MEDICAL LIABILITY
MONITOR
PUBLISHING NEWS ABOUT MALPRACTICE ISSUES SINCE 1975

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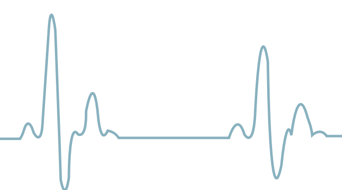

TRUMP ADMINISTRATION FISCAL YEAR 2020 BUDGET PROPOSAL ESTIMATES $31.5 BILLION IN SAVINGS FROM HYPOTHETICAL MEDICAL LIABILITY REFORM

In March, the Trump Administration unveiled its Fiscal Year 2020 budget proposal, outlining the President's tax and spending priorities for the next decade.

While the president's budget proposal is simply a request with no binding authority on Congress, it is best understood as a detailed statement by the administration of its fiscal goals and policy preferences. And the Fiscal Year 2020 budget lays bare the Trump Administration's continued goal of reshaping the American healthcare delivery system, including medical professional liability reform at the federal level, which it assumes would create a potential savings of more than $31.5 billion between 2020 and 2029.

"There are only a few policies where we have pretty good evidence that they will reduce total healthcare costs — and medical liability reform is one of them," said Marc Goldwein, senior vice president and senior policy director for the Committee for a Responsible Federal Budget, in an interview with *Medical Liability Monitor* about the Trump Administration's Fiscal Year 2020 budget proposal. "It's a policy where the evidence-base is sufficiently strong that we think it can have a significant effect on both total healthcare costs and Medicare. It's one of only a few [policies] you could sort of think of as 'free lunches,' the kinds of policies that basically are able to press overall costs down without you being able to point easily to the winners and losers, outside, of course, those who would get less in [medical liability awards] and the lawyers that represent them."

The Trump Healthcare Agenda

Healthcare programs comprise almost 30 percent of federal spending, and the Trump Administration's Fiscal Year 2020 budget proposal estimates more than $1.3 billion in total savings would result from a hypothetical repeal and replacement of the Affordable Care Act (ACA) as well as enacting various healthcare reforms.

> 'I don't think it's very likely that the president's [tort reform] proposals will be enacted, in particular the cap on noneconomic damages. I do think there's room for passing safe harbor rules and things like that, but there's a very strong community of interest groups that are opposed to things like caps.'

Specifically, the Trump Administration estimates around $660 billion in savings should Congress repeal the ACA and replace it with something similar to the Graham-Cassidy proposal from 2017, which would supersede the ACA's premium subsidies and Medicaid expansion with either a state block grant or per-capita cap, while restricting the growth of Medicaid base payments.

The president's budget proposal appraises another $645 billion in healthcare savings from reforming and reducing Medicare provider payments. Specifically, the budget would equalize payments for similar services offered in hospitals and physician's offices, while slowing the growth of post-acute care payments and reducing compensation to hospitals for bad debts.

The budget further estimates about $31.5 billion in savings by enacting medical professional liability reforms that include limiting noneconomic damages to $250,000 adjusted for inflation, instituting a three-year statute of limitations, allowing evidence of a claimants' income from other sources such as workers compensation and auto insurance to be introduced at trial, replacing joint and several liability with a fair-share rule, excluding expressions of regret or apology from evidence and establishing "safe harbors" against claims that have clinical justification. A significant portion of these savings is attributable to the estimated reduction in unnecessary services and curbing the practice of defensive medicine.

"The biggest thing that this budget does with medical malpractice is cap noneconomic damages at $250,000," Goldwein said. "It also

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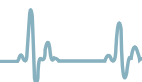

SORRY DOESN'T WORK: APOLOGIES RAISE MALPRACTICE CLAIMS RISK

Laws intended to reduce medical liability litigation by protecting doctors who want to apologize don't work, according to a new Vanderbilt analysis of proprietary insurance data. According to researchers, this analysis provides the most detailed look yet at the impact of apology legislation on such claims.

Reducing malpractice litigation has become a target of policymakers seeking to address the rising cost of healthcare. Put together, malpractice and defensive medicine — the practice of making treatment decisions to reduce the likelihood of getting sued — costs the United States billions of dollars per year.

One way policymakers have tried to achieve this is by passing laws that encourage physicians to apologize for treatment mistakes. These laws make apologies inadmissible in court so doctors don't have to worry that their apologies may be used against them if a patient decides to sue anyway.

