Trials, Trends and Tribulations
State of the State of Medical Malpractice
February 2015

AzSHRM

Our AGENDA Today

• Introductions
• Your Wish List?
• W.K.Y.U.A.N.?
• The Marketplace
  – Why is this important
• Trends
  – Data, Data, Data
  – Drivers, Drivers, Drivers
• Tribulations
• Risk Management Success
• Our Profession
• Futurecast
• Questions and Answers

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And the answer is...

**W.K.Y.U.A.N.**

This Keeps Me Up at Night

**What’s Next?**

- Underwriters are expected to intensify their scrutiny of cyber risks within health care organizations as a result of the massive data breach affecting Anthem Inc., but competition and capacity could limit premium increases.
- The reaction of American International Group Inc., whose Lexington Insurance Co. is the primary cyber insurer for Indianapolis-based Anthem, is expected to set the pricing tone for the insurance market, experts say.
The Perfect Malpractice Storm
But we will be ok...

The Market, Risk Financing
### Market Drivers

- Cost Effectiveness
- RM Stewardship
- Financial Performance (Parent)
- Claims Experience
- Jurisdiction (e.g. positive)
- Terms and conditions (e.g. Batch coverage)
- US
- London/Europe
- Bermuda

### Market Pressures

- Malaysia Airlines
- Weather
- Ebola
- Johns Hopkins

### Malpractice Trends, including Arizona

**Note:** Coverys flat 2014, CRICO slight increases in 2014, Captives had generally slight increases in funding based on exposures and losses in South West.

**Source:** ASHRM/AON Professional Liability Closed Claims, October 2014. Frequency is flat to slightly increasing in the majority venues, Severity increasing in all venues including South West.
US CAT Losses in 2012 Will Likely Become the 2nd or 3rd Highest in US History on An Inflation-Adjusted Basis (Pvt Insured).  2011 Losses Were the 5th Highest

REINSURANCE MARKETPLACE OVERVIEW
Medical Malpractice Combined Ratio vs. All Lines Combined Ratio, 1991-2013F

Med Mal Insurers in 2012 paid out $0.91 in loss and expense for every $1 they earned in premiums

The dramatic improvement over the past decade has restored med mal’s viability

In 2001, med mal insurers paid out $1.55 for every dollar earned

Sources: AM Best, Insurance Information Institute, E= Estimate, F= Forecast
### HOT TOPICS for PL Excess Markets 2015

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>System Performance – Overall</td>
<td>Financial performance – update and future cast</td>
<td>Overview of CM program, staffing, structure</td>
<td>Overview of RM program, staffing, structure</td>
</tr>
<tr>
<td>Strategic Plans – Growth Strategy, JVs, affiliations</td>
<td>Key performance measures – e.g. cash on hand</td>
<td>Program loss trends, large loss review, general update</td>
<td>Major initiatives in loss prevention, patient safety, quality</td>
</tr>
<tr>
<td>Staffing Recruitment, Retention, Reductions – include benchmarks within venue, region</td>
<td>Reimbursement challenges and system responses</td>
<td>Key Statistics review: CWOP, Known vs Unknown claims, trial statistics, general overview</td>
<td>Investments in risk reduction, technology: CPOE, EMR, Simulation, Robotics</td>
</tr>
<tr>
<td>Leadership Update, Physician Alignment</td>
<td>Alternative Risk Financing Vehicle</td>
<td>Review of jurisdiction, state and US</td>
<td>Training and Development Initiatives (e.g. OB)</td>
</tr>
<tr>
<td>Healthcare Reform in the US, ACO, Managed Care Network</td>
<td>Ratings, bond offerings (if any)</td>
<td>New program challenges, plaintiff “tactics”</td>
<td>Electronic reporting (web based) update (e.g. RL Solutions)</td>
</tr>
<tr>
<td>Awards, Accomplishments</td>
<td>Operations Update, new service lines</td>
<td>Regulatory update for venue</td>
<td>ERM approach to risk for system</td>
</tr>
</tbody>
</table>

