



- 2** | **OKLAHOMA BILL WOULD MAKE TAXPAYERS LIABLE**
An Oklahoma law would shelter doctors from large medical verdicts by making taxpayers liable for damages exceeding \$400k.
- 6** | **THE 2010 PIAA ANNUAL MEETING**
This year's PIAA Annual Meeting in Chicago focused on new liability challenges the industry faces in 2010 and beyond.
- 4** | **PLAINTIFF HITS \$500 MILLION JACKPOT IN LAS VEGAS**
A Las Vegas jury awarded \$500 million in punitive damages against two pharmaceutical companies for 2008 hepatitis outbreak.
- 8** | **ISSUES AT RISK**
In an era of prescription drug abuse, how a physician should treat a patient complaining of chronic pain.
- 5** | **THE INFLUENCE OF RISK RETENTION GROUPS**
For physicians seeking an alternative to traditional insurance, risk retention groups offer an attractive option.



STATE OF NEW YORK ISSUES ORDER OF REHABILITATION FOR PROFESSIONAL LIABILITY INSURANCE COMPANY OF AMERICA

On April 28, the Supreme Court of the State of New York—at the request of the superintendent of insurance for the State of New York, James J. Wrynn—issued an Order of Rehabilitation with respect to Professional Liability Insurance Company of America (PLICA). The New York Department of Insurance assumed full control of all aspects of PLICA's operations, which includes staying any activity on any pending litigation for at least 90 days from the order's issuance.

Under New York Insurance Law, rehabilitation involves the superintendent of insurance taking possession of the property of the insurer, conducting its business, and taking steps toward the removal of the causes and conditions that have made the rehabilitation proceeding necessary. The company cannot engage in any action in PLICA's name without the express written permission of the New York Department of Insurance.

The New York Order of Rehabilitation is the most recent in a string of legal difficulties for the medical professional liability insurer.

PLICA, which was formed in 2004, had been conducting business in Connecticut, Illinois, Maryland, Missouri, Ohio and Texas. In Texas, PLICA was writing coverage as Medical Liability Insurance Company of America.

On Aug. 21, 2009, the Connecticut Department of Insurance restricted PLICA's operations in that state to the service of existing business only, limiting its ability to generate future revenues in the state.

The New York Department of Insurance assumed full control of all aspects of PLICA's operations, taking possession of the insurer's property, conducting its business, and taking steps toward the removal of the causes and conditions that have made the rehabilitation proceeding necessary

On Oct. 22, 2009, the State of Illinois Department of Insurance announced it would be suspending PLICA's Certificate of Authority to do business in the state. The suspension took effect Nov. 1, 2009, and during the term of this suspension, "the company shall write no new policies in Illinois and shall nonrenew, after giving the appropriate notice to policyholders as required by statute or by contract, all in-force Illinois policies." PLICA fought for, and received, a temporary restraining order against enforcement of the suspension.

TIMELINE OF ILLINOIS TROUBLES

PLICA entered the Illinois medical liability

insurance market in 2004—at the apex of the state's hard market—when rates in the state had increased by as much as 116 percent over the previous year. A fully admitted, licensed insurer in Illinois, the company positioned

itself by marketing its products as an option that would insulate Illinois physicians from exposure to frivolous claims by providing an aggressive defense against such claims, while disposing early on claims that show merit.

In 2004, PLICA's expense ratio was 24 percent. Calculated as underwriting expenses divided by net premiums earned, the expense ratio measures an insurer's efficiency. Because every dollar paid in underwriting expense is a dollar that doesn't flow to the insurer's bottom line, the lower the expense ratio, the more efficiently an insurer is operating.

Soon PLICA's expense ratios began to climb. According to the Illinois Department of Insurance, PLICA's expense ratio steadily increased every year since it was admitted: from 24 percent in 2004 to 31 percent in 2005; 44 percent in 2006; 51 percent in 2007; 70 percent in 2008; 76 percent in the first quarter of 2009; and 95 percent in the first half of 2009.

According to the Illinois Department of Insurance, "the increasing nature of the exp-



OKLAHOMA BILL WOULD LEAVE TAXPAYERS 'ON THE HOOK' FOR EXCESSIVE MEDICAL MALPRACTICE VERDICTS

Oklahoma taxpayers may soon be required to pay damages to victims of medical malpractice, thanks to a bill that would shelter doctors and their insurance companies from responsibility for medical malpractice damages that exceed \$400,000.

Senate Bill 2163 (SB2163) is a follow-up to the tort reform plan passed by the state legislature last year. It creates a "Health Care Indemnity Trust Fund," from which damages will be paid to victims of medical malpractice when a jury finds the level of negligence great enough to justify removing the \$400,000 cap on non-economic damages. These include matters such as reduced quality of life or pain and suffering.

