APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

The Insured Colleague™

Volume 3, Issue 1 Newsletter January-February '06

Management Report

Richard Welch

President & CEO, BPIS

First and foremost, on behalf of all of us at Best Practices Insurance Services, I hope everybody had a safe and happy Holiday Season. 2005 was an exciting year and we are looking forward to another outstanding year in 2006. Before I comment on our goals and objectives for the New Year, I want to take a moment and review our experience in 2005. As many of you are aware, AMS RRG continued to grow and realized a solid financial and operating performance in 2005. This was due, in part, to the successful establishment of Best Practices Insurance Services, LLC (BPIS). We are convinced that bringing the underwriting and distribution management functions in-house were an integral part of our 2005 success. AMS RRG's reputation in the marketplace is exceptional and our focus on developing solid relationships with selected broker/agents has enhanced our ability to identify and evaluate physician groups in numerous territories. In fact, the number of states in which AMS RRG is registered, increased in 2005 as well as the business within those states. You will also notice, when you visit www.amsrrg.com , the Agent Resource Center which was developed to facilitate the flow of useful information to our brokers and agents, such as applications, company statistics, etc.

The benefits of BPIS and these relationships are evidenced by the preliminary financial results for AMS RRG: Total Gross Written Premium and Income in excess of $12 million. This amount is approximately $4 million greater than 2004. Additionally, AMS RRG claims experience remains below industry standards and we continue to enjoy exceptional reinsurance support from the London and International markets. Although we saw some rate stabilization in 2005, the degree of stabilization varied based on the state and territory. The overall rates for AMS RRG's book of business stayed level to slightly lower in 2005. At this time, we expect to see that trend continue in 2006.

As for this year, our premium goal for 2006 is $16 million. January was a strong month and we are off to a good start. We continue to see greater interest and awareness in AMS RRG as indicated by the increased number of qualified applications in the pipeline. While we certainly want to grow our number of insureds, we have not compromised on our focus. We will continue to enhance our strong financial position through our robust underwriting processes as well as our unwavering commitment and attention to risk and claims management. To that end, as many of you are aware, the Insured Colleagues Program™ got into full swing in 2005, and 2006 should prove to be even better. Dr. Shapiro will be discussing its progress in his article of the newsletter. Additionally, this year BPIS will be implementing a new information system. Dr. Udell will be describing our new information system and some of the enhanced productivity associated with it in his section.

As mentioned in the last newsletter, we are in the process of evaluating an AM Best rating. We are confident that our financial position and ratios are very favorable for a high rating. That said we will certainly keep you posted on our progress.

Lastly, we are looking forward to the AMS RRG annual board meeting in March. This year we have expanded the agenda to include the Insured Colleagues Program™, broker/ agent workshops and the BPIS operational meetings. We will keep you posted on the outcomes of these events. As always, we greatly appreciate your feedback. Please keep us informed of any ideas or suggestions you may have for *your* medical liability insurance provider.

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Update on Orthopedics

Report from the Specialty Medical Directors Meeting

Blane McCoy, M.D.

AMS RRG Specialty Medical Director, Orthopedics

On September 15th, an orthopedic specialty meeting was held in Cleveland, Ohio. The meeting proved to be an excellent opportunity to meet some of our specialty colleagues and discuss our practices and their current and future malpractice needs. As a group, we discussed modifying the orthopedic application to be more appropriate to our specialty. A general review of orthopedic related claims was followed by a discussion of two current claims that have been filed against AMS RRG physicians. Dr. Shapiro reviewed AMS RRG's current status in regard to the number of insured and our financial health. Both are good and growing. Dan Delfini reviewed the distribution process goal which we hope to benefit from in the future.

Everyone is encouraged to participate in future meetings and to continually share information that you feel may be helpful to your colleagues. Our goal is to continue to practice quality care which must include good communication and documentation. High quality routines documenting test results and their communication to patients are essential. Anyone who has developed an outstanding system in this regard is encouraged to share it with all. Similarly, discharge instructions can be confusing and written ones are worth considering for our practices. Again, if you are proud of any printed instructions you use in your practice please share them with your AMS RRG colleagues.

