The 3rd National DNP Conference

Leadership in Practice:

Handling of Adverse Events & The Prevention of Litigation

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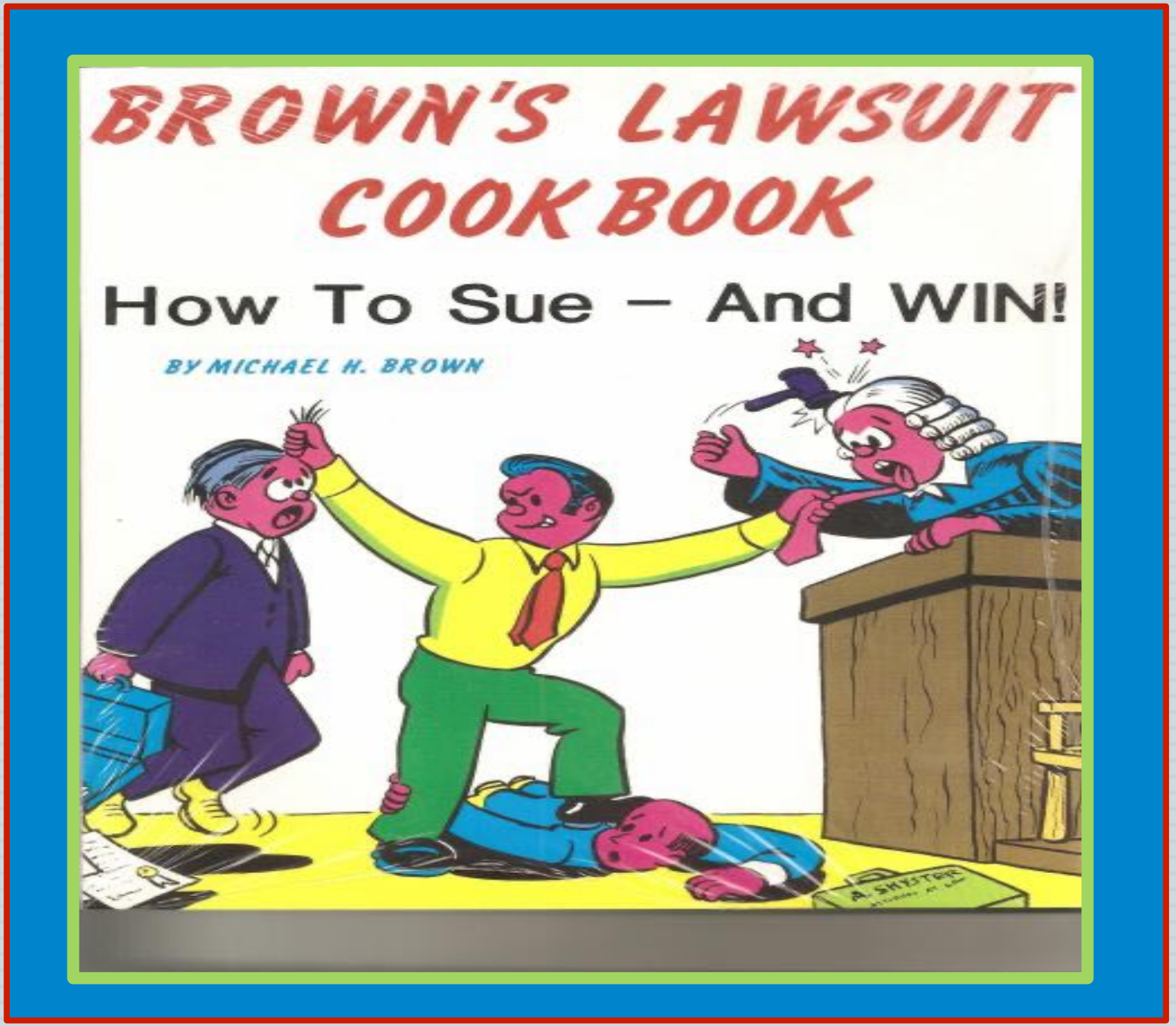

BROWN'S LAWSUIT COOKBOOK
How To Sue – And WIN!
BY MICHAEL H. BROWN
A. SHYSTER

Objectives

By the end of this presentation the participants will be able to:

- Name two factors that may increase one's risk for being named in a lawsuit.
- Identify two rationales for the traditional "deny and defend" approach to the handling of unexpected adverse events.
- Name two outcomes associated with the "disclosure and apology" approach to the handing of unexpected adverse events.

