AMS

Insured Colleague

APPLIED MEDICO-LEGAL SOLUTIONS RISK RETENTION GROUP, INC. NOVEMBER • 2007 • VOLUME 001

President's Message

By Richard B. Welch

As AMS RRG enters the last quarter of 2007, we felt it was time to introduce our new and improved member newsletter. Our objectives in publishing this form of communication are to offer a useful source of insurance and medical information that will benefit you in your day–to–day practice, and keep you abreast of AMS RRG's accomplishments throughout the year.

Market Conditions

I am pleased to report that AMS RRG has continued its solid operating and financial performance throughout 2006 and 2007. This is especially pleasing given the "softening" market conditions occurring in several territories where we have significant business. Many traditional insurers have re-entered these markets as well as other alternative risk companies. Although this may be positive relative to reduced premiums, please be wary of insurers that over promise significant premium reductions. This is sometimes done at the risk of longer term financial stability of the insurer. Many companies enter and exit markets leaving their insureds in difficult situations when attempting to secure insurance from a new carrier. That said, AMS RRG exists as a long–term medical liability solution for physicians. Our business model continues to focus on sound underwriting principles, risk mitigation, and aggressive claims management. The result: stable and competitive rates, excellent retention, engaged physician leadership, and strong financial condition.

Board Meeting

In April, we held our annual Board of Directors meeting in Arizona. The support from the Board and the physician leadership was outstanding.

Among the numerous topics discussed were:

- AMS RRG exceeding the Gross Written Premium budget of $16 million in 2006. Actual was $17,918,982;
- AMS RRG continuing to contribute to Capital and Surplus to maintain financial strength and secure growth;
- Continued growth in the number of states AMS RRG is registered: AR, AZ, CA, CT, DC, FL, GA, IL, KS, KY, LA, MD, MN, MO, MS, MT, NC, NH, NJ, NM, NV, OH, OK, RI, SC, SD, TX, VA, WA and WV
- Clinical initiatives undertaken by the Insured Colleagues Program™. *(Please see Dr. Shapiro's article on page 2.)*

We envision 2007 ending the same way as 2006: financially strong with steady, predictable growth. We are projecting premiums of greater than $20 million for 2007.

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Legal Bits

Department of Justice study

In March, the Department of Justice released a study that found virtually all (95 percent) of claims filed in a seven state study were settled prior to trial. But, if the case went to trial, payouts were generally much higher.

Physician settles lawsuit due to blog

Cyber Lawsuit: Blogging is done by many people but, as the below case illustrates, it can come back to haunt you—even when using a pseudonym—and the trail lives on in cyberspace.

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AMS RRG... exceeding expectations...

2003 - Partial year $1.8m in written premium

2004 - $8m+ in written premium

2005 - $12m+ in written premium

2006 - $18m+ in written premium

MedPASS … Your Ticket to Pioneering Risk Mitigation

By Steven M. Shapiro, M.D.

Malpractice is defined by Webster's Dictionary as "professional wrongdoing that results in injury or damage." In law, malpractice is a "type of tort in which the misfeasance, malfeasance or nonfeasance of a professional under a duty to act fails to follow generally accepted professional standards." Fortunately, the majority of "medical malpractice" cases brought against physicians do not actually involve malpractice. A maloccurrence, or "unanticipated outcome," is defined as a negative or unexpected result stemming from a physician's evaluation and treatment of a patient. Often times, the difference between a maloccurrence and malpractice is confusing to patients. What is known by a physician to be a potential complication of a procedure can be perceived by a patient to be medical malpractice.

Over the last 25 years, the cost of medical malpractice insurance has varied dramatically. Calls for tort reform abound and have been met with variable success. Where success has been achieved, there have been dramatic reductions in physician malpractice premiums. That said, with or without tort reform, there is one common theme that reverberates among all physicians — no one wants to be sued and no one wants to be found to be negligent.

