Insured Colleague

APPLIED MEDICO-LEGAL SOLUTIONS RISK RETENTION GROUP, INC.

September 2008 • Volume 003

AMS RRG President's Message

By Richard B. Welch

Since our last issue, we've celebrated a number of accomplishments and made significant progress toward key goals for 2008. Following are some of the highlights.

Board Meeting

In April, we held our annual Board of Directors meeting in Scottsdale, Arizona. At this well-attended event, we reiterated our focus for 2008: $25 million in gross written premium, continued focus on underwriting and risk management initiatives, and aggressive claims management. This successful approach has enabled us to continue to expand our infrastructure to ensure we meet or exceed our insureds' expectations.

Insured Colleagues Program™

Concurrent with our Board Meeting, we held our annual Insured Colleagues Program™ meeting that featured many of our Specialty Medical Directors. As always, their contributions were extremely valuable in continuing to shape and strengthen our clinical initiatives – as well as the overall organizational goals – and I want to personally thank those in attendance:

Peter Alaverez, MD
Clay Heighten, MD
Joseph Kleinman, MD
Blane McCoy, MD
Steven Shapiro, MD
Frank Smeeks, MD
Brian Udell, MD

Please be sure to read Dr. Shapiro's article on our Insured Colleagues Program™ and his discussion of the latest developments in orthopedic medicine in particular. If you would like to get involved with the program or share your suggestions for improving our organization, please contact Dr. Shapiro or one of our Specialty Medical Directors.

A Rating

In June, Demotech awarded AMS RRG a Financial Stability Rating® ("FSR") of A, *Exceptional*. This achievement validates our exceptional financial position and strengthens our position in the market.

Our success in this effort would not have been possible without the support of all our insureds – the foundation of our financial health – and our dedicated staff who worked tirelessly to ensure a smooth process and the most favorable results.

Please see Pat Riley's article on the Demotech rating for more information about the process and what it means for our organization.

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Annual Insured Colleagues Program™ Meeting

Specialty Medical Directors, insureds and AMS RRG staff gathered in Arizona for our annual Board of Directors meeting.

From left to right:

Front Row: Blane McCoy, MD; Joe Kleinman, MD; Peter Alvarez, MD

Back Row: Brian Paterick, MD; Steve Shapiro, MD; Clay Heighten, MD; Brian Udell, MD; Frank Smeeks, MD

New Applications Will Soon Be Available

We're updating our old application and replacing it with two new versions: one for new business and one for renewal. We're making both easier to complete to streamline the application process.

Reducing Risk in Orthopedic Practices

By Steven M. Shapiro, M.D.

Through our Insured Colleagues Program™, we recently hosted a nationwide conference call on risk topics affecting orthopedic surgery physicians around the country. Led by our orthopedic Specialty Medical Director Blane McCoy, MD, the call highlighted multiple areas of risk, including:

Refusal of Care: Physicians can take the same time and effort to help a patient understand the consequences of their refusal of care that they take to help obtain an informed consent for care.

- Does the patient understand the nature of their condition and the choices available?
- Does the patient understand the potential outcomes or consequences of their choices?
- If the patient doesn't meet these criteria, their ability to make decisions should be questioned and a surrogate decision maker sought.
- If the patient still refuses the appropriate care, the physician is still obligated to prevent harm. A risk management evaluation and ethics committee evaluation should be sought. While ultimately the physician should respect the patients' decision, you still need to provide consistent advice. Involving the patient's family, as allowed by the patient, can also be helpful.
- Be sure your medical record documentation is appropriate and documents all of the above.

Supervision of Nurse Practitioners and Physician Assistants: While nurse practitioners or physician assistants can improve practice efficiency and profitability, you need to employ a standardized approach that is clearly delineated and consistent with state regulations. This delineation should include a list of symptom complexes that may initially be evaluated and addressed by the PA or NP and a list of medical procedures they can perform:

- Without consultation with the physician
- Before consultation with the physician
- Only after consultation with the supervising orthopedic surgeon
- Only under the direct supervision of an orthopedic surgeon

Discharge Instructions: The discharge instructions are the last chance the healthcare team has to ensure the patient is aware of their responsibilities following discharge. Be sure to:

- Document your instructions in the progress notes or on the order sheets. Discuss them with your patient and make sure the nursing staff in the hospital includes them on the discharge instructions the patient signs before leaving.
- Include the names of all physicians the patient should see post-discharge, including a date and time of follow-up, if possible.
- Advise the patient to call your office or return to the ER if they have any concerns about their condition post-discharge.
- Understand that you may be included in the follow-up plans established by the emergency department and hospital staff when you are on call, and what responsibilities you bear because of them.
- Leave an order to have all lab and/or x-ray results faxed to you if tests are pending.
- If the patient is opposed to discharge, make sure that everything has been addressed, appropriate tests have been ordered and reviewed and the most serious potential problems for discharge have been dealt with.
- As the last people to see the patient before they leave the hospital, make sure the nursing and ancillary staff at the hospital watch for changes in the patient's health status and notify you if any occur.

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Bucking the Odds

Orthopedist Blane McCoy, MD, bucks the odds when he saddles up after the Board of Directors meeting in Arizona.

Trial vs. Settlement
Evaluating a Medical Malpractice Claim

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

When faced with a malpractice suit, it is not always clear whether a physician should defend the case or move toward settlement. AMS RRG believes that frivolous cases should be vigorously defended, but most lawsuits do not fall into that category. They may be "defensible" but can the defense team prevail in a courtroom?

Although the facts and medical record documentation impact the strength and/or weakness of the claim, other important components often play a greater role in determining case strategy.

Parties to the Claim or Litigation

A key element in the evaluation of the case is the credibility of the plaintiff and/or family members. It is always troublesome when I get a new medical malpractice case and, after depositions, discover the plaintiffs are very likeable, local folks with whom a jury will identify. Alternatively, plaintiffs can come across as greedy and unsympathetic. In Texas several years ago, a young female sued an ED physician for failure to appropriately resuscitate, etc. She was critically ill when she presented to the ED, and frankly, the ED physician saved her life. Unfortunately, the plaintiff went on to develop DIC and all of her limbs were amputated. Although a very tragic outcome with huge damages, she was not a very believable or empathetic witness. She clearly exaggerated her problems and admitted to certain bad behaviors on the witness stand. After ruling in favor of the physician, the jury explained that they believed the plaintiff was just trying to "milk the system" for her own personal gain, while the ED physician did all of the right things to save her life, acted reasonably, and shouldn't be faulted for her tragedies.

The defendant physician is probably the MOST critical aspect of the case. Juries WANT to believe healthcare providers. If the physician has a professional appearance, good credentials, and testifies as a caring and competent physician who tried to do the best for the patient, the case has less value for the plaintiff and the defense has a better chance of prevailing. If the physician is defensive, appears arrogant and disinterested in the case, or doesn't know the records in the care or treatment he or she rendered, the case should probably be settled. In another recent case, an interventional cardiologist was sued for his care post cardiac catheterization. At the end of the trial, after the jury appropriately ruled for the defendant physician, the jurors asked the physician for his card. They commented that if any of their family members needed a cardiac catherization, they wanted him to do it – the ultimate compliment for any physician!!

Judge and Jury

The trial judge assigned to the case, and the jury verdicts in the area, must also be considered. If the venue is very conservative, with a reasonable trial judge who is not biased toward defense or plaintiff, it is clearly better for the defense of the case. If the judge is pro-plaintiff and always rules in favor of the plaintiff, and there are huge verdicts in the venue with fairly liberal jurors on the panel, that is much better for the plaintiffs and plaintiff attorneys. In a Florida case several years ago, a verdict for the plaintiffs was very small and the jury put some contributory negligence on the patient (who was deceased), and it infuriated the judge. She immediately ordered a new trial. All of the defendants were so worried about taking the case back to trial, it was settled for much more than the original verdict.

Liability and Damages

Liability and damages are other important factors when evaluating a case. A case with limited or marginal liability, but large economic damages, may be dangerous for a physician if the case will be tried in a more liberal venue, especially if the insurance limits are low and the case has a multi-million dollar value. I have also been involved in the opposite situation where the liability is probable, however, plaintiff's damages are very limited and not over the physician's policy limits. Even if the physician admits on the witness stand "I would have done things differently if I had known this would have occurred to the patient," juries will usually not punish physicians – even for medical errors – if they believe that physician is honest and remorseful.

