

Liability Exposure
Informed Refusal Patient
Selection Criteria
Malpractice Claim
Evaluating Insurers

What You May Not Have
Learned in Your Residency
— *What every neurosurgery
resident needs to know*



Effective Informed
Consent Risk Management
Patient Characteristics
Aspects of Treating Pain



American
Association of
Neurological
Surgeons

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Introduction

Although all physicians are aware that practicing medicine in the United States is virtually impossible without some form of liability insurance, many physicians have a limited understanding of how the American system of professional liability insurance works. It is important for every practicing physician to become familiar with both the business principles underlying insurance and the types of insurance that are available. The first part of this brochure, “Insuring the Practice of Medicine,” will help doctors understand the distinguishing features of an effective insurance program.

While the quality of neurosurgical training in most residencies is excellent, there is often limited exposure to the variety of practice management problems that present themselves daily in neurosurgical practice. The second part of this brochure, “Medical Liability and the Neurological Surgeon,” will help familiarize the new surgeon who is entering into practice with some of the common situations he or she is likely to confront.

I. Insuring the Practice of Medicine

Virtually all practicing physicians in the United States require medical malpractice insurance. Though it is legally required in only a few states, the vast majority of hospitals and other health care institutions mandate that all medical staff members be insured.

1. TYPES OF INSURANCE COMPANIES

Physicians have choices when selecting a professional liability insurance company:

- **Mutual and reciprocal insurance companies** have no stockholders and are owned by their policyholders. Two thirds of practicing physicians get their coverage from physician-owned mutual or reciprocal insurance companies. These companies were formed to provide their policyholder-owners with a dependable source of insurance. They generally offer only medical malpractice insurance. Any profits that a mutual or reciprocal company makes are used to strengthen the company’s ability to pay claims or are paid back to policyholders in the form of dividends. Only a reciprocal company can return profits to policyholders by placing funds into a Subscriber Savings Account payable upon death, disability, or retirement.
- **Stock insurance companies** are public, for-profit corporations owned by their stockholders. These commercial carriers are publicly traded and provide coverage for about one third of American physicians. Stock companies offer multiple lines of insurance, and they often move in and out of the malpractice market as the business climate dictates.

If a carrier is not sufficiently capitalized, it may issue an **assessable policy**. This means that if the carrier cannot meet its financial obligations, it can require its insured physicians to make up the deficit; e.g., if the company's claims reserves are inadequate, the current policyholders could be required to pay additional money to cover its past claim losses. A carrier that is sufficiently well capitalized can issue a **nonassessable policy**. This frees policyholders from any obligation to pay additional money for past losses if reserves are inadequate.

2. THE ALTERNATIVE MARKET

The alternative market provides other sources of coverage that are typically exempted from certain insurance laws, such as minimum capital requirements. If you are considering nontraditional coverage through the alternative market, carefully investigate all aspects of the policy—especially the organization's provisions regarding tail coverage, its financial solvency, its regulatory requirements, and its rules regarding assessability.

- **Trusts** are a somewhat controversial alternative to insurance. In some states, trusts are not regulated by the state insurance department and are not protected by the state's guaranty fund in the event of their insolvency (a guaranty fund is a state operated fund that pays claims of insolvent insurance companies and is supported by contributions from insurance companies doing business in that state). In order to join a trust, capital contributions are frequently required. Premium is based on the claims paid in the prior year. Since most trusts do not maintain reserves, trust members are retroactively assessable if the trust's assets prove insufficient to pay losses. Furthermore, some trusts stop defending and paying open claims for members who leave and go elsewhere for coverage if the members do not agree to remain assessable or do not purchase tail coverage from the trust.
- **Joint underwriting associations (JUAs)** are state-sponsored programs for physicians who have no access to other sources of professional liability insurance, typically because the standard medical malpractice insurers refuse to insure them. In some JUAs the insured doctors are assessable, and the ultimate financial obligations are unpredictable and can be significant.
- A **risk retention group (RRG)** is a group of doctors who form an insurance company that is required to follow the insurance regulations of the state in which it is domiciled. When first joining an RRG, a physician is typically required to pay a capital contribution in addition to the annual insurance premium. If an RRG is appropriately capitalized and operated, it can be a viable insurance alternative. However, due to less regulatory scrutiny, insolvencies imperiling the financial assets of the insured have occurred. Doctors considering an RRG should carefully evaluate the extent to which the state requires the high standards of solvency and management necessary to ensure that the company is able to fulfill its insurance obligations.