Risk mitigation is the key to achieving this common goal. How do we practice medicine? How do we compare to our peers? Are there opportunities to reduce our risk of being involved in a medico–legal event? Physicians have historically been at the mercy of formal hospital risk management programs. These programs often analyze an adverse event to reduce potential exposure from that event. Some physicians have utilized risk management consulting firms, incurring significant costs, time and effort to have their group's practice of medicine analyzed.

MedPASS Offers Solution

An important addition to our Insured Colleagues Program™, MedPASS, Medical Practice Analytical Statistical System, gives physicians an easy–to–use tool that they can use to compare themselves with peers in their specialty, evaluate their practice's medico–legal risk and implement solutions to reduce their risk. MedPASS offers physicians a simple online tool that will require a lot less time and will save a considerable amount of money — while providing tangible solutions physicians can implement to reduce their risk. The first MedPASS specialty developed by the Insured Colleagues Program is Internal Medicine/Family Practice. A number of subspecialties of Internal Medicine are available as well.

Emergency Medicine and Orthopedic Surgery will be available shortly. Other specialties will follow in quick succession.

Physicians can work with MedPASS online, at their convenience. The program is comprised of a series of questions in 13 different risk categories and generally takes approximately 30 to 45 minutes to complete. MedPASS evaluates prospective practice risk and identifies specific areas where opportunities exist to reduce liability.

Reducing Medical Liability

The development of MedPASS, through the Insured Colleagues Program, continues with the input of our physician colleagues, medical directors and members of our specialty medical advisory panels. Categories cover a wide array of factors — including physician "burnout," documentation, patient responsibility, and physician — nurse communication — that provide a comprehensive analysis with a clear idea of areas where medical liability can be reduced.

One of the most important aspects of MedPASS is that each physician is compared to their specialty specific peers. Knowing what other physicians are doing can help an individual physician understand what they can do as well. Many physicians may think, "I can't do that." When they see that a sizeable number of their peers already implement this process, they will re–evaluate their position. When given a solution that they may not have thought of previously, they may then actually implement the solution.

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News Bites

- AMS RRG was featured in two separate articles in *Crittenden's Medical Insurance News*. The first, entitled "RRG Sizes Up Geographic Expansion; Premium Doubles in Two Years," appeared in the March 5, 2007 issue. The second article appeared in the September 10, 2007 issue and was entitled "RRG Expands Into More States."

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Claims Management Moves In-House

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

As Richard mentioned in his management report at the beginning of this newsletter, AMS RRG moved the claims management function in-house as of January 2007, with the goal of resolving liability claims expeditiously and trending cases for systematic issues. I've known of BPIS and AMS for quite some time, serving as in-house counsel for one of the AMS RRG' largest clients. I am looking forward to working with everyone.

Background

Let me tell you a bit about myself. I am a nurse attorney; out of law school for 12 years and have been general counsel for the last few years with one of the larger AMS RRG clients.

My claims background complements the integrity and mission of AMS RRG, which includes managing claims, litigation and risk management activities for a large, national emergency medicine group. I have worked in a private practice setting defending physicians in lawsuits, as well as representing physicians in regulatory investigations (EMTALA). Prior to law school, I worked for many years as an emergency department nurse manager and director of busy trauma centers across the North Texas area, including Parkland Memorial Hospital.

Ongoing Communication

My claims management philosophy is simple — when a claim comes in, review it early. If it's a case where the physician clearly has exposure, and wants it settled, then I will want to negotiate with the plaintiff or plaintiff's attorney early in the process. Alternatively, if the claim has multiple defendants or needs to be further investigated and defended, then counsel will be assigned at the appropriate time, and AMS RRG will defend it vigorously.

