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Empowering hospitalists.
Transforming patient care.

SHM Rapid Clinical Updates: Medical Liability and Hospital Medicine

Moderated by Jagriti Chadha, MD, FHM
G. Randy Smith Jr., MD MS FRCP(Edin) SFHM | Adam C. Schaffer, MD, MPH

October 27, 2022, 4 PM EST

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CME Information:

- **Claim via link – end of presentation**

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Brief Pre-test

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Associate professor of Hospital Medicine

Unit Medical Director

Northwestern Memorial Hospital

- **Health services researcher**
- **Has led quality improvement projects in community and academic hospitals as well as internationally**
- **Has served as an expert witness in over forty medical malpractice cases involving hospitalists across nine states**

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CME Disclosures

The faculty and planners of this activity have no relevant financial or advisory relationships with ineligible companies related to this activity.

Other disclosures:

Smith:

Principal, Ivory Door Healthcare Consulting

Expert Witness Testimony (DE, FL, GA, IL, IN, NC, NM, PA, VA

Schaffer:

None.

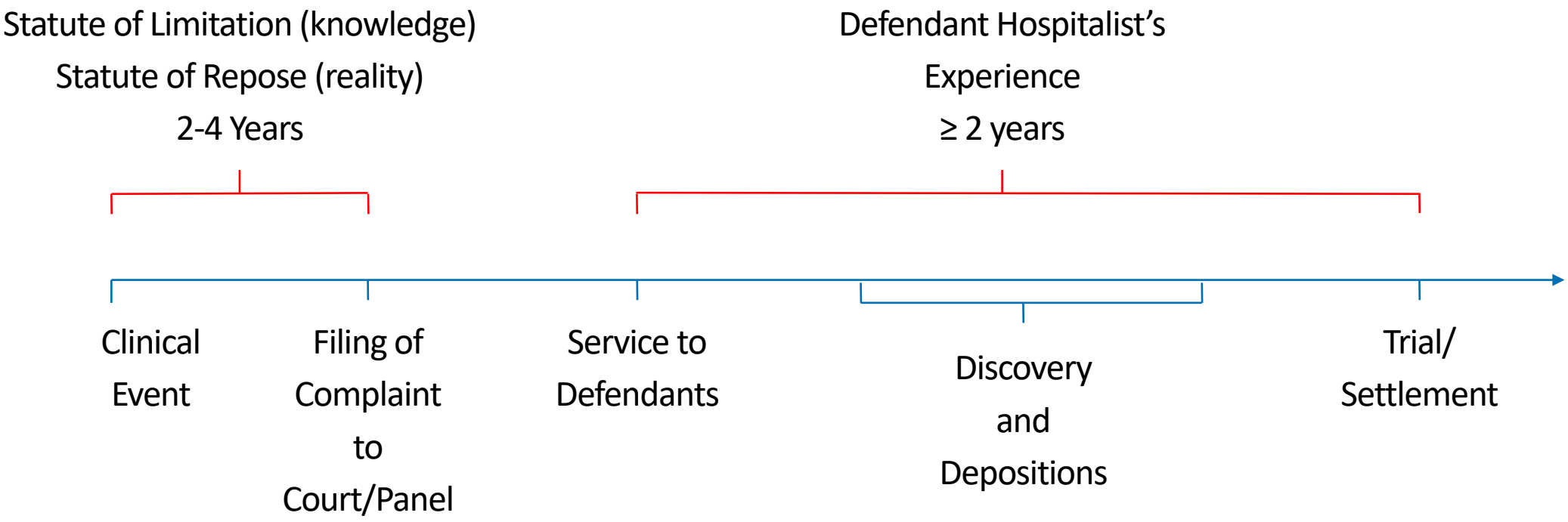
Objectives

- Being sued: the process
- Data on the liability risks of hospital medicine
- System approaches to address litigation risk
- Personal approaches to address litigation risk (ipse dixit)

Non-Objectives—Not Discussed Today!

- Specific cases or disease syndromes.
- Merits and disadvantages of US/state malpractice environment.
- Data from attorney-client or fiduciary sources.

