Insured Colleague

APPLIED MEDICO-LEGAL SOLUTIONS RISK RETENTION GROUP, INC.

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AMS President's Message

By Richard Welch

AMS RRG Sets Ambitious Expansion Goals, Adds Senior Executives

It has been a challenging decade for medical liability insurance companies. From market cycles to sweeping legislative changes and high-profile claims, the industry has experienced significant challenges. It takes a strong company, with vision and tenacity, to navigate today's tumultuous marketplace. Yet, for the past six years, AMS RRG has consistently improved its performance year over year.

Our success speaks to our commitment: To bring physicians proactive "best practices" initiatives for mitigating risks, improved patient safety and better insurance rates. Moreover, engaging physicians to reduce their risk and improve their practices translates into a robust and dynamic organization with the ability to offer competitive premiums plus valuable services to its members.

An Expanding Team

To help the company successfully manage its expansion program, we have recently brought on board G. Scott Cantini, a noted investment banker from New York, and former managing director at Morgan Joseph & Co. Scott has joined the company as CFO of Best Practices Insurance Services. He brings a wealth of financial markets knowledge, as well as business development and merger & acquisition expertise.

In addition, Pat Riley, former managing director of Marsh USA, joins us as COO of Best Practices Insurance Services. Pat has extensive experience in the insurance industry and a proven record of accomplishment in managing successful organizations.

Over the next few months, Scott, Pat, and the rest of the Best Practices team will continue to examine infrastructure, technology, broker arrangements and distribution channels. This intensive analysis will help us actualize a strategic plan to achieve our goals while we continue to meet our commitments to our insureds.

While Best Practices welcomes new staff, we wish Dr. Brian Udell the best of luck as he transitions out of Best Practices and AMS RRG. He has played a pivotal role in the growth and success of AMS RRG and Best Practices as President of AMS RRG and Chief Information Officer of Best Practices. Since we started, it has been his vision to use technology to assist in gathering and disseminating data that can help physicians and the company better manage risk. Dr. Udell is transitioning to MedPASS, to focus on its ongoing development, which will keep him involved in Best Practices as well as AMS RRG.

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Dr. Steven Shapiro and Steve Fiore to Highlight the Role of Practice Administrators in Reducing Risk At AAOE Conference in Charlotte.

Join us to find out more.

To find out more about the AMS RRG difference, and the latest strategies to reduce risk and manage premiums, join us at the AAOE (BONES) Conference in Charlotte for a joint presentation by Dr. Steven Shapiro, chief medical officer for Best Practices Insurance Services and Steve Fiore, group practice manager for Ortho Specialty Group. Their presentation will focus upon the role practice administrators can play in reducing risk. "The Crucial Role of the Practice Administrator in Reducing Risk," will discuss two elements of risk management—risk prevention and claims defense—and how each should be handled and addressed.

TITLE **"The Crucial Role of the Practice Administrator in Reducing Risk"**
DATE: April 14, 2008
TIME: 6:30 p.m.
LOCATION: Aquavina Restaurant and Wine Room – 435 South Tryon Street Charlotte, NC 28202 (704-377-9911)
If you have not RSVPd, please call Steve Ricke at 954-332-2423.

Remember to visit us at our Booth during BONES - #508.

Lawsuits Down, Investigations Up
MedPASS Protects You for Both

By Steven M. Shapiro, M.D.

There's good news on the malpractice reform front. In many states, tort reform is finally beginning to make a difference. In Texas, as an example, doctors were leaving en masse. Tort reform, enacted in response to rising malpractice premiums and cumbersome regulations has widely been acknowledged as a clear success. As noted in the *New York Times*, the number of physicians in Texas has now increased at a rate more than double the population increase.[1]

However, as tort reforms improve the medical liability horizon, clouds are appearing from another front: an increase in state and federal regulatory investigations of physicians. Most recently, a hospital in California was fined by regulators in the death of actor John Ritter. Regulators found the hospital at fault for failing to perform a chest x-ray ordered by the ER physician. (A lawsuit against two physicians was settled in March in favor of the physicians.)

Importance of Meeting Standards of Care

And while high-profile cases such as Ritter's may begin to show physicians the role regulators are playing, most physicians remain unaware of the risk of such investigations. However, they are a reality we all must face. The Agency for Healthcare Administration (AHCA), Medicare, Medicaid, and even the FDA are all stepping up investigations of physicians. These agencies specifically examine:

- Standard of care
- Proper consent
- Proper documentation
- Licensing
- Prescribing of narcotics

Even Ralph Nader has gotten on board with the release of their report on the PublicCitizen.org website entitled "Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2004-2006." In this report, they note 2,916 "serious disciplinary actions taken by state medical boards in 2006." While this was down 10% from 2005, they were calling for a much more aggressive approach to disciplining physicians including a proactive approach to investigations rather than only reacting to complaints. It is also noteworthy, that there has been a recent trend for state boards to post the particulars of disciplinary actions they have taken on the Internet.