Renewal Objectives: (1) Marketing approach, (2) Terms and conditions, (3) Program structure, (4) Underwriter offerings [RM, Claims services, drop down coverage] (5) Pricing
Closed Without Payment

CWOP – 2012-2013

Where Amount Case Type

**Nevada** $524,000,000 Negligent Retention Health Plan

Iowa $240,000,000 EEOC Farming

New York $190,000,000 Failure to Warn Water Products

Texas $142,000,000 Fraud Mercedes Benz

**New York** $130,000,000 Medical Malpractice Healthcare

Florida $100,000,000 Workplace Negligence Retail

Maryland $90,000,000 Vehicle, Accident Motor company

Florida $53,000,000 Products Liability Motor company

Texas $48,000,000 Breach of Contract Retail

Arkansas $47,000,000 Fraud Communications
Batch Coverage

- **Standard Batch Policy Language**
  - Any one patient
- **Enhanced Batch Policy Language**
  - Any number of patients
Market Focus: Is it appropriate to apologize? Disclosure, Apology and Offer (aka DAO)

- Harmful errors often not disclosed
- When disclosure does take place, often falls short of meeting patient or resident (family) expectations
- Little prospective evidence exits regarding what disclosure strategies are effective
- Impact of disclosure on outcomes unclear (e.g. will the family sue?)

Tribulations, Loss Prevention
A core question

Is all malpractice unexpected?
Yes, in each particular setting
No, there are trends and patterns

• (Why) are there patterns of loss?
  – Practice patterns, provider patterns, patient patterns, organization patterns

• (How) do organizations differ?
  – Claims, losses, exposures, activities, jurisdiction, clinical drivers, trends

• (How) can you reduce losses?
  – Reduce susceptibility to errors, reduce vulnerability to damage, improve situation awareness, improve mindfulness and resilience

Why Patients Sue...

• Anger and Frustration
• Lack of Transparency, “hiding something”
• Delay in providing information to patient, to family (timing)
• Silence
• Abandonment
• Finger Pointing, lack of responsibility
• Injury
• Loss of Wages, loss of consortium
• Advice from family member
• Had no choice, no offer
### Your Own Backyard…

<table>
<thead>
<tr>
<th>Report Type</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Total</th>
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<tbody>
<tr>
<td>Medical Malpractice Payment</td>
<td>239</td>
<td>235</td>
<td>221</td>
<td>221</td>
<td>225</td>
<td>2,910</td>
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<tr>
<td>Adverse Action</td>
<td>1,641</td>
<td>1,529</td>
<td>1,494</td>
<td>1,319</td>
<td>991</td>
<td>17,526</td>
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<tr>
<td>Reinstatement/Restore</td>
<td>151</td>
<td>147</td>
<td>99</td>
<td>96</td>
<td>78</td>
<td>1,453</td>
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<tr>
<td>All Reports</td>
<td>2,031</td>
<td>1,911</td>
<td>1,814</td>
<td>1,636</td>
<td>1,294</td>
<td>21,889</td>
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</table>

### Your Own Backyard, payment report by payment group

<table>
<thead>
<tr>
<th>Payment Group ( $ Thousands )</th>
<th>Payment Year</th>
<th>All</th>
<th>$0-$49</th>
<th>$50-$99</th>
<th>$100-$249</th>
<th>$250-$499</th>
<th>$500-$999</th>
<th>$1,000-$1,999</th>
<th>$2,000+</th>
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<td></td>
<td>2003</td>
<td>371</td>
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<td></td>
<td>2004</td>
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<td>54</td>
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<td>53</td>
<td>34</td>
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<td></td>
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<td></td>
<td>2006</td>
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<td>31</td>
<td>16</td>
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<tr>
<td></td>
<td>2007</td>
<td>282</td>
<td>52</td>
<td>36</td>
<td>67</td>
<td>62</td>
<td>45</td>
<td>18</td>
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<tr>
<td></td>
<td>2008</td>
<td>226</td>
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<td>59</td>
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<td></td>
<td>2009</td>
<td>239</td>
<td>66</td>
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<tr>
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<td></td>
<td>2011</td>
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<td>221</td>
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<td>34</td>
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<td>3</td>
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<td></td>
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<td>48</td>
<td>56</td>
<td>34</td>
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<td>0</td>
</tr>
<tr>
<td>Total</td>
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<td>694</td>
<td>393</td>
<td>661</td>
<td>588</td>
<td>390</td>
<td>168</td>
<td>16</td>
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</table>
## Your Own Backyard, Total payments in payment group