"The idea is simply that if providers could just say they're sorry, that's what patients really want. They really don't care about punishing the doctor in a financial context, they care about having them express remorse," said Larry Van Horn, associate professor of management and executive director of health affairs at Vanderbilt's Owen Graduate School of Management, one of the researchers who published the paper "'Sorry' is Never Enough," which appears in the *Stanford Law Review*. "But what we find is that no, people sue for money. 'Sorry' is not enough."

Non-Surgeons Bear the Brunt of Apology Laws

Using proprietary data from a nationwide insurer of medical liability (due to confidentiality concerns, researchers could not identify the insurance company), the researchers were able to analyze malpractice claims for about 90 percent of U.S. providers in a single specialty composed of surgeons and non-surgeons — about 9,000 providers. Overall, about 4 percent of these physicians experienced a malpractice claim during the course of eight years. About two-thirds of all claims went to court.

'The laws do protect providers from having their apology introduced in court as evidence that they were at fault, but apologies also alert the injured patients to the physicians' errors and the possibility of making a successful claim.'

For surgeons, they found, apology laws made no difference in either the number of claims or the share of those claims that ended up in court.

For non-surgeons, however, apology laws had a dramatic effect. While the overall number of claims was unchanged in states with apology laws, those claims were 46 percent more likely to result in a lawsuit. The researchers say that's probably because surgical errors are usually more obvious than non-surgical ones — for example, a patient will know that a sponge left inside the body is a surgical mistake, but will probably not have the expertise to know whether their worsening illness is due to bad luck or an overlooked symptom. That is, unless the doctor apologizes for it.

"The laws do protect providers from having their apology introduced in court as evidence that they were at fault, but apologies also alert the injured patients to the physicians' errors and the possibility of making a successful claim," Viscusi explained.

Even more dramatic was the change in payouts from successful lawsuits. Again, surgeons didn't see a great difference, but non-surgeons did. In states with apology laws, the payouts to patients of non-surgeons more than doubled compared to states without apology laws.

How to Make Apologies Work

There are clear psychological benefits to apologizing for both physician and patient, Van Horn said, but in order for those benefits to translate into reduced litigation, more work needs to be done.

The researchers note that in some health systems that provide training to their providers on when and how to apologize, lawsuits and payouts are in fact lower. Additionally, the laws themselves could be improved — currently, most only protect physicians for expressions of sympathy, not an explanation of what went wrong. However, recent scholarship on apology best practices suggests that victims are more satisfied by apologies that do include that explanation.

This suggests that while apology laws alone are not enough to reduce malpractice litigation, proper training and more comprehensive laws could potentially be more effective. As they stand now, however, apology laws raise, rather than reduce, malpractice claim risks.

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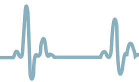

MEDICAL MUTUAL HOLDINGS INCORPORATED REBRANDS TO CURI

North Carolina-headquartered insurer of medical liability Medical Mutual Holdings, Inc., announced that it is rebranding to Curi, a new name and brand that is intended to better reflect the company's mission to help physicians in medicine, business and life. According to the company, the Curi name captures the constant curiosity that the company has had since its founding — a curiosity to continually look for new ways to meet the ever-evolving needs of physicians.

A mutual insurance company owned by physicians, Curi has also expanded its offerings beyond medical malpractice insurance to a variety of services for physicians and medical practices, including wealth management and other financial services, health policy consulting and well-being programs.

"The Curi brand is a more accurate reflection of our mission to help physicians in medicine, business and life. It's a mission we've been focused on internally for some time now — it's been our North Star as we've expanded into new offerings and geographies in recent years," said Dale Jenkins, Curi chief executive. "While many of our practice services have been embedded in the insurance part of our business, offerings like health policy consulting are new to the mix. Our wealth management services for physicians and retirement plan solutions for practices are also newer to our core set of resources for physicians and those who support them.

"We're continuing to explore the needs and opportunities that aren't being met for physicians. We're here to care for the caregivers, and we know that can and will take many shapes in the future. You can expect to see new ideas from us soon."

The company that became Curi was established as Medical Mutual Insurance Company of North Carolina in 1975, when other carriers stopped offering medical professional liability insurance to physicians in North Carolina. Since then, the company's insurance offerings have expanded to 46 states and the District of Columbia, with concentrations of customers in the Southeast and Mid-Atlantic regions.

A mutual company owned by physicians, Curi has also expanded its offerings beyond medical malpractice insurance to a variety of services for physicians and medical practices, including wealth management and other financial services, health policy consulting, and well-being programs.