Taking appropriate steps to address all areas of potential investigation is important. However, one of the most critical areas to take action on now is compliance with standards of care. Because of the increase in investigations and the risk it presents to your practice and reputation, we want to provide you with information, consulting, and other tools to help you achieve this goal.

Adhering to recognized standards may be a step we all think we take on a daily basis. However, closer examination shows that often physicians are not following recognized protocols. For example, according to the *New England Journal of Medicine*, only about one-half of Americans receive recommended healthcare services.[2] An article in the *Annals of Internal Medicine* notes that 64% of general practice physicians and 36% of internists don't use hemoglobin A1C tests correctly.[3] Even for a disease as potentially deadly as colon cancer, studies show that only 42% of Americans received fecal testing for blood or endoscopy screening for colorectal cancer in the previous five years.[4]

For some helpful guidance for patients who refuse treatment, see the story "The Reluctant Patient" on page five.

How MedPASS Can Help

The AMS RRG model is built on the premise that physicians can take proactive action to reduce their level of risk and improve the quality of care they provide. By participating in MedPASS (Medical Practice Analytical Statistical System), our doctors can do both. MedPASS is an easy-to-use online tool designed by physicians for physicians. It allows you to:

- Analyze your actual practice of medicine on a prospective basis.
- Compare your practice to that of your peers.
- Receive information that can help to minimize risk and reduce your premium, even in areas where you may have thought there were no solutions.

For more information on the issue of increasing regulatory investigations and/or participating in MedPASS, please email me at sshapiro@bpmp.com.

1 - Blumenthal, R. More Doctors in Texas after Malpractice Caps. *New York Times*, Oct. 5, 2007.
2 - McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003; 348:2635-2645.
3 - Qaseem A, Sandeep, V, Snow V, et. al. Glycemic Control and Type 2 Diabetes Mellitus: The Optimal Hemoglobin A1C Targets. A Guidance Statement from the American College of Physicians. *Ann Intern Med*, Sept. 2007; 147:417-422.
4 - *Cancer*, News Release, Sept. 24, 2007.

Beware of Critical Lab Values
Physician Office Practices and Procedures

By Susan Martin, R.N., J.D.

It is the end of the day on another frantic Friday. Lab results come in and a note is posted to a chart. Maybe there is a new person on staff, maybe everyone is just incredibly busy. But somehow you, the physician, are not notified about the results until Monday.

While it may be easy to understand how this scenario could occur, this administrative lapse can nonetheless produce dire consequences and expose the physician or the physician group to potential liability.

A Tragic Outcome

Consider this tragic case. A 52-year-old male went to his physician's office on a Friday morning presenting with weakness and flu-like symptoms. The physician ordered a full chemistry panel. Late that afternoon, after the office had closed, the lab called and left a message stating that the patient's sodium levels had came back critically low.

No one called to check receipt of the message. The office did not learn of the results until the following Monday morning. They immediately called the patient, who had been admitted to an ICU (out of town) over the weekend and subsequently died.

The patient's family sued the hospital, lab, pathologist, and physician office for negligence. The family pursued the case against the physician, particularly, because there were no policies in place to address just this type of situation. The case was later settled for more than $2.5 million.

If this case sounds frighteningly possible, it should. Far too many physician offices do not have formal office policies to clearly delineate roles, responsibilities, and expectations regarding communication of critical lab values, x-ray results, or patient calls needing immediate call backs. The potential for errors is especially likely before a holiday or weekend. In fact, many physician offices continue to get lab results or other test results with simply a Post-It™ note to the chart. This practice is fraught with possibilities for error and can be difficult to defend in court actions.

Policy Development Guidelines

Once a physician orders a test, he or she is legally responsible for follow-up on the results of that test. If the results come back abnormal, those results must be documented in the patient chart and immediate action must be documented in the patient's medical record. "I'll follow up when the patient comes back," or "The office staff never told me," may not be appropriate or defensible responses if earlier intervention would have provided a better outcome for the patient. Following up on the results of tests requested by specialists could also be the responsibility of the patient's primary care physician. He or she may be held liable for not acting on those results and communicating them to the patient.

Plaintiff attorneys will point out that if the physician ordered the test, he or she must have had some concerns (otherwise why did you order it?), and that lack of follow-up was clearly negligent.

To help minimize liability, a standard policy should include:

- Written notice to all staff, answering service, covering physician, and other relevant personnel that the physician must be contacted immediately upon receipt of a critical lab value or x-ray result.
- Guidelines for recording information into the chart immediately, including:
  - What time the call was received;
  - What time the physician was notified;
  - When the patient was called; and
  - What action (go to the ER, come to the office tomorrow) the patient was directed to take.
- A mandate for follow-up from staff with the physician to ensure that appropriate action was taken.