To Err is Human

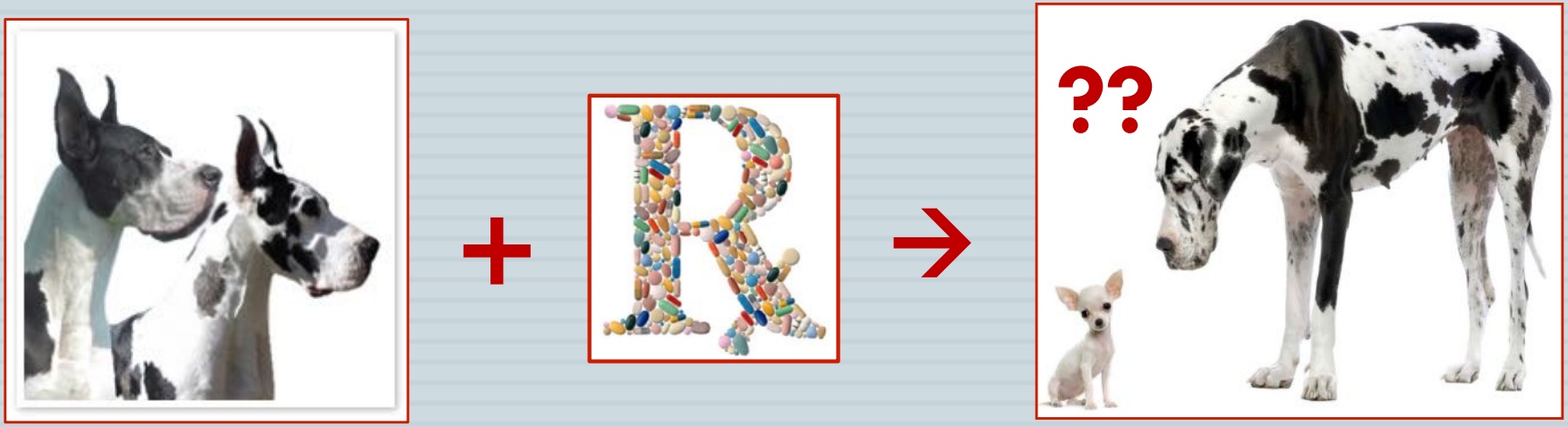
- **Preventable medical errors (IOM,2000)**
  - $17 billion to $29 billion per year
  - 98,000 hospitalized patient deaths per year
    - MVA (43,458), breast cancer (42,297), AIDS (16,516)
- **Cost of medical errors 19.5 billion in 2008**
- **Frequency of malpractice judgments/settlements**

	2004	2008
NPs	68	140
MDs	597	6872
PAs	149	126

Adverse Event

Definition:

- Harm, injury or complication that was caused by medical management rather than the patient's underlying disease
- When things go wrong
- It may or may not be the result of an error



Adverse Event

Do the Right Thing!

Defendant:
Provider's Perspectives

Plaintiff:
Patient/Family's Perspectives

Ethics?
Values?
Norm?

Questions?

Emotions?

Reactions?

Competence
Charting
Caring
Communication
Committing to prevention of medical errors

Adverse Event

JW was 36 y.o. school teacher with a master's degree, earning $68,000/yr & benefits, married, mom of 2 kids (ages 6 & 8).