The comprehensive rebrand includes:

- The new Curi name, which points to curiosity, a trait that drives the Curi team forward in pursuit of supporting physicians.
- A new logo (see above) inspired by the company's legacy and its previous logo. The Curi mark signifies passion and curiosity.
- A brighter color palette that breaks from the traditional greens and blue of the healthcare industry with bright shades that differentiate the company from its peers.
- A more modern digital presence with the launch of three new websites — Curi.com, Curi Practice Services and Curi Capital — each of which represent a more streamlined experience for visitors, returning members and customers.

REGISTER, SAVE ON ACI OBSTETRIC MALPRACTICE FORUM

The American Conference Institute's (ACI) Obstetric Malpractice Claims forum will convene June 26 - 27 at the Union League of Philadelphia. Those who register before May 10 will save $200. *Medical Liability Monitor* is a media sponsor of the event, and subscribers will receive an extra 10-percent discount on registration with discount code: D10-673-673CX01.

A fully revamped agenda will include discussions on the latest developments with the cranial compression ischemic encephalopathy argument, the plaintiff and defense's perspective on mother and child genetic testing, timing of an injury, opioid-related injuries, reducing maternal morbidity/mortality, the defense and plaintiff's perspective on early settlement of BI cases and more.

For more info, or to register, visit www.americanconference.com/advanced-forum-obstetric-malpractice-claims/

INDUSTRY NEWS BRIEFS

Federal prosecutors unveiled the first criminal charges against pharmaceutical executives for illegally diverting opioids, accusing the former chief executive officer and the head of compliance at a major U.S. drug distributor with a narcotics conspiracy. According to prosecutors, Laurence F. Doud III, CEO of Rochester Drug Co-operative, and William Pietruszewski orchestrated a scheme to distribute high volumes of Oxycodone, fentanyl and other highly addictive opioids to pharmacies knowing the drugs would be sold to people who had no medical need for them.

CRICO Strategies recently announced an agreement with Physicians' Reciprocal Insurers (PRI) of New York to become the newest member of its national Comparative Benchmarking System. PRI's partnership with CRICO Strategies is meant to strengthen its risk management programs and its ability to learn from medical malpractice data.

Amazon announced last month that a version of its virtual assistant technology, Alexa, is now HIPAA-eligible. This means it's available for applications subject to the data privacy and security requirements of HIPAA. The new HIPAA-eligible version of Alexa, specifically the Alexa Skills Kit, is now available to a limited number of developers by invitation only.

First-year doctors, or interns, spend 87 percent of their work time away from patients, half of which is spent interacting with electronic health records, according to a new study from researchers at Penn Medicine and Johns Hopkins University. The study was published in *JAMA Internal Medicine*.

A new study by the British Medical Association found that 27 percent of 4,300 surveyed physicians have been diagnosed with a mental health condition as the result of burnout. Two in five doctors in the United Kingdom are facing psychological and emotional problems, including stress, depression, anxiety and emotional distress. A third of those surveyed admitted using alcohol, drugs or self-medication to cope.

OKLAHOMA SUPREME COURT OVERTURNS $350K DAMAGE CAP

In a 5-3 opinion released on April 23, the Oklahoma Supreme Court ruled that the state's $350,000 cap on recoverable noneconomic damages is unconstitutional.

According to the majority opinion in *Beason v. I.E. Miller Services, Inc.*, the Court found the noneconomic damage cap to be an unconstitutional "special law" because it limited damages for only those who survive an accident and bring a civil lawsuit. The law did not limit damages for wrongful death lawsuits brought on behalf of the estates of persons killed in accidents. A statute is a "special law" when part of an entire class of similarly affected persons is segregated and targeted for different treatment and is prohibited by Article 5, Section 46 of the Oklahoma Constitution.

"The failing of the statute is that it purports to limit recovery for pain and suffering in cases where the plaintiff survives the injury-causing event, while persons who die from the injury-causing event face no such limitation," Justice John Reif wrote in the majority opinion.

The Justices noted that the Oklahoma Constitution explicitly forbids any limitation on the amount of recoverable damages for injuries resulting in death.

"By forbidding limits on recovery for injuries resulting in death, the people have left it to juries to determine the amount of compensation for pain and suffering in such cases, and no good reason exists for the Legislature to provide a different rule for the same detriment simply because the victim survives the harm-causing event," according to the opinion. "And the people have demonstrated their intent that the Legislature not discriminate in this way by expressly prohibiting the Legislature from enacting special laws."

