



CORNERSTONE

Professional Liability Consultants

Specializing in Medical Malpractice Insurance

SPRING 2010

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INSIDE THIS ISSUE

ACCURATE MEDICAL RECORDS 2

AMERICANS WANT MEDICAL MALPRACTICE REFORM 3

HOW TO REFORM THE BROKEN MEDICAL MALPRACTICE SYSTEM 4

FORMERLY INSURED MIIX PHYSICIANS 4

LACK OF TORT REFORM COSTING PENNSYLVANIA 5

NEW RISK MANAGEMENT PROGRAMS 6



Hop for joy!

Spring is finally here!

MEDPRO ENTERS THE NEW YORK MARKET TO PROVIDE RELIEF AND STABILITY FOR DOCTORS

Medical Protective, a Warren Buffett and Berkshire Hathaway subsidiary, has entered the New York medical malpractice insurance market to provide stability and relief for those doctors trapped with few options and forced to pay for the state's high-risk pool.

Around the nation, as the rates for medical malpractice insurance continue to stabilize and even decrease, New York is bracing to see a significant increase in rates once the state-imposed rate freeze is lifted in July 2010. Forced to pay for the state's high-risk pool, the top two carriers have been pushing for the rate increase in an effort to keep themselves financially solvent. Protected under New York State Law, admitted

carriers cannot be forced into insolvency; however, company surpluses, used to pay doctors' claims, are quickly being depleted or are non-existent.

As the oldest (100+ years) and highest rated (A++) medical malpractice insurance carrier in the country, Medical Protective has entered the New York market as MedPro RRG. Not subject to the over-regulation of the New York market, MedPro RRG can offer rates that are more competitive for physicians with good claims histories, and the security of superior financial strength.

Chris Zuccarini, President of Cornerstone Professional Liability Consultants, said,

"We are honored to represent MedPro RRG and know this is a tremendous step forward in solving the medical malpractice crisis in New York."

Cornerstone is one of Medical Protective's largest independent agents, and recently provided the opportunity to distribute MedPro RRG in New York. If you have any friends or colleagues who practice in New York, please pass this information on to them. Please email or call our office with any questions.



ACCURATE MEDICAL RECORDS: YOUR PRIMARY LINE OF DEFENSE

BY PAULA A. JENKINS

Every medical malpractice suit can be won or lost based on the quality and content of the defendant physician's medical records.

A suit without merit can be lost because the medical record was vague, incom-

plete, or altered. Conversely, a potentially damaging suit can be won because the medical record was precise, thorough, and accurate – and events were well documented.

To help make your medical records valuable in de-

fending a claim, include in the patient's medical record detailed and accurate entries that fully describe the patient's medical history and physical findings, your differential diagnosis, the treatment plan and care rendered,

(continued on Page 2)

ACCURATE MEDICAL RECORDS CONTINUED FROM PAGE 1

advice given, and all other matters that you believe are pertinent to the patient's medical course.

General Guidelines

The following general guidelines should be observed when completing a medical record:

- Be certain that your entries in all medical records are clear and readable. If possible, dictate all long entries that require more than brief or routine annotations.
- Never squeeze words into a line or leave blank spaces of any sort. Draw diagonal lines through all blank spaces after an entry.
- Never erase, write over, or try to ink out an entry. In case of error, draw a single line through the incorrect entry – with the date, time, and your initials in the margin.
- Never add anything unless you write a separately dated and signed note. The patient, a third-party payer, or a plaintiff's attorney may have obtained a copy of the patient's original records. The entry date for ink or type can be accurately determined retrospectively, and any alteration after the fact will seriously compromise the defense of your case.
- Always indicate the date and time of an entry. Be sure that each page is dated and bears the patient's name and that each progress note is accompanied by the date and time. Make certain that all entries are initialed or signed.
- Avoid personal abbreviations, ditto marks, or initials. Use only standard and accepted medical abbreviations.
- Do not use lengthy, self-serving entries that may appear defensive in nature to explain a complication or medical catastrophe.
- Do not use the patient's record as a place to record confidential communications between you and your professional liability insurance carrier or your attorney – or

to criticize another caregiver.

- Always keep a record of when and by whom your medical record is photocopied.
- Always retain records for adult patients for at least 10 years from the date of the last visit; for minor patients, keep 28 years from birth.

Surgery Case Records

Monitor the following reporting procedures of other medical personnel to ensure that they are performed routinely:

Anesthesiologists should record:

- Accurate record entries, including type of monitoring device.
- Condition of patient on transfer to recovery ward, including status of airway and position of the patient.
- Postanesthesia instructions signed by the patient or a responsible person on behalf of the patient.