- **8/03** annual PE: No problem
- **11/03** noted lump in R. breast:
  - Lesion not worrisome/SBE q month for changing-asymmetric lesions
  - Begin mammogram at age 40
- **8/04** annual PE:
  - Pt: "no problem whatsoever"
  - MD: charted normal exam
  - MD: No mention of previous lump
- **7/05** c/o tender R. breast lump
  - MD palpated nodule
  - Mammogram/ultrasound/FNA
  - Dx: invasive ductal CA w/ metastasis
- **4 months** of chemo before lumpectomy
  - Positive surgical margins and 2/35 lymph nodes
  - Complete mastectomy
- **2/06** post-mastectomy radiation
- **2/06** received a claim letter from JW's attorney: failure to diagnose breast cancer in 8/03, 11/03, 8/04
- **6/06** JW described as disabled due to chronic fatigue syndrome, depressed, chronic shoulder pain, anxiety over fear of recurrence

Provider's Perspective
Deny & Defend

Fear/Concern/Anxiety:

- Confronting angry people
- Invite a claim/lawsuit
- Compromise courtroom defense
- Lead to lost of malpractice insurance or higher premiums
- Financial ruin

Provider's Perspective
Deny & Defend

"We can't say 'I'm sorry' because we're just going to get sued...essentially, we've been told not to say anything. You're not mean to people, but you don't come out and say, 'I'm sorry this happened.' It's a crime that you can't just be honest with people."

Dr. Steven Malkin

President of the Illinois State Medical Society

Deny & Defend

- Expensive:
  - 54% went to administration cost (lawyers, experts, & courts)
  - 37% claims did not involve errors , accounts for 13-16% of the total costs
- Detrimental to:
  - Trust
  - Communication
  - Caring & Compassion
  - Committing to prevention of errors
  - Patient safety

Boothman et al (2009).

Patients' Perspective

Drivers of Lawsuits

- Caregivers' reluctance to disclose
- Worry same mistakes could be made for others
- Need for an advocate
- Anger

Factors Avert a Lawsuit

- Need to understand:
  - 37% respondents says an explanation & apology would have made a difference
- Need to protect others
- Negligent system & caregivers are accountable

Vincent et al (1994)
Hickson et al (1992)

Factors Associated with Increased Risk for Litigation

"The most important factor in people's decision to file lawsuit is ***not negligence****, but* ***ineffective communication*** *between patients and providers. Malpractice suits often result when an unexpected adverse outcome is met with a* ***lack of empathy*** *from physicians and a* ***perceived or actual withholding of essential information****"*

Clinton, H.R., Obama, B. (2006). Making patient safety the centerpiece of medical liability reform. The New England Journal of Medicine, 354(21):2205-2208.

Responding to Adverse Events

Dealing with medical errors:

- Tell the patient and family what happened
- Take responsibility
- Apologize at once
- Explain what will be done differently in the future

Guiding principles:

- Medical care must be safe
- Must be patient centered

When Things go Wrong, Responding to Adverse Events: A Consensus Statement of the Harvard Hospitals. 3/2006 (16 hospitals)

Responding to Adverse Events

SORRYWORKS! Coalition http://www.sorryworks.net/threestep.phtml

- **Step 1: Initial Disclosure**
  - Say "sorry" without assigning or admitting fault
  - Empathy, re-establish trust & communication
  - Care of the immediate needs
  - Promise swift & thorough investigation