Best wishes,

Blane McCoy

Preoperative Cardiology Risk Assessment

Richard Ader, M.D.

Cardiovascular Clinic, Inc., Cleveland, Ohio

As cardiologists, we are frequently called upon by the surgeons to provide "cardiac clearance" for those patients who will be undergoing various surgical procedures. The first thing to understand is that the cardiologist does not make a decision as to whether to operate since that is a decision for the surgeons. There are two components that must be known in order to make a decision as to whether surgery goes forward. The two components are the cardiac risk and the surgical need for the procedure. The cardiologist knows the cardiac risk but it is the surgeon who knows the surgical need. Our job as cardiologists is to provide a cardiac risk assessment for the surgeons so that they can better make a final surgical decision. An example of this would be a patient who the cardiologist feels is high risk from a cardiac standpoint but who has a life threatening surgical condition. Most likely the surgeon would proceed with surgery in that situation in spite of the high cardiac risk. To summarize, the cardiologist's job is to assess the patient's cardiac risk and share that information with the surgeons so that they are better able to make a decision as to surgery and, if surgery is performed, also make suggestions as to pre and post operative cardiac management.

The guidelines I use are the American College of Cardiology Practice Guidelines for Perioperative Cardiovascular Evaluation for Noncardiac Surgery (Eagle et.al. Perioperative Cardiovascular Evaluation for Noncardiac Surgery update J Am Coll Cardiol 2002; 39:542-53-these guidelines may also be downloaded from www.acc.org). These guidelines provide a way to define the cardiac risk of an individual patient and the cardiac risk of a particular surgical procedure. Using these guidelines, the cardiologist is able to stratify both patients and surgical procedures into high, medium or low risk and then, using this information, plan any further testing that may be needed to determine a final overall cardiac risk.

Surgical procedures are classified as to the combined incidence of cardiac death and nonfatal myocardial infractions. Procedures such as aortic and other major vascular surgery for example, would be considered high cardiac risk surgeries, carotid endarterectomy and major orthopedic procedures would be considered intermediate cardiac risk surgeries and endoscopic procedures would be considered low cardiac risk surgeries.

Patients are classified into risk categories for cardiac complications based on various clinical parameters. Patients with unstable coronary syndromes or severe valvular disease for example, would be considered to have major clinical predictors, patients with prior myocardial infarction or diabetes mellitus would be considered to have intermediate clinical predictors and patients with an abnormal EKG or low functional capacity would be considered to have minor clinical predictors.

These variables are used to determine further cardiac testing which may vary from an EKG to cardiac catheterization. When testing is completed, the cardiologist should be able to fairly accurately gauge that individual patient's cardiac risk for the surgical procedure. In our practice, this information is put together in a "Risk Assessment" form which is then faxed directly to the surgeon. The form includes the proposed surgery, the patient's clinical variables, cardiac testing performed, the cardiologist's estimation of cardiac risk and recommendations for pre and post operative cardiac management.

Some examples of recommendations for pre and post operative cardiac management are the use of intravenous beta blockers to avoid beta blocker withdraw in patients where they are NPO, placing higher risk patients on telemetry in the postoperative period, avoid fluid overload in patients with a history of

congestive heart failure and poor left ventricular function and the possible use of preoperative beta blockers in selected patients. To avoid errors in communication, the form is faxed directly to the surgeon's office and not preadmission testing. The reason for this is that there is a chance that a form faxed directly to the hospital would be placed directly on the patient's chart and not seen by the surgeons.

Although assessing cardiac risk is an imprecise science at best, I find that this approach using the American College of Cardiology Practice Guidelines provides a rational way to estimate a patient's preoperative cardiac risk and a "Risk Assessment" form provides a reliable way to communicate the cardiologist's assessment and recommendations to the surgeon.

We are pleased to announce that Richard Ader, M.D. has been named as our Specialty Medical Director for Cardiology.

