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Integro's Healthcare Update - Fall Edition, 2009



Fall Edition, 2009

RiskRX provides healthcare risk management and insurance professionals with relevant information regarding new, updated, and developing issues within the healthcare industry.

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UNDER THREAT



Protecting Healthcare Organizations from Disruptive Clinician Behavior

By Grena Porto, RN, MS, ARM, CPHRM

With a growing focus on the role of culture as a contributing factor in medical errors, healthcare providers are under pressure to foster a culture of safety as a means of improving quality of care and minimizing costs. Yet despite the benefits, a culture of safety remains an elusive goal. This is due in no small part to disruptive clinician behavior, as outlined by The Joint Commission in Sentinel Event Alert #40.¹

A culture of safety is one in which:

- Every member of the healthcare team feels safe in voicing opinions and concerns regarding a patient's plan of care
- Every team member is welcome and input solicited
- The fear commonly associated with reporting errors or disagreeing with those in positions of authority is eliminated

Because disruptive behavior clearly undermines quality of care as well as operational stability and efficiency, it must be addressed as part of an organization's comprehensive approach to improving safety. But disruptive behavior remains a common problem that many organizations have failed to address effectively, in some instances leading to widespread news coverage.² The first step toward eliminating this behavior is to understand its causes, frequency and impact. Only then can you design a plan that will succeed where so many others have failed.

What is disruptive behavior?

Disruptive behavior is any intentional behavior that interferes with the effective care of patients or with effective operation of the organization. This includes behavior that interferes with the ability of others to perform their jobs effectively, such as intimidation.

Examples of disruptive behavior:³

- Profane or disrespectful language
- Demeaning behavior, such as name-calling
- Outbursts of anger
- Throwing instruments, charts, or other objects

- Criticizing caregivers in front of patients or other staff
- Comments that undermine a patient's trust in other caregivers or the hospital
- Comments that undermine a caregiver's self-confidence in caring for patients
- Failure to adequately address safety concerns or patient care needs expressed by another caregiver
- Intimidating behavior that has the effect of suppressing input by other members of the healthcare team
- Deliberate failure to adhere to organizational policies without adequate evidence to support the alternative chosen
- Retaliation against any member of the healthcare team who has reported an instance of violation of the code of conduct or who has participated in the investigation of such an incident, regardless of the perceived veracity of the report

It is important to note that disruptive behaviors are not limited to physicians. While their behavior can have a much greater impact on others and the system as a whole because of their relative power in the organization, regular disruptive behavior has been documented among nurses, pharmacists, and radiology technicians.^{4,5,6,7}

How often does disruptive behavior occur?

While it is unclear if the problem of disruptive clinician behavior is worsening, greater attention to the issue—physician abuse of nurses in particular—has revealed some startling statistics.

- 64% of nurses report that they experience some form of verbal abuse from a physician at least once every 2 to 3 months.⁸
- 23% of nurses report having received at least one physical threat from a physician, the most common being a physician throwing an object at them.

How widespread is the problem? In a 2002 survey of VHA hospitals, 96% of nurses witnessed or experienced disruptive physician behavior.⁹

It is possible that the increased attention given to disruptive behavior, combined with successful management of less serious behavioral issues, makes the problems appear much worse. Still, disruptive behavior has an enormous impact on quality of care and organizational management.

How disruptive is disruptive behavior?

Turnover is the most frequently cited result of disruptive behavior, especially physician behavior directed at nurses. In fact, nurses rate disruptive behavior as the single most important contributing factor to job satisfaction and morale. 31% of nurses said they knew at least one nurse who left because of it.¹² One early study found that 18% of nurse turnover was directly attributed to verbal abuse.¹³

Disruptive behavior's impact on patient safety is equally alarming. An ISMP survey¹⁴ showed that 49% of clinicians have felt pressured to dispense or administer a drug despite serious and unresolved safety concerns. 40% have kept quiet rather than question a known intimidator. Other studies have shown that recipients of abusive behavior avoid the abuser, failing to call when warranted and avoiding making suggestions that might improve care.^{15,16,17} In one study, 17% of respondents reported that an adverse event occurred as a result of disruptive behavior.¹⁸

Disruptive clinician behavior bears hidden costs as well, such as decreased productivity, delayed patient care, and the need for increased administrative attention to manage the problem and its effects. Disruptive behavior also wastes material resources, as when thrown instruments and supplies must be re-sterilized or discarded. Eliminating disruptive behavior is clearly in everyone's best interests.

