

Dealing With Rising Malpractice Premiums

Over the past five years, physicians throughout the country have been experiencing the effects of a professional liability crisis. The American Medical Association has identified 20 states that are in the midst of a full-blown crisis, marked by soaring malpractice premiums that are threatening patients' access to care. The AMA says that 24 other states and the District of Columbia show signs of a potential crisis. This situation has dramatic effects on the entire healthcare marketplace.

Medical liability adds billions to the cost of healthcare each year. As premiums skyrocket and liability coverage shrinks or becomes too difficult to obtain, many doctors have decided to retire early, eliminate some of the services they would normally deliver to patients or move to states that have enacted reform measures and/or where premiums are lower.

Medical liability adds billions to the cost of healthcare each year. As premiums skyrocket and liability coverage shrinks or becomes too difficult to obtain, many doctors have decided to retire early, eliminate some of the services they would normally deliver to patients or move to states that have enacted medical malpractice reform measures and/or where premiums are

lower. This makes it difficult for patients to find physicians to deliver the services they need. A 2004 survey by the American College of Obstetricians and Gynecologists (ACOG), for example, found that one in seven obstetricians in the U.S. said they no longer deliver babies.

The litigation crisis also spurs an increase in the practice of defensive medicine. According to a 2003 survey of physicians by Harris Interactive, 94 percent of physicians said that unnecessary or excessive care is very often or sometimes provided because of

medical-liability fears. The survey found that, because of the fear of liability:

- 79 percent of physicians order more diagnostic tests than are medically needed.
- 74 percent of physicians refer patients more often than they would if based only on their professional judgment.
- 51 percent of physicians suggest invasive procedures such as biopsies more often than they would if based only on their professional judgment.
- 41 percent of physicians prescribe medications more often than they believe the medications are medically needed.

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survey. Among practitioners of defensive medicine who detailed the most recent defensive act, 43 percent reported using imaging technology in clinically unnecessary circumstances.

Avoidance of procedures and patients that were perceived to elevate the probability of litigation was also widespread. Some 42 percent of respondents reported that they had taken steps to restrict their practice in the previous three years, including eliminating procedures prone to complications, such as trauma surgery, and avoiding patients who had complex medical problems or were perceived as litigious. Defensive practice correlated strongly with respondents' lack of confidence in their malpractice insurance and perceived burden of insurance premiums.

"The most frequent form of defensive medicine, ordering costly imaging studies, seems merely wasteful, but other defensive behaviors may reduce access to care and even pose risks of physical harm," the authors write.

Unnecessary care adds significantly to the nation's healthcare bill. The AMA says that the costs of defensive medicine are estimated to be between \$70 billion and \$126 billion per year.

The impact of the litigation crisis is reflected in higher health insurance premiums for employers and patients and in rising malpractice premiums for physicians. Triple-digit increases in liability insurance premiums continue to plague physicians in a number of states, according to an annual nationwide rate survey published by the Medical Liability Monitor (www.mlmonitor.com), an independent publication that reports exclusively on medical liability insurance. It surveys major insurance carriers of professional liability coverage for physicians and reports on three specialties: internal medicine, general surgery and obstetrics/gynecology.

The most recent survey found that the majority of rate increases were between 6.9 percent and 24.9 percent in 2004. This compares with the 2003 survey in which the majority of increases were between 10 percent and 49 percent. The survey reports premium rates from 46 companies, which represent as much as 75 percent of the physician malpractice insurance market.

According to the survey, Florida's Dade County reported the highest rates in the country with ob/gyns and general surgeons paying as much as \$277,241 for coverage, which represents increases of 11.3 percent and 22.4 percent respectively.

Highest and Lowest Premiums

Here are the states and counties where internists paid the most and states where they paid the least for professional liability coverage in 2004.

State	Highest Premium	State	Lowest Premium
Florida (Dade)	\$69,310	Nebraska	\$3,212
Michigan (Wayne)	63,898	Minnesota	3,375
Illinois (Cook)	58,514	South Dakota	3,697
Ohio		Idaho	3,770
(Northeastern Ohio)	41,998	Wisconsin	5,147
Texas			
(Cameron, Hidalgo)	36,018		

Source: Medical Liability Monitor.

On the other hand, some internists in Nebraska have the lowest rates in the country, paying \$3,212 for annual premiums, which include the state's compensation fund surcharge. Patient compensation funds are government-established liability funding vehicles that provide medical malpractice coverage in excess of a specified primary amount for defined healthcare providers. Some states make participating in these funds voluntary, while

Many factors contribute to the high cost of professional liability insurance, but in 2003 the U.S. General Accounting Office (now known as the Government Accountability Office) found that "losses on medical malpractice claims, which make up the largest part of insurers' costs, appear to be the primary driver of rate increases in the long run."

others require it. Nebraska also has the lowest rates for the two other specialties reported in the survey: \$10,976 for general surgeons and \$16,194 for ob/gyns.

Most companies in the survey reported that their underwriting practices are still very restrictive. When carriers face ever-escalating losses, many are forced to tighten their underwriting standards and revise their business plans. Further, the report states that many insurers are continuing to retreat

to "core" states and are not renewing coverage for some physicians in certain territories.

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The Physician Insurers Association of America (PIAA) points out that the mean settlement amount on behalf of an individual defendant in 2003 was just over \$322,500. The mean verdict amount in the same year was over \$430,600 per defendant. PIAA is the trade association of medical liability insurers owned and/or operated by physicians and hospitals.