Surgeons should record:

- Accurate operative notes dictated the day of the procedure, including postoperative orders signed by the operating surgeon.
- Postoperative instructions signed by a responsible person on behalf of the patient.

Nurses should record:

- Signed and witnessed consent forms that conform to the actual procedure to be performed.
- Verification of NPO (nothing by mouth), allergies and physical limitations; results of laboratory, x-ray, and other examinations; status of patient on arrival in the operating room.
- Preoperative and intraoperative intravenous solutions, blood or blood products, and medications.
- Location of electrosurgical grounding pads.
- Type of prep; condition of skin,



"A suit without merit can be lost because the medical record was vague, incomplete, or altered."



(continued on Page 3)

ACCURATE MEDICAL RECORDS CONTINUED FROM PAGE 2

- Disposition of surgical specimens, tissue, or implant (surgical pathology forms must contain appropriate information to ensure adequate examination).
- Identification of all drains, packing, catheters, and surgical implants, including serial number, amount, and type.
- Sponge, needle, and instrument count (if irregular, document corrective measures or reason for deferral).

Recording Parenteral Medications, Fluid Intake and Output

It is important to record the following:

- Type and amount of fluid, rate of administration, and medications (if any added).
- The time and site of injections and any untoward reaction.
- Any abnormalities at the site of an IV infusion and the time when noticed.
- The function of the drain, including the amount and nature of secre-

tion.

- Any abnormalities in urinary output, both quality and quantity.

Recording Patient Care Instructions

It is important to remember the following when recording patient care instructions:

- Always record your instructions in writing.
- Review your instructions with the patient and his or her family.
- Ensure comprehension. Record any patient questions.
- Document language limitations and attempts made to overcome them through use of translators, as well as questionable comprehension. Note any literature provided to the patient and family.
- Retain a copy of instructions given.
- Note patient failure to comply with instructions and your informing of noncompliance risks.

As found in the Medical Liability Monitor, November 2009 VOL 34, NO 11.

"A potentially damaging suit can be won because the medical record was precise, thorough and accurate—and events were well documented."



AP POLL: AMERICANS WANT MEDICAL MALPRACTICE REFORM

The majority of Americans say federal lawmakers should make it more difficult for allegedly aggrieved patients to sue for medical malpractice, a November 2009 poll indicates. The Associated Press poll found:

- 54% of Americans say they would like to see it more difficult to sue hospitals and doctors over alleged malpractice
- 32% said they are opposed to placing limits on medical malpractice litigation
- 58% of independents and 61% of Republicans said they are in favor of lawsuit limits
- 47% of Democrats said they favor making it harder to sue, while 37% of Democrats said they are opposed to such measures

Lisa Maas, Executive Director of Californians Allied for Patient Protection, which supports limits on medical malpractice lawsuits, said it should come as no surprise that Americans favor limiting medical malpractice lawsuits.

"Clearly, frivolous lawsuits don't result in better care, just more dollars spent on defensive medicine and unnecessary tests that drive up the cost of health care for everyone," she said.

The Associated Press poll of 1,502 adults from Oct. 29 to Nov. 8 was conducted by Stanford University with the Robert Wood Johnson Foundation. Its margin of error is plus or minus 2.5 percentage points. As found in Legal Newsline, by Chris Rizo, November 19, 2009.

DO WE HAVE A WINNER?

HOW TO REFORM THE BROKEN MEDICAL MALPRACTICE SYSTEM.

BY DARSHAK SANGHAVI

For many doctors, the malpractice case against a family physician named Daniel Merenstein epitomized how the broken medical liability system drives up costs. In 1999, Merenstein, then a resident, saw a 53-year-old man for a routine checkup and discussed with him the dubious value of a blood test to screen for prostate cancer. Since the test leads to many false positives and pointless treatments that can cause impotence and other harm, neither the American Cancer Society nor U.S. Public Health Service supports its routine use. Presented with the data, the patient chose not to get the test.

When the man later developed prostate cancer, he sued Merenstein and the residency training program and ultimately won \$1 million. According to the plaintiff's attorney, the doctor should have ignored the evidence-based national guidelines and not even have given the patient the choice to refuse the test.

These kinds of anecdotes fuel a siege mentality among physicians. A study in the *Annals of Family Medicine* showed that after the verdict, nervous family practitioners nationwide began to order the unproven and potentially harmful test more frequently. In a survey last year, one-quarter of doctors reported that liability concerns affected their practice "a lot." For example, internists reported that 15 percent of their lab tests

and hospital admissions were ordered for "defensive reasons." As a result, many authorities consider malpractice reform a key way to reduce medical costs. Using a controversial report from the National Bureau of Economic Research, the U.S. Department of Health and Human Services proclaimed in 2003 that limiting malpractice damages could save the health system up to \$126 billion annually.