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>All</th>
<th>$0-$49</th>
<th>$50-$99</th>
<th>$100-$249</th>
<th>$250-$499</th>
<th>$500-$999</th>
<th>$1,000-$1,999</th>
<th>$2,000+</th>
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<td>91.40</td>
<td>1.97</td>
<td>4.01</td>
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<td>22.93</td>
<td>28.61</td>
<td>14.31</td>
<td>4.50</td>
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<td>2004</td>
<td>73.65</td>
<td>0.95</td>
<td>2.81</td>
<td>11.62</td>
<td>17.96</td>
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<td>18.13</td>
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<tr>
<td>2005</td>
<td>89.63</td>
<td>1.66</td>
<td>3.58</td>
<td>11.06</td>
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<td>25.74</td>
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<td>2006</td>
<td>77.96</td>
<td>1.69</td>
<td>3.42</td>
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<td>21.23</td>
<td>18.79</td>
<td>2.40</td>
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<tr>
<td>2007</td>
<td>88.34</td>
<td>1.04</td>
<td>2.43</td>
<td>11.32</td>
<td>19.88</td>
<td>20.92</td>
<td>19.81</td>
<td>4.57</td>
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<td>2008</td>
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<td>1.70</td>
<td>7.97</td>
<td>17.41</td>
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<td>20.67</td>
<td>0</td>
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<td>2009</td>
<td>69.97</td>
<td>1.20</td>
<td>2.22</td>
<td>7.44</td>
<td>14.65</td>
<td>23.53</td>
<td>18.93</td>
<td>2.00</td>
</tr>
<tr>
<td>2010</td>
<td>60.35</td>
<td>1.02</td>
<td>2.56</td>
<td>7.65</td>
<td>17.68</td>
<td>17.98</td>
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<tr>
<td>2011</td>
<td>80.65</td>
<td>1.05</td>
<td>1.74</td>
<td>6.65</td>
<td>16.84</td>
<td>21.01</td>
<td>15.11</td>
<td>17.66</td>
</tr>
<tr>
<td>2012</td>
<td>69.08</td>
<td>1.27</td>
<td>1.68</td>
<td>9.39</td>
<td>14.62</td>
<td>23.52</td>
<td>15.39</td>
<td>6.26</td>
</tr>
<tr>
<td>2013</td>
<td>68.61</td>
<td>0.98</td>
<td>1.86</td>
<td>7.52</td>
<td>20.13</td>
<td>23.74</td>
<td>14.97</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>842.69</td>
<td>13.69</td>
<td>27.21</td>
<td>106.05</td>
<td>201.13</td>
<td>263.14</td>
<td>189.64</td>
<td>42.42</td>
</tr>
</tbody>
</table>

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**Just the Facts...**

- **Fact:** According to the Journal of the American Medical Association (JAMA), medical negligence is the **third leading cause of death in the U.S.**—right behind heart disease and cancer.

- **In 2013,** over $3 billion was spent in medical malpractice payouts, averaging one payout every 43 minutes.

