APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

The Insured Colleague™

Volume 2, Issue 3 **July-August 2005**

Management Report

Richard Welch,

President & CEO, BPIS

I trust that all of you have had a wonderful summer. I am pleased to report that AMS RRG continues to exceed its operational and financial goals and to strengthen its position in the marketplace. From January through July 2005 we have written over $8 million in Gross Written Premium. This puts us on track to meet the goal of between $12 and $15 million for 2005 as mentioned in our previous newsletter. As with any insurance company (or any business for that matter), preservation and growth of capital reserves is paramount to the long-term success of the organization. We are fortunate to be in excellent financial health and one of the premier risk retention groups operating in the medical liability marketplace.

Our commitment to financial strength is evidenced by the deepening support from the reinsurance market. Now in its third treaty year, AMS RRG continues to experience improved terms. The reinsurance market remains focused on ensuring rate adequacy and accuracy in all their reinsurance relationships. Their support for AMS RRG is an affirmation of our ability to meet our operational and financial goals on an ongoing basis. Additionally, as we have developed our brokerage and agency relationships over the last three years, we continue to experience the benefits. Most notably, the market holds AMS RRG in high esteem due to our underwriting processes, claims history and, perhaps above all, our financial stability. We continue to see numerous applications from all of our jurisdictions from both large groups as well as individual providers. We are also pleased that hospitals and health systems have recognized us as a premier insurer and we continue to be accepted by their medical staff offices and credentialing departments. This is significant because many recent entrants to the medical liability market are not always received favorably by medical facilities.

We are acutely aware of the poor reputations of many alternative risk vehicles including some RRGs (as cautioned in the last newsletter, there are companies that physicians should be weary of, as detailed on the FAQs page of the AMS RRG website.)Additionally, we understand the market pressure to obtain admitted carrier status and/or an "A" rating. Strategically, as a Risk Retention Group, we realize some advantages by not being an admitted carrier in every state; namely, the flexibility to grow into new markets as additional quality physicians are identified. We are, however, very interested in pursuing a rating from AM Best at some point in the foreseeable future. The two more important factors for obtaining a high rating (as we can determine) are capital position and seasoning (time in the market). Fortunately, as I have indicated subtly throughout this piece, we continue to strengthen our capital position over time and will assess the right opportunity to become rated. Of course, like anyone, we want to make sure that if we go through the process we have positioned AMS RRG to receive an "A" rating.

Finally, while there are many factors that contribute to the ongoing success of AMS RRG, it begins with diligent underwriting. The quality of the physicians that are members of AMS RRG is unsurpassed. Because of the focus on underwriting and managed growth, AMS RRG has enjoyed positive claims experience since inception. Let's keep up the great work!

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Specialty Medical Director's Updates

Blane W. McCoy, M.D., Southwest Orthopaedics, Inc.

Dear Colleagues:

Currently, three orthopedic practices comprise the orthopedic section of AMS RRG. We continue to encourage everyone to practice "wise" orthopedics and recommend other groups or individuals who also practice quality orthopedic care to join us. Being "good guys" is not enough, we seek physicians that practice within their scope of expertise and encourage usage of good routines, such as appropriate medical clearance and protocols; for example, those relating to preoperative antibiotics or perioperative anticoagulation, to help develop and maintain a standard of high quality orthopedic care. In orthopedics, we are fortunate to have a very fine national organization and everyone is encouraged to avail themselves of AAOS (www.aaos.org) resources that are readily available. The quarterly newsletter, Orthopaedic Medical Legal Advisor, is an easy to read eight page journal that everyone is encouraged to read. In addition, their 80 page booklet, Managing Orthopaedic Malpractice Risk, is a worthwhile read for all practicing orthopedists. We currently use a test in evaluating new applicants based on questions from that booklet. The booklet is available through the AAOS by calling 800-626-6726 and has very practical recommendations based on national claims data. Lastly, we welcome suggestions or recommendations that improve all of our practices from our members.

We are planning our first Specialty Medical Directors meeting on September 15th in Cleveland and we encourage you all to attend. We value your input and know that collectively we can find ways to improve upon our practices and reduce the risk of medico-legal events.