How can organizations stop disruptive behavior?


Many past efforts to curb disruptive behavior have failed. This was largely due to failure to enforce existing policies promoting a culture of safety and because of a tolerance for disruptive behavior, especially from physicians. In addition, when action was taken, it was often ineffective. To finally stop disruptive

behavior, organizations must implement a comprehensive, multi-faceted, no-tolerance approach that provides a variety of options for dealing with disruptive behavior. And they must be willing to enforce their resolutions. Any successful plan will include the following parts:

- **Universal code of conduct.** The organization must implement a code of conduct that is identical for all stakeholders, without exception. Unacceptable behaviors, as well as desired behaviors, should be clearly spelled out. The code of conduct should be formally adopted by the hospital and the medical staff, and should be incorporated into all applicable policies.
- **Training for all staff.** Every staff member, including attending physicians and subcontractors, should receive a copy of the code of conduct and training on what is expected of them. The training should explain what to do in the event that any staff member witnesses behavior that violates the code.
- **Signed acceptance.** Every staff member, including attending physicians and subcontractors, should be required to sign a statement of intent to comply with the code of conduct. This notice should include an acknowledgement that failure to comply may result in disciplinary action up to and including suspension or termination of employment or privileges. The statement should be re-signed by physicians at reappointment and annually by employed staff as part of their performance reviews.
- **Compliance monitoring.** The organization must vigorously monitor for code compliance. This needs to go well beyond voluntary reporting to active monitoring. The organization must seek out information through surveys, rounding, and informal mechanisms of culture monitoring.
- **Enforcement.** ALL instances of disruptive behavior must be responded to with measures appropriate to the situation. Factors such as circumstances, severity, frequency, and impact should be considered when determining a proper response. However, regardless of circumstances, any instance of disruptive behavior that puts a patient at immediate risk must be acted upon immediately, and the offending individual must be removed from patient care at that time. Swift action is necessary to minimize potential damage. Above all, it is critical that the organization respond to all violations, regardless of source, and fight the perception that some people can break the code without consequences.



- **Prevention.** The organization must identify and eliminate any factors that may trigger disruptive behavior. In addition, the organization should consider implementing strategies that improve operational efficiency, such as conflict resolution training, standardized communication techniques (such as SBAR), and teamwork training designed to improve collaboration, cross-monitoring, and communication among healthcare team members.

Disruptive clinician behavior is a serious problem that impacts patient safety as well as operational effectiveness. Eliminating behaviors that undermine a culture of safety can only be achieved when the organization adopts and equitably enforces a uniform set of expectations that applies to everyone in the organization. 

References

1. Joint Commission Sentinel Event #40. "Behaviors That Undermine a Culture of Safety", July 9, 2008. http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm (accessed September 20, 2009).
2. USA Today, 4/18/06, The Indianapolis Star, 3/5/05, Advisen Front Page News, 9/17/08.
3. Porto, G., Lauve, R. "Disruptive Clinician Behavior: A Persistent Threat to Patient Safety," *Patient Safety and Quality in Healthcare*, July-August 2006.
4. Institute for Safe Medication Practices (ISMP), 2003. Survey on workplace intimidation available at www.ismp.org.
5. Rosenstein, A. H., & O'Daniel, M. "Disruptive behavior and clinical outcomes: Perceptions of nurses and physicians," *American Journal of Nursing*, 2005. 105, 1, 54-64 (2005).
6. Rosenstein & O'Daniel, 2005.
7. ISMP, 2003.
8. Weber, D. O. "Poll results: Doctors' disruptive behavior disturbs physician leaders." *The Physician Executive*, 2004. 30, 4, 6-14.
9. Diaz, A. L., McMillin, J. D. "A definition and description of nurse abuse." *Western Journal of Nursing*, 1991. (13)1, 97-109.
10. Rosenstein, A. H. "Nurse-physician relationships: Impact on nurse satisfaction and retention." *American Journal of Nursing*, 2002. 102, 6, 26-34.
11. Rosenstein & O'Daniel, 2005.
12. Cox, H. C. "Verbal abuse in nursing: Report of a study." *Nursing Management*, 1987. 18, 47-50.
13. ISMP, 2003.
14. Diaz, 1991.
15. Rosenstein & O'Daniel, 2005.
16. Maxfield, D., Grenny, J., McMillan, R., Patterson, K., & Switzler, A. "Silence kills. The seven crucial conversations for healthcare." *American Association of Critical Care Nurses, VitalSmarts*, 2005. Available at www.silencekills.com.
17. Rosenstein & O'Daniel, 2005.