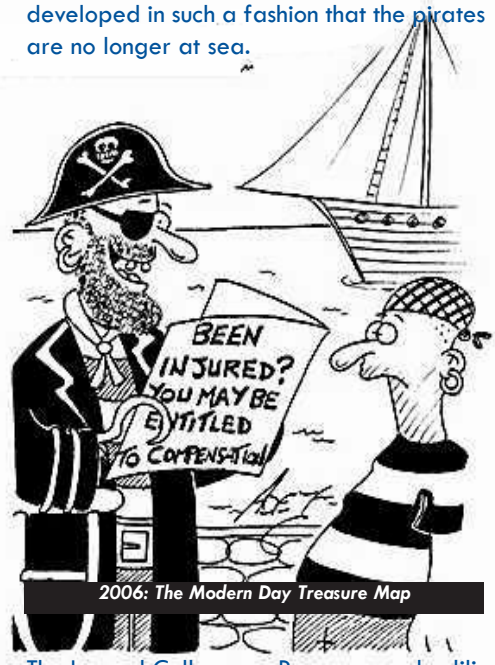
Richard S. Ader, M.D. has been in the private practice of cardiology since 1980. He is a senior member of Cardiovascular Clinic, Inc., a 10 physician single specialty cardiology practice in Cleveland, Ohio. He received his M.D. from Case Western Reserve University in Cleveland, Ohio and did his cardiology fellowship at the University of California, San Francisco. His current interests include clinical cardiology and CT coronary angiography.

The Insured Colleagues Program™

Steven M. Shapiro, M.D.

Chief Underwriting / Medical Officer

Over the last two newsletters, we have looked at the first two functions of the Insured Colleagues Program. First, we looked at the development of the application process as administered by Best Practices Insurance Services. Secondly, we looked at risk management and its role in reducing both claim frequency and severity, and lastly, we will look at the claims process itself. Over the last 30 years, the tort system in the United states has developed in such a fashion that the pirates are no longer at sea.



2006: The Modern Day Treasure Map

The Insured Colleagues Program works diligently to evaluate and monitor all claims. Our third party administrator for claims management is Cambridge Integrated Services Group Inc. In the event of a claim, you can contact Dana Robinson directly at 954-602-5918. If there is any difficulty in contacting Cambridge directly, please call our offices in New Jersey at 866-461-1221 ext. 301.

When you receive a notification from an attorney that you may be involved in a medical malpractice action, **IMMEDIATELY NOTIFY AMS RRG** through the numbers noted above. There are deadlines that must be met under different circumstances and the sooner we know about the claim, the easier it is to meet these deadlines. In addition:

1) **Do not discuss the case** with the patient, the patient's attorney, or other physicians involved in the care and treatment of the patient. Do not discuss the case with hospital personnel including the risk manager without first checking with us. Anything you say to them can be used against you at a later time.

2) Gather and secure all patient records and make no corrections or addenda to the record. This includes your office staff.

3) You will be contacted by a field representative who will begin an investigation of the case. Please review the records prior to this and have all pertinent information available including any literature you may have relied upon.

4) As needed, a defense attorney may contact you as well. In the event that you have worked with a defense attorney in the past that provided excellent legal service to you or your group, please let Cambridge know so that we may evaluate this group and as appropriate hire them to represent you.

THE LAWSUIT

1) A complaint is filed

2) An answer is filed by your attorney

3) Written discovery is completed. This includes interrogatories and requests to produce documents served on all parties.

4) Depositions are taken

5) Final discovery completed

6) Trial

7) Post-Trial motions/ appeals

THE DEPOSITION

The deposition is testimony given under oath before a court reporter. They are very important in the preparation of a case for court and are very important in helping resolve cases before trial. It is important to remember that less than 10% of medical malprac-

tice lawsuits go to trial. The deposition allows for the following:

1) The discovery of facts pertinent to the case and to uncover additional avenues of investigation.

2) The clarification and narrowing of issues involved in the case.

3) The development of the facts used to evaluate the merits of the case which can be used to help a physician be released from or settle the case.