Medical record documentation should be contemporaneous to the time of the patient visit, return of lab work, etc. You should never go back to "correct" a chart from several months ago. This may appear self-serving and in some instances, records have already been requested by patients, and should not be altered. If a later entry must be made, it should be dated and timed with reason for late entry.

Policy for Patient Messages

Similar situations can occur when patients call with messages, particularly if a patient calls regarding no improvement or a worsening condition. Most physician offices tell patients to let them know if they have concerns or they are not improving. These are especially true with post operative patients. After all, discharge instructions tell the patient to "call your doctor if you have symptoms such as …". When a patient later calls with these symptoms, these patients should be given high priority to see the physician immediately in his office or be given directions to the emergency department if necessary. Each physician should KNOW what his or her office staff instructs patients to do in this scenario.

Worth the Effort

Most physicians do maintain good practice principles when it comes to notification of critical values or patient messages. This article is simply a reminder to make sure that no matter how busy the office becomes, and regardless of new office staff, the importance of communicating critical information to physicians must be top of mind for all staff. Implementing these simple tips is well worth the effort to help improve patient care while minimizing liability risk.

Susan Martin, R.N., J.D., directs the Claims and Litigation Management program for AMS RRG. She can be reached at 866-520-6896. Her email is smartin@bpmp.com. Lawsuits or other notices can be faxed directly to her at 972-739-2631.

Reducing Malpractice in Orthopedic Practices

By Blane McCoy, M.D.

The quest to find ways to provide optimal care and reduce the risk of lawsuits is a constant effort for most orthopedists. Sometimes, we simply need to return to the basics. Here are three simple steps that we should all remember to help improve the care we provide patients while reducing risk.

Improving Communication with Patients

Proper communication with patients is at the heart of risk prevention. This communication encompasses everything from how we talk with patients in the office, to the formal informed consent process. Poor communication continues to be a major reason behind many lawsuits today.

As surgeons, we often describe the same procedure dozens of times a week. But while you may know the information, your patients most definitely do not. Each time you have a conversation with your patient, the explanation of procedures needs to be approached as if it were the first time you have spoken about it.

Consider not only what you are saying, but also to whom you are saying it. Adjust your language and presentation style based on your individual patient. Your goal must be to ensure that the patient has not only heard, but also understood what you said. In addition, the manner in which you communicate should encourage the patient to ask questions or discuss concerns.

Better Informed Consent Processes

While improving communication is an important step for physicians, we must also ensure that our informed consent procedures are clear, easy-to-understand and up-to-date. It is not enough to simply provide patients with a piece of paper and ask them to sign it. It is up to each surgeon to make sure that the informed consent process clearly explains what to expect before, during, and after a procedure.

The informed consent process is an opportunity to set appropriate expectations. For example, some patients may not understand that following spine surgery there could be severe neurological pain that can take up to one year to resolve. Left unaware of that medically recognized possibility, the patient may become unhappy with his or her physician and opt to sue.

Explanations about complications are also important. As surgeons, we know that with total hip replacement procedures there could be a malposition of implants, instability, nerve injury or risk of blood clots. While many patients may be attracted to the benefits of minimally invasive procedures for hip replacement, there is greater risk of a femur fracture with that type of procedure.

Most patients think that medical procedures will "cure" their ailment and that once a medical problem is "fixed" they'll be able to get back to their routine. We need to set the expectations so that patients understand that in some instances, it can take months to return to full functionality, and that some surgical choices may carry more risk than others. If you haven't warned the patient about these potential outcomes, it will not be hard to find someone to testify against you in court.

The informed consent process is not a piece of paper. It is a function best left to you, or to highly experienced medical staff in your office. The office manager should not hand over the form and say, "here, read and sign this." The communication and written acknowledgement of informed consent should take place in the office, when possible, not just before surgery or in the hospital. If another staff person handles the discussion, the physician should still look in, discuss the procedure, and ask the patient if all of their questions were answered. Finally, make sure to fully and immediately document all portions of the informed consent process as well as all conversations and written communications in the medical record.

Follow the Latest Guidelines

Adhering to the appropriate standard of care, according to published guidelines from recognized sources, is another fundamental of risk prevention. In May, the American Academy of Orthopaedic Surgeons (AAOS) announced clinical guidelines addressing the prevention of symptomatic pulmonary embolism (PE) in patients undergoing total hip or knee arthroplasty. The recommendations go beyond stockings, or increasing mobility, and clearly state the need for some type of anticoagulation therapy for all patients undergoing hip and knee replacements. If a physician is not going to anticoagulate, it should be for a reason, such as a major risk for bleeding with a particular patient.