An extremely important aspect of dealing with claims is communications with the insureds — something that I think is frequently missing in the claims management process. It is important to let our insured practitioners know what's going on in the case; and why we believe he or she does or does not have potential exposure. Most physicians appreciate the carrier taking the time to talk with them directly about the case and asking for their input. After all, the insured physician is the one party who really knows the medicine. Since plaintiffs usually do not have the medical expertise to determine what occurred, they hire attorneys who then retain medical experts to tell them. These experts have retrospective vision and can always "dissect" the medical record and then make assumptions as to what may have occurred.

Unfortunately, physicians tend to be forgotten as the claim moves through the process; they are sometimes not kept current as the claim is passed along from the claims department to an attorney. The attorney and the claims person may correspond, but the doctor sometimes get dropped out of the loop. I'm very sensitive to that, and I think that's one area where our insured physicians will see a real difference with in–house claims management.

Fixing Small Issues Before They Become Big Problems

One of the major advantages to having in-house claims and a risk management background is that the feedback all goes through one person in one department, and that allows for comprehensive analysis of issues. Outsourced claims management firms are concerned with the handling of the claims or litigation, but frequently do not have the capacity to address risk issues with the insureds.

If there is a malpractice case involving a break down or miscommunication in a hospital system, then there is an opportunity to get back with the physician or physician group, and try to remedy the issue in order to prevent further claims in the future. A risk management tool is invaluable for physicians; most are very anxious to have that type of service. It's better for patients, doctors and the insurance carrier, too.

Partnering with You

We provide our physician insureds with more than just claims and litigation support and management. We also have the expertise to help them in their day–to–day risk management and patient quality questions — making us a true partner with our insured doctors. Most carriers do not have this expertise.

For example, I have conducted several risk assessments for emergency medicine group practices. The groups wanted to know if, and where, they had potential liability exposure. The assessments included walking through and observing the hospital routines and interviewing the nurse manager and medical director on various patient procedures, patient protocols, triage, use of mid–levels practitioners, and other in–hospital critical areas. We then provided reports back to the groups that focused on the areas of potential exposure.

Most physicians appreciate this "preemptive strike" that AMS offers. We can offer professional, experienced views on where some of the problems may occur; even if the physician has never had a claim or lawsuit.

The Notification Process

If you are notified of a claim or lawsuit, please advise me as soon as possible. If the practice manager gets the notice and the named physician is on vacation or otherwise unavailable, then the practice manager should notify me immediately. Many practices prefer to go through their brokers for reporting claims. If so, please ask the broker to get to me within the next 24 hours. All states have certain statutes or requirements that necessitate a quick response to a notice of claim or require an answer to a lawsuit.

My phone number is (866) 520–6896 and email is: smartin@bpmp.com. Lawsuits or other notices can also be faxed directly to (972) 739–2631.

Physicians may also report significant medical incidents for trending purposes. Although the reporting of incidents does not trigger coverage, it does allow for the physician or group practice to secure the records, get AMS RRG on notice of a potential claim, and alert to potential quality or system problems. More about incident reporting and monitoring will be in future newsletters.

MedPASS …

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The majority of solutions available through the Insured Colleagues Program are easy to implement and cost effective. Some solutions, such as an accredited Electronic Medical Record, are more costly and will take some time to become the "standard."

Over time, with the use of MedPASS we will be able to identify trends and evaluate each specialty in terms of the risk of practicing in that specialty. The more we understand and subsequently decrease risk, the greater reductions in malpractice premiums can be passed on to our physicians.

We actively look to receive your input about your experience with the MedPASS survey. As each specialty is added to the MedPASS survey website, we will be contacting all of our physicians with the appropriate link, username and password so that everyone can participate in this process. Many physicians have already completed the MedPASS survey process and we greatly appreciate their involvement.

If you wish to access the MedPASS system, please email me at sshapiro@bpmp.com and we will forward you the appropriate sign–on information.

Lastly, if you would like to schedule a formal risk management analysis of your practice, please email me at the above address as well.