4) It also "Freezes" your testimony and will be used during any later testimony should answers given at trial be different from those given during the deposition. Once an attorney can show that any party's testimony has changed, they can then use that as a challenge to that party's credibility.

It is very important that you are well prepared for your deposition. You will need to know as much as possible about the case before the deposition. If there are any concerns you have about your testimony, about the deposition process itself, or any other questions in general, please consult with your attorney in advance so that you can be appropriately prepared for this event. The following can be used as an initial guide to your deposition.

1) Prepare for the deposition as above.

2) Be well groomed. The attorneys will be evaluating your appearance, your stature, your demeanor, your potential credibility to a jury during your deposition. The more professional you appear, the easier it will be to work on your behalf later in the case.

3) Always tell the truth. If you make an error, simply say so and correct your statement.

4) Do not guess. If you do not know or do not recall, say so.

5) Think before your speak. Listen to the question being asked and formulate your answer in your mind before you speak. There is no time limit for your response.

6) Answer only the question that is asked. Do not volunteer information. If the question is vague or doesn't make sense, ask the examiner to repeat/rephrase it.

7) Your words count, not the examiners. Do not accept characterizations of personalities, events, dates, times, etc. from the examiner. Make sure that the information collected is accurate based upon your knowledge of the case.

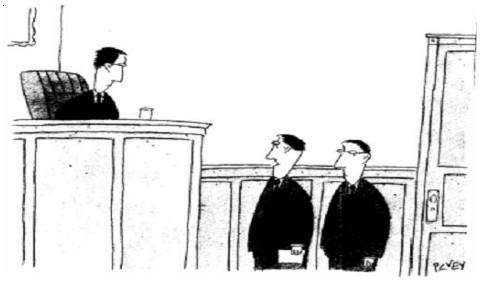
8) Never become angry or argue with the examiner. We all know the frustration that can occur from being in a deposition. Once the examiner has you on the defensive they are also winning the battle. Let your attorney intervene as necessary.

9) Beware of the LOOK. The examiner at times will look at you as if asking for more information. Once your answer is complete, wait patiently for the next question.

10) Beware of Leading Questions. These questions often contain statements that are either half-true or contain facts that you do not know to be true. Do not let the examiner put you in the position of accepting these statements as facts.

11) If you are interrupted by the examiner. Let the examiner finish, then nicely and courteously state that you were interrupted and that you need to finish your response to the previous question, then answer that question.

The above are only some helpful hints to try and demystify the deposition process. Over time, we will be placing samples of actual depositions on the AMS RRG website to help physicians better understand this process. Again, please work with your attorney in the preparation for this significant event and ask all the questions that you can think of in advance of the actual deposition. Lastly, you will get a chance to review the deposition transcript and be asked to sign it. Read it carefully. If you find errors, please inform your attorney immediately and make the appropriate corrections as directed.



"We would like to request a change in venue to an entirely different legal system."

The only way to ensure victory is not to play the game.

The Insured Colleagues Program™ has been actively involved in this claims process. In 2005, we had our first three Medical Advisory Panel meetings. The Emergency Medical Advisory Panel met first in February, and the Cardiology and Orthopedic Surgery Panels met later in the year. All claims relative to those specialties were reviewed and the physicians present provided excellent insight into those claims. Their participation has continued after the process.

In my next article, I will go into much greater depth regarding the ideas that have been advanced through these meetings. One change that has been implemented is the development of a forms section on the AMS RRG website. It has become clear that many of our physicians have developed either policies or order sets or even patient encounter documentation forms that may be helpful for other groups to use.

Dr. Ader, our new Specialty Director for Cardiology Services, has been integral in the development of this section of the website. You will see as 2006 progresses the addition of multiple forms that you may find helpful. Examples that are to be added include:

1) Pulmonary Medicine office discharge instruction form. This includes the great majority of recommendations that a pulmonologist would recommend to a patient. The patient receives a copy and signs this document as well. It is the d/c instruction form that provides the last chance for a physician to document their recommendations to the patient.