The GAO report also explains that high investment income or adjustments that account for lower-than-expected losses may legitimately permit insurers to price insurance below the expected cost of paying claims. However, because of the long time lag

between collecting premiums and paying claims, underlying losses may be increasing while insurers are holding premium rates down, requiring large premium rate hikes when the increasing trend in losses is recognized. The GAO says the largest writer of medical malpractice insurance in Florida, for example, increased premium rates for general surgeons in Dade County by approximately 75 percent from 1999 to 2002.

In analyzing plaintiff awards between 1997 and 2003 in medical malpractice cases, Jury Verdict Research, a Horsham, Pa.-based publisher of data on personal injury litigation, found that the most frequently claimed injury was death, with a median award of \$1.03 million. (Jury Verdict Research defined the median as the middle value among awards listed in ascending order). This was followed by brain damage and genital injuries. Jury Verdict Research maintains a nationwide database of plaintiff and defense verdicts and settlements resulting from personal injury claims.

Medical Malpractice: Verdicts, Settlements and Statistical Analysis, a report published by Jury Verdict Research, found that the median award for medical negligence in childbirth cases from 1997 to 2003 was \$2.5 million, the highest of all types of medical malpractice cases analyzed. The following were the median awards for other types of malpractice cases:

Tort Reform Increases Doctor Supply

Tort reform at the state level is having an impact on physician services. A recent study in the June 1, 2005, issue of JAMA found states that enacted malpractice reforms had an increase in their overall supply of physicians.

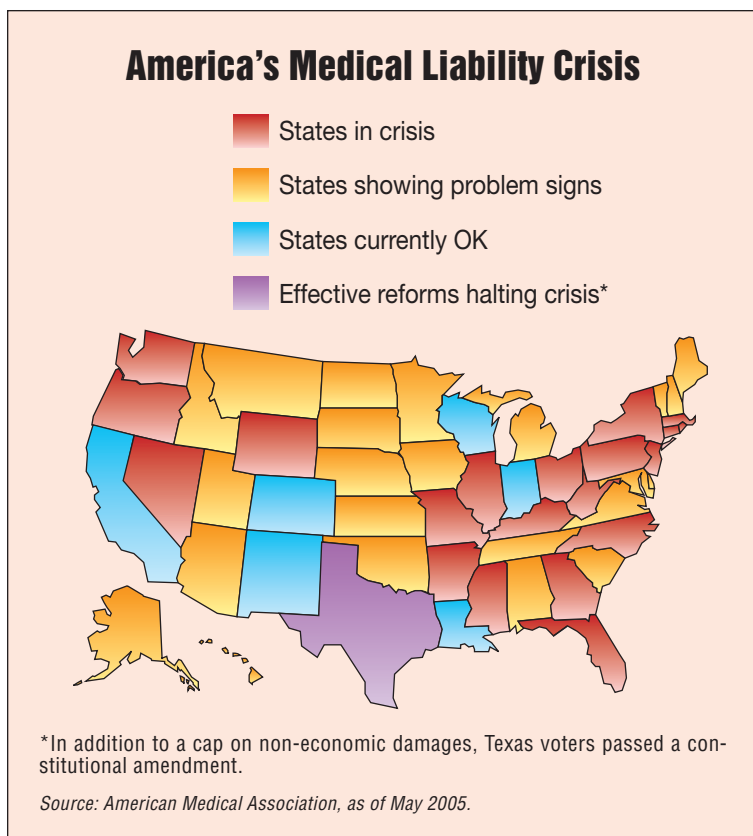
Daniel P. Kessler, Ph.D., J.D., of the Stanford University Graduate School of Business, Hoover Institution, and colleagues investigated whether and how liability pressure affects long-term trends in physician supply from state to state. They found that the adoption of "direct" malpractice reforms that reduce the size of awards, such as caps on damages, led to greater growth in the overall supply of physicians.

Three years after adoption, direct reforms increased physician supply by 3.3 percent, controlling for fixed differences across states, population, states' healthcare market and political characteristics, and other differences in malpractice law.

- \$1.55 million for delayed treatment cases.
- \$1.3 million for cancer diagnosis cases.
- \$975,000 for diagnosis cases.
- \$705,000 for cases involving medication.
- \$410,000 for lack of informed consent.
- \$384,500 for cases of negligent supervision.

Saving Money on Premiums

According to Medical Liability Monitor's survey, physicians continue to look for ways to save money on medical malpractice premiums. In addition to placing deductibles on their policies, they are lowering limits of coverage and eliminating certain types



of insurance coverage. Typical deductibles ranged from \$5,000 to \$100,000, in any combination of indemnity and/or expense, depending on the size of the group, the survey says.

Medical practices have also discovered other ways to trim liability premiums. A survey by the Medical Group Management Association (MGMA) found, for example, that 17.1 percent of the physician groups surveyed took steps to reduce their liability coverage amounts, while 16.2 percent decided to suspend practice expansion plans.

Experts say that while it may be difficult to do, physicians should take the time to try to negotiate rates in this hard insurance market. They should check with several insurers for quotes on premiums,

make sure they understand the provisions of their coverage, and develop and document an effective risk-management program that may help reduce premium increases and avoid liability claims. More and more carriers want to provide coverage to physicians who have impeccable safety records.