DISRUPTIVE BEHAVIOR SELF- ASSESSMENT:

IS YOUR ORGANIZATION
READY FOR
ACCREDITATION?

The following survey is designed to help healthcare organizations measure their readiness—in terms of managing disruptive behavior—for Joint Commission accreditation and Medical Staff credentialing. A “yes” to all measures should affirm major compliance and accountability:

- We have a universal Code of Conduct at our organization and make the code available to all administrative and medical staff.
- We review the Universal Code of Conduct during new staff orientation and at regularly scheduled meetings.
- We have a system to monitor compliance with the Code of Conduct.
- Our system allows staff to report instances of disruptive behavior.
- Our organization has a Chain of Command policy and has made it clear that staff should use this protocol when faced with disruptive behavior.
- Our Code of Conduct supports an organizational and leadership position of “non retaliation” for reporting disruptive behavior.
- Our Code of Conduct includes a clear enforcement provision.
- Our Code of Conduct promotes mentoring for clinicians involved with or causing disruptive behavior.
- Our Code of Conduct supports on-going prevention measures and education.
- Our organization documents all information and activity related to a complaint or report of disruptive behavior.
- The Risk Management Department maintains all information related to a disruptive behavior claim as confidential.



OUT AND ABOUT

Sponsors and Exhibitors

American Society for Healthcare Risk Management

Denver, CO

October 22-25, 2009

Cayman Captive Forum

Grand Cayman

December 1-3, 2009

MA Society for Healthcare Risk Management

Westborough, MA

February 26, 2010

New England Conference for HC Risk Management

Portsmouth, NH

May 3-5, 2010

Speaking of Speaking

Ruth Kilduff, Moderator

Panel: Compliance Rules

Cayman Captive Forum

December 1-3, 2009

Ethan Crain, Panel Member

Panel: Ask The Healthcare

Captive Consultant

Cayman Captive Forum

December 1-3, 2009

Ethan Crain, Speaker

Update on Medical Malpractice

Chamber of Commerce Healthcare Conference

October 15, 2009

Bill McDonough, Speaker

Moving Beyond Your Comfort Zone

NJ Hospital Association

Organization of Nurse Executives of New Jersey

October 30, 2009

Save the Date – Integro Healthcare Winter Webinar Series

Perspectives on Managing

Healthcare Conflict

December 10, 2009

New Year, New Risks and New Perspectives –

Market Update for Healthcare Organizations

January 27, 2010

Changing Liability Landscape –

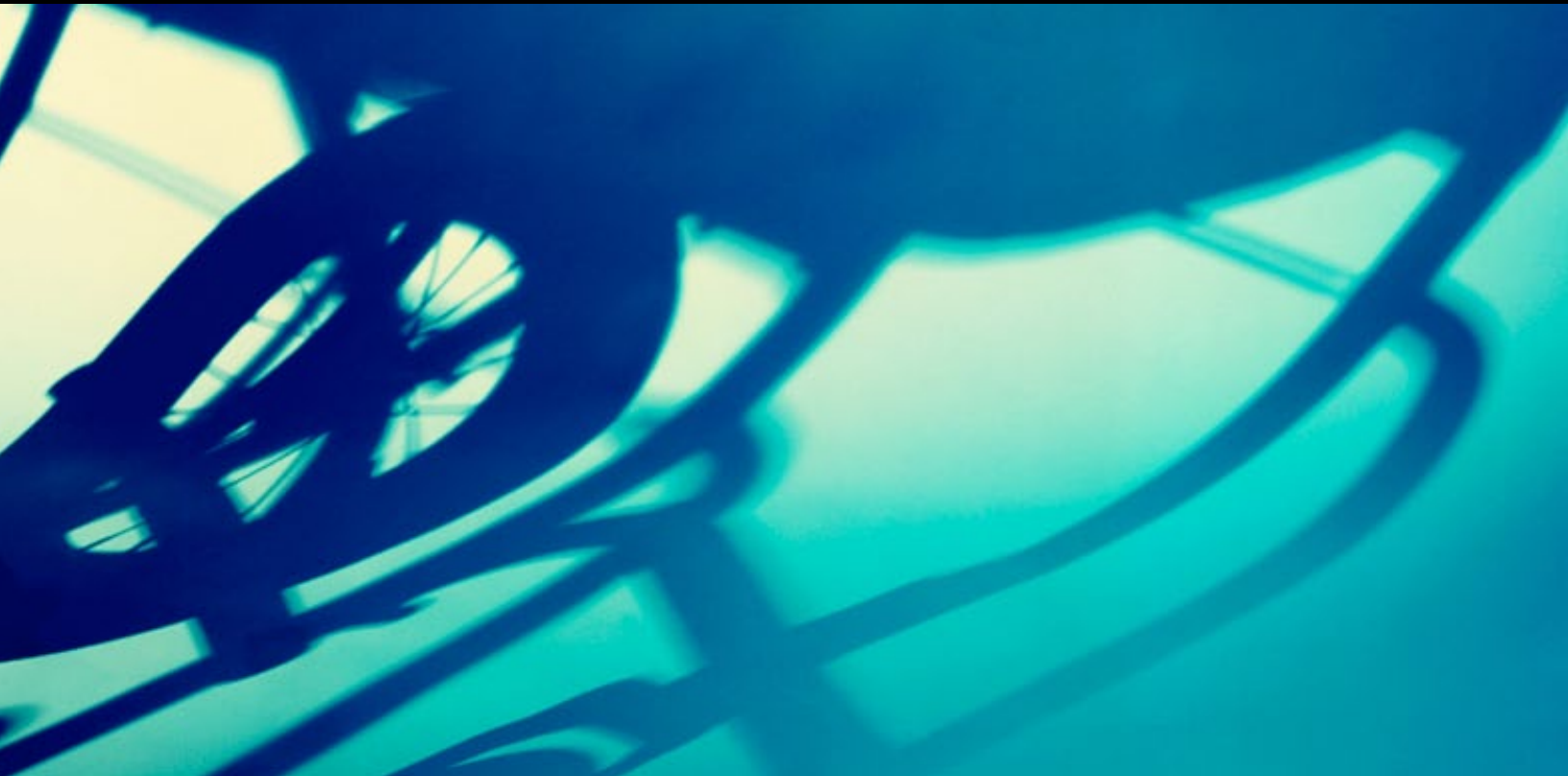
Negligent Credentialing

February 25, 2010



CASE STUDY

WORKERS' COMPENSATION



The Opportunity