Please Watch for

More Information on

Our Upcoming Insured Colleagues Meetings

<u>Cardiology</u>

Wednesday, September 14th

10:00 a.m. to 4:00 p.m.

Club at Key Center

Cleveland, Ohio

<u>Orthopedics</u>

Thursday, September 15th

10:00 a.m. to 4:00 p.m.

Club at Key Center

Cleveland, Ohio

<u>Radiology</u>

Wednesday, November 9th

Time and Location TBA

Fort Lauderdale, Florida

<u>Internal Medicine</u>

Thursday, November 10th

Time and Location TBA

Fort Lauderdale, Florida

Frank C. Smeeks, M.D., Mountain Emergency Physicians

Dear Colleagues,

As we continue to strengthen and move forward with our Insured Colleagues Program, I believe we must reduce risk and forge partnerships. In order to reduce risk, AMS RRG is working hard to refine the application process and identify the key drivers of a good of good risk.

Examining the dynamic of a group from the interplay of department coverage, utilization of mid level providers, the impact of patient satisfaction, discharge instructions, nursing procedures, and medical staff bylaws are just some of the key components of overall risk in the emergency department. Many of the key risk drivers are also revenue driven and working to partner key revenue aspects will make our groups stronger financially and less vulnerable to professional misadventures.

The professional liability market has seen an enormous amount of change across many states with some states in crisis and other states stabilizing. Our responsibility as a group of professionals is to push for error reduction in our risk retention group and govern our own rate of premium escalation while at the same time fighting for national and state level professional liability insurance reform. As we make gains in some states we appear to lose ground in others.

As the Insured Colleagues Program™ continues to grow, and we are able to attract good risk to our risk retention group, all of us will benefit. I encourage any of you to contact me with your comments, questions and concerns as we move forward reducing and sharing the risk!

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The Insured Colleagues Program™

Steven M. Shapiro, M.D.

Chief Underwriting / Medical Officer

What is Medical Malpractice? Malpractice is defined in the Oxford dictionary as "improper, illegal, or negligent professional activity or treatment." Perhaps the term medical malpractice is best described as a misnomer "an inaccurate or misleading name".

Two widely publicized studies have focused on the nationwide problem of medical errors/negligence and its effect on patient care. To summarize:

Harvard Medical Practice Study – 1991	**Institute of Medicine report - 1999**
30,195 discharged patients 1984	30,121 random records from 51 facilities
3.7% with an adverse event	8.8% to 13.6% of errors lead to death
25% of these due to negligence (280)	Medical errors 8th leading cause of death
8 patients filed malpractice claims	More than one death per 1000 encounters
Overall 1.5% of injured pts. file claims	

The primary focus of medical organizations and societies has been on the passage of tort reform. This, of course is very important in helping to keep the costs of litigation, potential awards and ultimately malpractice premiums low. Texas provides a good example of what can be accomplished with tort reform. This said, where there is tort reform, there still are medico-legal events. Lawsuits, notices of intent as well as threats of the same all persist. Ultimately, it is up to the Doctor to decrease their risk of medical errors.

What qualities make a physician less likely to be sued? We all intuitively know this. We know what we need to do to provide care that is not only better, but is perceived as better. Of the two, perception is perhaps the more important. If physicians show their concern in establishing an effective patient-physician relationships, are available to the patients and their families and respect their patient's rights, then they have gone a long way towards preventing a potential claim. Communication is ultimately the tool that accomplishes this. Not only must we communicate with our patients, we must communicate with each other. How often have you seen a STAT consult written for in the hospital to be called by the nursing staff as the physician leaves? How often does the consultant verbally communicate their results to the primary physician on the case? Meeting these goals is something we must all strive towards. If you read this and think to yourself, "I don't have the time for that", or perhaps, "This is not the job of a modern day physician", you will ultimately find yourself in the middle of a malpractice suit.

As noted above, providing the best care does not mean you are not going to be sued. What is your last line of defense? What is the one thing that can save you? What is it that will cause your insurance company to want to settle early if not done correctly? The answer is simple, DOCUMENTATION. The medical record is the most important piece of evidence in any malpractice lawsuit. "If it isn't charted, it isn't done".