3. TYPES OF INSURANCE POLICIES

The most common types of coverage are claims made and occurrence, although today most professional liability insurance carriers offer only claims-made policies. Since these types of insurance provide fundamentally different protection, you should clearly understand their differences.

In a **claims-made policy**, a covered event must occur and the claim made (reported) during the policy period. Claims-made coverage can be extended back by adding **nose coverage**, in which the insurer agrees to cover claims made during the policy period based on events that occurred prior to the inception date of the policy. When a physician retires, or moves to a different insurance carrier, he or she may obtain **tail coverage**. This provides insurance for a covered event that occurred during the policy period, even if the claim is not reported until later. If a physician moves from one carrier to another, the individual can choose between a tail policy with the expiring carrier and nose coverage with the new carrier.

In an **occurrence policy**, any claim arising from an event occurring in the policy period is covered, regardless of when the claim is reported or when in the future it needs to be paid. The long time between the occurrence of an adverse medical event and the time when a claim is paid (typically three to five years) makes it difficult for malpractice insurance companies to predict the ultimate costs of losses. Since today's premiums must cover future losses regardless of when they are reported, malpractice occurrence policies are seldom offered.

4. GENERAL PRINCIPLES OF INSURANCE

Most physicians are unfamiliar with the underwriting, actuarial, and reserving principles of professional liability insurance. The policy is usually filed away unread until a claim is filed. Yet without this crucial document, it is virtually impossible to practice medicine in today's litigious environment. The policy is a legal contract, and it is important to read it and understand what claims are covered, the exclusions to coverage, and the endorsements that modify the policy.

A viable insurance company is a business like any other in that income (premiums) must cover expenses (losses), or the company will not be "in business" when future claims need to be paid. However, the business of an insurance company is managing risk, and in important ways an insurance company differs from other businesses. The most important difference is the need to collect an appropriate amount of premiums today to cover losses and legal defense expenses that occur three to five years into the future. By definition, these future costs are unknown at the time the insurer must price and sell the policies and are difficult to predict due to the length of time involved in resolving malpractice claims. If an insurer underestimates future costs and fails to place adequate funds in claims reserves, physicians will be left without the liability protection that they have paid for. However, their personal liability remains.

Thus, an insurance company's survival depends on its ability to assess physician risk and predict future losses, appropriately price today's premiums to cover these losses, and place adequate funds in reserves to pay losses when they are incurred. Therefore, the true value of a policy (as opposed to its premium cost) may not be apparent until years after its purchase when a claim must be defended and possibly paid.

Underwriting is the risk-assessment of physicians applying for insurance coverage and their placement into subgroups sharing similar risk profiles thought to be predictive of similar

future claims losses. Factors that affect risk include specialty, level of training, nature of practice, clinical setting, unusual practice profiles, and the state and county where medicine is practiced (venue). Venue assessment considers the medical-legal climate, presence or absence of tort reform, and the attitudes of both patients and juries toward doctors. Thus, high-risk specialties (neurosurgery, OB, orthopedics) pay higher premiums than low-risk specialties (dermatology, pathology, psychiatry); and a neurosurgeon in New York pays a higher premium than a neurosurgeon in California.

Actuaries calculate the premium price by making specialty-specific estimates of the cost of future losses and associated expenses (legal defense and expert witness fees). Their estimates are based on the company's past experience and on predictions of future trends in claims **frequency** (the number of claims per 100 insured physicians) and **severity** (average indemnity and associated expenses paid per closed claim). The larger the physician risk pool, the more accurately losses can be predicted. The calculation for an individual physician is further refined by the loss history for the doctor's specialty in the geographic territory (**venue**) where he or she practices. Actuarial models must also reflect the value of investment income. Part of the fiduciary responsibility of any insurance company is to responsibly invest premiums until the money is needed to pay future losses and expenses. The investment income collected is used to subsidize the actual cost of premiums. For this reason, insurance rates are sensitive to the state of the investment markets, especially to interest rates, since claims reserves are held in fixed income investments.

