

#Contact#

YOUR PROFESSIONAL LIABILITY BROKER,



is pleased to be sending you, our *Cornerstone Spring Newsletter*.

Many of your colleagues may be in need of our assistance. Please have them give us a call at 800-508-1355.

Thank you,
Chris Zuccarini
President



CORNERSTONE

PROFESSIONAL LIABILITY CONSULTANTS

A QUARTERLY NEWSLETTER

ARE CAPS THE ONLY ANSWER? OF COURSE NOT!

As found in PCA Update Issue 2
The authors of this article are Barton L. Post, Esq., malpractice defense attorney; Joe Brady, CPCU, and Timothy McGuire, CPCU, both with extensive experience in handling the defense of malpractice claims as long time claims managers of major malpractice insurance companies. Bart, Joe and Tim are part of the management team of PCA.

It is commendable that the various medical organizations proceed with pressing for caps legislations, but at the same time, more of an effort should be made to press for changes that, **FIRST** will have an immediate effect in minimizing the malpractice crisis and **SECOND**, changes that have a reasonable chance of success to pass within the next year.

The following is an outline of such legislative proposals and court reforms:

1. Legislation facilitating countersuits by doctors who have been the subject of frivolous litigation. Countersuits and threats of countersuits have already had an impact on the amount of frivolous litigations and more can be done with additional rule changes. For example, the requirement that the original litigation be concluded before a countersuit is allowed should be dropped.
2. Penalties to be taxed to plaintiffs and plaintiff attorneys. When defendants lose cases, under certain conditions a yearly addition of delay damages is made to the verdict. The rationalization was to force settlements and that same reasoning should apply to plaintiffs; not to force settlements but to force them to drop a claim or not bring it in the first place unless it is clearly a claim with merit. Otherwise the plaintiff and/or the attorney have a price to pay in the form of costs, legal expenses, etc.
3. Attorneys fees: Legislations providing limits to the amount of contingent fees would go a long way in forcing plaintiffs' attorneys to make sure they only press the claims of clear malpractice. The number of claims brought would drop dramatically if such legislations were enacted. This change would have PA constitutional implications unless drafted perfectly. *(continued on page 2)*

Rhode Island – 2005 could be the year for Tort and Judicial Reform

Gov. Don Carcieri spoke earlier this year about proposing measures that would slow down the ever-increasing premiums and hopefully stabilize the medical malpractice market. He proposed capping noneconomic awards at \$250,000, placing a 3 yr statute of limitations on medical malpractice claims which would speed up the court process and lower interest rates on prejudgment awards from 12% to 5% as well as clarify rules for expert witnesses. The Rhode Island legislature refused to go forward with what the governor proposed and no action is expected until 2005.



We would like to congratulate Regina McGinley, who
was named **Customer Service Representative of the Year in 2004 for Pennsylvania.**

(continued from page 1)

4. Time limits on minor actions: Rather than have the statute of limitations start running only when majority is reached, a definite time limit (advocate 5 years) from the time of treatment should be established. Under the present system it can be as long as 20 years. The delays make no reasonable sense and account for much of the premium cost and need for "tail" coverage.
5. Further liberalize the rules for remittitur, wherein a judge has the right to reduce verdicts.
6. Reduction of expenses to present value. Under current law some relief to those issues is provided, but more relief is necessary.
7. Preclude testimony of so called experts who are solicited or "arranged for" by expert service companies. For example, there are 2 New Jersey companies who solicit doctors for expert witness engagements on behalf of plaintiffs' attorneys. These referral services, providing professional witnesses, should be outlawed and plaintiffs' attorneys precluded from suing any such "expert."

There are a number of additional changes that could be proposed at risk of making this list too burdensome. The point to be made is that these proposals should not be ignored and have as much legitimacy as caps in reducing rates. Most importantly, there is a chance of getting some or many of these proposals passed if properly pressed.

PCA ANNOUNCES "Cutting Edge" Risk Management Program

As found in PCA Update Issue 2

Professional Casualty Associations is pleased to announce an agreement recently reached with Rightfield solutions, LLC to provide Emmi (Expectations Management and Medical Information) to physicians insured by PCA.

Emmi is an interactive patient education series, which is primarily designed to manage the expectations of patients who are scheduled for surgery. Using easy-to-understand language, Emmi walks patients through the entire experience from pre-op to post-op including risks and alternatives. Enhancing traditional informed consent, Emmi captures and documents the entire information exchange, making it a powerful risk management tool. Best of all, patients love it because it focuses the communication between them and their doctors.

PCA insureds will receive the following benefits from Emmi:

- Reduce your malpractice risk
- Improve patient satisfaction
- Differentiate your practice
- Save time during consults
- Increase patient referrals
- Reduce burden on your staff

PCA is convinced of the value of this program and will provide a credit on the next issued policy after registrations with Emmi. The credit will offset the full cost of the computer program. If you are interested in receiving more information about Emmi, please give us a call at 800-508-1355 or contact Tim McGuire at 610-337-3374 ext. 204.