- **Alarming, right?**
Understanding Risk – clinical system dynamics

Clinical Practices

- Patient
- Provider(s)

Outcomes
- Injuries
- Allegations
- Severity

Care episodes in different departments

Understanding Risk – improvements

Clinical Practices

- Patient
- Provider(s)

Patient Experience
- Communication (expect)
- Partnership (respect)
- Follow-up & coordination
- Information

Well-being

Care episodes
- Point of care information
- Point of care tools
- Qualified personnel
- Communication

Outcome

Operational infrastructures
- Leadership and teamwork
- Training and education
- Standards and procedures
- Tools and documentation

Systems infrastructure
- Organization and staffing
- Policies
- Resources
- Systems and coordination

Productivity

Care episodes in different departments

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Understanding Risk – manage the unexpected

Patient → Clinical Practices

Provider(s) →

Prevent

Reduce errors
• learn from mistakes
• mindful of error
• aware of situation

Respond

Manage unexpected
• early detection
• situation awareness
• practiced response

Control

Contain loss
• investigation
• evaluation
• resolution

Injuries
• allegations
• severity
### OB Case Example: Lessons Learned

#### Questions to Ask

<table>
<thead>
<tr>
<th>Questions to Ask</th>
<th>Recommendations</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is there a teamwork issue in the OR?</td>
<td>• Drive out fear</td>
<td>• Standardized shift reports</td>
</tr>
<tr>
<td>• Are there staffing issues in L&amp;D? How is morale?</td>
<td>• Improve access to information</td>
<td>• Teamwork training</td>
</tr>
<tr>
<td>• Are interpreters available when needed?</td>
<td>• Improve direct communications</td>
<td>• Clarification of policies</td>
</tr>
<tr>
<td>• Are there checklists for class II airways?</td>
<td>• Increase immediate feedback</td>
<td>• Improved availability of code teams</td>
</tr>
<tr>
<td>• Is stress common?</td>
<td>• Obtain leadership commitment</td>
<td>• Redesign of waiting areas to make patients visible to staff</td>
</tr>
<tr>
<td>• How can scheduling be improved?</td>
<td>• Optimize the work environment for safety</td>
<td>• Redesign of workflow for high-activity periods</td>
</tr>
<tr>
<td>• Are nurses able to speak frankly with physicians?</td>
<td>• Reduce handoffs, or manage</td>
<td>• Checklists for triage nurses</td>
</tr>
<tr>
<td>• Are staff trained with the technology?</td>
<td>• Reduce multiple entry</td>
<td></td>
</tr>
<tr>
<td>• Are staff trained to deal with family?</td>
<td>• Reduce reliance on memory</td>
<td></td>
</tr>
<tr>
<td>• Are handoffs standardized?</td>
<td>• Reduce reliance on vigilance</td>
<td></td>
</tr>
</tbody>
</table>

#### Getting started on improvements

**Leverage experiences from surprises to find vulnerabilities**

- Gather information on organization, processes, activities, exposures and culture
- Acquire data on unexpected occurrences, on malpractice claims, on patient experiences
- Analyze for patterns and trends, against a model for risk and in comparison with other organizations
- Drill into areas of opportunity
- Engage clinicians in improvement
- Address systems issues
- Focus on the patient experience
Some lessons can’t be taught. They simply have to be learned.

~ Jodi Picoult

G U O T E D I A R Y . R E
**Facts and Figures, the CRICO Study 2013**

**Performance of Medical Procedures**

1,497 medical procedure cases
$215M total incurred losses

57% management of medical care and conditions
43% performance of medical procedures

50% of procedural errors are associated with academic medical centers...
...and 43% with community hospitals.

**Where do they Occur?**

71% of procedure cases involve patients in ambulatory settings.

The prevalence of cases by location differs based on academic medical center or community status.