Part of the medical record includes informed consent. Some states have adopted specific guidelines about what needs to be included in an informed consent. Louisiana, for example, has a list of complications for each procedure/operation that needs to be included in any documented consent. In Florida, the Agency for Healthcare Administration (AHCA) has begun contacting the hospitals across the state to let them know that they will be looking at the informed consent process. If a complication occurs, and it is not documented in the informed consent as a risk of the procedure, including death, then it needs to be reported to AHCA as a code 15. This then prompts a review of the case by this governmental agency. Continuously improving your informed consent process can only help. It is important for your patients to have the sense that they not only understand the procedure, but what their options are in making the decision to proceed or not. They need to be part of this decision process.

Some last minute office reminders. Do you have a process in your office for:

1) Knowing that a patient missed their appointment and contacting them to reschedule?

2) Knowing that a test was performed and that the results were abnormal, communicated to the patient, and acted upon?

3) Documenting the medications your patient is on and informing the patients of potential significant side effects of these medications?

4) Providing for well written legible prescriptions?

You can make the difference. You can significantly decrease your risk of a medico-legal event. Look for appropriate risk management opportunities. Contact Best Practices Insurance Services if you need help in this regard.

The Insured Colleagues Program™ continues to grow with our next meetings scheduled in Cleveland for Cardiology and Orthopedic Surgery.

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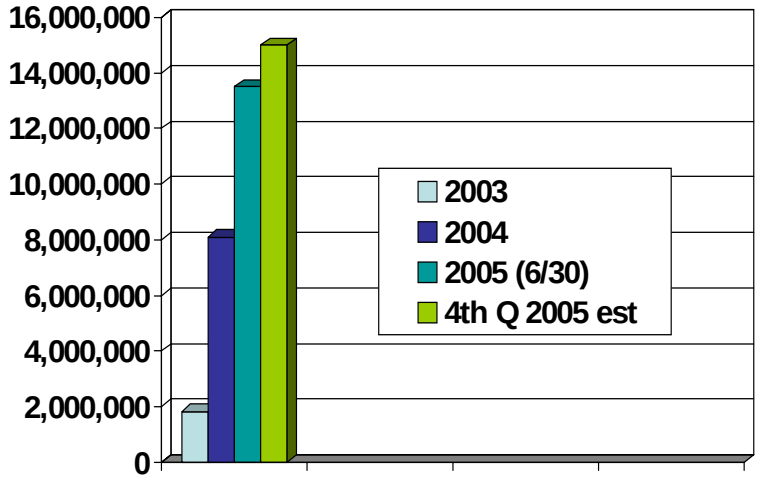
More from Dr. Shapiro...

GOOD	BAD
Write neatly	Don't alter the record
Date and time your note	Don't change the record after a lawsuit is filed
Line through once to "erase"	Don't argue
Be Factual	Don't imply another is at fault
Be Accurate	Criticism of others prompts lawsuits
Be Complete	Attorneys analyze inks, impressions on following pages and all aspects of the record
Be Timely	If your colleagues can't read your notes, believe them. If they can't read it, no one can.

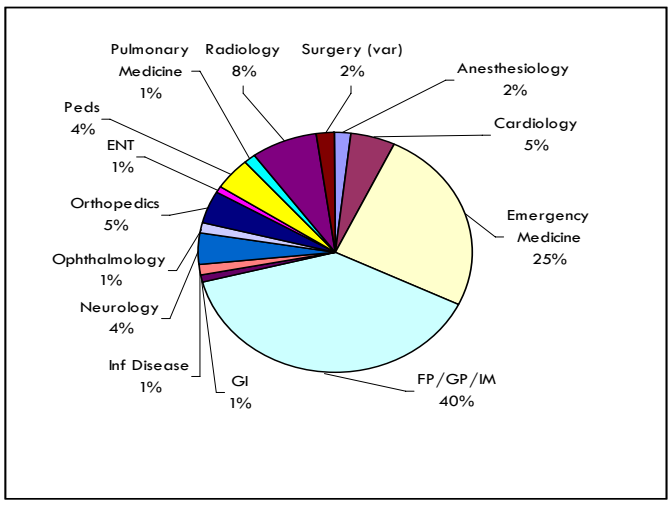
Some information from Ms. Susan Hughes...

