May 2006

Newsletter of Physicians Reimbursement Fund, Inc.

PRF NEWS

Volume 9, Number 1

Covering Practice and Risk Management Issues for Physicians

Genetic Counseling in an Obstetric Practice

BY DENISE M. MAIN, M.D.

Reflecting the rapid medical advances of the past 30 years, obstetricians can now present multiple options to pregnant women so that they can make informed, personally appropriate decisions about genetic testing during their pregnancy. The most exciting of these options are two new tests for Down Syndrome that either can be performed earlier in pregnancy or offer superior detection rates to the most recent clinical standards.

Until recently, the two most common screening options for Down Syndrome were performed in the second trimester at 15-20 weeks gestational age. The first of these tests, the California Expanded AFP ("Triple Screen") is mandated by the State of California. It measures maternal serum alpha fetal protein, estriol, and hCG and has a Down Syndrome detection rate of 69 percent with a false positive rate of five percent. The advantages of this program are that women screening positive are offered free follow-up services including genetic counseling, ultrasound and amniocentesis. Thus, the ability to pay does not affect a woman's decision regarding testing. Furthermore, it is widely reimbursed by insurance companies and is less expensive than commercial screens that do not pay for follow-up services. Because it remains the basic standard in California, many obstetric providers offer only the Triple Screen.

The "Quad Screen," also performed at 15 to 20 weeks, is available through commercial laboratories and is commonly offered in most other states. The Quad Screen adds a measurement of inhibin A to the Triple Screen. This increases the detection rate to 81 percent with no change in the false positive rate. It is anticipated that in the near future, California will make the Quad Screen the state-mandated standard.

The first of the new tests is referred to as the "Combined" screening, which combines an early fetal ultrasound looking for nuchal translucency with a measurement of serum hCG and pregnancy-associated plasma protein-A. The advantage of this test is that it can be performed between 10.5 and 14 weeks and has a detection rate equal to or better than the second trimester Quad screen. This allows for the possibility that a first trimester chorionic villus sampling can be performed for confirmation rather than waiting to perform amniocentesis.

The most sensitive testing of all occurs when the "Combined" is performed in conjunction with the second trimester Quad Screen. This combination, referred to as the "Integrated" screen, has a Down Syndrome detection rate of 92-96 percent with no increase in false positives and is especially advantageous for women older than age 35.

These new tests provide women two appealing options: either earlier detection (Combined first trimester screening) or improved overall sensitivity and lower screen positive rates (Integrated screening). Those most eager to avoid diagnostic testing and wanting the highest detection rate select Integrated screening. With the advent of more effective screening, women under age 35 are also interested in maximizing their detection of Down syndrome. Some insurance companies and often Medi-Cal reimburse for these more sensitive screens for women under age 35. Other women may also elect to pay out of pocket for the possibility of improved detection. Thus, it becomes important to inform women of all ages of the range of screening options.

Regardless of the screening test selected, women still need individualized counseling and assessment. For example, a young woman may opt to proceed with a diagnostic test even after a "negative" screen if she weighs the burden of raising a child with Down syndrome as significantly greater than that of a miscarriage of a chromosomally normal fetus. Just as a woman over age 35 may opt for diagnostic testing after a "negative" screen, a younger woman might want the option of an amniocentesis even if she needs to pay out of pocket or pressure her insurance company for reimbursement. ■

Dr. Main, an obstetrician gynecologist, is affiliated with the Prenatal Diagnosis Center and Genetics Program at California Pacific Medical Center in San Francisco.