<table>
<thead>
<tr>
<th>Location</th>
<th>M.D. Office/Clinic</th>
<th>Special Proc. Area</th>
<th>Emergency</th>
<th>Radiology/Imaging</th>
<th>Amb. Surg</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Medical Centers</td>
<td>15%</td>
<td>15%</td>
<td>12%</td>
<td>12%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>Community Hospitals</td>
<td>15%</td>
<td>10%</td>
<td>35%</td>
<td>20%</td>
<td>5%</td>
<td>12%</td>
</tr>
</tbody>
</table>
WHAT IS THE OUTCOME?

**Injury Severity:**
- 9% low
- 68% medium
- 23% high
  - including death

---

**Which Procedures Are Most Prevalent?**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>% Cases</th>
<th>AVG Total Incurred</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scopes</td>
<td>24%</td>
<td>$108 K</td>
<td>colonoscopy, cystoscopy, bronchoscopy, etc.</td>
</tr>
<tr>
<td>Injections</td>
<td>20%</td>
<td>$184 K</td>
<td>anesthesia, medications, chemotherapy, etc.</td>
</tr>
<tr>
<td>Punctures</td>
<td>19%</td>
<td>$175 K</td>
<td>venipuncture, spinal tap, thoracentesis, etc.</td>
</tr>
<tr>
<td>Biopsies</td>
<td>16%</td>
<td>$91 K</td>
<td>aspiration, excision, etc.</td>
</tr>
<tr>
<td>Tubes</td>
<td>13%</td>
<td>$214 K</td>
<td>ETT, CT, NG, PEG, urinary catheter, etc.</td>
</tr>
<tr>
<td>Imaging</td>
<td>7%</td>
<td>$33 K</td>
<td>diagnostic (CT, MRI, etc.) and interventional</td>
</tr>
</tbody>
</table>

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### Technical Skill

**Skill-Related Errors vs. Rule-Related Errors**

- **Skill-Related Errors:** 88%
- **Rule-Related Errors:** 21%

**Case Study...**

A 13-month-old male recently discharged from a year-long NICU admission was brought to the ED with a Marlowe-G tube. A surgical resident was called upon to perform the procedure under telephonic guidance from the patient’s pediatrician. When the resident arrived, the patient had been without nutrition for 18 hours. The resident, who had not previously inserted a G-tube in such a young patient, completed the procedure with some difficulty. Although his \( \text{O}_2 \) saturation dropped momentarily, the child maintained his vital signs throughout and was discharged without radiologic confirmation of appropriate placement location. Within 24 hours, the boy died. Autopsy revealed fluid in the peritoneum likely due to improper placement of the G-tube between his abdominal wall and stomach. (Case settled with payment.)
Patients who sue for procedure-related malpractice are increasingly receiving an indemnity payment.

For non-surgical procedure-based cases closed 2007–2011

<table>
<thead>
<tr>
<th>PROCENT OF CASES CLOSED WITH A PAYMENT</th>
<th>≥ $1 MIL.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVERAGE INDENITY PAYMENT ON CASES CLOSED WITH PAYMENT</td>
<td>$212,000</td>
</tr>
</tbody>
</table>

Surgery

<table>
<thead>
<tr>
<th>INPATIENT SURGERY CASE RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASES PER 100,000 RESIDENTS</td>
</tr>
<tr>
<td>2007</td>
</tr>
<tr>
<td>Academic Medical Centers</td>
</tr>
<tr>
<td>Community Hospitals</td>
</tr>
</tbody>
</table>

Top Contributing Factors* |

<table>
<thead>
<tr>
<th>TECHNICAL SKILL</th>
<th>PERCENT OF CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Errors in procedure or surgical approach</td>
<td>50%</td>
</tr>
<tr>
<td>Errors in obtaining a diagnostic test</td>
<td>30%</td>
</tr>
<tr>
<td>Errors in patient care</td>
<td>10%</td>
</tr>
</tbody>
</table>

AMBULATORY DIAGNOSTIC PROCESS OF CARE*

<table>
<thead>
<tr>
<th>AMBULATORY DIAGNOSTIC PROCESS OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERCENT OF CASES</td>
</tr>
<tr>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Patient failure to recall medication</td>
</tr>
<tr>
<td>History, physical and evaluation of symptoms</td>
</tr>
<tr>
<td>Performance of tests</td>
</tr>
<tr>
<td>Interpretation of tests</td>
</tr>
<tr>
<td>Referral management</td>
</tr>
<tr>
<td>Patient compliance with follow-up plans</td>
</tr>
</tbody>
</table>

*Causes may involve associations at multiple points in the process.
Current, complete records which assist diagnosis and treatment, and which communicate pertinent information to other caregivers also provide excellent records for risk management purposes.