"Imagine a person who went to the hospital for an appendectomy, and somehow ended up having an arm or leg amputated by mistake," said Democratic State Rep. Ryan Kiesel. "It's easy to see how a jury might decide to award that person more than the \$400,000 cap the legislature approved last year. Under the terms of SB2163, the negligent doctor would only have to pay the first \$400,000 of the non-economic damages, while taxpayers, including the victim of the malpractice, are left to pay the rest."

SB2163 proposes using an estimated \$20 million in state funds to create the fund, and requiring the state to purchase insurance that would replenish the fund when it is depleted by payments to victims.

Efforts by Oklahoma Democrats to return responsibility for main-

taining the fund to doctors and their insurance companies were blocked by the Legislature's Republican majority. A bill that would have barred the use of any taxpayer dollars to buy such insurance, HB2726, was sent to the state's Economic Development & Financial Services Committee, where it was killed by committee chairman State Rep. Daniel Sullivan, author of SB2163.

During debate, Kiesel suggested an amendment to SB2163 that would eliminate taxpayer responsibility for replenishing the fund, but the Republican leadership dismissed the idea.

"The net result of this is to leave taxpayers on the hook for millions of dollars in damages that should rightfully be paid by the doctors that caused those damages and their insurance companies," Kiesel said. "This is nothing less than a taxpayer-funded bailout for negligent doctors and the insurance companies that enable them to continue practicing medicine."

"It is beyond me how Republicans can oppose the Federal Health Care Reform that will cover over 200,000 Oklahomans who currently do not have insurance, and at the same time be in favor of forcing tax payers to buy a supplemental insurance policy for bad doctors. To me, it makes zero sense to oppose health insurance for sick people, but support buying insurance for negligent doctors."

The final vote on SB2163 in the state's House of Representatives was 53 to 41. It now goes to the governor for final consideration.

NEW JERSEY LOOKS TO ENTER CAPTIVE INSURANCE MARKET

Under the leadership of Assembly Financial Institutions & Insurance (AFI) committee chairman Gary Schaer and Assemblywoman Denise Coyle, legislation that would create a captive insurance market

in New Jersey successfully moved through committee. New Jersey Department of Banking & Insurance commissioner Tom Considine also announced the planned introduction of legislation that is intended to promote growth in the reinsurance market.

"These two bills represent a smart, bi-partisan effort that would make some common sense changes to regulation and allow captive insurers, and carriers of reinsurance and surplus lines to operate more expansively in New Jersey," Considine said.

By establishing a captive market, the bill would promote growth in the state's insurance market, create jobs, generate tax revenue and provide more choices for consumers. The legislation would allow captive insurers to do business in the lines of life insurance, health insurance, annuities, indemnity, property and casualty, medical liability, fidelity, guaranty and title insurance as well as reinsurance. The legislation is intended to encourage the growth of an industry that in some states has brought in billions of investment and new high paying jobs. Currently, the law does not allow captive insurance companies in New Jersey.

"This legislation serves two purposes," said Coyle. "It will send the signal that insurance companies of all types should be able to set up in New Jersey, and it will create jobs and allow captive insurers, reinsurers and surplus lines firms to serve as engines of economic growth as they have in other states."

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DESPITE PREMIUM DECREASES, MEDICAL PROFESSIONAL LIABILITY INDUSTRY PROFITABLE IN 2009

According to SNL Financial, the medical professional liability industry experienced a profitable year in underwriting, demonstrated by a combined ratio of 82.6 percent in 2009. However, the industry continued to endure declines in direct premiums written, which fell 3.7 percent to \$10.8 billion, compared to \$11.2 billion in 2008.

Small declines in premiums for most top writers led to little change in the top 20 rankings when compared to 2008.

Once again, Medical Liability Mutual Insurance Co. took the top spot with \$756.8 million direct premiums written, followed by Medical Protective (Berkshire Hathaway Inc.) and The Doctors Company.

One of the few movements included ProAssurance Corp. and American International Group swapping spots. AIG dropped to fifth place due to its 13.8-percent annual premium decrease. Allied World Assurance Co. Holdings Ltd. rose to the No. 17 spot with direct premiums written increasing 18 percent to \$150.9 million.

Despite the decrease in premiums, the

top 20 writers managed to post a combined ratio of 81.3 percent, with only three of the top 20 companies experiencing a net combined ratio greater than 100 percent.

"Favorable loss cost trends, tort reform and higher rates in prior years have led to the extraordinary results for these insurers," said Jon Wright, Director of Insurance at SNL. "However, soft market conditions are also evident in premium declines and

companies booking higher accident year loss reserves."