A healthcare organization based in California wanted to reduce their outstanding Workers' Compensation liabilities. The organization had a high self-insured retention, effectively retaining all of their loss cost. In spite of a strong relationship with their third-party claim administrator, quarterly claim reviews, and a focus on large claims, their claim severity continued to increase and their balance sheet showed \$25 million of discounted outstanding liabilities. That figure crept up each year as liabilities were added faster than they were being removed.

After a detailed review of their program, Integro committed to help them reduce their outstanding liabilities by at least 15%—a reduction of \$3,750,000.

Integro's Solution

We implemented Integro's Inventory Management solution to address the issue. We recognize that outstanding Workers' Compensation liabilities are variable and controllable. Our goal was to significantly improve the outcome of the claims and reduce the total liabilities.

This client, as is the case with most organizations, relied on an inefficient model for claim administration. In California, an average indemnity claim will ultimately cost more than \$46,000. Indemnity adjusters manage a caseload of 130 active files - \$6 million of liabilities at any time. Assuming 1,500 productive work hours per adjuster per year, this yields less than one hour per month per file of work, including compliance related activity. Integro's Inventory Management process addresses the claim management deficiency by applying our decades of claim expertise to the aged claims—those older than 18 months.

The first step of our process is to establish monthly goals to track metrics, including:

- Claim closure
- Paid development
- Incurred development

Our detailed program review established the baseline—the expected outcome with no intervention. Then we set goals to accelerate claim closure while slowing the development of both paid and incurred dollars. These goals were reviewed with the actuary as well as the TPA to get buy-in from all of the participants.

The second step of our process was an on-line review of each open claim—361 in this case—for review, categorization, comment, and diary. The month-long triage process helped us prioritize claims and identify trends, such as over-utilization of counsel.

Finally, we worked with the adjusters and their managers to pave a path on each claim leading to the best outcome. The adjusters welcomed our involvement. We provided our client with monthly status reports comparing the outcome to our goals and recalibrated the goals as necessary. In addition, we held quarterly meetings with our client and the TPA to present the results and to discuss opportunities for improvement. This portion of the project lasted 11 months.