The use of encounter forms, checklists, flowsheets, and computer-assisted documentation for high volume activities can save time and may also reduce the communication problems and errors caused by illegible handwriting.

Missing, incomplete, or illegible documentation can seriously impede patient care and the defense of a malpractice claim, even when the care was appropriate. The following advice on documentation includes issues identified through analysis of malpractice claims.
Documentation, part II

• The most current information. Keep your records up-to-date in order to provide the best resource for patient care and evidence that appropriate and timely care was provided.

• Clinically pertinent information. The medical record is a primary mechanism for providing continuity and communication among all practitioners involved in a patient’s care. To gauge adequacy of your patient’s medical records, consider what you would want documented if you were assuming management of the care of a patient you did not know.

• Rationale for decisions. Include your diagnostic rationale, especially for cases in which the medical record might suggest another course was overlooked. For example, document the rationale for not following the written recommendation of a consultant. This need not be lengthy, but should indicate alternatives considered, your medical judgment, and the clinical basis for your decision.

Documentation the “Tough Ones”

• Termination of a patient-clinician relationship. Include any correspondence related to the patient’s request or your decision to terminate the relationship.

• Missed appointments and attempted follow-up. Include notes on these and any other examples of patient non-compliance or failure to follow instructions.

• Medication. Include allergies and any prior adverse reactions to medications or contrast media.

• Obstetrical assessment. Include care during labor and rationale for an operative delivery.

• Handling conflicting data. If you disagree with a clinical conclusion, read other practitioners’ notes and reread your prior notes. Review radiology and other special study reports even if you have already read the films or seen the test data. If you must document a different diagnosis or recommended treatment, factually state your opinion and rationale.
Documentation no nos

• Derogatory or discriminatory remarks. In New York, patients have the right to access both office and institutional medical records and may be sensitive to notes they view as disrespectful or prejudicial. Include socio-economic information only if relevant to patient care.

• Arguments/conflicts with other physicians, nursing staff, or administration. Address these issues through the appropriate chain of command, not through the patient's medical record.

• Subjective statements regarding prior treatment or poor outcomes presented as facts. Use quotation marks to indicate patient’s or family’s impressions, e.g., “cerebral palsy due to a birth injury.”

• After an adverse event. Do not write any finger-pointing or self-serving statements in the patient’s medical record.

• Non-patient care information. Do not include the filing of incident reports or referrals to legal services.

Medical records often reflect differing diagnoses and treatment recommendations among multiple caregivers. However, oral or written criticism of previous health care contributes nothing to the patient’s needs. Patients may take casual remarks critical of prior care quite seriously, possibly destroying their relationships with previous caregivers and/or you.

Since all pertinent facts about prior care are rarely available, caution is advised in making judgments and comments if you disagree with a past or current caregiver. Likewise, basing your opinion of prior care solely on the patient’s report of prior circumstances may not reflect changes in symptoms and findings over time. In addition, the patient’s perceptions and recollections may be inaccurately reported. If, after complete information is considered, you do judge your patient’s prior care to have been flawed, a factual summary of clinical events and honest answering of patient inquiries is advised.

Accurately and objectively document a new patient’s condition at the time you assume care. This, combined with a thorough review of prior care treatment records, should “keep the record straight” without pointing fingers or blaming others in case the prior care is problematic.
Attending MD tells the resident to give the patient “free water” (meaning let her drink water)

Resident assumes he meant an IV and writes for water to be given IV

New RN can’t find IV water and calls pharmacy asking where they get IVs; pharmacy asks no questions and tells the RN they get them from C.S.