The decision involved a lawsuit filed by a worker whose left arm was amputated following an accident at an oil well. An Oklahoma County jury awarded James Beason and his wife a total of $15 million, including $6 million for pain and suffering. A judge reduced the jury award on noneconomic damages to $700,000 — $350,000 for each of the Beasons — in order to comply with the law.

Upon striking down the damage cap law, the Supreme Court remanded the case back to the trial judge with instructions to enter judgment in the full amount of the jury's verdict.

PHYSICIANS WITH MULTIPLE MALPRACTICE CLAIMS ARE MORE LIKELY TO STOP PRACTICING OR GO SOLO, STANFORD STUDY FINDS

Stanford University researchers released findings of a study examining what happens to physicians who experience multiple malpractice claims. Where do physicians with poor malpractice liability records go? Where do they practice? Who would actually hire them?

The answers to these questions are described in a new study released in the *New England Journal of Medicine*. After reviewing more than a decade's worth of data from nearly half a million physicians, Researchers David Studdert and Michelle Mello found that physicians who were sued repeatedly were no more likely to relocate their clinical practices than colleagues who had no claims. However, they were more likely to either cease practice or — if they continued to practice — to shift to smaller practice groups or solo practice.

"There is an emerging awareness that a small group of 'frequent flyers' accounts for an impressively large share of all malpractice lawsuits," said Studdert, lead researcher and professor at both Stanford Law School and Stanford University School of Medicine. "This study confirms that and begins to shed light on the professional trajectories of these physicians."

In a 2016 study, Studdert and Mello examined demographic characteristics of claim-prone physicians. "When we presented that work, people kept asking us questions about this group that we couldn't answer, like who would ever hire or insure them?" Studdert said. "Now we have a better idea."

A Small Group with Many Lawsuits

The research team reviewed data from 480,894 physicians who had 68,956 claims paid against them between 2003 and 2015. The researchers estimated that 2 percent of practicing physicians had two or more paid malpractice claims. Those physicians account for nearly 40 percent of all paid claims, confirming results from their earlier study.

"Our main goal was to follow these multi-claim practitioners over time as they accumulated claims and see where they went and what kind of changes they made to their practices," said Mello, professor of law and professor of health research and medicine at Stanford and a co-author of the study. "One surprising result was that they were no more likely to relocate than their colleagues."

In the late 1980s, concerns that physicians with poor liability records were moving interstate to put their reputations behind led to the Congressional creation of the National Practitioner Data Bank (NPDB), which stores physician claim history and certain forms of disciplinary action.

"Given the policy history here, it was gratifying to find that physicians prone to malpractice claims were not flight risks," Mello said, noting that it is clearly harder for physicians with bad records to escape their past than it once was.

They Don't Move, but Many Go Solo

The study also found that claim-prone physicians were more likely than their peers to quit practicing. Nonetheless, more than 90 percent of physicians who racked up five or more paid claims continued to practice.

The study further showed that claim-prone physicians were much more likely than their peers to shift into smaller practice settings. Physicians with five or more claims were more than twice as likely as physicians with no claims to switch to solo practice.

"Compared to practicing in large group practices or hospitals, physicians in small or solo practices are subject to less oversight from administrators and peers," Mello said. "Quality problems with solo practitioners may be more difficult to detect and report. From a patient safety standpoint, this is the study's most troubling finding."

While a single malpractice claim is a weak signal that there's a quality problem, repeated paid claims over a relatively short period of time sends an important signal about patient safety risk, Studdert said.

"We think the study's main message is that regulators and the companies that provide physicians with liability insurance should be paying closer attention to this signal," Studdert said. "I wouldn't want my family members to be treated by a physician who had paid out six malpractice claims in the past few years. Who would?"

VANDERBILT U. TO DEVELOP, TEST 'SAFE HARBOR' STANDARDS OF CARE

A team of researchers from Vanderbilt University's schools of Law, Medicine and Management received a $1.7 million, five-year research grant from the Agency for Healthcare Research & Quality (AHRQ) of the Department of Health & Human Services (HHS) to develop and test "safe harbor" standards of care based on scientific evidence. The study officially commenced last month.

A goal of the project is to reduce the number of unnecessary medical procedures performed primarily to reduce legal liability, a practice known as "defensive medicine." Benefits could include lower costs and improved quality of care, resulting from medical patients' reduced exposure to radiation.