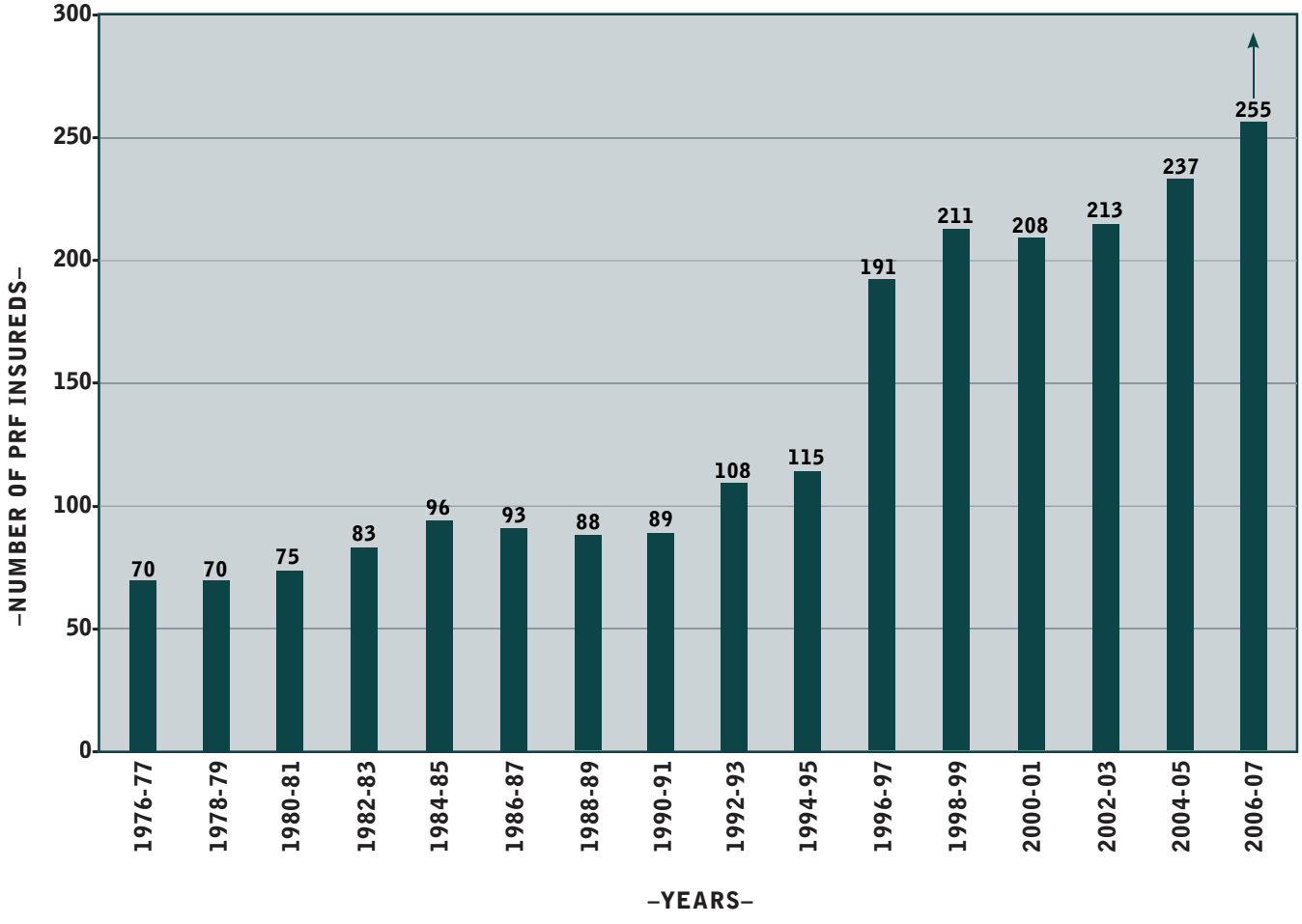
Inside PRF News

PRF–RRG: A Time For Strategic And Careful Growth

BY JUNE RILEY, MBA

Physicians Reimbursement Fund (PRF) was founded thirty years ago as a direct response to the medical liability insurance crisis of 1975. At that time, due to the soaring cost of plaintiff jury awards, some professional liability carriers withdrew from the medical malpractice insurance market completely, while others stopped offering coverage to specialties they considered high-risk. As a result, almost half of PRF's original 70 members were in the field of obstetrics and gynecology. As shown in Figure 1, since its inception, membership in PRF has almost quadrupled. Today PRF insures a variety of specialists—from anesthesiologists to perinatologists—yet almost a third of PRF insureds continue to be obstetrician/gynecologists.

Figure 1: PRF Growth in 30 Years



In 1975, PRF's founding physicians saw an urgent need in the local medical community and provided a timely solution in the form of an offshore captive insurance company. Since then, PRF has evolved into a risk retention group authorized by the Liability Risk Retention Act of 1976, domiciled in the State of Vermont, and regulated by the National Association of Insurance Commissioners (NAIC) and the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

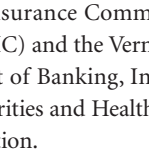
Risk retention groups (RRG) resemble a multi-owner captive insurance company (i.e. a group self-insurance program) that provides liability insurance for its members. RRGs must be owned directly or indirectly by the members who are engaged in similar businesses or activities with respect to the liability to which such members are exposed. RRGs must be organized for the primary purpose of providing liability insurance coverage to their members. PRF's compliance with the regulations of the NAIC and the Vermont Department of Insurance help to ensure PRF's stability and solvency in the face of future potential loss risk.