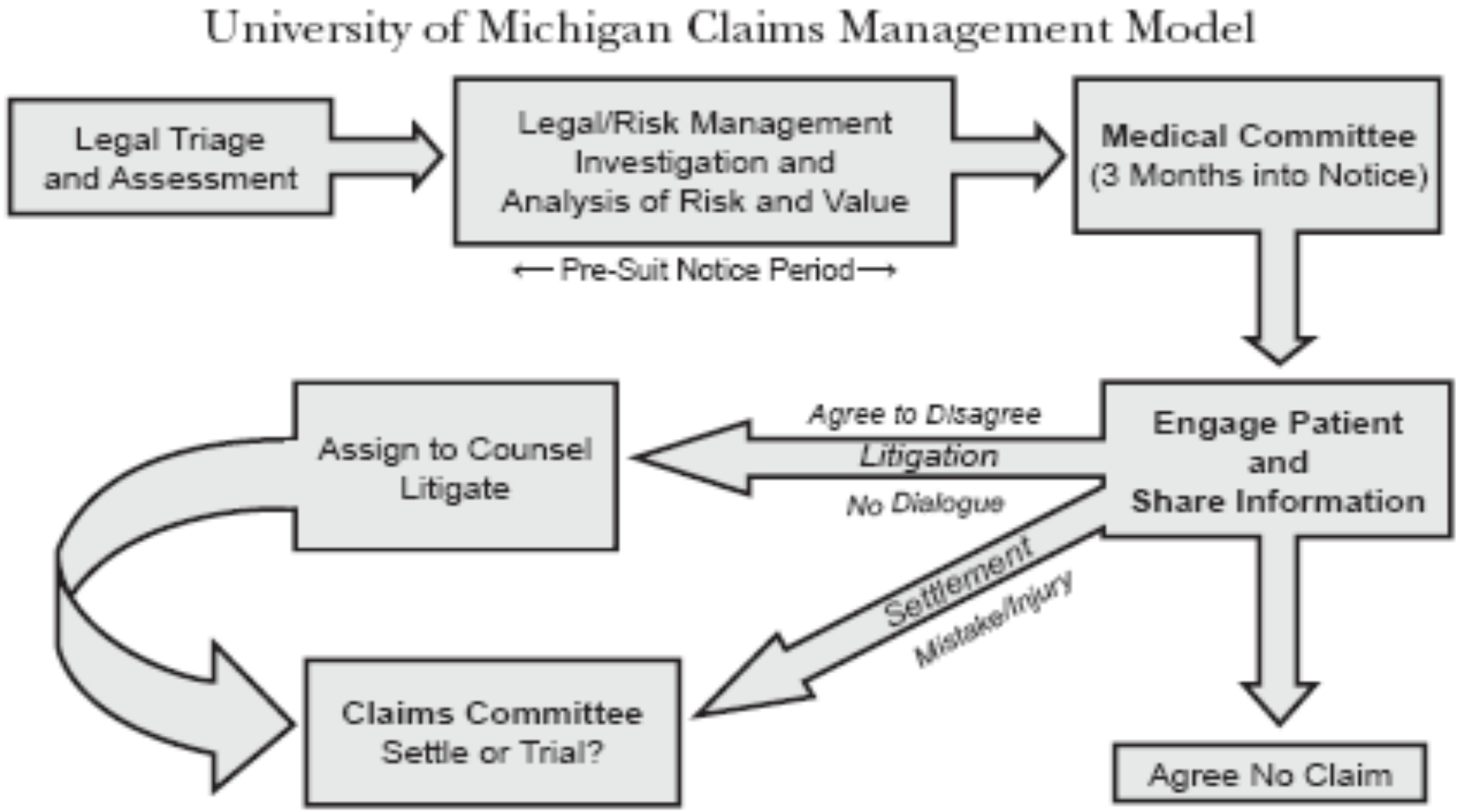
- **Step 2: Investigation**
  - Learning the truth
  - Breach of duty → damage
- **Step 3: Resolution**
  - Sharing result of investigation
  - If mistake → apologize, explain what happened, how will be prevented, & discuss a fair compensation
  - If no mistake → no settlement will be offered and lawsuit will be contested

Responding to Adverse Events

Support for Providers

- Provide empathy and suggest self-care
- Educate regarding the "do's" and "don'ts" of the disclosure process
  - Recommend wording for disclosure process
  - Educate and prepare for patient/family responses
- Identify most appropriate person to disclose information