Many doctors firmly believe there's an epidemic of frivolous malpractice suits. By limiting the money that patients can win (so-called "damage caps" on pain and suffering), goes the thinking, some bogus suits might go away. There may be some truth to that, since the number of malpractice suits in Texas reportedly dropped by half after damage caps were instituted in 2003, while the number of actual payments remained the same – implying the reform eliminated almost half of the lawsuits without merit. In early October, the Congressional Budget Office gave the nod to damage caps and estimated they'd save tens of billions of dollars.

But there's a major problem with seeing malpractice reform as a quest to reduce bogus lawsuits: doctors make huge, negligent mistakes quite regularly – and they usually get away with it. In a landmark 1991 study, Harvard researchers reviewed the hospital records of tens of thousands of New Yorkers and estimated that

almost 27,000 patients were harmed by negligent medical care – yet only 3,500 actually filed claims. The system, the report concluded, "rarely holds providers accountable for substandard care." In 2006, another Harvard study concluded that only about 15 percent of malpractice litigation costs involved claims without errors – and only 3 percent of all claims involved no patient injury. Further, about four in five claims were adjudicated properly. In 2006, a study in *Health Affairs* concluded there was no crisis in doctors' malpractice costs, since inflation-adjusted premiums were lower in 2000 than in 1986; another study last year found most doctors in Massachusetts (declared a "crisis state" by the American Medical Association) paid lower premiums in 2005 than in 1990.

And while doctors hate to admit it, lawsuits can save lives. Motivated in part by liability suits, anesthesiologists dropped the risk of death in surgery from one in 5,000 to one in 250,000 over two decades, and their premiums have dropped from being the highest among doctors to some of the lowest. At the hospital where I trained in pediatric cardiology, a publicized malpractice case in which a child died led quickly to critical improvements in patient safety throughout the hospital.

As found in State Magazine, November 9, 2009.

ATTENTION ALL FORMERLY INSURED MIIX PHYSICIANS:

New Jersey carriers are still offering MIIX gap coverage for any formerly insured MIIX physicians. Effective 4/9/10, the coverage from the NJ Guaranty Fund will expire and you will have no coverage for the entire policy period you were insured by MIIX. Please contact our office to receive a MIIX gap quote or if you have any questions.



"Limiting malpractice damages could save the health system up to \$126 billion annually."

LACK OF TORT REFORM COSTING PENNSYLVANIA

BY ABHILASH SAMUEL

As Washington continues debating how to curb health care costs, one area largely ignored is medical malpractice reform. However, ample evidence from states indicates tort reform is central to overhauling the healthcare system.

The Pacific Research Institute's (PRI) 2008 Tort Liability Index ranks states' tort laws, giving Pennsylvania a lowly 45. Lawrence J. McQuillan, co-creator of the index, said, "Because Pennsylvania has done little in terms of meaningful tort reform compared to other states, it is poorly positioned to contain its future tort costs and risks."

The index also rates Pennsylvania 14th from the bottom in medical malpractice losses. A related study by the National Practitioner Data Bank found that the aggregate judgments and settlements paid by Pennsylvania medical professionals were exceeded only by New York.

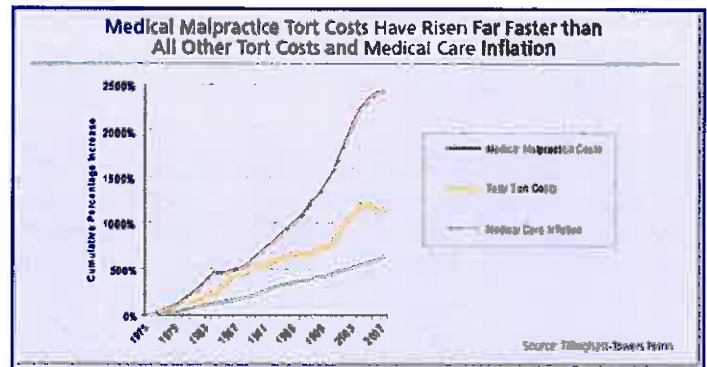
Pennsylvania is losing doctors to other states, in large part because of the high costs of malpractice

insurance in the Commonwealth. PRI poignantly notes that, in many ways, Pennsylvania is a "judicial hellhole," a designation it gives to regions in which doctors are reluctant to set up shop because personal injury lawyers seek excessive settlements, favorable precedents, or both. Many Pennsylvania physicians practice defensive medicine, especially those who pay the most for liability insurance because they are in high-risk fields. In order to reduce their legal costs, nearly all doctors avoid procedures and patients known to have higher litigation rates.

