Medical Malpractice Legal Problems !!!

Aaron G Hill CCP
Sentara Careplex Hampton Va
VCU Medical Center Richmond, Va
I thought we were going to play doctor.

We are playing doctor! I'm a lawyer and I'm suing you for malpractice.
Estimated Deaths Due to Medical Error

Accidental Deaths in the U.S.

An estimated one million people are injured by errors during hospital treatment each year and 120,000 people die as a result of those injuries, according to a study led by Lucian Leape of the Harvard School of Public Health. Here’s how that number compares with other causes of accidental death in the United States*.

*SOURCE (for accidental deaths shown in blue): National Safety Council. Data are for 1996.
KEVIN BURKETT / Inquirer Staff Artist

- 43,649 motor vehicle deaths
- 14,986 deaths from falls
- 3,959 drowning deaths
- 329 commercial aviation deaths

Source – The Philadelphia Inquirer
How Hazardous Is Health Care?

(Modeled from Leape)

Dangerous
 (>1/1000)

Regulated
 (<1/100K)

Ultra-Safe

HealthCare

Bungee Jumping

Mountain Climbing

Driving

Chemical Manufacturing

Chartered Flights

Scheduled Airlines

European Railroads

Nuclear Power

Numbers of encounter for each fatality

Total lives lost per year
Medical Errors, Negligence, and Litigation

I. Medical Errors
II. Relationship of Medical Errors to Negligence
III. Why do People Sue?
IV. Potential Solutions to the Problem of Medical Errors
Decisions Made

**Legal-justice system:**

- Guilty --or-- Not Guilty
- Liable --or-- Not Liable

**Medicine/science:**

- Research hypothesis --or-- Null hypothesis
- True True
## Standards of Proof

<table>
<thead>
<tr>
<th>Kind</th>
<th>Level of Evidence</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory</td>
<td></td>
<td>Precautionary Principle</td>
</tr>
<tr>
<td>Legal--Civil</td>
<td>★</td>
<td>More likely than not</td>
</tr>
<tr>
<td>Legal--Civil</td>
<td>★★</td>
<td>Clear and convincing</td>
</tr>
<tr>
<td>Legal--Criminal</td>
<td>★★★</td>
<td>Beyond a reasonable doubt</td>
</tr>
<tr>
<td>Scientific</td>
<td>★★★★</td>
<td>Irrefutable</td>
</tr>
</tbody>
</table>
Definitions

• Error
  – Failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning)

• Adverse Event (AE)
  – An injury caused by medical management rather than the underlying condition of the patient

• Preventable Adverse Event
  – An adverse event attributable to an error

Source – IOM, 2000
Epidemiology of Medical Errors

- California Medical Insurance Feasibility Study (1974)
  - 20,864 hospital admissions
  - 4.65 injuries per 100 hospitalizations

- Harvard Medical Practice Study (1984)
  - 30,121 hospital admissions in NY state
  - Reported adverse events (AE’s)
  - 3.7% of admissions had an AE
Patient Safety: Scope of Problem

- **Human Costs:**
  - Estimated as many as 44,000 to 98,000 deaths each year
  - More than motor vehicle accidents, breast cancer and AIDS combined annually
  - The total number of deaths that would occur if a 747 airplane crashed killing all aboard every other day for one year! **

- Source: “To Err is Human”, Institute of Medicine, 1999 *
- Source: Newhouse et.al., Measuring Patient Safety, 2005**
Patient Safety

• Financial Cost of Medical Errors: $29 billion each year in the United States alone

• Doctors, patients, insurers and hospital systems play a role in eradicating errors
Patient Safety: Scope of the Problem

• 1 out of every 5 people says that they or a family member experienced a medical mistake

• 51% reported the error as serious

• 28-35% of admissions experience an event that causes HARM (IHI, Dec 2007, Global Trigger Tool, Roger, Resar, MD)

  – Source: Commonwealth Fund 2001 Health Care Quality Survey
MEDICAL ERRORS

“If medical errors were a disease, they would be the sixth leading cause of death in America—just behind accidents and ahead of Alzheimer's”