Legal Bits …

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Department of Justice study

In March, the Department of Justice released a study that found virtually all (95 percent) of claims filed in a seven state study were settled prior to trial. But, if the case went to trial, payouts were generally much higher. The study looked at medical malpractice suits in Illinois, Florida, Maine, Massachusetts, Missouri, Nevada and Texas from 2000 to 2004. These states were identified as having comprehensive medical malpractice insurance claims databases, some of which extended back to the early 1990s. AMS writes in Illinois, Florida, Missouri and Texas.

Few medical malpractice insurance claims produced payouts that exceeded $1 million. Less than 10 percent of the claims in Florida, Maine, Missouri and Nevada had payouts of $1 million or more. In Florida, Maine and Missouri, about two-thirds of the claims were closed with insurance payouts of less than $250,000.

Among persons receiving compensation, insurance payouts were highest for claimants who suffered lifelong major or grave permanent injuries. In Florida and Missouri, claimants with these types of injuries received median payouts ranging from $278,000 to $350,000. Insurance payouts were lowest for claimants who suffered temporary or emotional injuries.

In Florida and Missouri, claimants who suffered these types of injuries received median payouts ranging from $5,000 to $79,000.

The median damages paid to medical malpractice claimants have increased since the early to late 1990s. In Missouri, for example, the median insurance payouts grew from $33,000 in 1990 to $150,000 in 2004. During the various time periods covered by these insurance claim databases, median payouts also increased by 57 percent in Massachusetts, 49 percent in Illinois, 36 percent in Florida, 26 percent in Nevada and 27 percent in Texas.

The report, Medical Malpractice Insurance Claims in Seven States, 2000 – 2004 (NCJ-216339), was written by BJS statisticians Thomas H. Cohen and Kristen A. Hughes.

The complete report summary and additional information can be found at http://www.ojp.usdoj.gov/bjs/abstract/mmicss04.htm.

# # #

Boca Raton case could test changes in medical malpractice law. Constitutional challenge could start after ruling.

By Patty Pensa, South Florida Sun-Sentinel | August 24, 2007

How much was Sheldon Sussman's life worth? To a jury, $2.8 million.

According to the state, though, Sussman's wife of 20 years should collect no more than $1.5 million.

The question of how much Rhoda Sussman, of Boca Raton, will get for her husband's death after routine knee surgery now lies with Circuit Judge Jeffrey Winikoff. After his judgment, the case could climb through the appellate courts and potentially determine the constitutionality of medical malpractice caps passed in 2003.

Such cases can take up to five years to litigate, which is why the caps just now are being tested. With then — Gov. Jeb Bush's backing, the Legislature passed caps of $150,000 for "pain and suffering" damages for emergency patients and $500,000 for all other patients. When a patient dies, though, plaintiffs can collect a maximum of either $1 million or $1.5 million, depending on the case.

"The beauty of the jury system is they get to determine a case based on the evidence before them," said Miami attorney Maria Rubio, who represents Rhoda Sussman. "But this legislation says, 'When it comes to medical malpractice cases, we can't trust you.'"

Boca Raton Community Hospital, where Sheldon Sussman was treated and later died, has filed several motions for a reduced verdict. Winikoff's decision is expected within 60 days.

On Sept. 15, 2003, Sussman, 64, tore a tendon just above his knee while moving a computer at his home. On the same day, caps went into effect after a prolonged and animated fight staged largely by physicians socked with rising malpractice premiums.

Sussman stopped breathing about a week after his Sept. 24, 2003, surgery when an undiagnosed clot traveled from his leg to his lungs. His death on the day he was to return home shocked and devastated his wife. Having married later in life, the two had no children and spent their retirements going to the theater and fishing.

"He died because of their mistake," Rhoda Sussman, 60, said of the hospital. "It's very hard for me. There's an empty spot, like there's something missing from my life."

Attorney Mike Mittelmark, who represents the hospital, declined to discuss the details of the case. But he said if the case reaches the state Supreme Court, he expects the caps will be declared constitutional.