Surplus is the amount by which a company's assets exceed its liabilities. It is accumulated profit that, in a mutual or reciprocal company, belongs to the policyholders. It serves as the company's capital, and it supports operations during years when unpredicted high losses have occurred. A company's surplus (capital) allows it to take on risk (write new business) and also serves as a cushion in the event that losses from that risk exceed the reserves intended to cover them. This is because surplus can make up for deficiencies in the loss reserves. *Thus, surplus serves to provide strength and to maintain fiscal integrity in the face of adverse loss experience that was not anticipated. It is the most obvious mark of a company's strength and stability—and it is closely monitored by state departments of insurance and rating agencies in order to assure policyholders that a company has sufficient assets to pay for future claims.*

Reserves are the funds set aside to pay for future losses. The reserves are invested, and the interest earned becomes an additional source of income to pay for future losses. Over time, some claims settle, and the reserve estimates on open claims are modified as additional information becomes available. This necessitates a continuous re-evaluation of the adequacy of reserves. If reserves fall below a level considered adequate to pay future claims, the company is under-reserved. Money is then transferred from surplus into reserves, and premiums may have to be raised in order to rebuild surplus. On the other hand, if a mutual or reciprocal company becomes over-reserved, the "excess" dollars are transferred to surplus and taxed. If the surplus is more than adequate for the capital needs of the company, funds may be returned to policyholders in the form of a **dividend**. A reciprocal company may also place funds into a **Subscriber Savings Account** payable to the insured upon death, disability, or retirement.

The **reserves-to-surplus ratio** is an important measure of a company's reserve adequacy. It measures a company's financial ability to pay claims if reserves prove to be inadequate, since the additional reserves would have to come from the insurer's surplus. The target range of reserves-to-surplus is 2–3:1. Thus, it is important to grow surplus, since it is both the company's capital and the source of funds to bolster reserves if needed.

The percentage of premiums used to pay incurred losses is called the **loss ratio**. Losses include indemnity payments made to plaintiffs as a result of jury awards or settlements and the legal defense expenses associated with dismissal, defense in court, or settlement of claims (primarily defense attorney and expert witness fees).

The percentage of premiums used to run the company is called the **expense ratio**. These operating expenses include underwriting, claims administration, finance, marketing, and agent commissions.

The sum of the loss and expense ratios is called the **combined ratio**; this is the percentage of premiums used to operate all aspects of an insurance company (losses and expenses). A combined ratio (CR) of 100 percent is the breakeven point, i.e., losses and expenses equal the premium collected, and the profit equals investment income. If the CR exceeds 100 percent, there is an underwriting loss; and if it is less than 100 percent, there is a profit.

Historically, for most insurance companies, the CR exceeds 100 percent. How then do malpractice insurance companies stay in business? The answer is that they conservatively invest the premiums collected (primarily in treasury notes and investment-grade bonds), and the investment income generated is usually sufficient to offset the company's operating losses. If investment income is insufficient to compensate for losses, funds must be transferred from the company's surplus into its reserves.

5. EVALUATING A CARRIER

Focusing only on the price of coverage (premium) can be a serious mistake. Financial stability, not premium price, should be the first consideration when selecting a malpractice carrier. It is essential that the insurance carrier have sufficient financial resources to pay all current and future claims against policyholders. Consider the following factors:

- **Financial strength**—This is reflected in the rating it receives from an insurance industry analyst such as A.M. Best Company or Fitch Ratings. A company's financial rating is an assessment of its ability to pay future claims.
- **Management philosophy**—Carefully evaluate a carrier's management philosophy, which is reflected in its underwriting standards, claims management, commitment to promoting patient safety, and level of service it provides to its policyholders.
- **Underwriting standards**—Well-managed carriers are staffed by experienced underwriters who understand the risk assessment factors essential to properly evaluate a doctor's application for coverage. A financially sound carrier exercises underwriting discipline by not insuring doctors whose practice profiles or claims histories suggest a high risk for

future indefensible claims. Such claims could imperil the assets of the company and, in the case of a doctor-owned company, the security of its insured physicians.

- **Claims management**—Claims should be reviewed promptly by experienced claims specialists. Policyholders should be vigorously defended against nonmeritorious claims. In instances where there is negligence, the company should attempt to settle claims quickly and fairly with the physician’s consent. Where permitted, a guaranteed consent-to-settle provision should be included in the policy. Such a provision requires that the carrier must obtain the physician’s written consent in order to settle any claim. This gives the physician control over how claims are settled. Absent this provision, a policy may contain a “hammer” clause that pressures the physician into consenting to settle; i.e., if a jury award exceeds a settlement offered by the carrier and accepted by the plaintiff but rejected by the physician, the proposed settlement amount becomes the policy limit and the company is not obligated to pay the amount that exceeds the offered settlement.
- **Patient safety/risk management**—Patient safety programs, including loss prevention and traditional risk management assessments and interventions, should be an integral part of the services provided by a medical liability insurer. The company should conduct expert claims reviews in each specialty to uncover recurrent problems of medical error, system failure, and patient injury. It should also provide its policyholders with ongoing patient safety programs and information designed to enhance the safety of their medical practices, reduce the risk of patient injury, and decrease their exposure to a claim resulting from an adverse outcome.
- **Organizational structure**—It is important to learn if it is organized as a mutual company, a reciprocal company, a stock company, or a trust.