Process Timeline

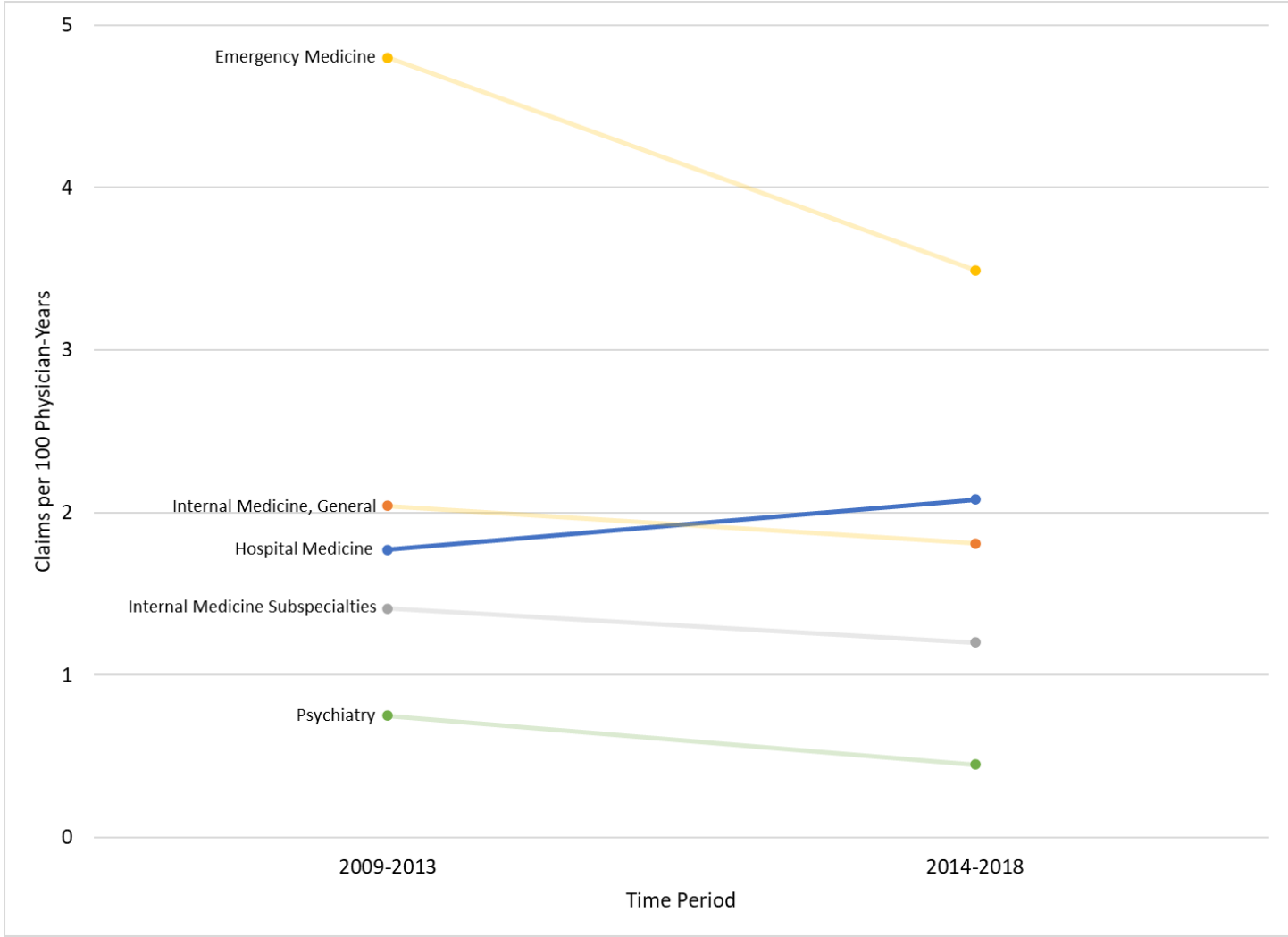


Malpractice Standard

- Successful tort requires all of the following:

1. Generally: lack of a criminal act.
2. Existence of a national **standard of care.**
3. Presence to defendant of **means** to deliver standard of care.
   - Licensed and certified for independent practice.
   - Resources.
   - No extraneous circumstances (holiday, crisis standards of care).
4. **Deviation** from standard of care. (Can argue to defend care delivered in excess of standard)
5. Deviation led to patient **harm**.
6. Harm led to tangible **loss** (life, functionality, financial loss, loss of relationship) to patient or patient's family/estate.*

Claims Rates in Hospital Medicine are Trending Up



Source: Schaffer AC, Yu-Moe CW, Babayan A, Wachter RM, Einbinder JS. Rates and Characteristics of Medical Malpractice Claims Against Hospitalists. J Hosp Med. 2021 Jul;16(7):390-396.