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Legal Bits …

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In the Sussman case, a jury in February awarded $2.8 million for pain and suffering and about $430,000 for medical and funeral expenses.

A statement from the hospital said, "We do not feel that the jury outcome was merited. At this time, we are waiting for the judge to render a final decision on the verdict."

In 2000, a flurry of medical malpractice cases prompted insurers to raise their rates and, in turn, doctors to push for changes. Since the law passed, a third fewer cases have been filed, several insurance companies have returned to Florida and premiums have dropped.

"There's been no tangible benefit for physicians as a result of a cap" other than a small drop in premiums, he said.

The Florida Medical Association initially wanted a $250,000 cap, but that figure was doubled to win passage of the bill.

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# # #

Physician settles lawsuit due to blog

Cyber Lawsuit: Blogging is done by many people but, as the below case illustrates, it can come back to haunt you — even when using a pseudonym — and the trail lives on in cyberspace. This article generated quite a buzz in our offices.

Blogger unmasked, court case upended

By Jonathan Saltzman, Boston Globe Staff | May 31, 2007

It was a Perry Mason moment updated for the Internet age.

As Ivy League–educated pediatrician Robert P. Lindeman sat on the stand in Suffolk Superior Court this month, defending himself in a malpractice suit involving the death of a 12–year–old patient, the opposing counsel startled him with a question.

Was Lindeman Flea? Flea, jurors in the case didn't know, was the screen name for a blogger who had written often and at length about a trial remarkably similar to the one that was going on in the courtroom that day.

In his blog, Flea had ridiculed the plaintiff's case and the plaintiff's lawyer. He had revealed the defense strategy. He had accused members of the jury of dozing.

With the jury looking on in puzzlement, Lindeman admitted that he was, in fact, Flea.

The next morning, on May 15, he agreed to pay what members of Boston's tight-knit legal community describe as a substantial settlement — case closed.

The case is a startling illustration of how blogging, already implicated in destroying friendships and ruining job prospects, could interfere in other important arenas. Lawyers in Massachusetts and elsewhere, some of whom downloaded Flea's observations and posted them on their websites, said the case has also prompted them to warn clients that blogs can come back to haunt them.

Still, Andrew C. Meyer Jr., a well known Boston personal injury lawyer who followed the case, said he had never heard of a defendant blogging during a trial.

"Most of us investigate whatever prior writings our clients might have had, so they are not exposed to their inconsistencies in their testimony," said Meyer, who has begun warning clients against the practice.

"But it's impossible to do if you don't know that your client is blogging under an assumed name."

Neither Lindeman nor his lawyer, Paul R. Greenberg, would comment. Vinroy Binns, the father of Jaymes Binns, of Dorchester, who died of complications from diabetes in 2002, also declined to comment.

Elizabeth N. Mulvey, the lawyer who represented Vinroy and Deborah Binns and unmasked Lindeman as Flea, said she laughed when she read a posting at the start of the trial in which Lindeman nicknamed her Carissa Lunt, noticed that she bit her fingernails and mused, "Wonder if she's a pillow biter, too?"

But she was appalled that readers in the blogosphere who knew little or nothing about the case rallied to his defense.

The wrongful death suit alleged that Lindeman, who works at Natick Pediatrics, failed to diagnose that Jaymes Binns had diabetes on March 11, 2002, Mulvey said in a court document. Less than six weeks later, the boy died of diabetic ketoacidosis, said Mulvey, who described the condition as "diabetes gone haywire."

In recent years, he has shared his medical views on local television news programs, on the "Manic Mommies" podcast produced by two Ashland mothers, and in magazines.

He is also the author of drfleablog, in which he calls himself Flea and identifies himself only as a pediatrician in the Northeast. A flea, he told the Globe this year, is what surgeons called pediatricians in training.

Mulvey, who said she only learned of the blog a couple weeks before the trial, said after reading scores of back postings that it was controversial yet intellectually stimulating.