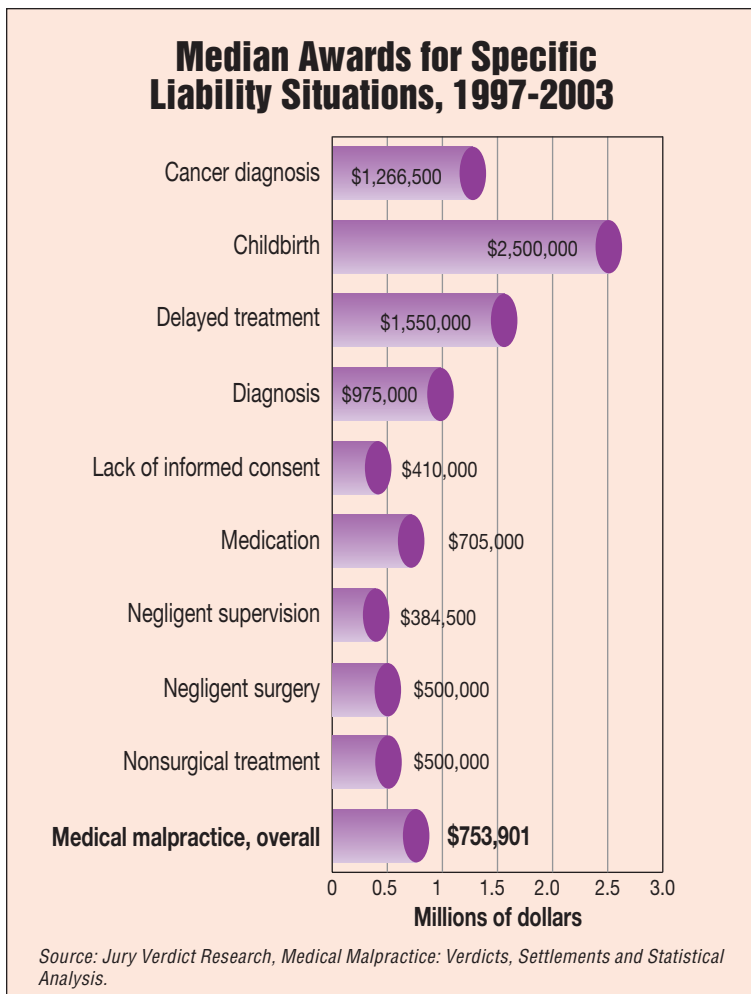
The most common type of physician liability policies provides \$1 million coverage per incident and \$3 million coverage per year. The amount of coverage a physician buys should be based on specialty, geographic location, willingness to risk personal assets in the event of a large claim and the affordability of premiums. Coverage requirements may also be dictated by hospital bylaws or managed-care contracts.

There are several different types of professional liability policies available to physicians. Most policies written today, however, are claims-made or discovery policies. Claims-made policies cover claims made against the policyholder during the period in which the policy is in effect. An occurrence policy covers the insured for any incident that occurs (or that did occur) while the policy is (or was) in force, regardless of when the incident is reported or when it becomes a claim. Occurrence insurance for

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medical liability coverage is rarely offered now because of the difficult of projecting long-term claims costs under this type of policy. Physicians who are covered by claims-made policies need to obtain “tail” protection if they cancel the policy; this will provide coverage for any claims that may arise after the policy is no longer in effect.

When applying for professional liability insurance, it is impor-



tant to complete the applications thoroughly and accurately, so you do not jeopardize coverage in the event of a claim, write healthcare attorneys David R. Dearden and Michael R. Burke in an article entitled “Do You Have the Right Malpractice Insurance Policy?” (Family Practice Management, Nov./Dec. 2004). Mr. Dearden and Mr. Burke are shareholders in the healthcare law firm of Kalogredis, Sansweet, Dearden and Burke in Wayne, Pa. They state that the failure to list a prior disciplinary action or a prior malpractice action may give the insurance company the opportunity to disclaim coverage in the event a malpractice suit is filed.

Premium rates are based on anticipated losses on claims and related expenses by insurers, expected investment income and

the need to build a surplus. For-profit insurers must also earn a reasonable profit for shareholders. In most states insurance regulators have the authority to approve or deny proposed changes to premium rates.

When determining premiums, insurers also take into consideration a number of other factors including medical specialty, geographic location of the practice and policy limits. Other factors that influence the cost of premiums include procedures performed, claims history and the risk-management practices that the medical office has in place.

The primary sellers of physician medical malpractice insurance are the physician-owned and/or operated insurance companies that insure approximately 60 percent of all physicians in private practice in the U.S. Most physician-owned companies are organized as mutual insurance or reciprocal insurance companies. A mutual insurance company has no stockholders. It holds the company's assets, and the entire company is owned by its policyholders. A reciprocal insurance company is an unincorporated association.

To deal with potential liability problems, many physicians practice defensive medicine. This often involves undertaking medical responses to avoid liability rather than to benefit the patient. The AMA says that defensive medicine can take many forms, including referring patients to emergency departments and specialists declining elective referrals from emergency departments.

Other healthcare providers may obtain coverage through commercial insurance companies, mutual coverage arrangements or state-run insurance programs.

Legal experts say it is important to take the time to understand what your policy says. If you are hit with a malpractice suit, for example, you need to know what you can and can't do. The policy will list your responsibilities to the insurance carrier, such as not saying or doing anything that might prejudice your defense or exacerbate the alleged damages.

In addition, be sure you understand any "consent to settle" provision in your policy. These define the terms under which a settlement may be agreed upon by the insurer and the physician. In some cases, if you refuse to consent to the insurer's recommendation of settlement, you may be responsible for ongoing defense costs and the amount of any verdict that exceeds the amount of the recommended settlement, according to Mr. Dearden and Mr. Burke.