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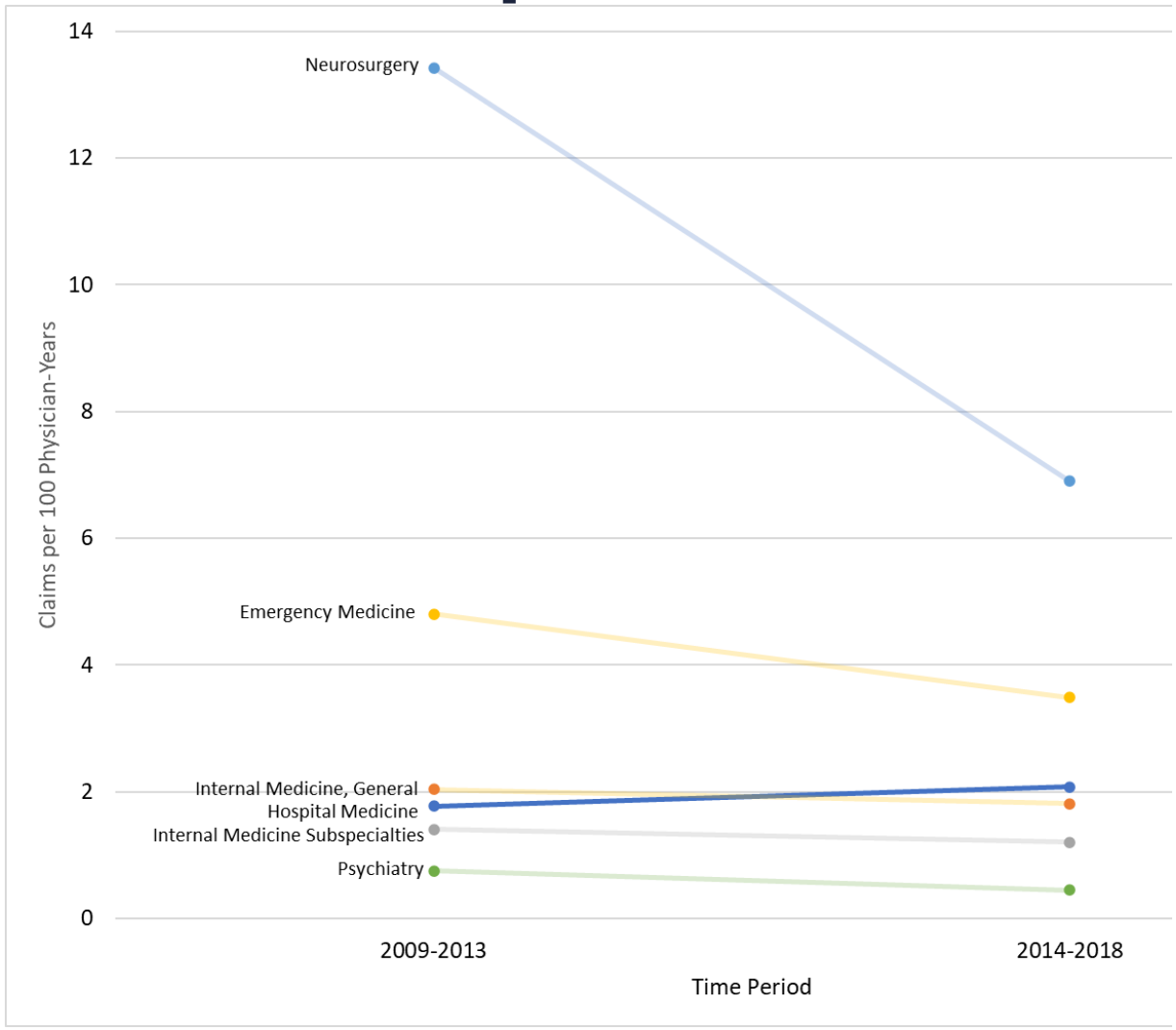