The Results

The bottom line was a reduction of \$4,200,000 of the total expected cost of the liabilities. An independent actuary determined this result based on:

- 32% increase in the claim closure rate
- \$2 million decrease in the expected incurred development
- \$500,000 decrease in the expected paid development

These results have been sustained, and our client has seen improvement in the handling of the current claims as well as the older claims. The key to our success was looking beyond the low-hanging fruit and addressing the systemic issues that were at play. **RX**

The “Other Insurance” Dilemma

As part of our due diligence for all our healthcare clients, Integro has uncovered a number of Directors and Officers (D&O) coverage deficiencies that must be addressed when placing these important programs for healthcare organizations. One critical area is the “Other Insurance” clause, a key coverage component embedded within these contracts.

Each underwriter addresses the “Other Insurance” clause differently. The language is usually placed somewhere in the general terms and conditions as a way for the insurer to convert their own primary D&O or EPLI policy to excess coverage if there is any other insurance policy which may apply in the event of a claim. Further, the language specifically states that the policy will in fact convert to excess if there is any other “duty to defend” policy in place.

Insureds Beware

We have seen the “Other Insurance” clause invoked on a number of occasions and for a variety of scenarios. One reason this has become such an issue for healthcare organizations is that much of their healthcare professional liability (medical malpractice) is provided by a wholly owned captive insurance company. While these licensed insurance companies are regulated in their own right, captive insurance policies tend to be broad in coverage and scope. They also often have language specific to certain D&O claims, such as “peer review” or employment practices matters like discrimination or harassment.

This wide coverage approach can result in some potential crossover or duplicate between the D&O contract and the captive insurance company. When this occurs, it is our experience that many D&O insurers reserve their rights and request to convert their policy to first excess above the captive even though the policy was clearly written and placed to serve as primary protection in the event of a claim.

The “Other Insurance” clause may also be invoked when dealing with harassment claims involving and/or against physicians. The employment practices section of a non profit D&O contract is specifically designed to protect employees of the

CASE STUDY MANAGEMENT RISK

organization (including physicians) against any allegations of discrimination or harassment.

Although not common, some homeowner policies protect their policy holder against similar allegations. We have seen creative insurance adjustors and claims professionals maneuver around the organization and reach directly out to the physician to obtain a copy of their homeowner’s policy to review the “Other Insurance”

language. This naturally shakes up the risk management department and leaves the healthcare organization to deal with a confused and usually angry physician.

Solution

When dealing with any potential coverage dispute, the best option is to address it upfront when placing or renewing insurance contracts. Don’t wait until a claim or reservation of rights letter has been received by an insured organization or other party. All D&O contracts have some form of “Other Insurance” clause, but not all insurance carriers handle the request to resolve this issue the same way.

Integro has designed a variety of solutions to consider:

- Draft an endorsement which specifically carves the captive insurance company out of this clause for purposes of determining primary coverage.
- State that the insurance policy will serve expressly as primary when determining coverage for any employment practices related matter, either by endorsement or within the contract itself.
- Lastly, we recommend that you have your broker review your captive language in conjunction with the D&O and EPLI policies to determine any potential overlaps (and/or gaps) which may arise and to devise an action plan for dealing with this in the appropriate manner.

Our goal for healthcare organizations is to secure state-of-the-art D&O coverage while affirming that other lines of coverage do not conflict and/or minimize the coverage terms and conditions or protection offered to the entity, to the Board, or other insured parties.

ASK THE RISK PROS

Q: We are launching a strategic planning process and plan for our captive insurance company. Are there specific tools or recommendations you have which have proven helpful to other captive owners?

A: Integro has assisted several healthcare captives with the strategic planning process. We help craft a Strategic Plan and guiding document to assist Boards and staff in developing concrete goals for the program. In our experience, these three tools are very helpful in advancing these types of initiatives:

SWOT Analysis – The SWOT (Strength, Weaknesses, Opportunities and Threats) Analysis is a concrete method to identify both internal and external factors that affect the captive:

- **Strengths:** attributes of the captive insurance company and its program offerings (coverage) that help to achieve the goals as set out in the captive’s business plan.
- **Weaknesses:** attributes of the captive insurance company that harm or do not support the achievement of the program’s goals. Many programs have identified the lack of a financial rating (e.g., AM Best, S&P, Fitch) in efforts to expanding captive utilization.
- **Opportunities:** external conditions that help to achieve the captive’s goals. One example is joint ventures with strategic partners who may be looking for more efficient professional liability coverage for their providers.
- **Threats:** external conditions that could cause damage or failure to the program. This includes competing captive programs in the region or commercial market offerings with better coverage and/or lower pricing.