"Our project integrates the perspectives of experts in law and policy, emergency medicine and risk management to examine medical liability with the aim of developing medical malpractice 'safe harbors' by establishing standards of care that are accepted by both medical and legal policy makers," said James Blumstein, JD, Vanderbilt University professor of law and research team leader. "We will focus on the legal, policy and empirical dimensions of defensive medicine and develop medical practice protocols with the goal of reducing unnecessary medical procedures that represent a risk to the patient and drive up healthcare costs."

Alan Storrow, MD, Vanderbilt associate professor of emergency medicine, who practices in Vanderbilt Medical Center's adult emergency department and part of the research team, notes that the Choosing Wisely campaign, an American Board of Internal Medicine initiative, has issued detailed guidelines to help patients and providers reduce overuse of potentially harmful diagnostic tests and procedures by engaging in a frank discussion of their risks and benefits in advance. However, the guidelines do not address liability risks, which Storrow believes is why they have yet to be widely adopted by doctors and other providers. "Until these liability issues are addressed, fear of litigation will continue to drive providers to perform more tests and procedures than may be truly necessary," he said.

> 'Until these liability issues are addressed, fear of litigation will continue to drive providers to perform more tests and procedures than may be truly necessary.'

The project will be completed in three phases. To complete phase one, the research team will assemble a representative group of technical experts and advisors to define safe-harbor standards for a narrow set of distinct clinical conditions within emergency medicine. The safe-harbor standards they develop will include both medical and legal components and will be reviewed and considered for approval and adoption by the appropriate quality improvement organizations.

During phase two, emergency medicine practitioners will deploy the safe-harbor protocols at Vanderbilt University Medical Center. Their efficacy in reducing unnecessary medical procedures, including the effects of the safe-harbor protocols on clinical decision making, adverse reporting, utilization, radiation exposure, patient satisfaction and clinical outcomes, will be examined and evaluated in phase three. Northwestern University Medical Center is also participating in the study to provide a basis for comparison.

According to Blumstein, he has envisioned such an interdisciplinary research project for more than a decade, having proposed the development of safe-harbor standards of care as a means of curtailing defensive medicine in his 2006 *Vanderbilt Law Review* article,"Medical Malpractice Standard-Setting: Developing Malpractice 'Safe Harbors' as a New Role for QIOs." He argues that diagnostic and other procedures performed primarily to reduce potential legal liability not only increase the cost of medical care, but also expose patients to radiation and other risks of medical treatment unnecessarily.

In his *Vanderbilt Law Review* article, Blumstein proposed the establishment of science-based standards of care which, if rigorously followed by medical practitioners, would represent a "safe harbor" — a legal defense against malpractice lawsuits.

"Juries are currently determining the standard of care, which means non-experts end up deciding what the standard of care should be long after it's delivered," Blumstein said. "Plaintiffs and defendants in malpractice lawsuits bring in competing medical experts who testify in court that a doctor did or did not follow prevailing standards of care, and the jury must decide which story they believe. If we develop detailed standards of care that are accepted in advance by both medical practitioners and legal policy makers, and rely on those standards to deliver care and establish liability, we can reduce the practice of defensive medicine and the cost of care and reduce risks to patients."

The Vanderbilt team engaged in the standard-setting process

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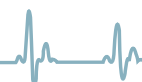

COURT DECLINES TO DISMISS EXCESS CARRIER'S SUIT SEEKING REIMBURSEMENT OF AMOUNTS PAID IN UNDERLYING MEDICAL MALPRACTICE SETTLEMENT

by Gregory A. Gidus, Esq.

In the case *Ironshore Specialty Insurance Co. v. Conemaugh Health Systems, Inc.*, the Western District of Pennsylvania refused to dismiss an excess carrier's suit seeking reimbursement from its insured for settlement amounts the excess carrier paid in an underlying medical malpractice lawsuit. According to the court, Ironshore plausibly alleged that Conemaugh Health Systems Inc. breached its obligation to cooperate with Ironshore and failed to disclose circumstances that gave rise to the underlying claim on its application for the Ironshore excess policy.

Ironshore issued Conemaugh an excess liability policy that provided coverage in excess of a $12 million primary layer. If Ironshore elected to associate in the defense of a claim, the excess policy required that Conemaugh "will cooperate with [Ironshore] and will make available all such information and records as [Ironshore] may reasonably require."

In addition to the provisions in the excess policy itself, the excess policy "followed form" and incorporated the provisions from Conemaugh's primary policies. One primary policy required Conemaugh to cooperate with its insurance provider in the defense of claims and suits. Another primary policy contained an exclusion for known claims and circumstances that Conemaugh knew of but failed to disclose on its policy applications.