SNL ranked the insurers based on their 2009 NAIC statutory P&C statement filings. SNL calculates medical professional liability direct premiums written by summing the claims made and occurrence premiums, which are as-reported lines of business in the NAIC quarterly statements. The rankings are limited to U.S. filers only.

SNL Financial collects, standardizes and disseminates all relevant corporate, financial, market and M&A data banking, financial services, insurance, real estate, energy and media/communications industries.

'Favorable loss cost trends, tort reform and higher rates in prior years have led to extraordinary results for medical professional liability insurers.'

and disciplinary actions.

According to research by website founder Roddy Lochala, MD, surgeons in the 75 most populated counties in the U.S. have an annual 25-percent chance of being sued. Only 23 percent of those trials against non-surgeon doctors—and 26.5 percent against surgeons—are actually won by the plaintiff. The majority of malpractice suits are "fishing expeditions," contends Lochala.

"With the looming healthcare provider shortage in America, we will find more room for legitimately sick patients when we get the deceptive ones out of our offices," Lochala said. "Think of PracticeDefense.com as the Ratemds.com for physicians."

INDUSTRY NEWS BRIEFS

On May 24, the Illinois Supreme Court decided to deny the appeal to re-hear elements of the Lebron v. Gottlieb Memorial Hospital decision, thus maintaining its rendering of Illinois' Medical Lawsuit Reform Law—and previous caps on noneconomic damages—unconstitutional.

The Michigan Supreme Court was recently asked to determine whether a plaintiff satisfied the notice of intent requirement under Michigan law when her malpractice lawyers mailed the notice of intent to file a claim to the doctor's prior address. The doctor did not receive the notice until after the deadline. The Michigan high court decided to elevate form over substance, concluding that plaintiff satisfied the mandates of MCL 600.2912b(2) because the statute states that proof of mailing constitutes prima facie evidence of compliance with Michigan law.

The Louisiana Legislature is currently considering House Bill 1453, which would exclude healthcare providers who perform certain abortions from coverage under the state Medical Malpractice Act. The Louisiana Medical Malpractice Act established the state's patient compensation fund.

St. Joseph's Medical Center in Baltimore recently sent out a total of 585 letters to former patients of Mark Midei, MD, who allegedly placed unnecessary intracoronary stents in barely-blocked arteries. Malpractice attorneys claim the letters represent an admission of liability. Midei denies any wrongdoing; he lost his privileges at St. Joseph's in July 2009.

A medical malpractice lawsuit was recently filed on behalf of the sons of a man who fatally shot his wife in a church parking lot in 2008. The lawsuit filed in 3rd District Court contends that a nurse practitioner and a doctor prescribed, but failed to adequately monitor, a range of mood-altering drugs that were toxic to David Ragsdale, who shot Kristy Ragsdale 13 times on Jan. 6, 2008. He later pleaded guilty to aggravated murder and was sentenced to prison. The lawsuit seeks a jury trial and unspecified damages to compensate the couple's two children.

NEW WEBSITE GIVES PHYSICIANS ABILITY TO DO BACKGROUND SEARCH, DISCOVER LITIGIOUS PATIENTS

PracticeDefense.com, a start-up patient-background-check website, offers physicians and healthcare providers the ability to protect themselves from potentially problem patients. The site aims to identify patients who target physicians with the intent of suing for frivolous malpractice settlements. The company claims the website has been reviewed extensively by experts in HIPAA and HITEC laws, and that PracticeDefense.com provides both civil and criminal background checks, exposing litigious patients.

PracticeDefense.com offers physicians the ability to probe patient backgrounds, in much the same way that patients scrutinize doctors online for education and training, specialties, board certification



JURY RETURNS \$500 MILLION VERDICT IN LAS VEGAS HEPATITIS C CASE

On May 7, a Las Vegas jury ordered two pharmaceutical companies to pay a combined \$500 million in punitive damages in the first of hundreds of lawsuits that stem from a hepatitis C outbreak in 2008. The punitive damages were in addition to \$5.1 million in compensatory damages.

Jurors ordered Teva Parenteral Medicines to pay \$356 million to Henry Chanin and his wife; Baxter Healthcare Corp. was ordered to pay the couple \$144 million. The jury found Teva and Baxter liable for 50-milliliter vials of the sedative propofol that plaintiffs' attorneys say encouraged reuse by healthcare professionals on multiple patients, making them vulnerable to the potentially fatal hepatitis virus.

In 2008, it was discovered that hepatitis

C and other blood borne diseases threatened thousands of Nevadans, due to the unsafe way anesthesia was administered at the Endoscopy Center of Southern Nevada in Las Vegas.

The Endoscopy Center of Southern Nevada Health had been under investigation, after health officials learned of three people who had been diagnosed with Hepatitis C. The Southern Nevada Health District investigation revealed that "unsafe injection practices related to the administration of anesthesia medication might have exposed patients to the blood of other patients," the statement said.