If you are sued, you should consult with your own attorney even though your insurer provides a lawyer to handle your case. "Hiring an independent attorney who specializes in defending physicians to discuss your case is likely to save money later and maintain your standing within the professional community," says

Questions to Ask When Selecting a Carrier

- What type of carrier is it? Is it a stock company, a mutual or reciprocal carrier, or an alternative market carrier?
- Is the carrier endorsed or sponsored by any medical associations, and does it offer discounts for membership?
- How long has the carrier been in the business of writing medical malpractice insurance?
- If you have a claim, will it be reviewed by a consultant of your own specialty? Further, try to find out if you will be able to receive prompt service that includes answering your questions and providing necessary advice, from an experienced claims staff member.
- What is the background and experience of the claims staff? A company with a seasoned medical liability claims staff that includes attorneys, paralegals and personnel with medical backgrounds will have a better knowledge base to draw from in defending claims.

Dr. Martin MacNeill, D.O., J.D., and medical director of the Utah State Developmental Center.

Practice Modifications

To deal with potential liability problems, many physicians practice defensive medicine. This often involves undertaking medical responses to avoid liability rather than to benefit the patient. The AMA says that defensive medicine can take many forms, including referring patients to emergency departments and specialists declining to accept elective referrals from emergency departments.

The U.S. Office of Technology Assessment (OTA) defines defensive medicine as “when doctors order tests, procedures, or visits, or avoid certain high-risk patients or procedures, primarily (but not necessarily solely) because of concern about malpractice liability.” Most defensive medicine is not of zero benefit, according to a 1994 OTA report. “Instead, fear of liability pushes physicians’ tolerance for medical uncertainty to low levels, where the expected benefits are very small and the costs are high,” the report states. “Many physicians say they would order aggressive diagnostic procedures in cases where conservative management is considered medically acceptable by professional expert panels.”

But medical standards of care are increasingly determined by legal and community standards and not based on scientific evidence, says Dr. Richard E. Anderson, chairman of the Board of Governors of The Doctors Company, a physician-owned medical malpractice insurance provider based in Napa, Calif.

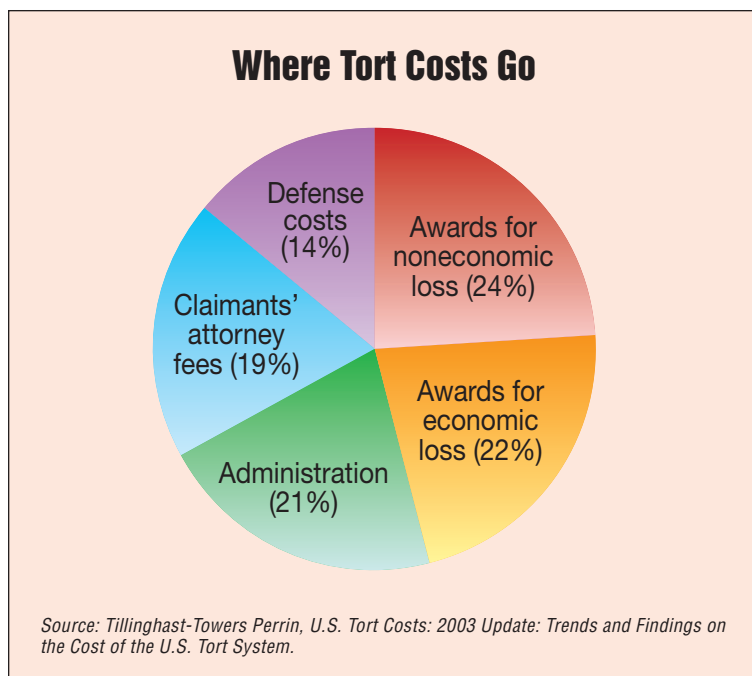
One strategy to help reduce the possibility of lawsuits is to ask patients to sign a waiver, which states that the patient will not sue for frivolous reasons. This conceivably could work as long as your state allows such a request, although such an approach is likely not viable in a number of jurisdictions, says Mark Langdon, an attorney with the Washington, D.C., law firm of Arent Fox. Your attorney should be able to advise whether such a waiver would be enforceable in your state.

In addition, some physicians are urging patients to sign voluntary arbitration agreements as a way to resolve medical malpractice disputes. Supporters of these agreements say that arbi-

tration is less expensive for both patients and physicians, and negligence claims are settled faster than those that go through the court system.

With binding arbitration, an arbitrator or panel of arbitrators unconnected to a case hears arguments from both sides and arrives at a decision that both parties must accept. Kaiser Permanente, the large nonprofit health plan headquartered in Oakland, Calif., has used arbitration to resolve all legal claims since 1971. Under this program, arbitrators are free to award any amount of damages because there is no cap on the size of an arbitration award, and members are eligible to receive punitive damages.

It may also be wise to explore alternative risk-financing mechanisms, such as risk retention groups and/or captive insurance companies, says Mr. Langdon. These are essentially insurance companies wholly owned by a group of insured doctors. There must be enough physician participation in such groups to make them financially viable, he explains. "This type of arrangement



has some attractiveness because the physicians are actively involved in managing their own risks," he adds. Keep in mind that risk retention groups would need to comply with applicable federal and state laws.

Evaluating Insurers' Solvency

It is important to thoroughly check out the solvency of professional liability insurers before purchasing coverage. A number of medical malpractice insurers have gone bankrupt or have withdrawn from the market, leaving physicians to scramble to find adequate liability coverage.