Responding to Adverse Events



Boothman, R. C. et al. (2009). A better approach to medical Malpractice claims? Journal of the Health & Life Sciences Law. http://www.med.umich.edu/news/newsroom/Boothman%20et%20al.pdf

University of Michigan Health System
Claims Management

- Pt/Fm are approached, acknowledged, & engaged in the acute phase
- Pt care needs are prioritized
- Pt/Fm receive answers, what is known
- Expectations for FU are established
- Investigation
- Receive thorough explanation, acknowledgement and apologize for true mistake
- Pt experience studied for improvement and share w/ Fm
- Future clinical care is monitored via metrics established and measured to evaluate efficacy and durability of improvements

Handling of Adverse Events
University of Michigan Health System

Cost Savings:
$3 vs. $1 million

Claims 1999 to 2006:
136 vs. 61

Safer & Better care:
Learn from mistakes
Reinvest cost savings

Avg. Litigation Cost:
$65,000 vs. $35,000

Processing time
2001-2007:
20.3 vs. 8 months

Greater MD satisfaction

Survey of plaintiff's bar in Southeastern Michigan

- 100% rated UMHS system best or among the best for transparency
- 86% agreed that transparency allowed them to make better decisions about claims they chose to pursue
- 81% said their costs were lowered
- 71% admitted when they settle, the amount is lower
- 57% admitted they declined to pursue cases

Adverse Event
JW's Case

JW was 36 y.o. school teacher with a master's degree earning $68,000/yr & benefits. Married, mom of 2 kids, ages 6 & 8.

- **8/03** annual PE: No problem
- **11/03** noted lump in R. breast:
- **8/04** annual PE: No problem
- **7/05** w/ tender R. breast lump, dx: invasive ductal CA w/ metastasis

- Standard of care was violated
  - 3 reviews recommended FU mammography and referral to a surgeon
  - 2 others recommended short term FU in 11/03

Defendant

2/06 Exposure calculation:

- 3.1-3.7 million (lost wages/future care/ non-economic losses/cost to try)
- Negative publicity

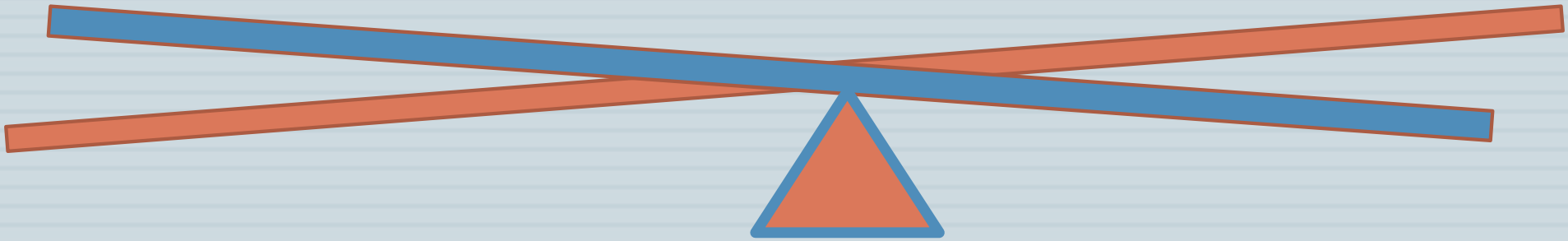
10/06 offered $400,000

Plaintiff

8/06 Plaintiff's demand:

- $ 2 million
- Plaintiff concern: kids' education

10/06 $1.2 million



12/06 Settlement:

- Apology
- $400,000
- Promise to videotape the patient for medical education purposes

Adverse Event
JW's Case

- **1-2/07** case was presented to multiple groups
- **3/07** patient & lawyer were videotaped & shared with MDs
- Total cost $402,900.
- Pt returned to teaching
- No more chronic fatigue or depression
- Enjoying her life and family
- UMHS primary care MDs educated from her case &Video
- Remained an UMHS pt

Adverse Event
JW's Case

In her video, JW said:

"After that night (of the meeting), I left there like I was on a mountaintop. I felt like I had finally been heard, they listened… If that had been the end of the legal pursuit, that would have been fine with me. I was perfectly satisfied after that night. What that apology meant to me was that they had listened finally and I had been heard. I can't even describe how euphoric I felt when I left that meeting…"

Ethics

- **Hippocratic Oath:** I will keep them (patients) from harm and injustice
- **Patients' Bill of Rights:** right to information geared toward greater autonomy over their medical care
- **Joint Commission:** mandates open, honest discussions with patients and about their treatment and outcomes

American Medical Association "Code of Medical Ethics"

"It is a fundamental ethical requirement that

a physician should at all times

deal honestly and openly with patients…

Concern regarding legal liability which might result following truthful disclosure

should not affect the physician's honesty with a patient"

2002 edition

American College of Physicians "Ethics Manual"

" …physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient's well-being. Errors do not necessarily constitute improper, negligent, or unethical behavior, but failure to disclose them may."

Fourth Edition

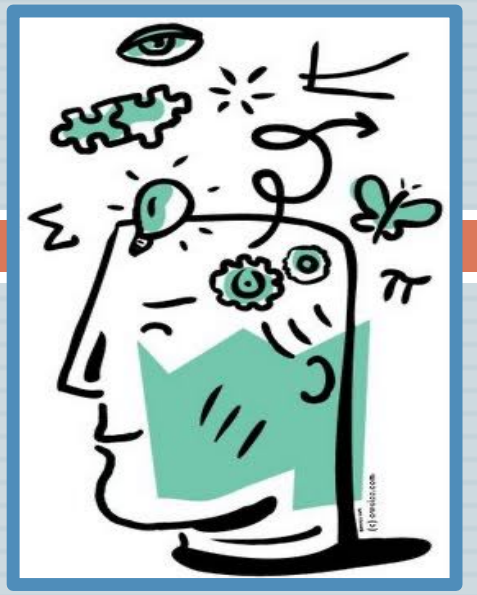
American Nurses Association "Code of Ethics"

"…when errors do occur,
nurses are expected to follow institutional guidelines
in reporting errors committed or observed
to the appropriate supervisory personnel and
for assuring responsible disclosure of errors to patients.
Under no circumstances
should the nurse participate in, or
condone through silence,
either an attempt to hide an error or a punitive response that serves only to fix blame rather than correct the conditions that led to the error."

Disclosure Policy

- Advocate Lutheran General Hospital
- Catholic Healthcare West
- Children's Hospitals and Clinics, Minneapolis-St Paul, Minnesota
- COPIC Insurance
- Harvard Hospital System
- Johns Hopkins Hospital
- Kaiser hospitals
- Rush University Medical Center
- Stanford University Teaching Hospital
- University of Illinois Medical Center in Chicago
- University of Michigan Hospital System
- Veterans Affairs Hospitals

Handling Adverse Events Prevent Litigation



A systems-oriented approach

- Improving patient safety
- Identifying the causes of medical errors
- Implementing strategies for prevention
- Inviting openness, trust, a spirit of cooperation rather than an adversarial relationship

Handling Adverse Events Prevent Litigation

- Goals for improve patient safety & liability climate
  - Reduce preventable patient injuries
  - Promote open communication between providers and patients
  - Ensure patients' access to fair compensation
  - Reduce liability insurance premiums for providers

Clinton, H.R., Obama, B. (2006). Making patient safety the centerpiece of medical liability reform. The New England Journal of Medicine, 354(21):2205-2208.