WHY USE EMMI?

As found in PCA Update Issue 2

Bart Post and Joe Brady founded Professional Casualty Association with an aggressive risk management program in mind. We feel Emmi is a perfect complement to other measures already in place such as our countersuit philosophy. We believe that patients who view Emmi are far less likely to file lawsuits because they now know what to expect before, during and after surgery. IF a lawsuit is filed, PCA is in a stronger position to fight the “informed consent” aspects of the litigation, as well as other allegations which may be brought.

We have extensive courtroom experience and know the importance of the Emmi presentation. In addition to defense of the informed consent issued, defense counsel will be able to point out that defendant physician has gone the extra mile to communicate with his or her patients.

The Emmi presentation will negate the issue which comes up at every trial – “the doctor did not spend enough time with me”

VIOXX RECALL – WHAT DO PHYSICIANS DO?

The Clinical Risk Manager Leader for GE Insurance Solutions has put together some ideas physicians should include in their strategy in dealing with the Vioxx Recall.

Below are some strategies as well as websites to consult.

Dear Doctor::

Due to the recent recall of Vioxx you may have new concerns about patients to whom this drug was prescribed, either by you or another physician. As the clinical risk manager for your professional liability carrier, I want to offer you our support as you address these concerns and to provide you with our best suggestions for how best to respond to this unfortunate event.

Our experience indicates the importance of quickly developing a formal plan to address the concerns of patients who contact your office —and those who don't contact you. In doing so, you may want to include some of the following as part of your strategy:

1. At this early stage it would be wise to meet with your colleagues and other health care professionals to discuss strategies for approaching the withdrawal of this drug. Document these discussions and include them in your formal plan. Identify the different types of responses you need to make depending upon the patient's age, health condition and length of Vioxx use.

2. If possible identify patients who have been taking Vioxx for more than 18 months. According to Merck's study, this group comprises those at highest risk. You may want to directly contact these patients to advise them of the study and of the drug's withdrawal by its manufacturer. Ask them to contact your office so you can arrange for an alternative prescription, if indicated. Develop a plan for communicating further updates and for distributing new information about additional clinical tests as they become available.

3. Develop a single consistent approach to patient calls regarding the drug. Appoint a qualified individual (nurse, PA, NP, office administrator, etc.) who can address patient concerns — and be sure callers are uniformly referred to this individual when they call. Be sure this individual is knowledgeable about the withdrawal of the drug, capable of answering patients' questions with tact and reassurance, and compliant with a process for follow-up that has been devised and approved by you and other physicians.

4. Reassure your patients that Merck voluntarily withdrew this drug. The FDA did not require this action. Obtain further information from Merck at www.merck.com and www.vioxx.com or from the FDA at www.fda.gov/cder.

Yours truly

Theresa Essick, RN, CPHRM Clinical Risk Management Leader

GE Insurance Solutions

¹ *On September 30, 2004, Merck, the manufacturer of Vioxx, issued a voluntary recall of this drug. The voluntary withdrawal of the drug was triggered by a study that seemed to indicate that patients taking Vioxx were exposed to an elevated risk of cardiovascular events such as heart attack and stroke during chronic use. Vioxx is a Cox-2 selective non-steroidal anti-inflammatory. Approved by the FDA in 1999, Vioxx has been primarily prescribed to treat signs and symptoms of arthritis, acute pain in adults, and painful menstrual cycles.*

If you have additional questions and would like to speak directly with a Risk Manager please call the following numbers:

GE Insurance Solutions 800-348-4669 *ask for your regional risk management consultant*
Pro Mutual Group 800-225-6168 *ask for your regional risk management consultant*
Professional Casualty Association 610-337-3374 *ask for Tim McGuire*

IT IS UP TO YOU

As found in PCA Update Issue 2

While PCA is searching for every possible way to help our insured physicians reduce exposure to lawsuits, we fully realize that perhaps that most important risk management technique is totally up to the doctor. Your relationship with your patient can do more to prevent claims than anything we can offer. In addition to practicing good medicine, it is vitally important that you "sell yourself" to your patients. The simplest way to do this is to practice the "golden rule". Translated this means "treat your patients as you would like to be treated". The following are some thoughts about maintaining good patient relations:

- Minimize patient waiting time in both reception area and in the exam room
- Require your staff to act in a friendly and courteous fashion when assisting patients
- Make eye contact when interaction with your patient
- Act like the patient you are presently seeing is your only patient
- Find a way to personalize your doctor-patient relationship
- Send follow up questionnaires and surveys which provide feedback about patient satisfactions levels

While there is much more you can do to improve patient relations and reduce your risk of litigations, this is a "short list" which should be considered.