RN obtains IV from C.S. never questioning RN why she by-passed pharmacy; water bag says “water for irrigation”
• MD #1: used an unfamiliar term “free water” when he meant let the patient drink water

• MD #2: intimidated to clarify so he wrote what he assumed was supposed to be an IV

• RN: well-meaning, wanted to help her patient; she called pharmacy and talked to whoever answered the phone; went to obtain the IV directly from Central Storage Department

A true comedy of errors

• RN attaches the bag to regular IV tubing; RN infuses 600 mL of “free water”

• At change of shift, more experienced RN notes patient is lethargic, sees bag of water, removes it, and calls MD

Free water has no electrolytes and would likely have caused burst red blood cells and death if the second RN hadn’t interceded
## Doctors’ Emotions
- Dread
- Fear of Punishment (sued)
- Isolation
- Guilt/Shame (harming a pt)
- Anger (poor system set them up)
- Powerlessness
- Worry (job, reputation)
- Self-doubt

"The Second Victim"
Wu AW BMJ 2010;320:726-7

## Patients’ Emotions
- Dread
- Fear (retribution form HCWs)
- Isolation
- Guilt (Family: feel they didn’t keep close enough watch)
- Anger
- Powerlessness
- Worry

NEJM 2007

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90% of Doctors support the principle of disclosure

but

**Only 30% actually do disclose**
### Barriers to Disclosure

- Skeptical of benefits
- Unnecessary distress to patient and family
- Patients unlikely to find out
- Lawsuits
- Lack of training in error disclosure

**NEJM 2014**

### What Is the Threshold for Disclosure?

"You would want to know about the event, if it had happened to you or a relative, or it may result in a change in treatment, now or in the future."

- Dr. Robert Truog, Executive Director
  Institute for Professionalism and Ethical Practice,
  Harvard Medical School
“This is a tragedy all the way around,” Holzberg said. “Obviously, the victims lost their childhood and, in some cases, their lives have been upended and or ruined. In the case of the insurance coverage, I can’t imagine that when these policies were written 30, 40, 50 years ago, that they had any expectation that they’d be paying tens of millions of dollars as a result of this diabolical monster. And St. Francis itself is a remarkable health care facility. I’m hopeful these cases have been resolved in a way that is at least reasonably satisfactory.”

The lawsuit cited 40 former patients, all young boys at the time, who said Levine performed unnecessary genital examinations. Edward Mahoney, a Boston attorney who represented Levine, did not return calls. Last week after Levine’s death, he said, “This entire episode is a tragedy. Throughout it, Dr. Levine never wavered that his care and treatment of all children was appropriate in all respects, and he steadfastly denied the allegations against him.”

What Constitutes Diagnostic Error?

- Wrong (Another made...)
- Unintentionally Delayed (Sufficient information available)
- Missed (Diagnosis was never made)

How is Diagnostic Error Identified?

- Autopsy
- Patient reports
- Provider reports
- Paid claims

Paid Claims

- Outpatient Claims:
  - 32% Diagnostic
  - 68% Other
  - 31% of Deaths

- Inpatient Claims:
  - 31% Diagnostic
  - 69% Other
  - 47% of Deaths

**Paid Claims**

**DxE: NPDB 25 year retrospective review**

- 350,706 paid claims yielded 100,249 diagnostic errors
- Leading misadventure - 28.6%
- Leading cause of death – 40.9%
- Highest proportion of total payments - 35.2% ($38.8 B)


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**Provider Report**

**Diagnostic Error (DxE) Frequency**

N = 6400

- Rarely
- Few times per year
- Sometimes
- Weekly to monthly
- Frequently
- Most days
- Never

QuanitaMD. Physician Perspectives on Preventing Diagnostic Errors. September 2011
Cognitive Bias