The most important factor in selecting a malpractice carrier is whether it has adequate capitalization to remain in the market over the long term. On average, it takes 22 months for a claim to be reported and an additional 33 months to make payment. Your carrier should have sufficient financial resources to meet all current and future claims against policyholders.

Does the malpractice carrier you're considering have adequate capitalization to remain in the market over the long term? On average, it takes 22 months for a claim to be reported and an additional 33 months to make payment. You want your carrier to have sufficient financial resources to meet all current and future claims against policyholders.

Take the time to check out a carrier's annual report and other financial statements. The company should be operating with a surplus, which is the amount by which a company's assets exceed its liabilities. It is also important to determine the amount of a company's loss reserves.

Keep in mind that claims against a policyholder are recorded as expenses as well as the insurer's estimate of future losses on those same claims. The liability associated with the portion of these incurred losses that has not yet been paid by the insurer is known as the insurer's loss reserve. To maintain financial soundness, insurers must maintain assets in excess of total liabilities.

The GAO points out that state insurance departments monitor insurers' solvency by tracking, among other measures, the ratio of total annual premiums to this surplus. The financial and operating strength of a company is also indicated by the ratings it

receives from insurance industry analysts such as A.M. Best Company (www.ambest.com), which evaluates insurers annually and publishes ratings. Experts say that companies with ratings lower than B+ by A.M. Best may not have the financial stability to handle a large jury verdict.

In addition, when evaluating insurance coverage and cost, you must consider the premium paid in relation to the protection, service and financial strength of the carrier. It is important to consider a number of factors with regard to insurance carriers, including claims defense performance, risk-management services, underwriting standards and actuarial discipline.

Should You 'Go Bare'?

Some physicians who have experienced large increases in premiums or who may not be able to obtain coverage have dropped malpractice insurance and are self-insuring in states where it is allowed. A number of states, including Pennsylvania and Con-

Malpractice Reformers Look to California

The American Medical Association has declared 20 states in a medical liability crisis, a situation in which patients lose access to care as a result of the existing medical liability system. The AMA and other associations representing physicians have strongly urged the federal government as well as state governments to enact medical malpractice reform measures to help alleviate the crisis.

California's Medical Injury Compensation Reform Act (MICRA), which became effective in 1976, is considered a model reform measure for other states and the federal government to emulate. It places a \$250,000 limit on non-economic damages (pain and suffering) on a per-incident basis, limits contingency fees to attorneys and allows periodic payment of future damages, among other provisions. Under MICRA, injured patients receive full compensation for all quantifiable damages, such as lost income, medical expenses, long-term care and even the value of otherwise uncompensated services provided by the injured party.

Annual data published by the National Association of Insurance Commissioners (NAIC) document the improvements California practitioners and healthcare consumers have enjoyed since the enactment

necticut, for example, require physicians to carry liability insurance if they want to practice in those states. In addition, many hospitals and health maintenance organizations require physicians to carry professional liability coverage.

While self-insuring can save money on administrative costs, physicians in such an arrangement assume greater financial responsibility for malpractice claims than they would if they had insurance coverage. As a result, physicians who “go bare” face a potential loss of their own personal assets in paying off a plaintiff and paying for an attorney. In some situations, it may mean that the physician will lose his or her medical license for the inability to pay on a judgment.

Causing even more concern for physicians is a recent New Jersey appellate court ruling indicating that plaintiffs can pursue defendants' personal assets in cases where the insurer is in liquidation and damages in the case exceed the \$300,000 cap allowed by the state's guaranty fund.

of MICRA. Total medical liability premiums reported to the NAIC since 1976 have grown in California by 245 percent, while premiums for the rest of the nation have grown by 755 percent.

In addition, Medical Liability Monitor's 2004 survey found that one company in California, NORCAL, decreased rates the most, by 16.8 percent across the board in San Mateo, Santa Clara, Santa Cruz, Fresno and Monterey counties. Internists covered by NORCAL pay \$6,869; general surgeons pay \$23,031, and coverage for ob/gyns costs \$30,463.

The U.S. House of Representatives recently passed tort reform legislation modeled on MICRA. The bill, which was approved 226 to 201, is the third version to pass the House in the past three years. The previous two measures died in the Senate.

MICRA has stood up against numerous court challenges over the years. But in Wisconsin, the Supreme Court recently struck down the state's cap on pain and suffering awards on constitutional grounds. The cap was set by the state legislature in 1995 at \$350,000 and now stands at \$445,775, adjusted for inflation. Wisconsin is one of only six states deemed by the AMA to have a stable malpractice climate, which some observers say is threatened by this ruling.

For physicians who decide to self-insure, it is important to take steps to protect personal assets. For example, experts say it is important to talk to an estate-planning attorney with expertise in asset protection. Asset protection strategies should be put in place well before a liability claim is made against you.

One approach is to take advantage of laws that shield from creditors assets owned by a spouse, equity in your personal residence or funds in qualified retirement accounts. In addition, you should build up a fund from which you could pay potential creditors.

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If you are paying \$60,000 to \$90,000 a year in malpractice premiums, putting that aside over a period of time will result in a good amount of savings.

Attorney Robert J. Mintz of the Asset Protection Law Center, in Oceanside, Calif., points out that a gift of property will be effective in

removing that property from the husband's or wife's potential creditors, as long as it is not a fraudulent conveyance. Such a transfer would be deemed a fraudulent conveyance if it was made in response to a claim or a potential claim. However, he warns, if after the gift the husband or wife continues to enjoy the use of the property, a court may find that the gift was not really a gift. Nevertheless, gifts that are made to a spouse in trust may eliminate this problem. If you decide to self-insure, legal experts say, be sure to get the assistance of an attorney to make sure that you have an effective asset protection plan in place.