- Business Week's cover story Nov. 23, 2009
  - Named disclosure as a top 10 idea for reforming healthcare

Handling of Adverse Events Prevent Litigation

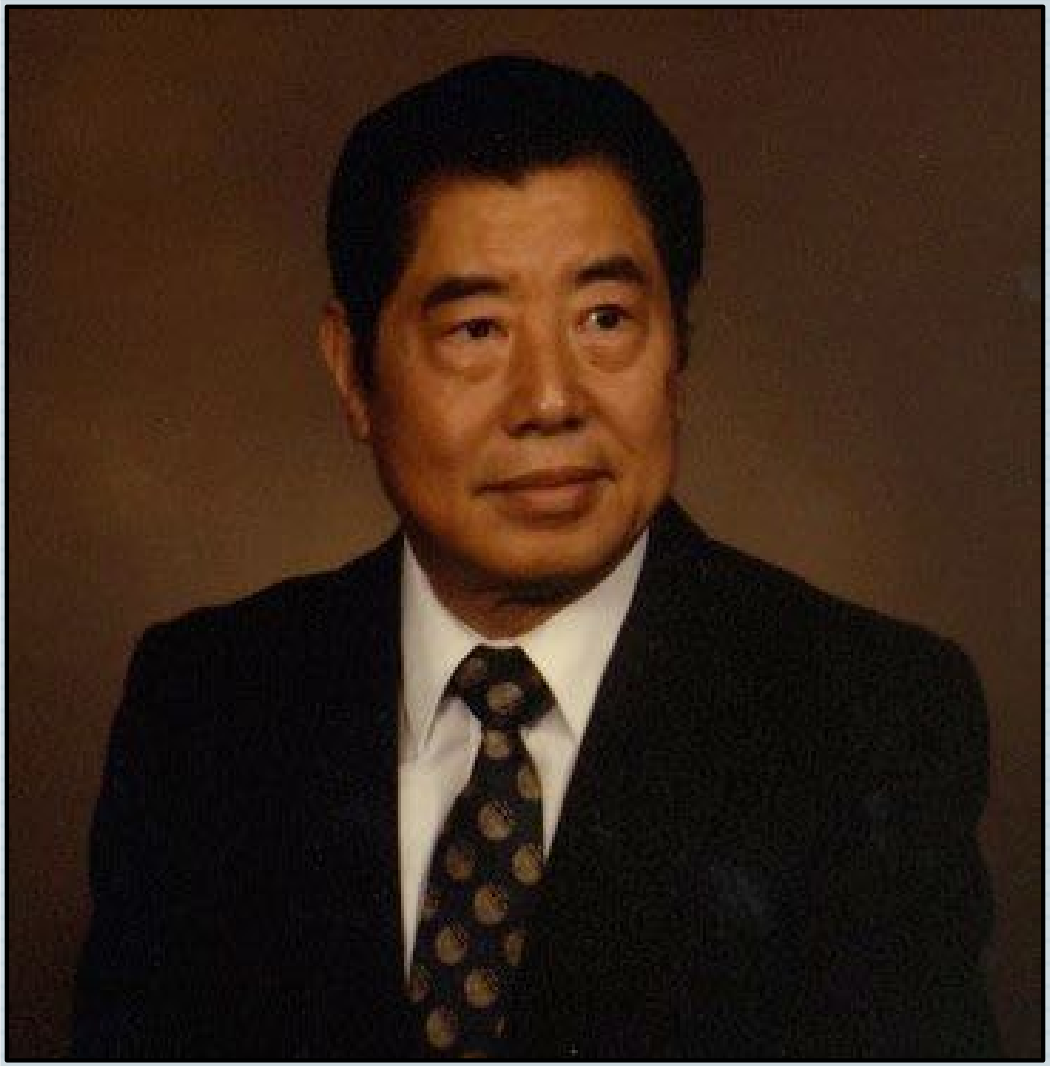
Summary

- ⬆ risk for lawsuit
  - Anger
  - Ineffective communication
  - Withholding of information
  - Lack of empathy
  - Lack of accountability
- 5 C's to prevent lawsuit
  - Competence
  - Charting
  - Caring & Compassion
  - Communicating
  - Committing to prevent Medical Errors

Deny & Defend **vs.** **Disclosure & Apology**

Dedication

Dr. Wu



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