2) Cardiology Clearance Form. The American College of Cardiology has specific guidelines regarding the preoperative clearance of a cardiac patient for non-cardiac surgery. This form, developed by Dr. Ader is useful in that it clearly documents these recommen-

dations to both the referring primary physician as well as the surgeon.

Again, I would like to thank everyone for another great year. If you have any ideas or recommendations, please do not hesitate to let me know. My email address is sshapiro@bpmp.com.

Sound Bytes

Brian Udell, M.D.

Chief Information Officer

We have gotten Sirius. Sirius Financial Systems, that is. Should you be wondering what technology your malpractice insurance company is utilizing to meet our mission of providing affordable premiums in such a complicated milieu, you might read on about how Best Practices and AMS RRG are working to keep costs in check, have the infrastructure to manage our members and growth, and include the IT expert systems to better record, understand, evaluate and mitigate medico-legal risks.

As mentioned previously in this venue, the first steps were taken by utilizing the newest and now (relatively) inexpensive technologies of server hardware, software and scanning. That helped keep filing and staffing to appropriate levels as the company grew. Information has already been acquired that is retrievable and useful for upcoming systems. Next, Best Practices joined with industry experts including Ramy Reddy (information technology), Dawne Adams (underwriting) and Dan Delfini (brokering) to continue and enhance our insurance services capabilities. These individuals have worked in multiple medical malpractice environments over many years, and so Best Practices Insurance Services has been able to surpass the services which we had previously contracted out to a larger company. We have been able to avoid many of the known pitfalls of growth and technology: acquiring (or spending resources trying to acquire) volumes of data that appear to have little use in the present or value in the future.

Let's get back to being Sirius (sic). The company that we choose to provide new software had to meet more than simply the mundane chores of financial and insurance management. Frankly, much of that work *continues* to be handled by Microsoft Excel Spreadsheets, even by the largest of insurers. Therefore, it appears that the environment of medical malpractice dictates a slightly different model of insurance than traditional property and casualty entities. Claims, for example, are one area of unique scrutiny as are the size of today's premiums (I didn't need to tell you that). Company financing, therefore, is much more common due to the latter and necessitates extra software. Additionally, today's medical provider environment has unique situations such as multispecialty groups and slot positioning for certain specialties. Our status as a Risk Retention Group with capital contributions encompasses other unique software extensions. All told, one could spend a fortune tailoring an insurance software package for medical malpractice. Sirius Financial Systems, recognizing many of these special circumstances, saw the situation as an *opportunity*, then, to utilize its software building model, "Product Builder", to provide an affordable package for AMS RRG. We met with people who are responsible for writing, correcting, modifying, upgrading and using the software package. The product is built with Microsoft products such as Access, Basic, and Word. Actual human beings from this planet can change forms or make data queries. They have a user group. This enables upgrades to get on-line faster and much less expensively for the "little guy". Also, when the product is "web-berized", we get the upgrade as part of the license costs (not available elsewhere). By the way, the other vendors exhibited the same product that they have been touting for years.

sirius

INNOVATION INTELLIGENCE INTEGRATION INFORMATION

Will all of this work? Will AMS RRG succeed where others have failed so miserably? You can bet on it! It will work because the individuals from both companies have been talking and working together to get this product up and running. Our incentive is obvious. Our new vendor from the U.K. is anxious to grow some serious business here in the U.S.A. especially from the burgeoning captive business which has been spawned by the hard insurance market. And, I am happy to report, it is actually working so far. We have been able to get all of the important errors and modifications to the basic product so that there will be a timely and accurate porting from the old system to the new. Costs have been kept at or under-budget. There have been few interruptions to the routine work of AMS RRG and the employees seem satisfied that things are going as planned. That says a lot. Even this article has focused on the people who write, service and use the service, not on boring jargon and software details.

Further updates will be provided in this newsletter about how our software experience is progressing. More importantly, you, the Insured Colleague, should feel a seamless integration and be provided with the most up-to-date information and service as is possible. Seriously.

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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 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!

The Insured Colleague™

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