Introduction

Healthcare

- Consolidation vs. Transformation
- The productivity paradox
- Doctor-patient relationship in the Digital Era
Introduction

Suing the Profession

- Litigation trends
- Practice guidelines and standards of care
Healthcare
Consolidation vs. Transformation
3,412 respondents

- Equally divided among primary care, medical specialties and surgical specialties

7 out of 10 physicians **unwilling** to recommend healthcare as a profession

- 54% of respondents plan to **retire** within 5 years
  - “I’m 52 and tired. If I won the lotto, I would quit. I am overworked and underappreciated”
Practice model

• 62% not planning to change (21% are)
  – 75% of solo practitioners plan to remain solo

Burnout

• EHRs and regulation leading causes
The Year in Healthcare

Health Insurance

• CVS acquires Aetna
• Trump administration expanded access to lower cost health plans with reduced benefits
• Site-Neutral payments - CMS reduced payments for office visits at hospital outpatient clinics to match the reimbursement rate for independent doctor offices
The Year in Healthcare

Investments

• Amazon, Berkshire and JPMorgan Chase partner to create Haven
  “…will create new solutions and work to change systems, technologies, contracts, policy and whatever else is in the way of better health care” – Atul Gawande MD

• Ascension, Intermountain, SSM, and Trinity form a generic drug company, Civica RX

• Private equity investment in global healthcare reached $42B
  – Venture funding of digital health startups approaches $7B
The Year in Healthcare

Healthcare IT

• Apple, Amazon, Google, IBM, and Salesforce collaborate on standardization of medical data to facilitate analysis

• Cerner contracts with Veterans Affairs to upgrade the EHR at cost of $16B over 10 years

• Average healthcare data breach cost $4M
  – 333 reported to HHS
Health Care Spending
No Limit in Sight

Projecting 5.5% annual increase in spending

• 2.5% annual increase in costs
• Will reach nearly $6T by 2027 - 19.4% GDP
  – Assumes 90% are insured
Hospital Charges Continue to Escalate

2007-2014

- Hospital *inpatient* prices increased 42% (vs. 18% for physicians)
- Hospital *outpatient* prices increased 25% vs. 6% for physicians
Hospital Mergers: Fewer, Bigger
Private equity: Moving into Independent Practices

**Hospital Mergers**
- Total transactions down 22% in 2018
- Average price exceeds $400M (14% CAGR since 2008)

**Private Equity Buying Medical Practices**
- Average price $1-2M per physician
- Positioned for sale 3-7 years

_Fierce Healthcare, 1/15/19_
Healthcare Pricing Transparency
“Hospitals must now post prices, but it may take a brain surgeon to decipher them”

Context: hospital spending $1.1 trillion 2018
Lists are thousands of items long

- Names like “visceral selective angio rad” and “HC PTC CLOS PAT DUCT ART”
- “This is gibberish, totally meaningless…”
  NY 1/13/19

Hospitals may yet be required to reveal prices negotiated with health insurers
  NPR 3/10/19
Healthcare Behemoths Battle Each Other Over Margins

Walmart threatened to leave CVS Pharmacy benefit networks

- Dispute over the costs of filling prescriptions
Telemedicine
From Fringe to Potential Disrupter to Mainstream

Direct to Patient
• Second opinions
• Remote patient monitoring
• Pharmacy services
• Chronic disease management

Provider-to-Provider
• Virtual consultations
• Remote on-call coverage (Telestroke, Tele-ICU)
Telemedicine
From Fringe to Potential Disrupter to Mainstream

- **Kaiser**
  - More than 50 million virtual physician visits annually

- **Walmart** has lowered cost of telemedicine visit for employees to $4

- **The Doctors Company**
  - Telemedicine used frequently by our employees
  - Few claims to date
    - Coverage: insured by 96% of MPL policies

- **Medicare** and **Medicaid** pay for the service

MPLAssociation, 2018
Retail Medicine
From Marginal to Mainstream

8 of 10 Americans live within 10 miles of a CVS pharmacy

- **43** in Orlando
- More than a thousand Minute Clinics

**RAND: Increased utilization outweighs cost savings**

- **Does not** reduce ER use
- Quality of care comparable to other settings for selected conditions
Productivity in medicine has not increased significantly despite multi-billion dollar investments in information technology