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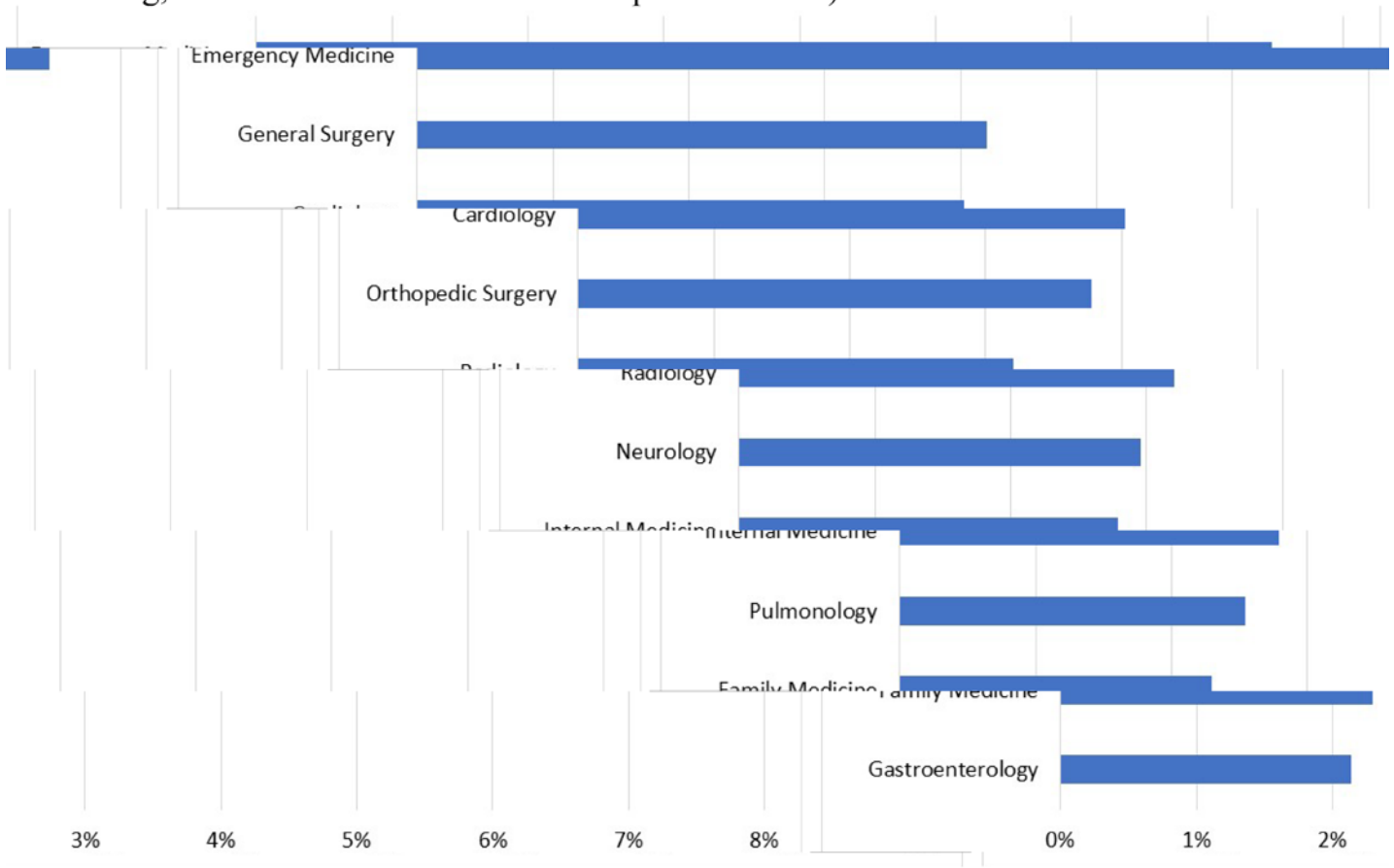