In 2002, Governor Mark Schweiker, in an effort to keep doctors from leaving Pennsylvania, signed legislation creating Mcare (Medical Care Availability and Reduction of Error), a supplemental malpractice insurance program that every physician must pay into. The Mcare Fund provides money for medical malpractice awards that exceed \$500,000, the amount that doctors are required to insure themselves against. But Mcare

simply serves as a pot of money for trial lawyers to go after, eschewing real tort reform.

rates while ensuring trial for incidents that are more apparent.



Unlike Pennsylvania, other states have enacted meaningful tort reform with positive outcomes. What lessons can Pennsylvania learn from other states?

Texas has experienced an influx of physicians and lower medical malpractice insurance premiums since capping jury awards for "pain and suffering" at \$750,000.

Indiana set the time limit for filing a medical malpractice lawsuit at two years from the alleged act of harm, and Kentucky set it at one year from the act or reasonable discovery, but no more than five years after the act. These actions have lowered litigation

Pre-trial screenings and arbitration are methods of dispute resolution that provide an alternative to trial. Nebraska mandates a review of malpractice claims by a medical-review panel before the case can proceed to trial. Oregon, meanwhile, requires all parties to participate in dispute resolution within 270 days of the malpractice lawsuit being filed.

A fair and efficient tort system is a significant component of a thriving free-enterprise economy. Allowing for unlimited jury awards, on the other hand, imposes significant costs on patients and forces doctors to move to other states.

As found in The Bulletin, November 1, 2009.

WHO WE ARE

CORNERSTONE'S FIRST PRIORITY IS TO OUR CLIENTS.

We pride ourselves on the level of service we afford each individual and constantly strive to meet and exceed our clients' needs.

Cornerstone is a firm large enough to offer you multiple coverage options and campaign on your behalf yet small enough to cater to your individual needs.

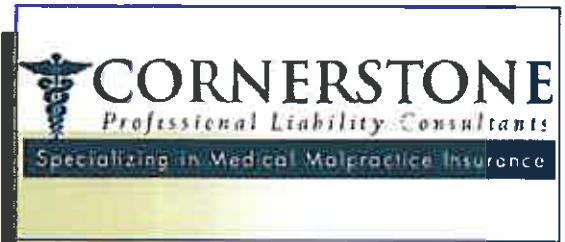
Cornerstone knows how specialized Medical Malpractice coverage is. We have made it the exclusive focus of our agency. In doing so Cornerstone has gained over 25 years of experience in covering physicians and surgeons.

Cornerstone operates in multiple states from Delaware to Massachusetts, and assists over 1,200 physicians. We are acutely aware of the special needs each region and physician presents.

Because Cornerstone is client driven, we are constantly looking for new markets to provide the highest quality of coverage available. We also look to add to services we can provide to your practice such as offering flexible financing at highly competitive rates.

Cornerstone's loyalty is to you and in these difficult times, you need the expertise and guidance of a broker that will stand behind you.

Cornerstone's mission is simple – to build long term client relationships by offering superior service and affordable quality coverage.



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We are on the web!

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ATTENTION ALL PHYSICIANS:

Many carriers are implementing new risk management programs for upcoming renewals.

Medical Protective continues to offer their Risk Management program which saves insured physicians 5% off of the manual rate for three policy years. They also offer additional discounts if an insured practice utilizes EMR.

ProMutual has just announced a new Fetal Heart Monitor Risk Management Education Program for all OBs and CNMs. Upon successful completion of this program, the insured will receive up to a 5% discount at their next renewal.

MD Advantage is offering several discounts to their insureds. They offer discounts for EMR, Electronic Prescription Writer, Educational Program Discounts, SecuReach, and have recently increased their discounts available for OBs for completing the APS Advanced Fetal Monitoring Course and CALM Shoulder Screen.

Princeton has renewed all of their existing business in 2009 to include the risk management discount the insureds were receiving in 2008. All policies will renew including the automatic risk management credit until 8/31/10. Effective 9/1/10, a new assessment will be available. Insureds who wish to earn the credit again will have to complete the new assessment.

PA PRI offers a 10% primary premium discount for 2 years once an insured completes their risk management program.

***These are only a few of the many discounts available from some of the carriers we represent. If you have any questions regarding discounts offered by your carrier, please give our office a call to discuss.*