PRF's annual actuarial claims analysis continues to verify the Company's excellent financial and professional performance. Attesting to the quality of medical care given by PRF's physicians, losses due to claims have exceeded $500,000 only twice in PRF's 30 year history. PRF's future goals include growth while continuing the same high standards the Company has maintained throughout its history. PRF is currently negotiating with some prominent specialty groups that will likely bring PRF's membership to 300 by the end of 2006.

Physician loyalty to PRF is reflected in the longevity of the membership, as generally PRF loses an Insured only through retirement or relocation. Not only does PRF still insure 13 of its original 70 members, but the average length of membership is approximately 10 years. Figure 2 illustrates the number of Insureds and their approximate years of membership and clearly demonstrates the confidence Insureds have shown in PRF by staying with the Company year after year.

We have always believed that PRF offers the best type of malpractice insurance (occurrence based) at highly competitive premiums. PRF is physician owned and operated. The physician leadership understands first-hand the needs of PRF's Insureds and they are able to provide Insureds with personal service based on this understanding. As a result, current PRF physicians have always been the best source for new membership. Selective growth will insure the continued viability of PRF as existing members retire from practice. As a PRF Insured, your recommendation to another physician to join PRF is the truest endorsement possible. Please have prospective applicants telephone the PRF office at (415) 921-0498 and ask to speak with Soad Kader, Director of Membership, or June Riley, Executive Director. We will be pleased to answer questions, provide information about PRF, or arrange to meet with interested physicians or their practice managers at their convenience. ■

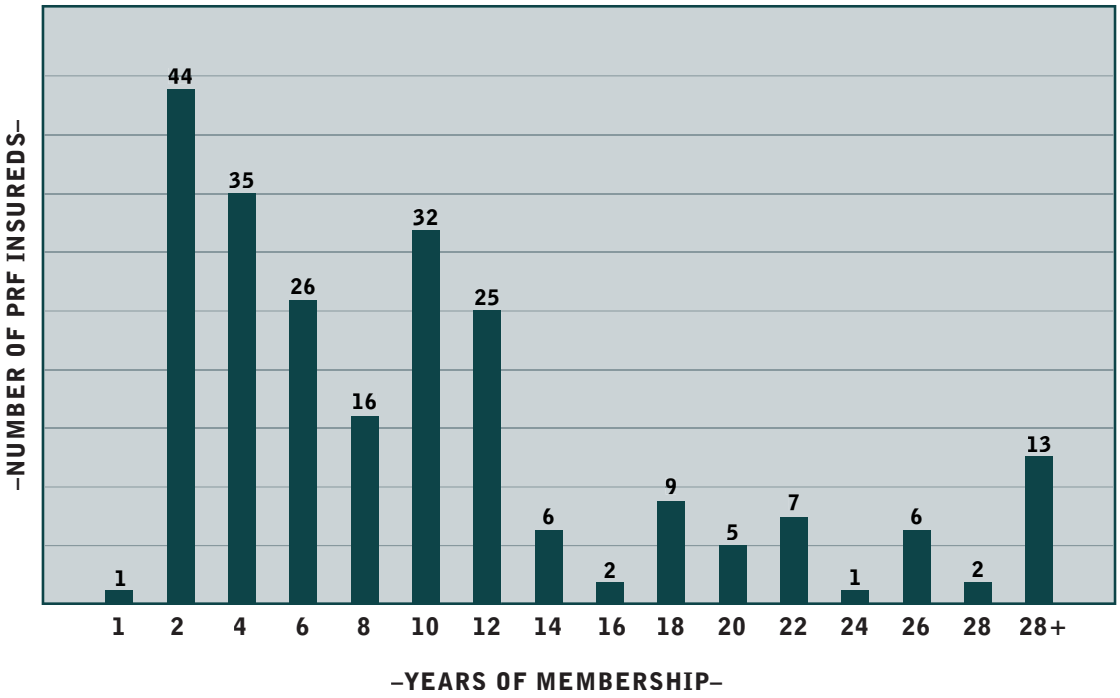
June Riley is executive director of PRF.