The underlying medical malpractice lawsuit arose out of a doctor's negligent treatment of a prematurely born baby. After the lawsuit was filed in 2015, Conemaugh sent a copy of the underlying complaint to Ironshore. In 2017, at Ironshore's request, Conemaugh provided Ironshore with a list of serious matters that Conemaugh was monitoring that could affect Ironshore's excess layer, noting that the expert reports in the underlying lawsuit were "unfavorable."

In February 2018, Ironshore received an updated report that caused Ironshore to appoint a claims representative to monitor the underlying lawsuit. This claim representative requested to be copied on all significant correspondence. Ironshore alleged that despite this request, Ironshore was contacted on March 21, 2018, one day before the jury reached a verdict, and informed that the case was nearing an end and that Conemaugh anticipated a negative verdict.

After the court's decision on remittitur, the damages award totaled approximately $19 million. Ironshore, the other insurers and the plaintiff agreed to resolve the underlying lawsuit, with each insurer contributing an undisclosed amount. In its complaint, Ironshore alleged that its contribution was subject to a reservation of rights, including a right to recoup.

Ironshore's recoupment lawsuit against Conemaugh included three counts: **(1)** a declaratory judgment for breach of the cooperation clause that required Conemaugh to make requested information available to Ironshore; **(2)** a declaratory judgment for breach of Conemaugh's obligation to disclose all known claims and circumstances on its insurance applications; and **(3)** unjust enrichment on the basis that Ironshore indemnified Conemaugh when no indemnity was owed.

> **Conemaugh is a reminder to policyholders that their duty to cooperate does not end with their primary insurers and that a settlement subject to a reservation of recoupment rights may allow an insurer to seek recoupment, even if this right is not specifically reserved in the policy itself.**

The court denied Conemaugh's motion to dismiss as to all three counts. First, the court ruled that Ironshore had plausibly alleged that Conemaugh breached the cooperation clause in the Ironshore policy, which the court found unambiguous. According to the court, Ironshore alleged that it elected to participate in the underlying medical malpractice lawsuit, requested information on the underlying lawsuit on at least four occasions and assigned a claims representative who requested copy on all significant correspondence.

Moreover, Ironshore's complaint averred that Conemaugh failed to provide Ironshore with trial dates for the underlying lawsuit and failed to notify Ironshore of settlement correspondence before and during trial. Based on these allegations, the court found that Ironshore plausibly alleged a breach of the cooperation clause and refused to dismiss count one.

Next, the court ruled that Ironshore plausibly alleged a breach of the known claims and circumstances clause. This clause, which was contained in a primary policy and thus incorporated into the follow-form Ironshore policy, excluded coverage for circumstances that were likely to give rise to a claim and that were not disclosed to Ironshore in the policy application. After finding the exclusion ambiguous, the court found that Ironshore's complaint alleged that Conemaugh should have known that the doctor's negligent treatment could give rise to a claim when it applied for the Ironshore policy but failed to disclose it on its application. The court therefore denied Conemaugh's motion to dismiss count two.

Lastly, the court found that Ironshore plausibly alleged that Conemaugh was unjustly enriched, noting that unjust enrichment is an equitable doctrine that requires a defendant to pay a plaintiff the value of a benefit conferred. The court rejected Conemaugh's argument that count three should be dismissed because the Ironshore policy did not expressly provide for a right of reimbursement. While the court found that there was uncertainty under Pennsylvania law regarding whether an excess insurer may recoup indemnity payments, the court ruled that this uncertainty could not defeat Ironshore's unjust-enrichment claim at the motion to dismiss stage. The court emphasized that while the policy did not explicitly allow recoupment, Ironshore alleged that it expressly reserved its right to recoupment when it contributed to the underlying settlement. Accordingly, the court found that Ironshore facially stated a claim for unjust enrichment.

Conemaugh is a reminder to policyholders that their duty to cooperate does not end with their primary insurers and that a settlement subject to a reservation of recoupment rights may allow an insurer to seek recoupment, even if this right is not specifically reserved in the policy itself. Most importantly, it highlights the duty of a

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TRUMP BUDGET STILL EMPHASIZES MEDICAL MALPRACTICE REFORM

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has provisions for creating new safe harbors, changes some statutes of limitations. It has some restrictions on attorney fees as well, but the largest thing it does is cap those noneconomic damages, which in some lawsuits can be in the millions and drive-up premiums that doctors pay."