Spending a little more time on patient relationships can save you a lot of time later by reducing time spent in the litigations process.

Medical Records

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Perhaps nothing creates more confusion or raises more questions for a physician leaving practice than disposition of medical records. As physicians decide whether to release retain, store or destroy records, they should remember that the physical record is the property of the practice; the information in the record is the property of the patient. Thus, the practitioner who is leaving one group practice for another should not simply take with him/her the records of the patients who will continue in his/her care. As a general rule, the original records should remain with the first practice. If state law or the state licensing body requires, the written authorization of the patient, parent of a minor, or guardian should be obtained before transferring a copy of the record may be stored in one site suggest 10 years from the date of the last encounter, longer if state law requires. Some state mandate that pediatric and obstetric records be kept until the check reaches the age of majority plus whatever period of time is required beyond that to meet the statute of limitations. Physicians should be familiar with the always concerning these records in their state. The records of a hospital-owned group belong to the hospital and are retained in accordance with the state laws governing hospital retention of records.

The physician who wants to move original records to a new practice should seek legal counsel to determine the feasibility of and method of doing so.

To maximize the defense of a physician who is sued after closing or leaving a practice, Pro Mutual Group suggests that physicians have a written agreement with any practice they leave guaranteeing them access to the records of their patients for at least 10 years after their departure from the practice. The agreement should also specify that the departing physician will be given the opportunity to obtain either the original or a copy of any record the practice intends to destroy or transfer within the 10 year period. (continued on page 5)

Retention of Records

Not all medical records need to be kept. Those that are kept, particularly those of active patients and those involved in civil, criminal, or administrative proceedings, should be retained in a place that is readily accessible.

State laws vary with respect to the length of time medical records must be kept. Pro Mutual Group has traditionally recommended that the office records of a private practice, both adult and pediatric, be kept for at least 10 years after the date of the last professional encounter, whether in person or by telephone or other means. However, some sources suggest keeping pediatric records up to 17 years past the age of majority or, more commonly, to the age of majority plus the statute of limitations. Some states require considerably less. The records of a hospital-owned practice will need to be kept for as long as the state requires the hospital record to be kept, often 25 or 30 years. Physicians should be familiar with the laws in their state. The Mammography Quality Standards Act (MQSA) of 1992 directs that mammograms be kept for at least 5 years, 10 years if the patient has had no other mammograms in the same facility (or office), or longer if required by state laws. As a general rule, other imaging films may need to be retained for 5 years, with variance possible from state to state. If a film was performed by the practice, it may be subject to the guidelines of the department of public health or equivalent organization. Retention in these cases may be required for up to 30 years. In some states there are separate regulations concerning the retention of the reports of imaging studies. In some states there are separate regulations concerning the retention of the reports of imaging studies. In Massachusetts, for example, such reports must be kept, that is 30 years. Patients should be familiar with laws in their state.

Pro Mutual Group suggests that the records of deceased patients be kept at least 10 years after the date of death or longer if required by law.

To be absolutely certain of being in compliance with federal and state regulations, the physician may wish to obtain a legal opinion before deciding which records to retain and which to discard.

Release of Records

The federal and state privacy rules relating to release of the medical record apply to exchanges of information between practices. Although it is always best to obtain patient authorization before releasing records to another physician or practice, authorization would not be required under federal privacy laws if the record is needed for treatment purposes. Some state laws, however, are more conservative in their privacy requirements and may, in fact, require written authorization. Physicians should be familiar with the laws in their state before sharing or transferring information.

A treating physician should have continued access to the records of patients he/she has treated. To accommodate release requests that come in after the practice has closed –and to give the physician access to the records in the event of litigation –the departing or retiring physician may wish to draw up a contractual agreement with a colleague or business associate who agrees (either for a fee or not) to keep custody of the medical records. The contract should define how long the records are to be kept and how long they can be accessed by both patients and the departing physician. It should also include a list of the active patients of the departing physician, and agreement under which the custodial physician or business associate agrees to respect the confidentiality of the records in accordance with federal privacy standards, and an agreement to give the departing physician access to the records for as long as needed.

Some basic principles to follow are these:

- As a general rule, only copies of medical records should be released, not originals.
- At the end of 10 years or any longer period of time a record must be kept by state law, an original record may be released with the patient's written authorization.
- Original mammograms may be released, with a copy kept by the sending physician. Originals of other imaging studies should not be released; copies should be sent instead.
- The entire contents of a record may be copied and sent, including documents generated by other practitioners. However, sensitive information should not be released without a specific authorization.
- A record should not be withheld because of an outstanding bill.
- Someone should be designated by the departing physician to assume legal responsibility for the records and become the keeper of the records.
- A fair and reasonable cost based fee may be charged for copying and sending the record. Federal privacy laws and state laws should be consulted before determining this fee.