AMS RRG is Pleased to Announce That We Are Now Registered in Virginia and Mississippi

AMS RRG Premium Growth Inception to Date:



AMS RRG Specialty Mix:



Sound Bytes

Brian Udell, M.D.

Chief Information Officer

Recently, while toiling over our ever-expanding clinical database, adding the answers which you, our membership have supplied, I came across this graffitti scrawled across the (now-scanned for posterity) .pdf file:

"These questions have no relevance to my family practice" (signature deleted)

Au contraire mon insured frère! Here at Best Practices we believe that, while these questions may not exactly address each and every valid medico-legal issue in the most revealing fashion, like the US government, it's the best we've got so far! What should your Insured Colleagues in underwriting ask for? Your best friend to write a reference? (Useless). Hospital records? (Barely forthcoming and redacted). Office behavior records? (Yeah, right).

Many of us are here because we understand that the traditional methods of obtaining insurance are no longer working, affordable, user-friendly or even valid (and so our last company either stopped offering policies or went under). A new generation of physicians now must figure out a new generation of professional insurance solutions. Certainly sheltering assets to the extent that it makes sense and is possible is a reasonable start. But we all realize that there needs to be some measure of well-being, just in case someone slips hydrolic fluid into the OR detergent bottle. Speaking of which, what attitudes do you think might have been uncovered about the supervisors in such a system if there were a mechanism to reveal such behavior?

1. Which of the following is TRUE? When your colleague complains that the surgical instruments feel slimy, you:

a) Don't do anything 'cause it's not your problem

b) Don't do anything 'cause you're lazy

c) Don't do anything 'cause you forgot

d) Check it out

e) None of the above

I bet that the "responsible" personnel would have answered incorrectly on one or more questions about regulations, responsibility, use of external resources, and a bunch of factors that we haven't thought of yet. Heck, just the Hawthorne effect might make the affected individual at least THINK about doing something, while incorrect answers might result in positive action or preventive measures.

It's medico-legal issues that our company addresses, and so the questions and their answers are unique and evolutionary. Outcomes may be measured not only in possibly decreased numbers of lawsuits or decreased financial verdicts but in areas concerning patient safety or other senarios that are unmeasurable. Questions like, "How many patients wouldn't have gotten a staph infection if the sterilizer was turned on?", or "What are the chances of picking up an uncommon condition if the practitioner sees a patient every five minutes?" If you think that bad handwriting is not important you either have great handwriting and are just unaware, or you need a PDA. By identifying appropriate and abjectly inappropriate answers, we may be undentifying situations which would otherwise be labelled as "unfortunate events" or medical misadventures.

Now, I'm not telling you this because I felt threatened or offended by the uninvited addendum offered by one opinionated applicant. I am writing because:

1) You're gonna get more surveys and questionnaires.

2) If you haven't filled out any so far, you will.

We need this information. As physicians, as members of AMS RRG and as scientists seeking answers.

So, be patient as our stalwart brain-in-the-box takes in your answers and let's just see what relationships we all come up with, OK? Maybe, you'll even want to use some of our "stuff" in the places where you practice, and it won't seem so irrelevant. Stay tuned.

P.S. Our physicians rarely got all of the answers correct - even though they are posted on our website!

Pennington, NJ Office & Staff

(L-R) Ramy Reddy, Chris Edge, Dan Delfini, Dawne Adams

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This newsletter is brought to you by...

Best Practices Insurance Services LLC, in association with Best Practice Medical Partners LLC, who assist in providing services to Applied Medico-legal Solution Risk Retention Group. This quarterly newsletter is presented to disseminate information, stimulate communication among the members, and provide the membership with another venue to address their medico-legal challenges.

All members are strongly encouraged to write and submit articles and topics for future issues. You may direct communication through info@amsrrg.com and tic@amsrrg.com

Your Feedback is Welcome!

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