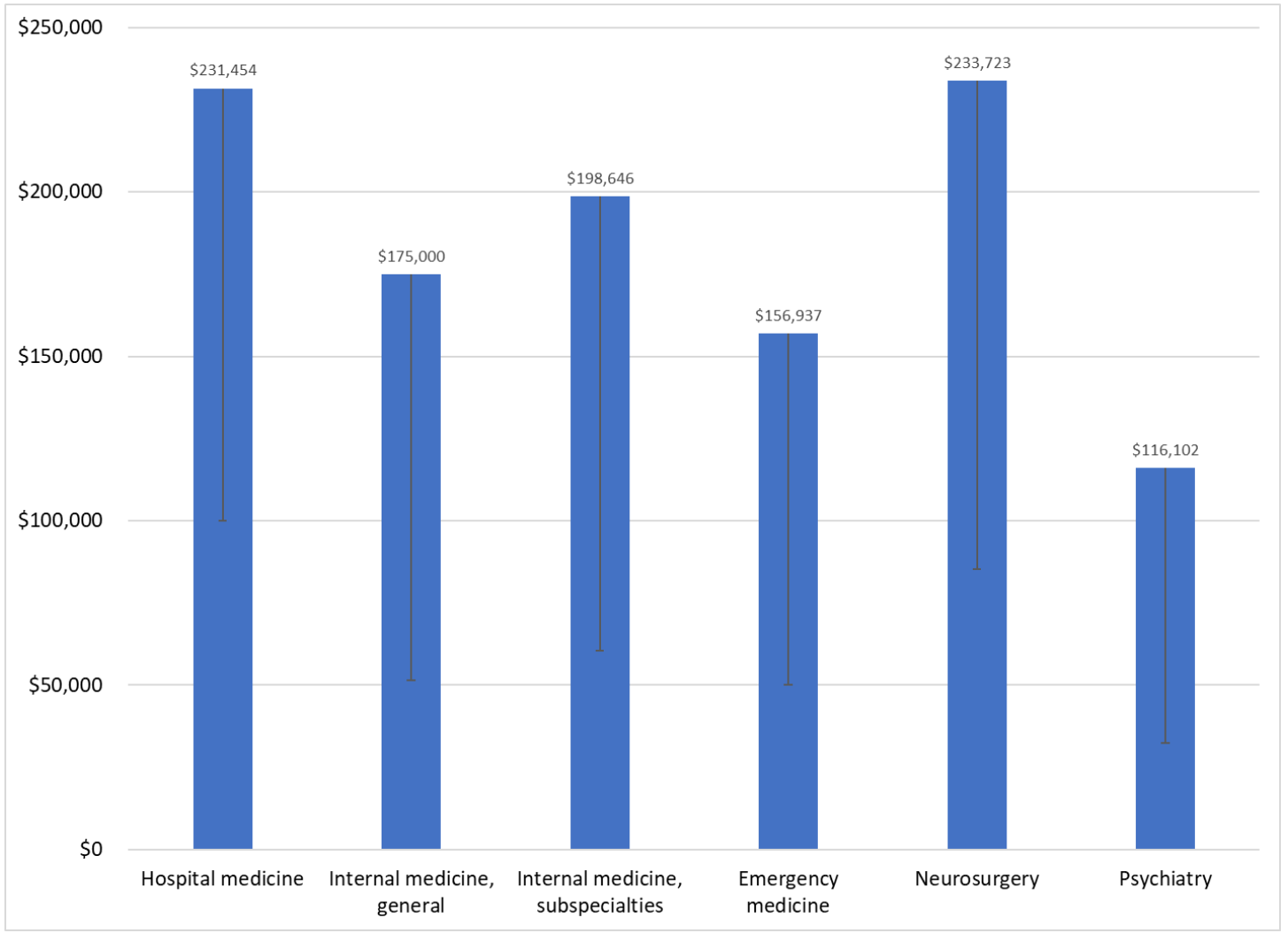
Possible Explanations for Trends in Hospitalist Claims Rates