The Hepatitis C virus may have been spread when clinic staff reused syringes and used a single dose of anesthesia medication

on multiple patients, the district said. A syringe would become contaminated by the backflow of blood when patients with a blood-borne disease were injected with medication, health officials said. That syringe, in turn, would be reused to withdraw medication from a different vial. That vial could become contaminated and result in infection.

The Southern Nevada Health District found that the unsafe practices had been in place for several years at the Endoscopy Center of Southern Nevada, and put as many as 40,000 patients at risk.

Both Teva Parenteral Medicines and Baxter Healthcare maintain that the vials were marked with instructions and warnings that the vials were for single use only. The companies plan to appeal the verdict.

ST. VINCENT'S HOSPITAL MANHATTAN ENTERS BANKRUPTCY, PHYSICIAN STAFF WORRIED ABOUT 'PRIOR ACTS' MOVING FORWARD

In April, the board of directors of Saint Vincent Catholic Medical Centers reluctantly voted to authorize the closure of St. Vincent's Hospital in Manhattan inpatient services. After six-months trying to save the financially troubled institution, which had operated for more than 160 years, the institution has filed for bankruptcy.

The May 1 closing of the hospital resulted in the layoff of 3,500 employees in total. Of particular concern to its now unemployed physician staff is how their medical professional liability insurance issues will be handled. Some physicians are concerned they will no longer be covered for the work they did while employed at the hospital prior to its closing, since St. Vincent insured their medical staff.

It is still unclear whether the now unemployed physicians will have to purchase their own, expensive tail coverage to insure themselves for any lawsuits that may arise from their St. Vincent Hospital tenure. The tail coverage could cost as much as \$40,000, and adult patients in New York have as long as two-and-a-half years from the time of treatment to file a malpractice lawsuit; children have 10 years to file.

St. Vincent's filed a Chapter 11 petition with the United States Bankruptcy Court for the Southern District of New York on April 15 to facilitate the sale of its non-Manhattan hospital healthcare services and implement a plan of closure for the Manhattan Hospital inpatient services.

"This is obviously a difficult step for the

greater St. Vincent's community, but the relief afforded by the Chapter 11 filing ensures we will be able to continue caring for our patients as we implement the plan of closure, and also to continue to meet the payroll and obligations to the physicians, nurses and staff at the hospital," said chief restructuring officer Mark Toney. "It also provides St. Vincent's with the ability to facilitate the sale of the non-Manhattan hospital healthcare services as on-going operations in an efficient manner."

According to St. Vincent's, because the hospital is currently involved in bankruptcy proceedings, it does not have an answer for its former staff's liability concerns. Several of the former St. Vincent staff members have retained legal representation to explore their options.

GEORGIA HOSPITAL ADMITS 900 MAMMOGRAMS NOT REVIEWED BY RADIOLOGIST

Police are currently investigating the processing of mammograms at Perry Hospital in Perry, Ga., which allegedly were not read by a radiologist, authorities said.

The discovery came during an internal quality check, resulting in a call issued by Houston Healthcare for 900 mammograms to be redone. This impacted patients who had mammograms at Perry Hospital in 2009 and early 2010. Perry Hospital is a part of Houston Healthcare, which serves the Perry, Centerville, Warner Robins and Houston County, Ga., communities.

"Perry Hospital discovered a discrepancy

during a recent quality check of mammography tests," explained the hospital in a press release. "As a result, a broader review of the mammography program at Perry Hospital was immediately initiated.

"During that review, it was discovered that a radiology employee had processed a number of mammography tests done in 2009 and early 2010 without obtaining a reading of the tests by a radiologist. To be conservative in our approach and absolutely certain that no one was overlooked, Houston Healthcare will have approximately 900 mammograms completed at Perry Hospital

from April until early June 2010 read by a Radiologist to verify the results. This group includes the small percentage of patients impacted, as well as patients that had previously had mammograms in 2009 and 2010 at Perry Hospital."

Houston Healthcare said that it has already contacted almost all of those patients by telephone, offering an opportunity to obtain another mammogram at no charge.

The police investigation will determine whether any criminal activity was involved, and the findings will be forwarded to the Houston County District Attorney's office.



THE CONTINUED INFLUENCE OF RISK RETENTION GROUPS IN THE MEDICAL PROFESSIONAL LIABILITY INSURANCE MARKET

For physicians seeking an alternative to traditional lines of liability insurance, risk retention groups (RRGs) offer an attractive option. This is especially true during hard markets and in states where medical professional liability insurance premiums are stifling.