6. QUESTIONS TO ASK WHEN SELECTING A CARRIER

- What kind of carrier is it? (Is it a stock company, a mutual or reciprocal carrier, or an alternative market carrier?)
- If it's a mutual or reciprocal carrier, is there a dividend policy in place? If it's a reciprocal carrier, is a Subscriber Savings Account offered?
- How long has the carrier written medical malpractice insurance?
- Does the carrier offer policy deductibles? Does it offer discounts for physicians with favorable claims histories or to those who participate in patient safety activities?
- Is the carrier endorsed or sponsored by national specialty societies or medical associations, and does it offer program discounts for membership?
- Does the carrier have a certificate of nonassessability that protects policyholders from unlimited personal liability for losses incurred by the carrier's past claims?
- What payment plan options does the carrier offer?
- If I take family leave, disability leave, leave for military service, or a sabbatical, will the carrier charge me while I'm not practicing?
- Will I have easy access to the carrier's medical director and its policyholder services?
- Does the carrier have its own patient safety department?
- If I have a claim, will it be reviewed by a consultant in my specialty?
- Can the carrier settle a claim without my consent?
- Will the carrier cover my locum tenens and ancillary personnel?
- Does the carrier cover the assumed liability that results from physician supervision of a nurse practitioner or physician assistant functioning as an independent contractor with his or her own malpractice insurance?
- What does the policy cover beyond traditional malpractice insurance? Will it cover actions and reviews by Medicare, Medicaid, medical licensing boards, credentialing agencies, and professional review organizations?
- Will I be reimbursed for lost income if I have to go to court? What kinds of services are provided as part of my defense?
- How do the carrier's insurance industry ratings compare with those of its competitors? How sound are the carrier's reserves and surplus?
- Does the carrier actively support national medical-legal tort reform?
- If I move my practice to another state, can I carry my coverage with me?
- What are my extended reporting (tail) coverage options if I retire or decide to move to a practice covered by another carrier?
- Do physicians serve on the board of directors?

II. Medical Liability and the Neurological Surgeon

Contrary to the belief held by many, most liability problems in neurological surgery arise from elective surgical procedures, not from emergency surgery. A number of characteristics are commonly shared by patients who initiate a malpractice suit. Usually a combination of the following factors has occurred in their care and outcome:

- The patient has experienced an outcome that falls below his or her expectation. This may relate to a failure to rid the patient of a preoperative neurological deficit, or more commonly it results from the operative production of a worsened neurological status or a complication of the surgery.
- Another source of disappointment is failure to meet the patient's expectation for the relief of preoperative pain.
- The patient perceives that there has been a breakdown in the care provided by the surgeon, the hospital nursing staff, or the surgeon's office staff. Commonly the patient believes that, had a complication been recognized and dealt with earlier, the outcome would have been better.
- There is the perception (or sometimes the reality) of failure in practice continuity when the surgeon has passed responsibility to others for a weekend off call or for a vacation.
- A mismatch exists between the patient's and the surgeon's expectations.

1. LEGAL PRINCIPLES APPLIED TO THE STANDARD OF CARE

Malpractice is defined as medical care that falls below accepted medical standards and causes patient injury. Most medical malpractice actions are based on laws governing professional negligence. Thus, the cause of action is usually the alleged failure of the defendant-physician to meet the standard of care and to exercise the reasonable degree of skill, learning, and care ordinarily possessed by other doctors in the same medical specialty in the community. Whereas in the past the term *community* meant the local community, it is now presumed that all doctors keep up with the latest developments in their field, and *community* is now generally interpreted as the "specialty community." Thus, the standards are now those of the specialty without regard to geographic location. In practical terms, what this means is that if you are practicing in a small community, you can be held to the "standard of care" of a university medical center.