APPENDIX FIG: Most Common Clinical Services Also Named in Malpractice Claims against Hospitalists as the Percent of All Hospitalist Claims in which the Service was Named (exclusive of nursing, who was named in 22.1% of hospitalist claims)



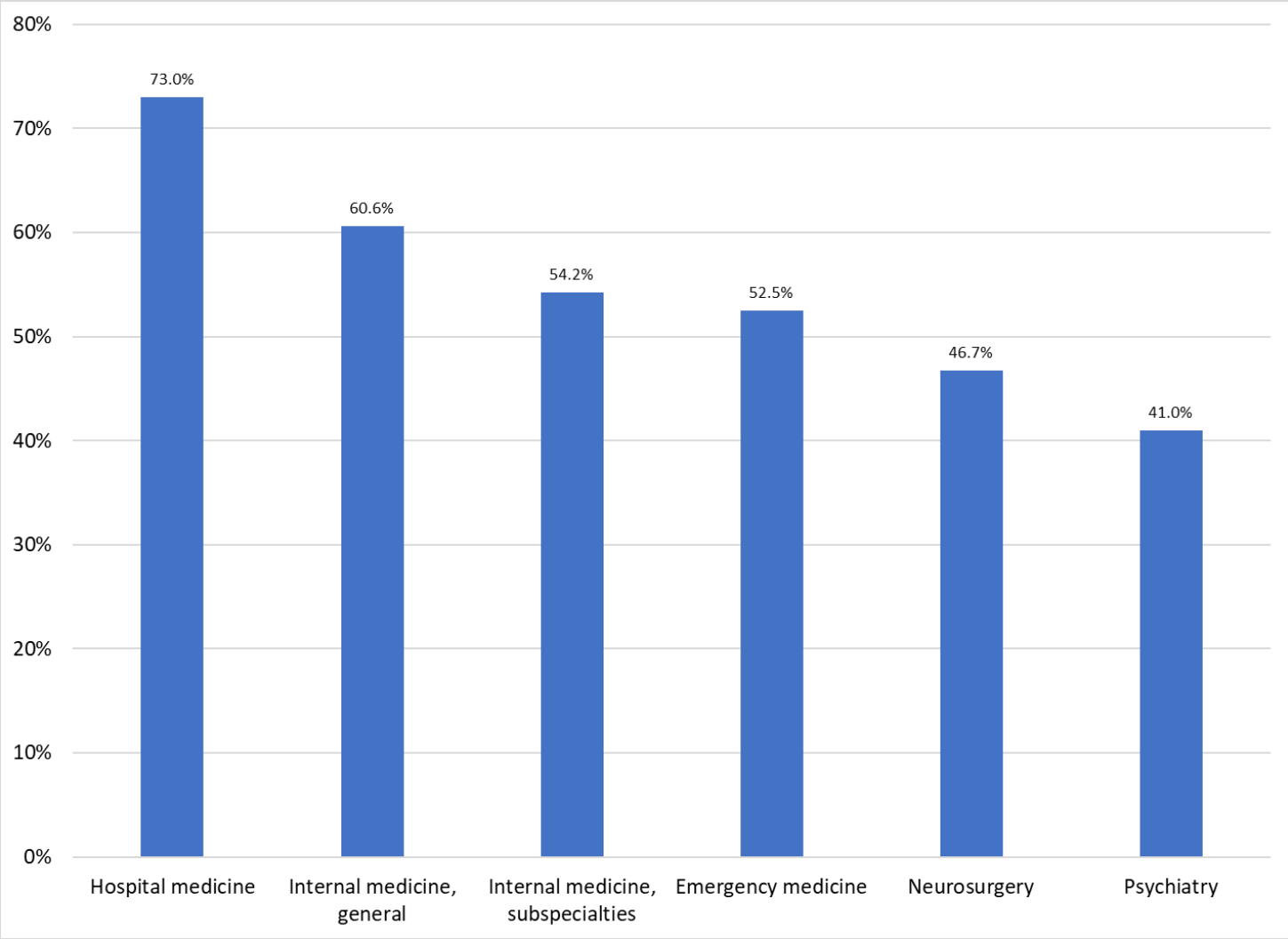
Source: Schaffer AC, Yu-Moe CW, Babayan A, Wachter RM, Einbinder JS. Rates and Characteristics of Medical Malpractice Claims Against Hospitalists. J Hosp Med. 2021 Jul;16(7):390-396.

Hospitalist Median Indemnity Payment Amounts are High



Source: Schaffer AC, Yu-Moe CW, Babayan A, Wachter RM, Einbinder JS. Rates and Characteristics of Medical Malpractice Claims Against Hospitalists. J Hosp Med. 2021 Jul;16(7):390-396.

Injury Severity in Hospitalist Claims is High



Source: Schaffer AC, Yu-Moe CW, Babayan A, Wachter RM, Einbinder JS. Rates and Characteristics of Medical Malpractice Claims Against Hospitalists. J Hosp Med. 2021 Jul;16(7):390-396.