Owner-controlled insurance mechanisms authorized by the Federal Liability Risk Retention Act of 1986, an RRG allows members who engage in similar, or related, activities to write liability insurance for the exposure of its group members. RRGs are domiciled in one state, and must be admitted in all other states, but are preempted from certain state insurance regulation, including rate and form approval as well as taxes. Vermont currently is the state that domiciles the most RRGs.

Because an RRG is funded by its members, the insureds are the owners of the insurer. As such, each physician has a voice within the company, and this control often translates into lower rates, a greater understanding of effective loss control and risk management programs as well as a generally more favorable loss experience.

The Risk Retention Act was written in response to the hard market of the mid-1980s; intended to increase the availability and decrease the cost of liability insurance. When the St. Paul Companies—the largest medical liability insurer throughout most of the 1990s—stopped writing policies in 2002, the traditional medical liability market significantly narrowed and the demand for healthcare RRGs began experiencing considerable growth.

There is no doubt that the success of medical liability RRGs can be attributed to the hard market and narrow availability at the start of the last decade, but conventional wisdom would dictate that during a soft market, similar to the one medical professional liability currently finds itself in, one could expect appreciable RRG retirements because individuals are freed to go out and shop for their own best deal. This has not proven true. The medical liability market currently encompasses 152 RRGs, posting a total premium of almost \$1.5 billion in 2009, and accounting for the largest revenue of any segment in the RRG

Premium for Healthcare RRGs 2003 to 2009 (\$M)

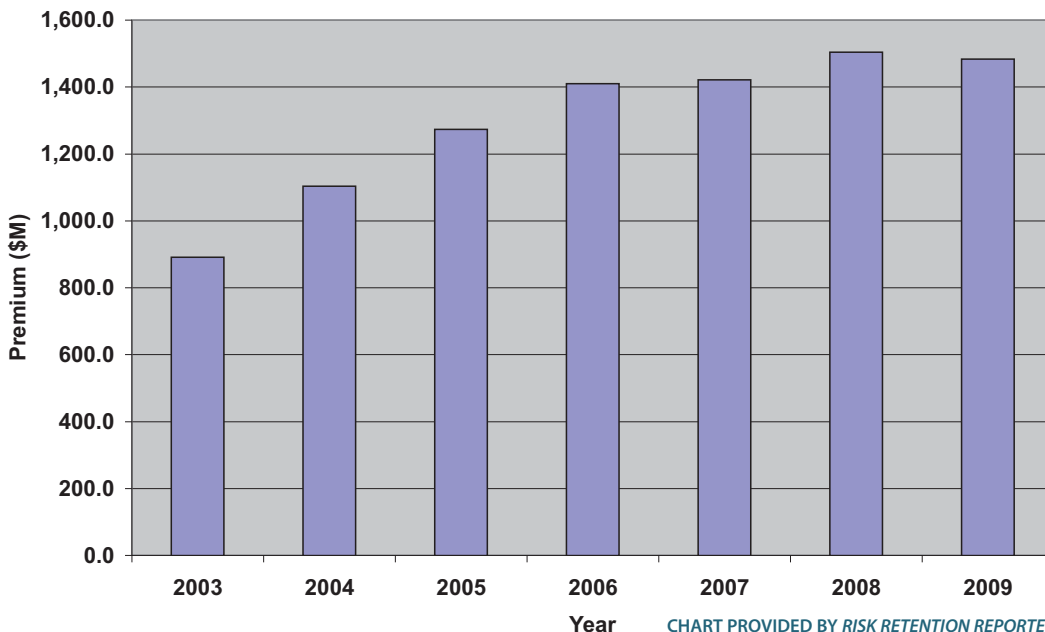


CHART PROVIDED BY RISK RETENTION REPORTER

Conventional wisdom would dictate that during a soft market, similar to the one medical professional liability currently finds itself in, one could expect appreciable RRG retirements because individuals are freed to go out and shop for their own best deal. This has not proven true.

industry.

In fact, until 2009, medical liability RRGs had posted premium growth every year since the boom of 2003 (see chart above, right).

“The soft market affects both traditional and alternative insurance providers,” said James A. Cutts, publisher of the *Risk Retention Reporter*, a monthly newsletter that reports on the RRG and purchasing group markets. “The key issue is how the alternative marketplace—in this case the risk retention industry—has responded. Healthcare premiums did fall slightly in 2009—by 1.4 percent—after many years of steady growth. However, the number of insureds appears to be still increasing and most healthcare RRGs are retaining their membership despite the competitive environment.”

The downside to coverage with an RRG is that should it go insolvent, federal law prohibits guaranty fund protection, leaving the individual physician on the hook for any existing exposure. This means that a skilled management team is critical. According to Cutts, the continued success of medical liability RRGs in the face of a soft market is evidence of accomplished oversight.