Medical Record Documentation and Witnesses

The medical facts and medical record documentation will also play a role in the case. Lack of documentation, although a problem for the defense, is not definitive. If it can be explained in a reasonable fashion, juries will listen. In a case several years ago, a physician and hospital were accused of negligence, and again, the patient was critically ill. The plaintiff's attorney played up the records because the nurse had not documented all of the IV fluid and the patient developed pulmonary edema. The hospital defense attorney said to the jury:

> "Ladies and gentlemen, Ms. X was obviously critically ill and dying and the nurses and doctors were trying to save her life. Now, it is always good to document everything they do, but is that really possible? I ask all of you: if your family member is dying and needs someone at the bedside at all times, do you want the doctors and nurses with your loved one or do you want them at the nurses' station or out in the hall trying to write everything in the chart?"

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Trial vs. Settlement

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When the trial was over and the jurors were questioned, they admitted that the records were not perfect, but they understood that the nurse was with the patient at all times and that was enough evidence to prove the nurse was attentive and provided good care.

Experts are always used in medical malpractice cases, and although they will disagree, their ability to summarize the care in clear and precise terms that lay persons can understand is very important. If the case is balanced with good defendants, credible plaintiffs, and the standard of care is clearly the main question on the jurors' minds, then a credible expert who can explain to the jury what and why something occurred is invaluable. In a recent trial involving the death of a young person, the final expert for the defense was the last person on the witness stand. This incredibly strong and believable expert summed up the care for the jury and gave obvious reasons for this person's death, citing the statistics on how many of these patients die, what the likelihood of survival is once the event occurs, and how it occurs in the absence of negligence. The jury believed and respected the defendant physician and the plaintiffs; however, the defense expert was much more credible than the plaintiff's expert and the jury ruled in favor of the physician.

Look to AMS RRG for Guidance

Some people believe they need a crystal ball to decide whether to take a case to trial, but there are ways to have more predictability in the outcome of a medical malpractice case. Hiring good defense counsel who have experience at trying lots of lawsuits and making sure that court motions and objections are filed to protect the physicians' interests are paramount in the foundation of a case.

In the end, physicians are not always right about whether to take a case to trial, but as an insured physician with AMS RRG, you deserve to know the good, the bad, and the ugly so that you can make an informed decision about whether to settle or sit through a trial. Dr. Shapiro is an incredible resource for physicians and has personal experience in this area. Please know that he and I are always available for any questions or concerns you may have.

AMS RRG President's Message

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AMS RRG Expansion

AMS RRG is now registered to do business in 35 states and the District of Columbia after recently moving into the following territories: Alabama, Colorado, Delaware, Kansas, Massachusetts and Michigan. This expansion furthers our strategic growth objectives by strengthening our focus in specific geographic markets, while accommodating the needs of multi-state clients.

Market Conditions

As we approach 2009, there are still some rate variations based on specific territories but we are beginning to see stabilization in the market and are confident AMS RRG rates will remain highly competitive. As always, we continue to focus on underwriting, claims management and capital preservation and growth. To that end, we recently took an important step to secure our financial picture by changing our investment manager to Brown Brothers Harriman ("BBH"). In these economic times, ensuring capital preservation and the security and risk profile of the investment portfolio is critical. After an exhaustive process, we are certain that BBH will exceed our expectations. Special thanks to Scott Cantini for assisting with this selection and transition.

Upcoming Conferences and Meetings

AMS RRG will be exhibiting at:

The American College of Emergency Physicians (ACEP)
Scientific Assembly
October 27-30 in Chicago

Representatives from AMS RRG will be attending:

The American Society for Healthcare Risk Management (ASHRM)
Annual Conference & Exhibition
October 2-5 in Boston, MA

News Bites

AMS RRG President & CEO Richard Welch will be featured in the October issue of *Risk Retention Reporter* as CEO of the Month.

See more News Bites on our website at: **www.amsrrg.com.**

Orthopedic Practices

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Problematic Diagnoses – Back/Neck Pain: In the case of back/neck pain, it is not uncommon for an orthopedic surgeon to be called to the ER. In this case, you should verify that:

- An appropriate, well-documented neurologic exam was performed.
- The patient can walk and is neurologically intact.
- If the patient is discharged – becoming your responsibility – pass the information on to your office to ensure that appropriate and timely follow-up is arranged.
- Request an MRI or CT scan of the affected area prior to discharge, as appropriate. Document these conversations independently for the patient's office record or subsequent hospital chart.