2. INFORMED CONSENT

Simply stated, *informed consent* means that adult patients who are capable of rational communication must be provided with sufficient information about the risks, benefits, and alternatives associated with a proposed treatment or procedure in order to make a decision and expressly give permission. In most states, physicians have an affirmative duty to disclose such information. This means that you must not wait for questions from your patients; you must volunteer the information. However, questions should be encouraged.

The Value of Informed Consent in Managing Patient Expectations

The informed consent for a treatment or procedure is not just a signed document; it is a process of managing the patient's expectations. Patients who are informed about the purpose, benefits, risks, alternatives, and expected outcome are less apt to have unrealistic expectations. The informed-consent discussion implicitly shifts the responsibility for decision making from the physician alone to a mutual responsibility of both the physician and patient that strengthens the physician-patient relationship.

When properly conducted, the process of obtaining informed consent can help establish a therapeutic alliance and launch or reinforce a positive doctor-patient relationship. If an unfavorable outcome occurs, that relationship can be crucial to maintaining patient trust. By focusing on how you say something as well as on what you say, you can transform a preoperative routine into an effective claims prevention mechanism.

To allay anxiety, you may seek to reassure your patients. In doing so, however, be wary of creating unwarranted expectations or implying a guarantee. Consider the different implications of these two statements:

1. "Don't worry about a thing. I've taken care of hundreds of cases like yours. You'll do just fine."
2. "Barring any unforeseen problems, I see no reason why you shouldn't do very well. I'll certainly do everything I can to help you."

The therapeutic objective of informed consent should be to replace some of the patient's anxiety with a sense of control resulting from the patient's participation in the decision making process. This strengthens the alliance between you and the patient. Instead of seeing each other as potential adversaries in the event of an unfavorable outcome, you are drawn closer by sharing acceptance of the uncertainty inherent in clinical practice.

Effective Informed-Consent Documents

While informed consent will not absolve you from responsibility if there is negligence, a well-drafted informed-consent document is proof that you tried to give the patient sufficient information to make an intelligent decision. This document, supported by a handwritten note in the patient's medical record, is often the key to a successful malpractice defense when the issue of consent to treatment arises.

The documentation (dictated or handwritten) usually does not need to be a laundry list of every possible complication. There is always the risk that in a long list the very complication that occurred is not listed. It is also important to discuss some of the risks that are specific to the proposed operation, such as the occasional swallowing difficulty and/or hoarseness that may follow an anterior cervical discectomy, for example. Remember to always follow your state's statutory requirements governing informed consent; some states, such as Texas, require a laundry list of risks to be disclosed for certain procedures. Documenting the informed consent in the preoperative consultation and then repeating the documentation in the preamble of the dictated operative note is a good practice.

Written and audiovisual materials for the patient to take home are a useful supplement to the informed-consent discussion. These are helpful because many patients cannot remember or explain to their family what they were told by their doctor.

If the patient is unable to communicate rationally, as in many emergency cases, there is a legally implied consent to treat. The implied consent in an emergency is assumed only for the duration of that emergency. However, if at all possible, it is safer to obtain the consent of the patient's closest relative.

The treatment of minors carries the responsibility of obtaining consent from the parents or legal guardians. An exception in most states is the “emancipated” minor (those who are pregnant, married, serving in the military, or legally free and financially independent). However, in an emergency, you must not delay in treating a minor or an incompetent person if such a delay might adversely affect the outcome of the case. In such circumstances, anything less than prompt attention and treatment will increase your exposure to liability.

Informed Refusal

Doctors must also warn patients of the consequences of failing to heed medical advice by refusing treatment or diagnostic tests. It is essential to carefully document such refusals and their consequences in the medical record and to note that the patient understood those consequences. If a claim is filed and such a refusal is not written in the medical record, it never happened!

Additional risk management and patient safety resources, including informed-consent forms, general and specialty-specific articles, and alerts, are available on The Doctors Company's patient safety Web site at www.thedoctors.com/patientsafety.

3. PATIENT SELECTION CRITERIA

Contemporary neurological surgeons practicing in the United States will find it virtually impossible to end a 30- to 40-year career unblemished by a claim of malpractice.

However, many of these claims are preventable. Most claims are based in part on a failure to communicate or on patient selection—not on technical faults. Patient selection is the ultimate inexact science. It is a mixture of surgical judgment, gut feelings, personality interactions, the strength of the surgeon's ego, and, regrettably, economic considerations. Regardless of technical ability, a surgeon who appears cold, arrogant, or insensitive is far more likely to be sued than a surgeon who relates at a “human” level. Obviously, a person who is warm, sensitive, and naturally caring, with a well-developed sense of humor and a cordial attitude, is less likely to be the target of a malpractice claim. The ability to communicate clearly is probably the most outstanding characteristic of the claims-free surgeon. It is the *sine qua non* of building a good doctor-patient relationship.