“Many of the RRGs are able to compete very effectively by professionally informed underwriting and by developing targeted loss control programs,” he said. “For many of these RRGs, claims occurrence has fallen sharply, allowing premiums to fall also and remain very competitive. The medical liability insurance community also has a long memory and realizes there will be an end to the soft market.”



MAG MUTUAL ANNOUNCES DIVIDEND, RATE DECREASE

MAG Mutual recently announced a dividend distribution to eligible physician-policyholders for the fourth-consecutive year.

Beginning June 1, the company began returning \$12.5 million to eligible MAG Mutual physician and surgeon professional liability insurance policyholders of record as of the close of business April 1, 2010.

Dividends are based on the number of years a physician has been insured with MAG Mutual and the premium amount paid. Beginning with policies renewing on June 1, the company has been applying the total dividend amount as a credit on the declarations page of each renewal policy. For eligible policyholders who retire or do not renew their policy, the dividend will be applied to any outstanding balance or paid by check.

In related news, MAG Mutual announced a rate decrease for its Florida insureds. Effective June 1, the company reduced medical liability insurance premium rates for Florida physicians by an average of five percent. The actual adjustment each insured received was dependent upon medical specialty, location and other factors.

PIAA 2010 ANNUAL MEETING: ADDRESSING NEW LIABILITY CHALLENGES

On May 12-15, at the Sheraton Chicago Hotel & Towers, the Physician Insurers Association of America (PIAA) hosted its 33rd Annual Meeting. More than 500 medical liability professionals attended the four-days of seminars, which this year focused on the new challenges presented by the 2010 liability landscape. Presenters discussed the new direction for medical practices in the wake of healthcare reform, medical technology advancement and associated medical professional liability risks as well as patient safety progress and priorities.

The Annual Meeting's keynote speaker—Gerald Hickson, MD, director of the Center for Patient & Professional Advocacy at Vanderbilt University as well as chair of the National Patient Safety Foundation—presented "Patient Safety Priorities & Progress: There's Still Much to Be Done," which looked back at progress made in preventing unintended outcomes of treatment as well as the many shortcomings that still exist. His lecture further examined what needs to be done to make changes conducive to the safer delivery of healthcare in order to reduce the potential risk of medical

malpractice claims.

The Annual Meeting also celebrated the 25th anniversary of the PIAA Data Sharing Project (DSP), which has accumulated and cataloged more than 260,000 claims and suits. The DSP analyzes member company data to develop a national overview of claim trends and identify the areas of practice most vulnerable to liability claims. PIAA researchers update the database semiannually, producing reliable and timely statistics for its member companies. Government agencies, media outlets, medical schools, private healthcare organizations and member companies have all benefited from information derived from the data and research.

Data from the DSP was prominently featured in a number of presentations at the meeting, including "Medical Technology Advancement & Associated Medical Professional Liability Risks;" "Increased Obstetrical Risks Due to the Economic Downturn;" "American College of Cardiology/PIAA Study: Aortic Dissection Claims;" and "PIAA Data Sharing Project: An Examination from the Perspective of Claims, Risk Management and Defense Counsel."

MASSACHUSETTS MEDICAL SOCIETY ANALYSIS SEES DETERIORATING PRACTICE ENVIRONMENT, PROFESSIONAL LIABILITY RATES CHIEF FACTOR

A new Massachusetts Medical Society (MMS) analysis indicates a prolonged decline in the state's physician practice environment and points to continuing concerns affecting physicians that are likely to affect the delivery of care to patients.

The MMS released its annual *Physician Practice Environment Index*, a statistical compilation of nine factors that influence the practice climate for physicians. For 2009, the index declined 0.8 percent, representing a continued deterioration of the practice environment for physicians in Massachusetts. The index has declined in 16 of the 18 years the Society has been compiling such data.

The decline in the MMS 2009 *Index* was led by four factors: (1) a growing burden of professional liability rates on physicians; (2) an increasing use of emergency departments by patients; (3) an aging physician workforce; and (4) the increasing cost of maintaining a physician's practice.

"The causes of the sustained decline in the practice environment have been with us

for some time," said Alice Coombs, MD, president of the Massachusetts Medical Society, "and this analysis is significant, because it carries implications for patients as well as physicians.

Of the four main factors causing the increase, the MMS deems the increasing medical professional liability rates and the rise in emergency department use by patients as the most troublesome.

According to MMS president Alice Coombs, MD, a critical step forward in improving the practice environment would be to enact medical liability reform.

"The high cost of liability rates has been the driving force behind the decline of the practice environment for years," Coombs said. "If there's one step to take to begin to reverse the decline, it would be enacting liability reform."

