support

All members' claims and litigation cases are managed in-house by AMS RRG's very experienced claims and medical malpractice attorneys, who are in direct contact with our radiologist specialty medical consultant, Dr. Joseph Kleinman. Our attorneys will also assign outside counsel to assist you in managing the deposition process, including your responses in the retrospective review of the films and studies. It is imperative that you do not give a deposition or sworn statement to any person unless you have discussed it with the claims attorneys.

AMS RRG's attorneys also provide many members support on risk-related issues in the office or hospital-based practices. We encourage you to contact our attorneys or Dr. Kleinman with any risk questions or concerns that may help you avoid a future lawsuit – or navigate you through current litigation. You can reach us at the numbers below:

Dr. Joseph Kleinman – cell (561) 901-1763

Dr. Steve Shapiro – office (954) 990-5864 or cell (954) 520-1097

Susan Martin, Esq. – office (866) 520-6896 or cell (214) 701-1878

Preferred Aesthetics Announces a New Partnership

As AMS RRG continues to expand Preferred Aesthetics™, a medical liability insurance program uniquely tailored to plastic and aesthetic surgeons, we are excited to announce our new partnership with the American Society for Aesthetic Plastic Surgery. "The Aesthetic Society is representative of the distinguished Board Certified Plastic Surgeons this program was designed for," commented Harry K. Moon, MD, FACS, Specialty Medical Director of Preferred Aesthetics. "We feel this partnership is a natural fit that will be mutually beneficial."

AMS RRG Launches Preferred Radiology and Imaging

Under the direction of Joseph H. Kleinman, M.D., AMS RRG has launched Preferred Radiology and Imaging™. Similar to Preferred Aesthetics™, Preferred Radiology and Imaging offers direct contact with our Specialty Medical Director, individual underwriting and competitive pricing.

The commencement of Preferred Radiology and Imaging further demonstrates AMS RRG's commitment to utilize medical experts to develop products that are cost-effective and superior from an underwriting and risk management perspective. To learn more about Preferred Radiology and Imaging, please contact Chris Edge, Vice President of Preferred Programs and Business Development, at (866) 461-1221 x301 or cedge@amsrrg.com.

Preferred RADIOLOGY & IMAGING

Welcome Melissa Carty

Melissa Carty

We're excited to announce the newest member of our company, Melissa Carty. Melissa joined AMS RRG on April 6, 2015, and currently serves as an Assistant Underwriter on our New Business Team. In this position, Melissa plays an integral role in the overall efficiency of processing new business by tracking and triaging new submissions, assembling essential information for indications, preparing preliminary proposals, and securing executed documents for binding coverage.

Melissa is eager to learn and excited to launch her career at AMS RRG. Please join us in welcoming her to the team!

AMS

A Medical Liability Insurance Company

AMS RRG, INC.
23 Route 31 North, Suite A-20
Pennington, NJ 08534

www.amsrrg.com

We welcome your feedback!

Please reach us via email at info@amsrrg.com or like us on Facebook.

www.facebook.com/AMSRRG