- Overconfident
- Premature Closure
- Confirmation Bias
- Context Error

Terminating the patient relationship

- **Parties Involved**
  - The Entity
  - The Provider
  - The Patient
  - The Family
  - Managed Care Organization
    - Patient’s Payer
    - ACO
**Why would you terminate...**

- Treatment noncompliance—The patient does not or will not follow the treatment plan.
- Follow-up noncompliance—The patient repeatedly cancels follow-up visits or is a no-show.
- Office policy noncompliance—The patient uses weekend on-call physicians or multiple health care practitioners to obtain refill prescriptions when office policy specifies a certain number of refills between visits.
- Verbal abuse—The patient or a family member is rude and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions.
- Nonpayment—The patient owes a backlog of bills and has made no effort to arrange a payment plan.

**When would we take pause...**

- If the patient is in an acute phase of treatment, termination must be delayed until the acute phase has passed. For example, if the patient is in the immediate postoperative stage or is in the process of medical workup for diagnosis, it is not advisable to end the relationship.
- If the practitioner is the only source of medical or dental care within a reasonable driving distance, he or she may need to continue care until other arrangements can be made.
- When the practitioner is the only source of a particular type of specialized medical or dental care, he or she is obliged to continue this care until the patient can be safely transferred to another practitioner who is able to provide treatment and follow up.
- If the patient is a member of a prepaid health plan, the patient cannot be discharged until the practitioner has communicated with the third-party payer to request a transfer of the patient to another practitioner.
- A patient may not be terminated solely because he or she is diagnosed with AIDS/HIV.
When would out take pause...

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Written notice...

- Reason for termination—A specific reason for termination is not required. Under certain circumstances, it is acceptable to utilize the catchall phrase “inability to achieve or maintain rapport,” or “the therapeutic practitioner-patient relationship no longer exists."
- Effective date—The effective date of termination should provide the patient with a reasonable time period to establish a relationship with another practitioner. Usually, 30 working days from the date of the letter is considered adequate, however, you should follow your state regulations. The relationship can be terminated immediately under the following circumstances:
  - The patient has terminated the relationship.
  - The patient or a family member has threatened the practitioner or staff with violence or has exhibited threatening behavior.
- Interim care provisions—Offer interim care. True emergency situations, however, should be referred to an emergency department.
New Research – Defensive Medicine

The study reports that **more than 80% of the respondents admitted to ordering imaging tests solely for defensive reasons, and more than three quarters said they had ordered laboratory tests and made extra referrals for these reasons.** About half of the neurosurgeons reported ordering extra medications and procedures because they were worried they might get sued if they did not.

- According to a new study published in the journal *Neurosurgery* (2014), "the vast majority" of neurosurgeons operating in the US conduct additional procedures and tests out of fear of malpractice lawsuits rather than necessarily for the benefit of the patient.
  - *Neurosurgeons in high-risk states pay almost twice as much in malpractice insurance premiums as those in low-risk states. These malpractice premiums were found to cost 15-20% of neurosurgeons' annual income.*
- Along with orthopedic surgery and obstetrics and gynecology, neurosurgery is a specialty with a high risk of expensive malpractice claims.
- To examine how this risk might affect the way neurosurgeons treat their patients, researchers at Northwestern University in Chicago, IL, sent questionnaires to 3,344 board-certified neurosurgeons on the subject of "defensive medicine."

FUTURECAST

- Continuing push on transparency
- Focus on 2nd Victim
- New theories of Liability
- Bad Faith, Claims
- Fairness and early resolution
Managed care errors and omissions

What are we trying to protect?

- Cost Control Systems which are a disincentive for Quality Care
- Negligent Utilization Review, or Case Management
- Bodily Injury as a result of care management
- Anti-trust, breach of contract
- Poor decision making based on managed care guidelines, protocols
- “Ill” financial incentives
Questions and Thank You