Coombs said liability reform would also bring additional benefits in reducing the practice of defensive medicine, which would help to reduce costs throughout the entire

healthcare system. The MMS' 2008 analysis of defensive medicine—tests, procedures, referrals, hospitalizations or prescriptions ordered by physicians out of the fear of being sued—conservatively estimated the annual cost of this practice to be \$1.4 billion in the state.

The MMS also proclaimed that the rise in emergency room use by patients—a phenomenon confirmed by other studies—"highlights a new and disturbing dimension" in the annual analysis, as it points to the delivery of primary care taking place in emergency departments.

The MMS reported that "Emergency department patient utilization rates are not only increasing over time in Massachusetts relative to the U.S., but Massachusetts patients are also continuing to rely more intensively on emergency departments for their medical care, both on a per hospital and per capita basis. The average hospital emergency department in Massachusetts reported 40 percent more patient visits than the average U.S. emergency department."



NEW YORK ISSUES ORDER OF REHABILITATION WITH RESPECT TO PLICA

→ CONTINUED FROM PAGE 1

-ense ratio could lead to an impairment of capital and surplus and indicates management's inability to efficiently manage PLICA's operations," and whereas PLICA's direct premiums were steadily decreasing from \$32.1 million in 2005 to \$10.3 million in 2009, "the decreasing revenues threaten the company's viability as a [going] concern."

PLICA's steadily growing expense ratio and its decreasing number of premium dollars, coupled with a 2008 underwriting loss of \$7,330,560, which resulted in a 44 percent loss of policyholders' surplus, and a \$1.9 million unfavorable prior-year development from Dec. 31, 2008, to June 30, 2009, caused the Illinois Department of Insurance to announce its intention to suspend PLICA's authority to write new or maintain old business in the state on Oct. 22, 2009.

CORRUPTION ACCUSATIONS AGAINST PARENT TRUST PRECEED THE SUSPENSION OF ILLINOIS CERTIFICATE OF AUTHORITY

The year prior to having its ability to write new and maintain old business in Illinois suspended, RBT Trust II, PLICA's parent trust, was named as one of 18 defendants in a class-action lawsuit brought by James & Gahr Mortuary, on behalf of itself and all other similarly situated plaintiffs, claiming "a massive fraudulent conspiracy among all defendants to defraud providers of services for pre-need funeral benefit contracts... [where] defendants are engaged in complex financial relationships with the purpose and intent of concealing their fraudulent scheme."

The life insurance companies named in the lawsuit—Lincoln Memorial Life Insurance and Memorial Service Life Insurance—offered the pre-need funeral insurance policies. The suit alleges that the policies were purchased from companies controlled by RBT Trust II, for which PLICA vice president and general counsel Howard A. Wittner is a trustee.

The plaintiffs alleged in the suit that "as a result of the defendants' complex business relationship, they had an incentive to churn the business by (a) selling policies and collecting high commissions and marketing fees; (b) systematically stopping premium payments causing the policies to lapse; and then (c) replacing those policies with

other policies which were inappropriate substitutes and failed to provide the security of the initial policies."

PLICA ATTEMPTS TO DIFFUSE INSURED'S CONCERN

In August of 2009, as industry rumors were swirling about PLICA's future, the company's then-chief executive, Howard Nathans, sent a letter to the company's policyholders and producers in regard to the "negative press" and recent indictment that has embroiled the company's parent trust, RBT Trust II, and caused concern for the state of all related companies. The letter was likely spurred by the indictment of a high-ranking executive of another company associated with RBT Trust II as well as the accusation that more than \$10 million of illegitimate proceeds were used to purchase PLICA.

"There has been some negative press recently regarding the ownership of PLICA[,] which is solely and exclusively collateral and insignificant as regards both PLICA and its policyholder obligations to our insureds," wrote Nathans. "I wanted all of our insureds and producers to know that neither PLICA the company, nor any of its assets, can be reached to satisfy obligations that arise from companies or entities other than PLICA[,] and with whom, furthermore, PLICA does not now have, nor ever had, any relationship either of a corporate or contractual nature."

In August 2009, Randall Sutton—chief financial officer, director and president of National Prearranged Services (NPS), another company controlled by RBT Trust II—was indicted by a federal grand jury on six felony counts of mail fraud, one felony count of money laundering and two felony counts of wire fraud, surrounding a ten-year, multi-million dollar fraud scheme involving the sale of prepaid funeral services.

Sutton and others at NPS are accused of causing \$50 million to be taken from the company in exchange for promissory notes from related individuals or companies. Unlike legitimate promissory notes, these notes were often backdated, sometimes interest was paid back to NPS with money that originated from NPS itself in "round trip" transactions, and promissory notes were often replaced with new promissory notes when they came due. According to the U.S. Attorney's Office, more than \$10 million of these funds were funneled through various entities and used to purchase PLICA, which is owned by RBT Trust II.