- Yet EHR decision support at the individual patient level is still rudimentary and can create its own problems
- Experience in other industries suggests this ultimately resolves, but may take 10-20 years (!)
  - Better technology and redesign of work flows are usually required
HIT: The Productivity Paradox
Wachter and Howell, JAMA, July 13, 2018

Obstacles specific to healthcare:

• Security and privacy issues
• Proprietary EHR vendor technology
• Inadequate collaboration between clinicians and technology companies
• Difficulty of real patients actually shopping for healthcare
• “Fail fast and iterate” model extremely problematic for medicine
Conclusion

• “...history suggests the most likely result will be higher quality, safer, more satisfying and less expensive healthcare, and better health outcomes”
Scribes
EHRs Reduce Productivity All Over the World

Emergency Rooms in Australia

• Scribes:
  – Increased patients seen per hour by 15.9%
  – Reduced length of ER visit by 19 minutes per patient
  – Would save hospitals $26/scribe hour
Google is developing EHR for clinicians

- Bolt on to existing systems
- Would **predict** clinical outcomes by real time analysis patient’s medical record

**Three parts:**

- **Memory**- storing aggregated health records from **millions** of patients in a standardized data format
- **System**- applying **deep learning/AI** models to records
- **Clinician interface**- provides predictions for **future** clinical events and pertinent past medical events for individual patients
New MPL Paradigms in the Digital Era?

**MPL today based on doctor-patient relationship**

In the digital world:

- Patient and doctor may never meet
  - Some interventions may not require an encounter with any medical personnel at all
  - Medical apps blur boundaries between physicians and products
- **Standard of care for algorithms?**
- **Move toward enterprise or product liability?**

Richman, NEJM Nov 1, 2018
Suing Physicians
TDC Frequency

TDC Claims Per 100 Doctors

Actuarial evaluation as of 4Q17. Full-time mature exposures on an IM equivalent basis.
Is Low Frequency Really the New Normal?

Cluster Claims
- Transmuting criminal behavior into medical malpractice claims
  - Dr. Nassar and Michigan State
  - Opioid Crisis
    - Drug pushers with MDs accused of medical malpractice

Erosion of Tort Reforms
- Laverne’s Law - changing the rules
  - New York extends statute of limitations for FTD cancer cases
- Caps threatened in Oregon
TDC RAND: Percent of Career with Defending Malpractice Claims

- Neurosurgery
- Cardio-Thoracic
- Orthopedic Surgery
- General Surgery
- Plastic Surgery
- OB GYN
- Gastroenterology (No...
- Urology
- Oncology
- Pulmonary Medicine
- Internal Medicine
- Cardiology
- Gynecology
- All Physicians
- Anesthesiology
- Neurology
- Diagnostic Radiology
- Pathology
- Ophthalmology
- Emergency Medicine
- Family General Practice
- Nephrology
- Dermatology
- Other
- Pediatrics
- Psychiatry

Claims with indemnity compared to Claims without indemnity.
Medical Oncology: Frequency

TDC Claims per 100 Doctors

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<th>Year</th>
<th>All Specialties</th>
<th>Oncology</th>
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Medical Oncology: Severity

The chart shows the severity of medical oncology cases from 2005 to 2018, comparing all specialties (black bars) and oncology cases (red bars). The severity is measured in thousands of dollars. The highest severity in oncology cases was in 2016 at $201K, while the highest for all specialties was in 2013 at $138K. From 2005 to 2010, the severity generally increases, with a notable peak in 2009 at $120K for all specialties and $120K for oncology. From 2010 to 2018, the severity decreases, with a stabilization in 2015 at $100K for all specialties and oncology. The lowest severity for all specialties was in 2005 at $71K, and for oncology was in 2018 at $73K.
Radiation Therapy: Frequency

**TDC Claims per 100 Doctors**

- **All Specialties**
- **Therapeutic Radiology**

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Radiation Therapy: Severity

All Specialties

Therapeutic Radiology
Litigation Trends

- **Batch claims** (resulting from related events)
  - Think Johns Hopkins, unnecessary procedures (e.g. stents and surgeries), rogue employee
  - Frequency of severity
    - Large losses more common
  - Cyber liability
    - Value of the information
    - Medical record vulnerabilities
    - HIPAA
• The American Cancer Society [110], American College of Radiology [111], American Medical Association [112], the National Cancer Institute [113], the American College of Obstetricians and Gynecologists [51], and the National Comprehensive Cancer Network (NCCN) [114] recommend starting routine screening at age 40. The American Academy of Family Physicians recommends screening mammography every one to two years for women ages 40 and older [115].