Marty Makary, MD – Johns Hopkins General Surgeon
WSJ – September 2012
Quality in Australian Health Care Study

• Reviewed 14,179 admissions in 1995
• 16.6% of admissions had an AE’s
  – Permanent disability 13.7%
  – Death 4.9%
• 51% of events preventable

Source – Wilson, 1995
Patient Safety: CMS Actions

- Serious preventable event—object left in place during surgery
- Serious preventable event—air embolism
- Serious preventable event—blood incompatibility
- Catheter-associated urinary tract infections
- Pressure ulcers (decubitus ulcers)
- Vascular catheter–associated infection
- Surgical site infection—mediastinitis after coronary artery bypass graft surgery
- Hospital-acquired injuries – fractures, dislocations, intracranial injuries, burn
Deaths due to Medical Error

• 44,000 to 98,000 unnecessary deaths each year
  – More Americans are killed in US hospitals every 6 months than died in the entire Vietnam War
  – Death rate equivalent to three “jumbo” jet crashed every two days
What is the Evidence?

• Teamwork is a key initiative within patient safety that can transform the culture within health care
  – 27% reduction in nurse turnover (Dimeglio, 2005)
  – 31% to 4% decrease in clinical error (Morey, 2002)

• Communication & other teamwork skills are essential to prevent & mitigate medical errors and harm
  – 50% Less Adverse Outcomes (Mann 2006)
  – 50% Less Post-Op sepsis (Sexton 2006)
Believe that decisions of the “leader” should not be questioned

Sexton, BMJ, 2000
TEAM FUNCTION & SAFETY

BEST TEAM
- Least Experience Surgeon
- Cohesive Team
- Simulation
- Pre case planning
- Debriefing
- Results tracked
- Removed hierarchy

WORST TEAM
- Most experienced surgeon
- Team members changed
- No (de)briefing
- No tracking of results
- No preplanning
- Hierarchical

Bohmer, R. Harvard Bus.School
High-Performing Teams

Teams that perform well:

- Hold shared mental models
- Have clear roles and responsibilities
- Have clear, valued, and shared vision
- Optimize resources
- Have strong team leadership
- Engage in a regular discipline of feedback
- Develop a strong sense of collective trust and confidence
- Create mechanisms to cooperate and coordinate
- Manage and optimize performance outcomes

(Salas et al. 2004)
Error Management Strategies

- Mitigate
- Detect & Trap
- Anticipate and Avoid

Error Prevention

Error Containment
Views of the Public on Medical Errors

• Percentage of adults experiencing an error
  – Medication or medical error
    22%
  – Mistake at the physician’s office or hospital
    10%
  – Wrong medication or dose
    16%

Source- The Commonwealth Fund, 2001
# Views of Practicing Physicians and the Public on Medical Errors

<table>
<thead>
<tr>
<th>Response</th>
<th>Physicians (N = 831)</th>
<th>Public (N = 1207)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Respondents</td>
<td>percent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Error made in own or family member’s care</td>
<td>35</td>
<td>42</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Health consequences: (Serious)</td>
<td>18</td>
<td>24</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Respondents reporting an error</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parties who had “a lot” of responsibility for the error: (Doctors)</td>
<td>70</td>
<td>81</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Health professional told respondent an error had been made</td>
<td>31</td>
<td>30</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Possible solutions to the problem of medical errors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing lawsuits for malpractice</td>
<td>1</td>
<td>23</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hospital reports of serious medical errors should be:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidential</td>
<td>86</td>
<td>34</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Made public</td>
<td>14</td>
<td>62</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Source: Blendon, 2002
Why Do So Many Mistakes Occur?
Human Error

• Extensively studied in other industries

• Cognitive psychologists divide errors into:
  – Errors occurring in “automatic mode”
    • Slips
      – Occur during fatigue, interruptions, anxiety
  – Errors occurring in “problem solving mode”
    • Mistakes
      – Occur due to incomplete knowledge and the tendency to apply rules to simplify problem solving
Why is medicine so susceptible?