The Reality of Divided Government

The United States is currently operating under a politically divided government and the likelihood of the president's healthcare agenda — as outline in his Fiscal Year 2020 Budget proposal — being enacted is less than modest. But according to Goldwein and the Committee for a Responsible Federal Budget, the budget proposal's continued inclusion of medical professional liability reform is significant.

"I don't think it's very likely that the president's [tort reform] proposals will be enacted, in particular the cap on noneconomic damages," Goldwein said. "I do think there's room for passing safe harbor rules and things like that, but there's a very strong community of interest groups that are opposed to things like caps.

"While I don't think it's very likely [the president's budget passes], I don't think that's the point of the president's budget. In reality, very little of the president's budget will be enacted. The point is to put the proposals out there, and then sort of push them one by one when the window opens. That may happen at some point in the future, but it's very unlikely in the next two years."

VANDERBILT U. TO DEVELOP, TEST 'SAFE HARBOR' STANDARDS OF CARE

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will adopt a set of standards, test them at Vanderbilt, compare the results with practices at Northwestern, and examine the overall results. Blumstein believes that, by providing clear guidance in advance regarding the standards of care needed to mitigate legal risk and liability, the standards will reduce physician uncertainty and improve the quality of patient care. "This study, which will focus on emergency care, affords us an opportunity to pick off the low-hanging fruit, and it will also help us develop the approach, methodology and analysis to extend safe-harbor standards to other practice areas where defensive medicine drives up costs and increases patient risk," he said.

COURT DECLINES TO DISMISS EXCESS CARRIER'S SUIT SEEKING REIMBURSEMENT

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policyholder to ensure that all its carriers, including excess carriers, are apprised of all significant developments in litigation.

The decision, although not on the merits, is a win for excess carriers seeking to exercise the right to recoupment of indemnity paid under Pennsylvania law, and highlights the importance of reserving that right.

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CASE STUDY: 31-YEAR-OLD MALE, SHORTNESS OF BREATH

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improvement in the care that they rendered the patient. The initial physician clearly knew that the patient was at high risk for pulmonary embolism, and was so suspicious that he ordered the correct test to diagnose it.

There were several ways around the fact that the patient weighed too much for the CT scanner. He could have been transferred to a different hospital that had the necessary equipment. He also could have been admitted to the hospital and started on anticoagulation, the appropriate treatment for a PE. It is very challenging to defend this physician's actions when he clearly understood the patient was at high risk for a potentially fatal disease process, but simply gave up on the diagnostic process once he encountered difficulty.

It is very challenging to defend this physician's actions when he clearly understood the patient was at high risk for a potentially fatal disease process, but simply gave up on the diagnostic process once he encountered difficulty.

Another area of improvement is the physician's documentation. Any discrepancy between the physician and other staff members will be scrutinized closely. In this case, the physician documented a normal heart rate ("RRR" = regular rate and rhythm) in his cardiovascular exam. The patient in fact did not have a regular rate, he was markedly tachycardic to 136bpm when he checked in, and was still tachycardic at 109bpm when he was discharged. This is especially concerning given that one of the most common signs of PE is tachycardia.

The physician may have known that the patient was tachycardic, but rapid documentation or a pre-filled template likely contributed to this inaccurate documentation. Inaccuracies in the doctor's documentation, especially which directly contradict the nurse's documentation, make his defense even more challenging.

Physicians can help avoid similar outcomes in the future by carefully considering alternative methods to complete challenging diagnostic testing and working to avoid discrepancies in their documentation. To see the full medical record from this case, as well as review other medical professional liability cases, visit www.MedMalReviewer.com.

Eric Funk, MD, is an emergency medicine physician. He is also editor of MedMalReviewer.com, a website dedicated to improving doctor's medical knowledge and documentation by reviewing real-life malpractice cases. To view other medical malpractice cases, visit www.medmalreviewer.com.

ISSUES AT RISK

CASE STUDY: 31-YEAR-OLD MALE, SHORTNESS OF BREATH

by Eric Funk, MD

A 31-year-old man presented to the emergency department (ED) with shortness of breath. He had been feeling short of breath for the past two days. The triage nurse who saw him noted that he had a cough, fever and pain in his upper back that restricted his breathing. The patient reported that his daughter had slept with her knees in his back, which he suspected was causing his back pain.

The patient was taken to an ED room and was seen by the physician. In addition to the triage nurse's findings, the physician also noted chest pain and chest congestion. Vitals signs showed a heart rate of 136bpm, blood pressure 157/107, temperature 102.8F, 97% on room air.