• The United States Preventive Services Task Force (USPSTF), the American College of Physicians (ACP), and the Canadian Task Force on the Periodic Health Examination recommend beginning routine screening at age 50 [116-118]. The Canadian Task Force in 2011 revised its recommendations to recommend against screening for women under age 50 [118]. These groups advise individual risk assessment and shared decision-making with patients regarding mammogram screening for women 40 to 49 years of age [116,117]. For women who do not wish to participate in shared decision-making, the ACP suggests mammograms every one to two years for women age 40 to 49 years. The USPSTF advises screening every two years for women who elect to be screened.

• The Advisory Committee on Cancer Prevention in the European Union recommended women between the ages of 50 and 69 be offered mammogram screening in the context of an organized screening program with quality assurance [119]. Women aged 40 to 49 should be advised of potential harms of screening, and if mammograms are offered to these women, they should be performed with strict quality standards and double reading.
• Age to discontinue — Several groups do not explicitly state at what age breast cancer screening should stop. The USPSTF recommends mammography screening to age 74, as does the Canadian Task Force of Preventive Health Care [116,118]. They state that there is insufficient evidence beyond age 74. The American College of Radiology recommends screening until life expectancy is less than five to seven years, on the basis of age or comorbidities [111]. The American College of Obstetricians and Gynecologists recommend that women aged 75 years and older should consult with their physician to decide whether to continue screening [51].

• In 2016, the ACS suggested age 45 to initiate

• And Breast examination guidelines differ in each

UptoDate, “Screening for Breast Cancer”
Clinical Guidelines Often Based on Weak Evidence Cut Both Ways in Court

- Two thirds of the 9,400 graded recommendations in UpToDate are based on inconclusive evidence
  
  B Djulbegovic, JAMA 10/1/14

- Just as easy for plaintiff to argue either side
  
  • If the outcome was adverse and guideline followed then the care itself was negligent
  
  • If outcome was adverse and guideline not followed then it should have been
Defensive Medicine Breast Cancer

- Approximately 4 times as many mammograms read as abnormal in U.S. as in Sweden (11% vs. 2.5%) with same sensitivity
- Harvard study of screening mammography: 9,762 women followed for 10 years*
  - Cumulative 10-year risk of a false positive study: 49.1%
  - 18.6% of women screened for 10 years will undergo a negative biopsy
  - More than 2 out of 3 breast biopsies are benign (Mayo Clinic)

*NEJM 1998; 338:1089
Standard of Care

- The legal system works backward from the outcome
- Plaintiff attorney will argue that

The standard of care is best imaginable outcome
Doctors Have No Faith in the System that Judges Them

- Jury of peers?
- Signal-to-noise ratio incredibly low:
  - 80% of claims close with no indemnity payment
  - What if the police made 80% false arrests, or District Attorneys prosecuted the innocent 80% of the time?
- Harvard, IOM, and Malpractice Litigation: Final Conclusion:
  - No correlation whatever between the presence or absence of medical negligence and outcome of malpractice litigation

Brennan et al., NEJM 335:1963,1996
Is Healthcare a Right or a Privilege?

This is a fundamental decision for our society, but until there is a clear answer, physicians are held accountable for the ambiguity.
MPL Implications of Loss of Insurance
4 Elements of Patient Abandonment

1. The **doctor-patient relationship** must be established and treatment underway

2. Abandonment must take place when the patient is still in **need of medical attention**

3. Patient did not have **time or resources** to find suitable replacement physician

4. Patient must suffer an **injury** as a direct result of the abandonment
Inability or refusal to pay for care does not allow the physician to terminate the relationship unilaterally

“Patient could not pay” is rarely, if ever, a successful defense strategy
Conclusions

1. Healthcare is consolidating
   – Transformation less certain

2. Litigation against physicians remains at unconscionable levels leading to medical-legal standards of care and defensive medicine

3. Access to care is critical for oncology patients increasing responsibility for ongoing treatment