• Lack of awareness to the problem

• Fatigue System constrain “Culture of Silence”
  – Blame and shame mentality
  – Staffing problem
  – Knowledge requirements
  – Communication and continuity of care
NEGLIGENCE v MALPRACTICE

- Negligence = breach of duty
- Malpractice - did act require exercise of professional judgment?
  - i.e.- dropping patient = negligence
  - Not properly restraining patient = professional judgment

Fatal error...
The Liability Formula

- Duty (Did a physician-perfusionist relationship exist) +
- Breach of duty (Did the perfusionist fail to meet the required standard of care) +
- Causation (Did the perfusionist’s breach cause the patient’s injury) +
- Damages (Did the patient incur medical expenses, pain, suffering, lost wages as a result of the breach)

= LIABILITY
Prevention of malpractice

• Anticipate what might go wrong
  – inform patient
  – prepare for complications
  – avoid surprises

• Competence, Communication,
• Consent, Compassion, Compliance,
• Current, Calm…

• Charting / documentation is critical in high risk situations (Accurate, detailed)

• Good record keeping
Anatomy of a Lawsuit

- Complaint, Summons
- Answer within 30 days
- Discovery (possibly a Scheduling Order)
- Interrogatories/ Requests for Documents/Admissions
- Obtain medical records, interviews, meetings
- Obtain expert witness reviews
- Deposition of the parties, witnesses (can subpoena)
- Deposition of experts
- IME (independent medical examination)
- Motion for Summary Judgment
- ADR: Arbitration, Mediation, Negotiation
- Trial
What is competent expert testimony?

- CERTIFIED

- Active practice in profession or specialty for at least 3 of the last 5 years

- Have actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given.
All Errors are not Negligent

• Medical negligence
  – Failure to meet the standard of practice of an average qualified perfusionist practicing in the specialty in question

❖ Occurs not merely when there is an error, but when the degree of error exceeds the accepted norm
Proximate Causation ??

Plaintiff must prove that she suffered injuries as a result of the defendant’s negligent act or omission and injuries would not otherwise have occurred.

Proof to reasonable degree of medical certainty = *more likely than not*
Claim made

- If a medical professional is contacted about a claim, they are not to discuss it.
- They refer the potential claimant to Risk Management.
- Investigation begins.

"Give me a scotch on the rocks and an ambulance chaser please."
Depositions

- May be videotaped
- Who can be present?
- Exercise control
- Objections
- Don’t guess
- Personal Questions
- Deponents must rely on the record and policies
Before Claim

- Have a crisis management plan
- Assess the situation the way outsiders will perceive it.
- Contain the likely or perceived “damage.”
- Comply with regulatory and ethical requirements, e.g. corporate [social responsibility].
- Enhanced risk management: obvious risks will be identified, and mitigated (where possible).
- Protected and often enhanced reputation; reduced risk of post event litigation.
After a Claim is Made

• Interviews
  – Attorneys represent hospital, doctors, nurses, perfusionists, etc.
  – Communications are privileged
  – Broader than later testimony

• Written Discovery
  – Complete and truthful
  – Bound by position taken
  – Accurate

• Depositions

• Trial
Negligent Medical Injuries


All Hospitalizations

Negligent Injuries (1-2%)
Percent of Injuries due to Negligence

California Medical Insurance Feasibility Study
- 17% AE’s

Harvard Medical Practice Study
- 28% AE’s
### Rates of Adverse Events and Negligence by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Rate of Adverse Events (%)</th>
<th>Rate of Negligence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedics</td>
<td>4.1</td>
<td>22.4</td>
</tr>
<tr>
<td>Urology</td>
<td>4.9</td>
<td>19.4</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>9.9</td>
<td>35.6</td>
</tr>
<tr>
<td>Thoracic and cardiac surgery</td>
<td>10.8</td>
<td>23.0</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>16.1</td>
<td>18.0</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>1.5</td>
<td>38.3</td>
</tr>
<tr>
<td>Neonatology</td>
<td>0.6</td>
<td>25.8</td>
</tr>
<tr>
<td>General surgery</td>
<td>7.0</td>
<td>28.0</td>
</tr>
<tr>
<td>General medicine</td>
<td>3.6</td>
<td>30.9</td>
</tr>
<tr>
<td>Other</td>
<td>3.0</td>
<td>19.7</td>
</tr>
<tr>
<td>P value</td>
<td>&lt;0.0001</td>
<td>0.64</td>
</tr>
</tbody>
</table>