Such a plan is based on the ability to convert your ownership of particular assets into a form that is legally and practically difficult or impossible to collect against, Mr. Mintz says.

It also is important to keep in mind that if you are insured, working with an uninsured physician can mean significant risks. If there is a case brought against the uninsured doctor, you may be viewed as the physician with the deep pockets, and the patient's attorney will work to show that you caused some of the harm. Under the theory of joint and several liability, each defen-

dant in a legal action is responsible for the entire amount of damages that a plaintiff is seeking, regardless of their relative degree of responsibility for the damages involved. A deep-pocket defendant will have substantial insurance coverage or significant personal assets for the plaintiff to try to tap in a lawsuit. (A number of states have moved to limit defendants' share of damages to their relative percentage of fault in the injury.)

One useful book that provides guidance on protecting your assets is *Asset Protection for Physicians and High-Risk Business Owners*, written by Mr. Mintz. You can read this book on-line at no cost by logging on to www.rjmintz.com.

Managing Risk

Whether you hold a professional liability policy or you self-insure, it is important to avoid lawsuits whenever possible. Healthcare experts maintain that developing a risk-management program is vital for physicians who want to avoid malpractice claims. In many cases, these programs also can have a positive impact on insurance rates. Taking the time to identify issues that arise with patients and reporting them—as well as mitigating problems as they take place—will help you avoid liability claims. In addition, risk-management programs may sometimes translate into premium discounts for physicians.

The Insurance Information Institute says that the effectiveness of risk-management measures such as developing practice standards is exemplified by the success of steps taken by anesthesiologists. In the 1980s, the anesthesiology community identified the cause of most claims and established standards to avoid them. The result was a significant drop in medical malpractice claims and awards and a corresponding drop in the cost of professional liability coverage.

Another risk-management proposal includes requiring doctors to study medical malpractice prevention as part of their licensing requirements. Massachusetts has such a program in force. Some maintain that a no-fault system that would provide more money for injured patients and would pay to treat all injuries, not just those caused by negligence, should be tried. While costs would be higher, they point out that under the current system, 60 percent of every dollar goes towards legal and administrative costs.

The Doctors Company, a physician-owned medical malpractice insurance provider based in Napa, Calif., maintains that most malpractice claims are preventable if the physician knows the circumstances that often lead to claims and works to prevent such risks in his or her own practice. Insurers often perform site surveys in which risk managers assess and evaluate practice locations, including medical record review, of their policyholders. These site surveys often identify system failures that commonly generate claims and can result in an increase in premiums if proper risk-management plans are not in effect.

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The American Physicians Assurance Corporation (APAC), an East Lansing, Mich.-based commercial carrier that provides malpractice coverage in six states, says that every year it receives claims regarding patients who were not notified of abnormal test results or other significant find-

ings. Cases involving lack of notification of abnormal test results are difficult to defend and expensive to settle, says APAC.

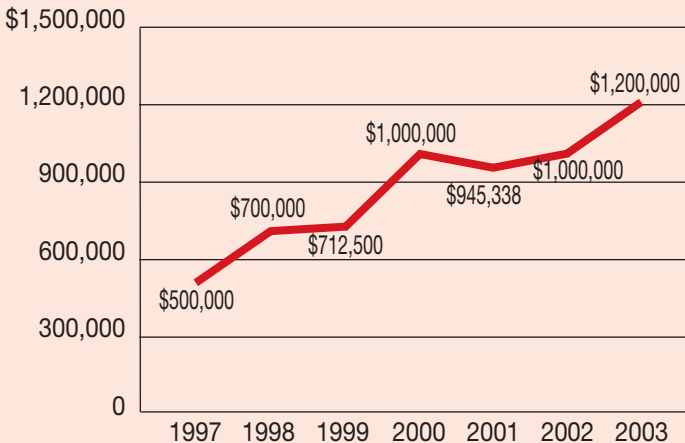
The failure to report abnormal test results typically happens because the physician did not receive or review the tests results, the results were misplaced, or the patient was simply not notified. In all of these instances, a delay in diagnosis and treatment or failure to provide timely treatment can result in physician liability. Time is especially critical with cancer cases. It is important to be able to show that you did have a mechanism or system to track the tests and the test results, that you did notify the patient and that appropriate follow-up was recommended.

To make sure you are adequately tracking tests and results, R. Stephen Trosty, senior risk-management consultant for APAC, offers the following recommendations:

■ Establish three separate tracking systems: one to track diagnostic tests, another to track referrals and consultations and a third to follow up on missed appointments.

- Be sure all test results are returned to the physician's office.
- The physician should review the results, then date and sign them to verify that they have been reviewed.
- Be sure the patient is notified of test results, including those within normal limits.
- Let patients know that abnormal test results will be communicated by a phone call from the physician. These results should have a higher standard and urgency for communication. Communication should be done by the physician.
- Send a certified letter to the patient if he or she can't be contacted by phone.
- The patient should be encouraged to contact the medical office if test results are not received within a specified time.
- Be sure to put documentation in the medical record to verify when and how the patient was notified, what was communicated and any recommended follow-up.
- Telephone calls from the doctor and those from patients should be documented in the patient's medical record. It is important to

Compensatory Award Medians, Year by Year



Source: Jury Verdict Research, *Medical Malpractice: Verdicts, Settlements and Statistical Analysis*.

be able to determine the date of the call and what was said.