TABLE 3. Unadjusted and Adjusted Odd Ratios for Claims Against Hospitalists Closing With an Indemnity Payment

Parameter	Unadjusted		Adjusted[a]	
	Odds ratio (95% CI) for a case closing with an indemnity payment	*P* value	Odds ratio (95% CI) for a case closing with an indemnity payment	*P* value
Errors in clinical judgment as a contributing factor	6.49 (4.61-9.15)	<.001	5.01 (3.37-7.45)	<.001
Problems with communication as a contributing factor	2.97 (2.31-3.83)	<.001	1.89 (1.42-2.51)	<.001
Problems with the clinical environment as a contributing factor	3.00 (2.19-4.10)	<.001	1.70 (1.20-2.40)	.0026
Problems with the documentation as a contributing factor	2.59 (1.91-3.50)	<.001	1.65 (1.18-2.31)	.0038
Patient age (per decade)	0.95 (0.89-1.01)	.099	0.92 (0.86-0.998)	.044
Injury severity[b]		<.001		.0012
Death compared with medium severity	2.02 (1.42-2.89)	<.001	1.79 (1.21-2.65)	.0035
High compared with medium severity	3.08 (2.03-4.67)	<.001	2.44 (1.54-3.87)	<.001
Medium compared with low severity	0.82 (0.44-1.56)	.55	0.46 (0.22-0.96)	.040

[a] The adjusted model is adjusted for all the other predictors contained in the model. The area under the curve for the adjusted model is 0.764.

[b] For injury severity, only those pairwise comparisons that were statistically significant in the adjusted model are presented.

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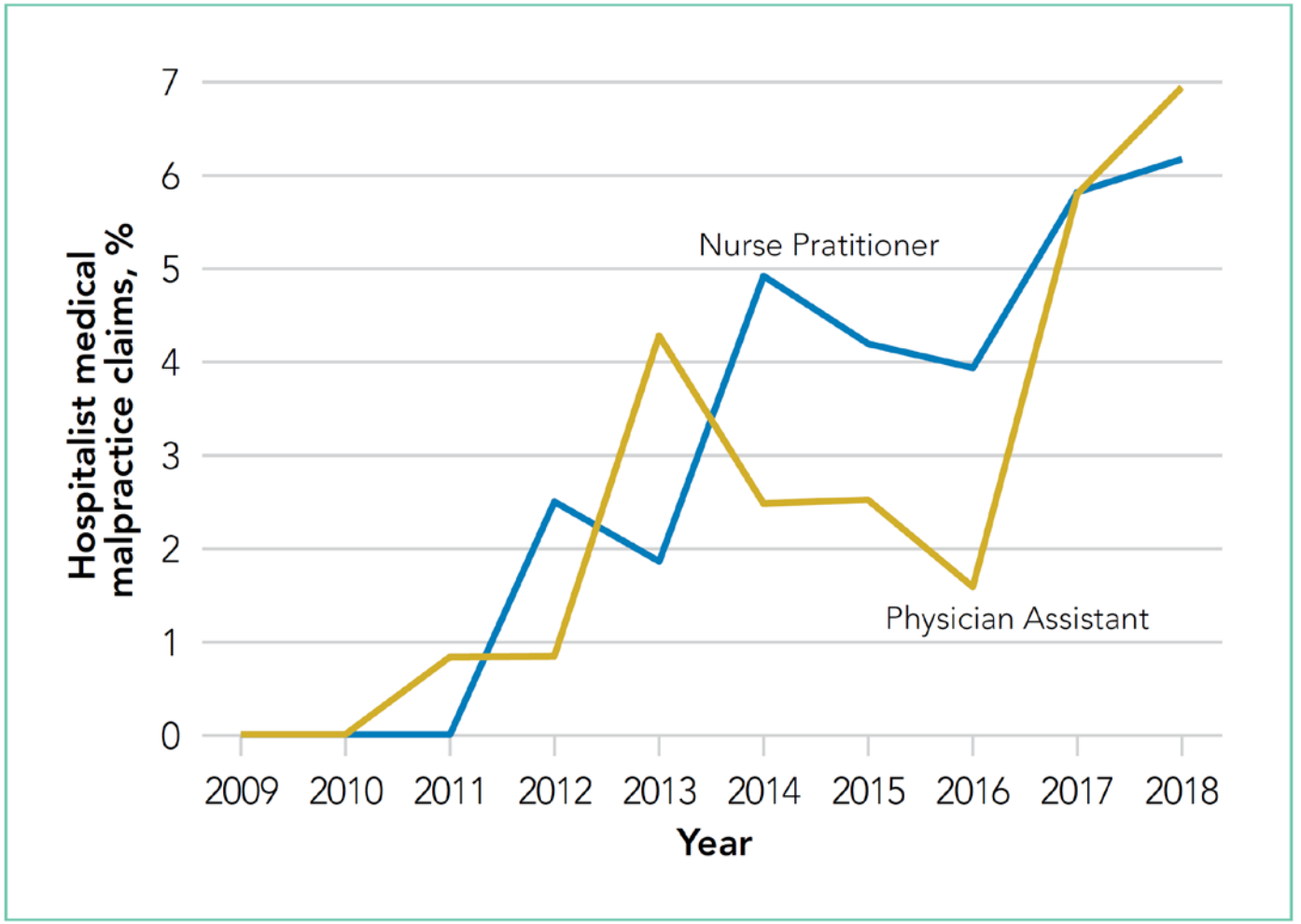