In April, before the trial began, Lindeman wrote about meeting with an expert on juries who advised him how to act when he was cross–examined. Flea was instructed to angle his chair slightly toward the jury, keep his hands folded in his lap, and face the jury when answering questions, slowly. "Answers should be kept to no more than three sentences," he wrote. The consultant told him juries in medical malpractice cases base verdicts almost entirely on their view of a doctor's character.

"We've said it before, and we'll say it again: If the basis of this case is that Flea is an arrogant, uncaring jerk who maliciously neglected a patient, resulting in his death, the plaintiff will not win, period," Flea wrote. "As much of a cocky bastard that Flea may appear in the blogosphere, the readers who have a personal acquaintance with the real 3–D doctor understand how such an approach cannot succeed."

Shortly before the end of his second day on the witness stand, while focusing on Lindeman's views of a pediatric textbook, Mulvey asked him whether he had a medical blog, she recalled. He said he did. Then she asked him if he was Flea. He said he was.

The exchange may have been lost on jurors, but Meyer said Mulvey had telegraphed that she was ready to share Lindeman's blog — containing his unvarnished views of lawyers, jurors, and the legal process — with the jury. The next day, the case was settled.

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President's Message

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This truly is a milestone and demonstrates AMS RRG is an ongoing concern and not simply a remedy to the hard market.

Best Practices Insurance Services
In an attempt to continuously find ways to integrate and improve our services, we brought claims and litigation management in-house. We have hired Susan Martin, R.N., J.D., a seasoned attorney, who is managing all claims and litigation for AMS RRG. Susan has worked in private practice defending physicians in lawsuits, as well as representing physicians in regulatory investigations (EMTALA), and insurance coverage issues. We also welcome Barbara Faulkner to our organization. She is assisting Susan in claims and litigation management services. *(For more about claims management, please see Susan's column on page 3.)*

Information Technology
We are very pleased that our upgraded insurance management system, Sirius, is up and running. Sirius has automated our back office functions such as underwriting, billing, invoicing and cash management. Thank you to everyone involved in this project, especially Ramy Reddy and Brian Udell, M.D.

Communication
As I mentioned at the beginning of this message, I am pleased to welcome everyone to the first edition of our newly redesigned newsletter. Along with regular company updates from me, the newsletter will focus on corporate highlights, a regular guest column, legal issues, technology updates, Insured Colleagues Program™ information, marketing news and any additional timely information we believe you'll find both interesting and helpful professionally.

This newsletter is part of our PR-communications initiative to improve the lines of communication between AMS RRG and our insureds so that we may disseminate information appropriately and consistently. To this end, we have partnered with Scott Public Relations to direct our communication activities.

This partnership is consistent with our philosophy and our strong clinical focus. We understand that time is valuable and want to make sure that the information we give to you is distributed in a way that is useful and consistent.

We welcome continued feedback regarding this newsletter and other information that we provide on an ongoing basis. We also encourage you to forward your email address to us at info@amsrrg.com for an online version of the newsletter along with additional updates.

2008 Physician Calls
save the date

January 15: Orthopedics
April 22: Cardiology
July 15: Primary Care Medicine
November 4: Radiology
All calls are 3:00 P.M. EST
more details to follow

NewsBites

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• A column by Dr. Brian D. Udell appears on the seca (sic) website in the North American Nurses Portal section of the site. His "Ask the Experts" column *(https://www.seca-online.com/index.php?id=810&L=1&C=us)* discusses safe weighing practices in the NICU and why having top-of-the-line scales, and highly skilled nurses who know how to use them, is vitally important in the NICU.

• Dr. Steven Shapiro authored a bylined article for Group Practice Journal, entitled "Three Key Principles for Reducing Medical Liability Risk," which will run in the November/December 2007 issue.

• Dr. Steven Shapiro was interviewed for an article on RRG trends for American Medical News, the article is scheduled to appear in the November 11 issue.