TREATING THE PATIENT COMPLAINING OF CHRONIC PAIN

→ CONTINUED FROM PAGE 8

dard of care in managing pain patients.⁵

The fear of addiction is another barrier to opioid pain management—the result can be under- or nontreatment of moderate-to-severe pain. Drs. Douglas Gourlay and Howard Heit, MD have advocated the use of a "universal precautions" approach to all pain patients, especially those who are considered for a therapeutic trial of opioids to improve quality of life. These universal precautions are standardized assessments and management approaches to chronic pain that include a substance use assessment, a stratification of patients into three groups to determine a particular setting to manage the pain, and applying 10 steps of precautions.⁶ Following these precautions may prevent another bad experience with managing the pain patient.

CLINICAL PEARLS

All patients deserve to be thoroughly assessed for pain and to have their pain managed appropriately to increase the quality of life. BTP is a common and frequently debilitating experience for patients with

non-cancer-related pain.

Because of the risk for misuse and/or abuse of opiate agents, patients with chronic pain should be evaluated and supported according to their level of risk.

Pain patients need to be listened to, receive validation of symptoms, have their fears calmed, be treated with respect and belief, and have a medical partner for dealing with their pain. Pain, although not objective, is real. Don't fail to treat the pain.

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ISSUES AT RISK

TREATING THE PATIENT COMPLAINING OF CHRONIC PAIN

by Susan Shepard, MSN, MA, RN, CPHRM

The patient's pain started on an otherwise normal day—another day of hard work as a certified nurse assistant who frequently does more physically demanding work than she should. She woke up with excruciating pain in her back. When she called her family physician, she was told that she didn't need to be seen, that she just needed to rest and use NSAIDs for a day or so.

Fast forward a few years. The patient, still in the same job, injured her back again, overexerting herself at work. This time, the pain didn't go away. The patient was seen by multiple physicians, none of whom could alleviate the pain to the patient's satisfaction.

Does this patient seem familiar to you? She represents your patient in the ED who hears the nurse say quietly, "There's another 'seeker' in bed two." She is the patient in the exam room who cries in disbelief when you tell her that she is being overly emotional and needs to see a psychiatrist. She is the customer in the pharmacy being lectured about the dangers of addiction to narcotics. Treating the chronic pain patient can be difficult and frustrating, not only to the patient but also to you.

FACTS & FIGURES

The American Pain Foundation tells us that pain affects more Americans than diabetes, heart disease and cancer combined. A National Center for Health Statistics Report found that more than one-quarter of Americans (26 percent) age 20 and over, an estimated 76.5 million Americans, reported problems with pain of some sort that lasted for more than 24 hours.

More than half of all hospitalized patients experienced pain in the last days of their lives and, although therapies are present to alleviate most pain for those dying of cancer, research shows that 50 to 75 percent of patients die in moderate to severe pain. An NIH survey indicated that low back pain

was most common type of pain, followed by severe headache or migraine pain, neck pain, and facial ache or pain.¹

NOT EVERYONE IS TREATED THE SAME

Disparities in healthcare are also evident in pain management. African Americans and Hispanics are affected by racial profiling for diversion and under-treatment by some

physicians. This is compounded by a lack of research on pain across racial and ethnic differences, as well as cultural attitudes toward pain management.

GUIDELINES

Physicians who treat chronic pain need to be comfortable and secure in their competency. Many times pain is under-treated because of lack of training. The California Society of Anesthesiologists provides online CME on pain management and end-of-life care that includes preventive measures to help reduce the practitioner's risk of suffering a medical-legal action.³

Physicians and surgeons may have to deal with breakthrough pain (BTP) in patients with cancer and non-cancer-related pain. Treatment regimens can incorporate non-pharmacologic and pharmacologic treatment that include opioids. Because different treatment approaches are possible, additional education may enhance the provider's ability to tailor BTP treatment by matching pharmacology of the drug to the subtype of BTP, the patient's risk for abuse, and the capacity to monitor the patient. Medscape, a free resource for physicians and nurses, provides more information on BTP management.⁴

Because narcotic prescriptions are aggressively monitored by multiple agencies, physicians may worry that prescribing narcotics can cost them their license. The Medical Board of California, which provides guidelines for prescribing controlled substances for pain, assures California physicians and surgeons that they need not fear disciplinary or other actions for the mere fact of having prescribed opioids in the course of treatment of a person for intractable pain. The appropriate use of opioids has been recognized in the California Intractable Pain Treatment Act (Section 2241.5 [c] of the California Business & Professions Code). The board expects physicians and surgeons to follow the stan-

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—> CONTINUED ON PAGE 7