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This important guideline affects all orthopedists. We urge all physicians to take note of these and other guidelines by staying up-to-date with the latest AAOS guidelines and recommendations. The AAOS has a wonderful website with information on the guidelines discussed above. We encourage you to visit the website at www.aaos.org/news/bulletin/jul07/clinical2.asp and www.aaos.org/research/guidelines/guide.asp.

We also encourage you to read the bi-monthly publication AAOS NOW. In the "Manage Your Practice" section you will find coverage on current medical legal issues, as well as medical malpractice tidbits.

At the same time, we recognize that physicians may not always agree with all guidelines – but it is of vital importance that the doctor shows that he or she is aware of them. These guidelines constitute the standard of care; unless there is a documented reason in the chart for not following them, it will be very difficult to defend in court a decision to omit or deviate from the guidelines.

Risk Management in Orthopedic Practices was the subject of the Informed Colleagues' Quarterly Physician conference call, held January 31, 2008. To hear a podcast of the call, visit our website at www.amsrrg.com.

If you are interested in participating in the next conference call, please email Best Practices Insurance Services at sricke@bpmp.com.

For more information on strategies to reduce risk, contact me at 440-887-8682 or Steven M. Shapiro, M.D. at 954-332-2423.

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The Reluctant Patient

While many physicians may follow the standard for treatment outlined by their respective specialties' association, there are often gray areas of standardization where there is room for improvement. Here's a case study that shows why it is critical to stay abreast of a wide range of recognized standards of care.

Recently, a 53-year-old male presented to his physician with chest pain typical of unstable angina. While his cardiac enzymes were negative and his pain had resolved with rest and nitroglycerin, the patient refused to be admitted to the hospital as recommended by his physician. The patient, a busy executive, had a "major deal" closing and didn't have the time. "I'll come in next month," he said.

In this situation, the temptation for many physicians is simply to allow the patient to sign out of the hospital "Against Medical Advice" and note their recommendations in the chart. There are, however, important issues for the physician to further consider. Without such considerations, an investigation might find sub-standard care. Steps the physician should take include:

- Confirm that the patient understands the serious nature of his condition and the choices available.
- Ask if the patient understands the potential outcomes or consequences of his choices, including death, if appropriate. His response should be recorded in the medical record.
- If the patient does not fulfill the above requirements, his ability to make this decision should be brought into question and a surrogate decision maker sought. The more serious the decision, the higher the standard is for meeting the above criteria.

Even if the patient continues to refuse the appropriate care, the physician is still obligated to prevent patient harm. While HIPAA guidelines are important, if the patient refuses to allow others to know of his condition, a risk management evaluation should be sought, particularly if the patient's condition is life threatening. An ethics committee evaluation should be requested, as well, as soon as possible. The physician should remain respectful of the patient's decision, while continuing to provide consistent advice.

Again, it will be very important that the documentation in the medical record, notes each of the steps in this process.

AMS President's Message

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Opportunities in the Marketplace

The softening market has created a multitude of opportunities for Best Practices and AMS RRG. For example, many companies in the medical liability industry today are territory and/or specialty-specific. These smaller, niche players typically have premiums under $10 million. As competition has become tighter, these companies are not as well positioned to survive a softening market.

Additionally, analysts predict that larger companies may divest themselves of some smaller divisions operating in non-strategic territories. These situations give us the ideal opportunity to pursue established companies with an existing client base, achieving growth through consolidation and acquisition.

These expansion options, paired with the opportunity to grow organically by marketing the stability and unique value of AMS RRG to physicians within our target states and specialties, hold great potential for our company in the immediate future.

Important Rating News

AMS RRG will be engaging a consultant to assist in preparing for an AM Best rating.

AMS RRG now has six years in the market. Company financials are strong and AMS RRG has shown it has the ability to grow, while effectively and profitably managing resources. Securing an AM Best rating is a long process, and one only the best carriers pursue. Within the next few months we will also be securing a rating with Demotech, a noted actuarial and financial analysis firm that is building its own reputation as a respected leader in the insurance rating industry. This step gives AMS RRG a prestigious industry ranking and will further support our efforts to secure an AM Best rating.

Our Ongoing Commitment

AMS RRG is the only medical liability insurance company to proactively identify and reduce physician's risk, writing insurance based upon the doctor's safety practices today and working with them to reduce risk in the future and continuously improve patient safety. We pledge to continue to provide stable, competitive rates, to anticipate market changes, and be trusted advisors and long-term partners to our clients.

We are excited about 2008 and about exploring new ways to help you and your practice grow and thrive. If you have any questions, please visit our website or contact us directly.

2008 Physician Calls
Save the date

- **April 22**: Cardiology
- **July 15**: Primary care medicine
- **November 4**: Radiology

All calls are 3:00 pm EST

More details to follow

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