An effective SWOT Analysis should not only include captive Board members but also consultants to the program. This includes brokers, actuaries, legal counsel, captive management

as well as risk management staff and others who may be directly involved in the captive insurance company on a day to day basis. See Table 1 for an example of a healthcare captive insurance company SWOT analysis.

- **Strategic Plan Timeline** – A timeline with deliverables, responsibility parties, and target and actual completion dates keeps the strategic planning process on track for the captive’s Board and supporting staff. The timeline should be updated regularly and used as a report card on progress.
- **Strategic Plan Dashboard** – After completing the SWOT Analysis and Strategic Plan, create a dashboard to track captive performance over time. This important management tool should be simple and track only those key Plan goals in the current year.

Q: We will be selecting a Risk Management Information System (RMIS) for our integrated healthcare delivery system. How do you recommend we plan for an RFP? What should we look for?

A: There are several steps that will help Risk Management professionals prepare for an RFP for a RMIS. These steps should be taken prior to sending the RFP to specific consultants/vendors:

1. Develop a budget and seek approval from leadership before conducting the RFP. A RMIS may involve a hefty investment by the healthcare system, including licensure, maintenance and on-going support.
2. Select a team or focus group to guide the RFP process and serve on a selection committee when consultants/vendors present their systems to the organization.
3. Develop a baseline of existing systems. If your healthcare organization includes multiple hospitals or clinics, some may

already have a system in place for incident reporting, claims tracking, patient complaints or other tasks.

4. Identify the most important features your organization is looking for with a RMIS. These may include:
 - a. Internet and intranet access
 - b. Modules for occurrence/incident reporting, claims reporting and reserving, trending reports, graphic display and/or billing for defense counsel
 - c. Automatic notification to superiors when major incidents are reported
 - d. Flexibility in defining data fields and development of a data dictionary which compliments the definitions in the organization’s risk management program (e.g., what is a claim, settlement authority, when is a claim closed, etc.)

5. Develop a list of preferred consultants/vendors to receive the RFP based on research and input from other healthcare risk management professionals.
6. Create a timeline/action plan which highlights key dates in the RFP process as well as milestones and responsible parties during the selection process.
7. Design a report card or consultant/vendor grading form to help review systems. This form should include those features identified in Step 4. Rankings may be as simple as “yes” and “no” or allow numerical ranking.

Please see Table 2 for a sample RMIS Product Scorecard. RX

Table 1: SWOT Analysis Template

Strengths	<ul style="list-style-type: none"> • Experienced and dedicated Board, Staff and Consultants • Mature and stable program • Positive financial performance, program surplus • Provides needs-based products and insurance policies • Competitive pricing for third party products • Claims Management expertise, Loss Prevention investments/excellence • Broad coverage, modified claims made, tail coverage • Management model that supports the mission • Ongoing support of loss prevention, patient safety 	<ul style="list-style-type: none"> • No financial rating (AM Best, S&P) • Concentrated risk – small company, primarily mono-line offering of coverage <ul style="list-style-type: none"> – High risk line(s) of coverage (medical malpractice) – Significant per claims limits as well as catastrophic • Less favorable program enhancements as compared to commercial market • Generally cannot “compete” in U.S. with market pricing • Reactionary to market trends and medical staff demands • Minimal focus on objective criteria for underwriting current and new risks to program 	Weaknesses
	<ul style="list-style-type: none"> • Control of destiny, program future • Third party programs with flexible design • Positioned for hard market pricing • Strategic partnering, other systems, programs <ul style="list-style-type: none"> – Joint ventures – Expanding third party offerings • Retention and deductible programs • New products, new lines of coverage • Dividends to parent, principal named insureds • Board member expansion to include representation from third party offerings • Transfer liability of company, reinvest in new vehicle for risk financing 	<ul style="list-style-type: none"> • Competition <ul style="list-style-type: none"> – Continuing soft market—third party program pricing pressure – Commercial market offerings with larger capital base • Healthcare organization’s financial pressures causes negative impact on patient safety investments • Regulatory climate changes for healthcare and captives <ul style="list-style-type: none"> – Venue unpredictability, Tort Reform – Restrictions of domicile, regulators, ratios – State regulatory authority of self insured programs • Risk of uncollectible reinsurance • Many competing initiatives at the parent level • Domicile tax changes 	

Table 2: Healthcare Program RMIS Product Scorecard

Rating form to be used for comparative analysis of product features.