ANNUAL MEETING IS MAY 17

PRF will hold its Annual General Membership Meeting on Wednesday, May 17, at 6:00 p.m. at the Radisson Miyako Hotel, 1625 Post Street, in San Francisco. Each Insured will receive a $100 bill for attending, as well as a complimentary buffet dinner with wine. Validated parking is available at the Japan Center Garage. ■

Figure 2: PRF Insureds–Years of Membership



PRF NEWS

Covering Practice and Risk Management Issues for Physicians

Volume 9, Number 1
May 2006

Stephen Scheifele, MD, Executive Editor
Robert D. Nachtigall, MD, Editor

PRF News is produced by Knox Communications

Physicians Reimbursement Fund, Inc.
711 Van Ness Avenue, Suite 430
San Francisco, CA 94102
(415) 921-0498 - voice
(415) 921-7862 - fax
June@PRFrrg.com

June Riley, MBA
Executive Director

Soad Kader
Director of Membership

Legal Considerations for On-Call Physicians

BY KRISTEN A. PICO, ESQ.

What are my legal obligations when covering the emergency room?

If a physician has entered into a contract to be on-call to an emergency room or expects or receives compensation for being on-call, a legal duty to provide medical treatment may be implied, and failure to evaluate or treat a patient requiring specialized medical care can result in liability.

When must I come in to see a patient in the emergency room?

Under California law, on-call specialists are required to provide telephone consultation at a minimum. However, if it is deemed medically necessary by the emergency room physician, the on-call physician must personally examine and treat the patient. Furthermore, emergency transfer laws prohibit an on-call physician from refusing to respond to a request for assistance for any non-medical reason.

"... if it is deemed medically necessary by the emergency room physician, the on-call physician must personally examine and treat the patient."

How fast do I have to respond to a call from the emergency room?

Response times are typically covered by call agreements or hospital policy. In the absence of a set requirement, the law requires a response within a reasonable time. What is reasonable typically depends on the circumstances, including the severity of the patient's illness; the adequacy of a telephone consultation in stabilizing the patient; the distance the on-call physician is from the hospital; and the activity the physician is engaged in at the time he is called. Failure to respond to a call for assistance may subject an on-call physician to civil liability and may also constitute a violation of the emergency transfer laws.

Who is responsible for patient follow-up?

If a physician undertakes treatment of the patient, he or she has entered into a relationship, and the physician has a responsibility to treat the patient until the relationship is terminated. In general, if a patient requires follow-up care and does not have any other resource for that care, then the on-call physician should assume that he or she needs to provide that care. When a specialist is seeing a patient in the emergency room, that implies a physician/patient relationship and the courts have not ruled definitively on when that relationship ends.

Ongoing responsibilities following a telephone consult will likely depend on whether the on-call physician has a pre-existing relationship with the patient, whether the on-call physician agrees to see the patient on an outpatient basis, whether the patient's condition requires follow-up by a physician with the medical expertise of the on-call consultant, or whether the on-call physician is contractually obligated to provide outpatient follow-up for patients about whom he or she has consulted.

Situations may also arise where the on-call physician is never contacted by the emergency room, but the patient is referred on an outpatient basis. Under these circumstances, there is generally no duty to provide follow-up care unless there is a pre-existing physician-patient relationship. However, if the physician agrees by contract or otherwise to see certain patients on an outpatient basis so as to avoid having to go to the emergency room, that physician runs the risk of creating an expectation in the patient that the physician will provide follow-up care. Under these circumstances, the physician's actions may imply a physician-patient relationship and the failure to provide follow-up care can result in liability.

Does the Good Samaritan Defense apply to on-call physicians?

The Good Samaritan statutes offer immunity in an effort to encourage those who are not otherwise obligated to provide medical care to a patient under emergency circumstances. However, where there is an on-call arrangement with an emergency room, the physician has agreed to respond to emergency calls and typically anticipates some form of financial remuneration in exchange for being on-call. Therefore, the Good Samaritan defense is generally not available to a physician who is on call. ■

Kristen A. Pico is an attorney with Hassard Bonnington LLP and specializes in the defense of physicians and facilities in medical malpractice claims.