- Test results should be filed in the patient's chart.
- Be sure that follow-up occurs if recommended.

In addition, when using the phone to communicate with patients, it is important to obtain as much information as possible about the patient on the other end of the line. You should prescribe or advise by phone only when you know the patient's medical history. Be sure to repeat all vital instructions to patients to help ensure comprehension. Ask the patient to repeat your instructions back to you.

Using electronic medical records is one way to maintain adequate medical documentation, Mr. Trosty says. But tracking and follow-up systems need not be high-tech. Effective systems can be as basic as a log book containing entries for each ordered test, with space to track and document returned test results; index cards sorted by day, month or patient, or tickler files or other reminder systems.

In addition, maintaining an appropriate medication list for each

Groups Mount Challenges to Frivolous Lawsuits

Physicians are fighting fire with fire when it comes to frivolous lawsuits. Two new organizations seek to stop such suits in their tracks by threatening to file countersuits on behalf of physician defendants.

Doctor's Advocate (www.doctorsadvocate.org), launched in August 2005, offers an inexpensive legal service designed to terminate frivolous malpractice lawsuits. "Physicians are vulnerable to frivolous lawsuits because plaintiffs and their lawyers have nothing to lose by suing a doctor," says Dr. Elliot Menkowitz, an orthopedic surgeon and a founder of the Pottstown, Pa.-based organization.

Participating physicians who are sued will provide a copy of the complaint to a Doctor's Advocate lawyer, who will analyze the facts in the case. If the lawsuit appears frivolous, the attorney applies pressure on the plaintiff's attorney to terminate the lawsuit with the threat of a countersuit. If litigation ensues after initial contact, and the doctor is found not to be at fault, the Doctor's Advocate attorney may file a countersuit on a contingency basis, seeking professional disciplinary action against the plaintiff attorney and medical expert witnesses.

The fee to join Doctor's Advocate is \$1,200 per year. In the case of

patient as well as known drug allergies is also recommended. If there are no known allergies, this fact should be documented and not left blank, says Mr. Trosty. "We are finding a number of liability cases where the physicians are prescribing medications to which the patient is allergic," he adds.

Informed Consent

Physicians also should identify any uncertainty and risk involved with a specific treatment plan. Whenever possible, be sure to supply educational materials for the patient to take home. Remember that documentation is a key component of the informed-consent process, and it cannot be fully delegated to a nurse or an office manager. "While lack of informed consent may not be a sole allegation of malpractice claims, it is becoming more frequently one of multiple allegations," Mr. Trosty says.

A successful exchange of information between the doctor and the patient accomplishes two things, according to The Doctors Company. First, the physician's willingness to explain diagnoses,

a doctor who has a medical malpractice lawsuit pending and wishes to receive Doctor's Advocate's services for that case, there is an additional one-time flat fee of \$5,000.

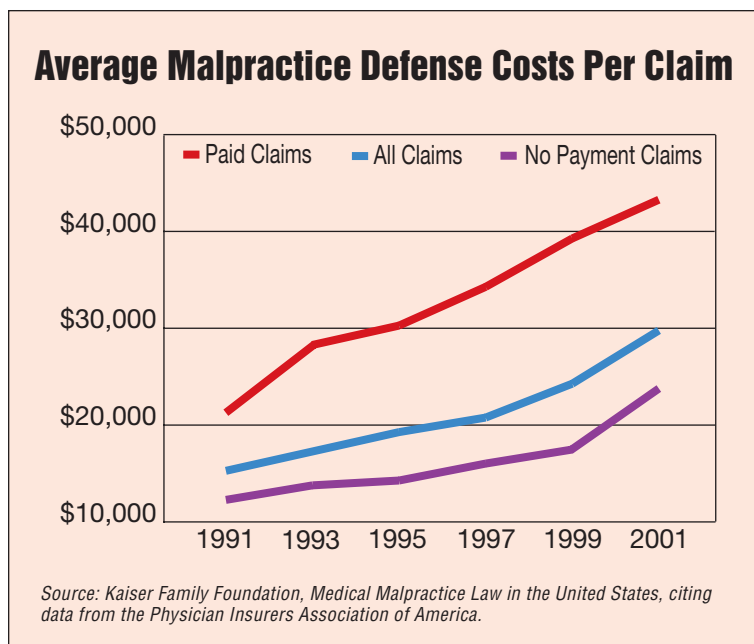
Another organization, Medical Justice Services (www.medicaljustice.com), based in Greensboro, N.C., provides a similar service. Medical Justice Services (MJS), launched in 2002, provides coverage to physicians in more than 35 states. Depending upon a physician's specialty, the annual fee ranges from \$625 to \$1,800, and additional retroactive coverage can be purchased for a one-time fee of \$1,400 to \$4,000. Members agree to review one case per year and require all patients to sign a contract that prohibits them from filing frivolous lawsuits and to settle legitimate disputes through board-certified experts.

But if a suit does wind up in a courtroom and the doctor wins, the case is reviewed by MJS members, says Dr. Jeff Segal, a neurosurgeon and founder of the organization. If the suit is considered frivolous, he says, MJS files a claim with professional societies, medical licensing boards or credentialing committees against attorneys and physicians who serve as expert witnesses. In some cases, doctors have been disciplined or suspended.

treatments, expected outcomes and potential risks to the patient demonstrates that the physician recognizes the patients' rights and will remain responsive to them. Second, it shifts the decision-making responsibility from the physician alone to a mutual responsibility of both physician and patient.