The physical examination was noteworthy for pain in the patient's chest, as well as area of slight erythema on the patient's right foot, which the physician suspected was a fungal infection. He documented a regular heart rate, although the heart rate documented by nursing staff directly conflicts with this.

Testing included a CBC and CMP that were unremarkable, in addition to a d-dimer that was elevated. A chest X-ray showed clear lungs and ultrasounds of bilateral lower extremities were negative for DVT. Given a positive d-dimer, a CT PE study was ordered.

Unfortunately, the patient's weight was over the CT scanner's limit. He weighed about 500 pounds, and the limit of the CT scanner was 467 pounds. The weight limit of the CT scanner would later be included in an exhibit at trial (see Exhibit 1).

Because the patient was over the weight limit, the CT scan was cancelled. The patient was treated with pain medication (Toradol and Tylenol), muscle relaxant (Norflex) and an antibiotic (doxycycline). He was discharged with a diagnosis of acute bronchitis.

Eighteen days after the initial visit, the patient developed worsening shortness of breath and had several episodes of syncope. The patient had moved across the country in the interim. His family called 911, and he was brought to an ED in a different state. As the ambulance pulled into the garage, he went into cardiac arrest. During the code there were a few minutes when he regained a pulse, but ultimately, he was pronounced dead after 30 minutes. An autopsy showed pulmonary thromboembolism in the right and left main pulmonary arteries (see Exhibit 2).

A lawsuit was brought against the doctor who initially saw the patient and discharged him with a diagnosis of bronchitis. The case went to a jury trial. The jury found the doctor and his employer negligent, awarding the plaintiffs $2.75 million in damages (see Exhibit 3). A careful review of this unfortunate case reveals several learning points that can help avoid similar outcomes in the future.

Both physicians had areas for

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EXHIBIT 1

Patient table 1600

Vertical table range	505 – 925mm	at table top
Max. table load	212 kg (467 lbs)	
Max. table movement after emergency stop ≤ 10 mm		

Table 22: Patient table 1600

EXHIBIT 2

AUTOPSY NO:
DECEASED: [redacted]
Page 2

SUMMARY OF CASE FINDINGS

I. PULMONARY ARTERY THROMBOEMBOLISM WITH
 A. PULMONARY THROMBOEMBOLISM IN RIGHT AND LEFT MAIN PULMONARY ARTERIES AND BRANCHES
 B. PULMONARY ARTERY THROMBOEMBOLI IN DISTAL PULMONARY ARTERY BRANCHES
 C. PULMONARY EMBOLI IN RIGHT VENTRICLE OF HEART
 D. NON-ACUTE INFARCTS OF LOWER LOBES OF BOTH LUNGS WITH FIBRIN IN PLEURAL SPACE
 E. LOWER LUNG ATELECTASIS WITH FOCAL PNEUMONIA

II. DILATED, OBESITY-RELATED CARDIOMYOPATHY WITH
 A. CARDIOMEGALY (HEART WEIGHT 760 GRAMS)
 B. BIVENTRICULAR CHAMBER DILATION
 C. LEFT VENTRICULAR HYPERTROPHY
 D. RIGHT VENTRICULAR HYPERTROPHY

III. OBESITY (BODY MASS INDEX: 56 Kg/m²)

IV. HEPATOMEGALY (LIVER WEIGHT 3950 GRAMS); STEATOSIS, EARLY BRIDGING FIBROSIS

V. SPLENOMEGALY (SPLEEN WEIGHT 700 GRAMS)

VI. TOXICOLOGY: SEE SEPARATE REPORT

OPINION:

This 31-year-old man had recent complaints of shortness of breath, and had completed a cross-country car trip. He was taken to the emergency room and became unresponsive, at the time of hospital admission.

The death is attributed to pulmonary artery thromboembolism. Bilateral pulmonary infarcts contributed to death.

[redacted] M.D. / [redacted] (date signed)
Forensic Pathologist

EXHIBIT 3

VERDICT

We, the Jury, on the issues joined, unanimously find in favor of Mrs. [redacted] against:

___ Dr. [redacted] only

✓ Both Dr. [redacted] and [redacted]

and fix the damages at $ 2,750,000.00

Optional: With interest on such amount from [redacted] (month, day, and year).

Optional: We unanimously specify the proportion of damages to be received by the beneficiaries of Mr. [redacted] as follows:

[redacted] (widow) 35 %
[redacted] (stepchild) 32 %
[redacted] (child) 33 %

[redacted]
Foreperson