Patient Characteristics in Trouble-Prone Relationships:

- They harbor great or unrealistic expectations.
- They have an excessively demanding character (indicates a failure to grasp limitations).
- They have a disapproving family (the doorway to litigation).
- They are “surgiholics” (may indicate the patient has significant psychological problems).
- They make you feel uncomfortable, you don’t like them, or they don’t like you (fertile ground for disputes).

Generally speaking, there is a clear risk-to-benefit ratio to every surgical procedure. If the risk-to-benefit ratio is favorable, the surgery should probably be encouraged and has a high degree of probability of success. If the risk-to-benefit ratio is unfavorable, the reverse not only applies, but the unintended consequences of the unfavorable outcome may also turn out to be disproportionate to the surgical result. The only way to avoid this debacle is to learn how to distinguish those patients whose personality characteristics make them unsuitable for the surgery that they seek.

4. THE PSYCHOLOGICAL ASPECTS OF TREATING PAIN

Frequently patients come to the neurosurgeon with a disabling pain complaint, an absence of or minimal signs on examination, and abnormal imaging studies at one or multiple vertebral levels. Treatment of these patients is very rewarding when the results are good. Unfortunately, when the results are below the patients’ expectations, there is much disappointment and an increased risk of suit.

In treating pain it is particularly important for the surgeon to exercise care in assessing the psychological makeup, goals, and expectations of the patient. A careful and fully documented informed consent is most important in this group of patients.

With some patients the likelihood of success is quite high. With others it will not be possible for the surgeon to assess the likelihood of success, and some will come to surgery fully informed but with unrealistically high hopes of achieving success. In this latter group, documentation that the surgical procedure is a “therapeutic trial with no assurance of success” is of value. Probably there is no place in neurosurgery where establishing good patient rapport prior to and after intervention has such value in the prevention of suits.

5. ANGER

Patients feel both anxious and bewildered when elective surgery does not go smoothly. The borderline between anxiety and anger is tenuous, and the conversion factor is uncertainty—fear of the unknown. A patient who is frightened by a postoperative complication or who is uncertain about the future may surmise: “If it is the doctor’s fault, then it is the doctor’s responsibility to correct it.”

The patient’s perceptions may clash with the physician’s anxieties, insecurities, and wounded pride. The patient blames the physician, who in turn becomes defensive. At this delicate

juncture, the physician's response can either set in motion or prevent a natural chain reaction. The physician must put aside feelings of disappointment, anxiety, defensiveness, and hostility in order to understand that he or she is probably dealing with a frightened patient who is using anger to gain control of the situation. The patient's perception that the physician understands this uncertainty and will join with him or her to help to overcome it may be the deciding factor in preserving the therapeutic relationship and forestalling a visit to an attorney.

6. THE CHOICE OF THE SURGICAL PROCEDURE

Over the past decade, there has been an explosion of technical advances that have broadened the choices available to the neurosurgeon in surgical therapy. This is particularly true in the field of spinal surgery and spinal instrumentation. In many cases the surgeon is not guided by well-documented evidence-based literature comparing the various choices. The variability of choices leads to more limited experience with each of the new procedures.

The factors noted above—combined with the fact that many of the procedures are applied to the patients with predominantly pain presentations—give rise to a perfect storm. There is a greater chance in this clinical setting to have a result that is below the patient's expectation as well as to have a technical complication, such as a misadventure with hardware. This combination is prone to give rise to a malpractice suit.

Simplicity: As a general rule, choosing the simplest solution to the patient's problem has the best chance of success and, importantly, the least chance of misadventure. The surgeon becomes experienced and adept at those procedures that are most commonly applicable.

CONCLUSION

Certification by The American Board of Neurological Surgery reassures your insurance carrier that you are committed to attaining the highest professional standards. This is a good start. With close attention to detail and continuing efforts, it is possible for a neurosurgeon to minimize the unpleasant prospect of a medical malpractice claim during his or her career. To reduce the likelihood of a claim, apply these simple principles: maintain good communication and rapport with the patient through good times and bad; restrict your practice to those procedures that you feel thoroughly comfortable performing; and document your activities with close and careful attention.