A consent document for a specific procedure or type of surgery must include the patient's name, doctor's name, diagnosis, proposed treatment plan, alternatives, potential risks, complications and benefits. Further, it must be signed and dated by the physician and the patient (or the patient's legal guardian or representative). In addition, an informed-consent document can include a statement to the effect that the information listed on the form covers only that information that applies generally, and that the physician has personally discussed specific factors with the patient.

The Doctors Company maintains that litigation often results from a discrepancy between the patient's expectations and the outcome of treatment. Informed consent cannot completely elim-



inate malpractice claims, but rapport between the patient and a physician based on solid exchanges of information may help prevent a lawsuit.

Patients do have the right to refuse specific care or treatment, provided that they understand what the potential negative ramifications are if they do, says Mr. Trosty. Physicians must provide patients with the ramifications and make sure that this is documented. "Doing all these things can reduce the likelihood of a lawsuit or significantly increase the ability to successfully defend a claim," he adds.

The odds of a malpractice plaintiff prevailing are relatively low, according to Jury Verdict Research. In 2003, plaintiffs had a 36-percent chance of recovering damages, the company says. This means that doctors still win more cases than they lose. But sometimes it may be better to settle a case than to risk losing in court.

When to Settle a Case

If you face a medical malpractice case, keep in mind that the plaintiff must prove that your care was substandard, that the injury suffered was a direct result of that medically negligent act, omission or error and that the damages claimed stem from that injury. The odds of the plaintiff prevailing are relatively low, according to Jury Verdict Research. In 2003, plaintiffs had a 36-percent chance of recovering damages, the company says. This means that doctors still win more cases than they lose.

But sometimes it may be better to settle a case than to risk losing in court. Experts say deciding when to settle is usually a difficult task. Richard Vento, president of Medical Risk Management Services, a malpractice insurance brokerage and consulting firm in Jamison, Pa., says that the decision to settle a case should be made on an objective basis by assessing the facts and issues of the case. Mr. Langdon agrees and adds, "All the pertinent facts must be investigated, and the physician must be able to evaluate the strengths and weaknesses of the case."

In addition, physicians must consider the jurisdiction (whether it is friendly or not), the judge and the nature of the injury that caused the case to be filed, Mr. Langdon says. It also is important to examine your insurance policy to determine your rights regarding settlement. For example, you may have an absolute

right to consent to and/or veto a settlement, or be able to give limited consent. These factors are usually a matter between the physician and the insurer, he adds.

You should be careful about “hammer clauses.” Under such a clause, if the plaintiff offers to settle for a specific amount of money, and you as the physician decline to do so for that amount, then the insurance company is not responsible for any judgment amount greater than the settlement offer. In such an instance, all legal expenses you incur after the settlement offer are your responsibility.

To avoid this problem, make sure your policy provides you with adequate rights on settling a case, says Dr. MacNeill. “It is in the physician’s best interest to pay extra for a professional liability policy that says settlement is based on when the physician decides, rather than when the insurance carrier decides,” he adds.

It is important to remember that when a physician settles a case, information about the physician and the case is reported to the National Practitioner Data Bank. NPDB is a flagging system that alerts users if a practitioner’s record should be reviewed more closely. It identifies practitioners with a history of adverse actions and medical malpractice payments. This nationwide database captures information on physicians, dentists and other healthcare practitioners; in addition, it provides the information to hospitals, health plans, professional societies and state licensing boards.

The reporting requirements and query rules of the NPDB are as follows:

- Medical malpractice carriers must report any payment resulting from a written claim or judgment. Reports must be submitted to the NPDB and appropriate state licensing board within 30 days of a payment. Carriers cannot query the NPDB about healthcare providers.
- State licensing boards must report licensure disciplinary action based on reasons related to professional competence or conduct. Reports must be submitted to the NPDB within 30 days of the action. State boards can query the NPDB at any time.
- Hospitals and other healthcare facilities must report professional review actions based on reasons related to professional competence or conduct that adversely affect clinical privileges

for a period longer than 30 days; or voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation. Reports must be submitted to the NPDB and appropriate state licensing board within 15 days of the action. Hospitals must query the NPDB when screening applicants for medical staff appointment or granting clinical privileges. They also must query every two years to obtain information on healthcare practitioners on the medical staff or those who have clinical privileges. Hospitals may query at other times as they deem necessary.

■ Professional societies must report to the NPDB professional review action based on reasons relating to professional competence or conduct that adversely affects membership. Reports must be submitted to the NPDB and the appropriate state licensing board within 15 days of the action. Soci-

eties may query when screening an applicant for membership or affiliation and in support of professional review activity.

■ The HHS Office of Inspector General must report exclusions from Medicaid/Medicare and other federal programs. Exclusions are reported monthly.

Healthcare professionals are not eligible to report information to the data bank. They can, however, query the NPDB for any information on file about themselves and take action to correct any erroneous information in the data bank. (For information on how to do this, log on to www.npdb-hipdb.com/pubs/fs/Fact_Sheet-Self-Querying.pdf.) The information in the NPDB is not available to the general public.

Whatever the outcome, lawsuits remain very stressful for the physician and the providers and caregivers with whom he or she works. Experts say it is a good idea to take preventive steps to avoid this problem or to make sure such an event isn't repeated.

When a physician settles or loses a case, information about the case is reported to the National Practitioner Data Bank. The NPDB is a nationwide database that compiles information on judgments and disciplinary actions against healthcare practitioners and provides the information to hospitals, health plans, professional societies and state licensing boards.