Assign points in each column.

Measure/Criteria	Product #1	Product #2	Product #3	Product #4
User friendliness, day to day				
Incident reporting module				
Claims and litigation module				
Clear commitment to Healthcare industry				
Flexibility, meet "our" needs for changes				
Assistance through 24/7 Help Desk				
Ability to produce reports				
Analysis and graphical displays				
Ease of data conversion from current or "old" system				
Healthcare User Group with on-going best practice sharing				
Customer service vision				
Pricing and value				
RMIS can be customized, field changes allowed				
Overall ranking, customer reviews				
Total Points				

Date of Review: _____

Reviewer's Name: _____

Excellent, exceed expectations	5 points
Very good to excellent	4 points
Good	3 points
Did not meet expectations	2 points
Poor performance	1 point

- **Since 1975, medical malpractice tort costs have grown at an annual rate of 11.7 percent**, compared to 9.3 percent for all other U.S. tort costs. (Source: "U.S. Tort Costs," Tillinghast-Towers Perrin, 2005)
- **Medical liability tort costs accounted for \$28.7 billion of the estimated \$260 billion** in total tort costs to the U.S. economy in 2004. (Source: "U.S. Tort Costs," Tillinghast-Towers Perrin, 2005)
- **States with caps on damages have average insurance premiums that are 9.8 percent higher** than insurance premiums in states without caps on damages. (Source: *Medical Liability Monitor*, October, 2004)
- **In the five states that passed new medical malpractice legislation with caps in 2003**, premiums rose at nearly double the rate as states that did not pass a damage cap. Those states are: MS, NV, OH, OK and TX. (Source: *Medical Liability Monitor*, October, 2004)
- **Some estimate the annual cost of defensive medicine at more than \$100 billion**. Because of the fear of malpractice lawsuits, 79 percent of physicians order more tests than are medically necessary. (Source: *Harris Interactive*, March, 2002)
- **About 83 percent of physicians report practicing defensive medicine**. On average, between 18 percent and 28 percent of tests, procedures, referrals, and consultations and 13 percent of hospitalizations are ordered defensively. (Source: *Massachusetts Medical Society and UConn Health Center, Informational Study*, November, 2008)
- **A review of medical malpractice lawsuits found that 40 percent are groundless**—meaning there is no evidence that a medical error was committed or that the patient suffered any injury. (Source: *Harvard School of Public Health*, May 10, 2006)
- **90 percent of high-risk medical specialists decided to stop providing certain services** due to liability pressures. (Source: *American Medical Association*, April 2003)

by the numbers

Fast Facts in Healthcare

Mark Your Calendar

**Property Casualty Insurers
Association of America
Annual Meeting**

October 25-28, 2009

Walt Disney World Swan
and Dolphin Resort

Orlando, FL
www.pciaa.net

**Building a Quality Measurement
System that Works**

October 27-28, 2009

The Charles Hotel
Cambridge, MA
www.ihl.org

**ASHRM Upcoming Webinar
Program - Transparency
and the Disclosure of Harm-
Causing Medical Error**

November 10, 2009

www.ashrm.org

**National Workers' Compensation
and Disability Conference & Expo**

November 18-20, 2009

McCormick Place
Chicago, IL
www.wccconference.com

Cayman Captive Forum

December 1-3, 2009

The Ritz Carlton - Grand Cayman
Grand Cayman, Cayman Islands
www.caymancaptive.ky

**21st Annual National Forum on
Quality Improvement in Health Care
Conference:**

December 6-9, 2009

Orland World Center Marriott
Resort & Convention Center
Orlando, FL
www.ihl.org

**11th Annual International
Summit on Redesigning the
Clinical Office Practice**

March 7-9, 2010

Gaylord National Resort &
Convention Center
National Harbor, MD
www.ihl.org

**American Hospital Association
Annual Meeting**

April 25-28, 2010

Hilton Washington
Washington, DC
www.aha.org



subscribe

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