Source – Leape, 1991
1000

280

36

13% of Negligent Injuries Results in a Claim

All Injuries

All Negligent Injuries

Files a Claim
• 42% of public report a medical error
• 66% reported serious consequences such as severe pain, substantial loss of time at work or school, disability or even death
• Only 6% had sued
2% of Negligent Injuries Results in a Claim
“Medical-malpractice litigation infrequently compensates patients injured by medical negligence and rarely identifies, and holds providers accountable for, substandard care”

Source – Localio, 1991
“My doctor told me to exercise. It gave me more energy and I got more work done. The more work I did, the more mistakes I made. Then I got fired. That’s why I’m suing my doctor.”
Reasons Why People Sue Their Doctors

- Advised to sue by influential other: 32%
- Needed money: 24%
- Believed there was a cover-up: 24%
- Child would have no future: 23%
- Needed information: 20%
- Wanted revenge, license: 19%

Source - Hickson, 1992
Malpractice Risk

- Malpractice activity is disproportionate among physicians
- 75% - 85% of awards, settlement costs over a 5-year period made on behalf of
  - 1.8% of internists
  - 6.0% of obstetricians
  - 8.0% of surgeons

Source: Sloan, 1989, Bovbjerg, 1994
Nine Percent of Physicians Account for Fifty Percent of the Complaints

% of Complaints

% of Physicians

Source – Hickson, 2002
## Communication and Malpractice Claims

<table>
<thead>
<tr>
<th>Category of complaint, %</th>
<th>No Claims</th>
<th>High Frequency</th>
<th>P - value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician-patient communication</td>
<td>8.2</td>
<td>27.6</td>
<td>0.01</td>
</tr>
<tr>
<td>Would not talk</td>
<td>6.7</td>
<td>23.5</td>
<td>0.01</td>
</tr>
<tr>
<td>Did not listen</td>
<td>1.9</td>
<td>7.1</td>
<td>0.01</td>
</tr>
<tr>
<td>Humanity of a physician</td>
<td>4.8</td>
<td>17.4</td>
<td>0.01</td>
</tr>
<tr>
<td>Yelled</td>
<td>4.8</td>
<td>9.2</td>
<td>0.15</td>
</tr>
<tr>
<td>No concern for me as a person</td>
<td>1.4</td>
<td>8.7</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Source – Hickson, 1994
Communications

• Although you will not find POOR COMMUNICATIONS listed anywhere as an official cause of MEDICAL MALPRACTICE CLAIMS, it underlies almost every malpractice action.

• Contributing factor is 80%.
Medical Errors, Negligence, and Litigation

I. Medical Errors
II. Relationship of Medical Errors to Negligence
III. Why do People Sue their Doctors?
IV. Potential Solutions to the Problem of Medical Errors
Malpractice Litigation
Malpractice as a Barrier to Safety

- Physicians overestimate the risk of being sued
- Less likely to report errors as a result
Malpractice Reform

• Reforms include
  – No-fault
  – Enterprise liability

• No-fault system used in other countries
Increased Regulations

• Private Organization Industry
  – Leapfrog Consortium
  – National Patient Safety Foundation
  – Joint Commission on the Accreditation of Healthcare Organizations

• Federal Legislation
Other Potential Solutions

• Learn lessons from other industries
  – Aviation, Military, Nuclear Power

• Development of IT infrastructures
  – POE, Communication
  – Less reliance on memory

• Restriction on working hours
  – AAMC proposed guidelines (80 hour week)

• Greater staffing to patient ratios
  – Improved nursing jobs

• Organizational Culture
“Perfusionists need to accept the notion that error is an inevitable accompaniment of the human condition, even among conscientious professionals with high standards. Errors must be accepted as evidence of system flaws not character flaws.”

Leape, 1994
Patient Safety

“Knowing is not enough; we must apply. Willing is not enough; we must do”

Goethe
Smile we are done!