Another way to help reduce your overall medico-legal risk is to ensure that you understand those standards of care that have been applied to your specialty. These can come from multiple sources, including, but not limited to:

1. Specialty-specific National Societies.
2. The FDA, which publishes a list of significant drug related problems/interactions.
3. The Physician Quality Reporting Initiative (PQRI) developed by the Centers for Medicare and Medicaid Services (CMS). While still a voluntary program, it's important for physicians to understand, whether reporting or not, the criteria affecting their specialty. Below is a sampling of quality indicators that CMS believes are already at the level of standard care in orthopedic surgery.
    - Timing of antibiotics in the peri-operative period
    - Selection of prophylactic antibiotics in the peri-operative period
    - Discontinuation of prophylactic antibiotics in the peri-operative period
    - Venous Thromboembolism Prophylaxis
    - Screening or therapy for osteoporosis for women aged 65 years and older
    - Communication with the physician managing ongoing care post fracture in a patient with osteoporosis
    - Diabetic foot and ankle care, neurologic evaluation for peripheral neuropathy
    - Diabetic foot and ankle care, ulcer prevention: evaluation of footwear
    - Adoption/use of health information technology and e-prescribing

I want to thank everyone who participated in the call, particularly Dr. Blane McCoy for leading the discussion. To suggest topics for our next meeting or call, please send an email to sshapiro@bpmp.com.

Applied Medico-Legal Solutions RRG, Inc. Earns Financial Stability Rating® of A, *Exceptional*

By Patrick J. Riley

In June, AMS RRG completed an intense review and analysis process to earn a Financial Stability Rating® (FSR) of A, *Exceptional* from Demotech, Inc. This level of FSR signifies that AMS RRG possesses exceptional financial stability related to maintaining positive surplus as regards policyholders, liquidity of invested assets, an acceptable level of financial leverage, reasonable loss and loss adjustment expense reserves and realistic pricing.

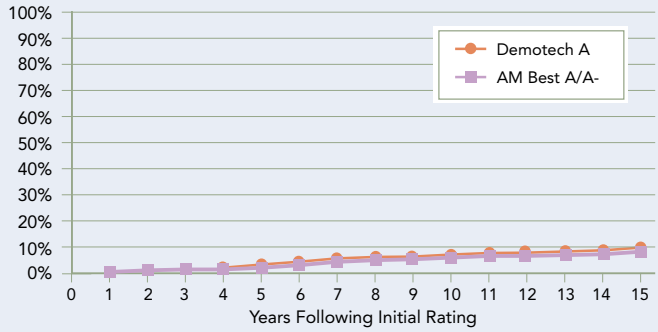
After five years of strong premium and surplus growth and ending 2007 with more than $20 million in gross written premium, AMS RRG felt it was time to enhance our credibility by undergoing a thorough financial due diligence process conducted by a third party. During an exhaustive review, Demotech studied our history and corporate structure, collected financial information, investigated our operations – including claims, underwriting, risk selection and pricing – and performed an on-site visit to understand our management approach first-hand.

While AMS RRG is a risk retention group, the review revealed that we run our organization much more like an insurance company. We are well capitalized, maintain all functional capabilities in-house, have a sophisticated pricing model, investigate backgrounds of risk and have a complex underwriting methodology. The process has also encouraged us to be more disciplined as we continue to grow the company.

In the past, we've been vetted by regulators, actuaries and reinsurers. Our assignment of an FSR stands as the latest validation of our company and better positions us in the market by demonstrating the stability of our financial position.

For more information about Financial Stability Ratings® and Demotech, Inc. visit www.demotech.com.

Demotech Financial Stability Rating® vs. AM Best Co. Financial Strength Rating *(Cumulative Average Impairment Rates)*



While a smaller rating agency than A.M. Best Co., Demotech's review of an insurance company's ability to meet its obligation and avoid insolvency is very rigorous. The chart above illustrates the long-term economic failure rates over a 15 year period for insurance companies with a Demotech, Inc. rating of A (Exceptional) compared to an A.M. Best combined rating of A/A-.

Source: "Best's Rating Methodology," A.M. Best Company, Inc. 2008 and "Serious About Solvency: Financial Stability Rating® Survival Rates 1989 through 2004," Demotech, Inc.

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