FIG. Percent of Hospitalist Malpractice Claims in Which Nurse Practitioners and Physician Assistants Were Named

Source: Schaffer AC, Yu-Moe CW, Babayan A, Wachter RM, Einbinder JS. Rates and Characteristics of Medical Malpractice Claims Against Hospitalists. J Hosp Med. 2021 Jul;16(7):390-396..

Litigation Utilizes the Person Approach to Human Error

Human error: models and management

James Reason

The human error problem can be viewed in two ways: the person approach and the system approach. Each has its model of error causation and each model gives rise to quite different philosophies of error management. Understanding these differences has important practical implications for coping with the ever present risk of mishaps in clinical practice.

BMJ 2000;320:768-770.

Protection from Litigation Utilizes the System Approach to Human Error

	Tort/Law	Quality Improvement/Healthcare
Philosophy of Motivation	Person Approach	System Approach
Motivator	Threat of Punishment	*Multiple*
Target Focus	Individual(s)	Team(s)
Philosophical Goal	Disincentivize bad behavior, administer justice.	Improve outcomes, minimize/mitigate harm from adverse events.

Strategies to Reduce Risk

Most patients (> 95%) who are injured due to medical errors do not make a malpractice claim

A key question to ask: why do patients decide to file claims?

Strategies to Reduce Risk

These data are derived from depositions of patients who made malpractice claims against their doctors (n=45)

This information provides us importance guidance on behaviors to avoid

Table 3. Categories and Frequency of Relationship Issues Identified in 45 Depositions

Issue	No. (%)
Not understanding the patient and/or family perspective	
Failure to solicit patient and/or family opinion	1 (2.6)
Inattention to patient's discomfort	3 (7.9)
Failure to recognize the psychosocial impact	1 (2.6)
Total	**5** (13.1)
Dysfunctional delivery of information	
Failure to provide an explanation	4 (10.5)
Failure to keep a patient and/or family up-to-date	2 (5.3)
Blaming a patient and/or family for bad outcome	2 (5.3)
Insensitively informing a patient and/or family	2 (5.3)
Total	**10** (26.4)
Devaluing patient and/or family views	
Discounting a patient and/or family opinion	2 (5.3)
Discounting a patient's illness and/or suffering	4 (10.5)
Not listening	3 (7.9)
Discounting a family's attempt to advocate	2 (5.3)
Total	**11** (28.9)
Desertion	
Perceived as unavailable	2 (5.3)
Abandoned	7 (18.4)
Physician too important	2 (5.3)
Sending a surrogate	1 (2.6)
Total	**12** (31.6)

Source: Beckman HB, et al. The doctor-patient relationship and malpractice. ... *Archives of Internal Medicine.* Jun 27 1994;154(12):1365-1370.

Disclosure: U Michigan

Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program

Allen Kachalia, MD, JD; Samuel R. Kaufman, MA; Richard Boothman, JD; Susan Anderson, MBA, MSN; Kathleen Welch, MS, MPH; Sanjay Saint, MD, MPH; and Mary A.M. Rogers, PhD

- Investigation of adverse events
  - If no fault found → vigorously defend against claim
  - If fault found → ***admit culpability and offer compensation***

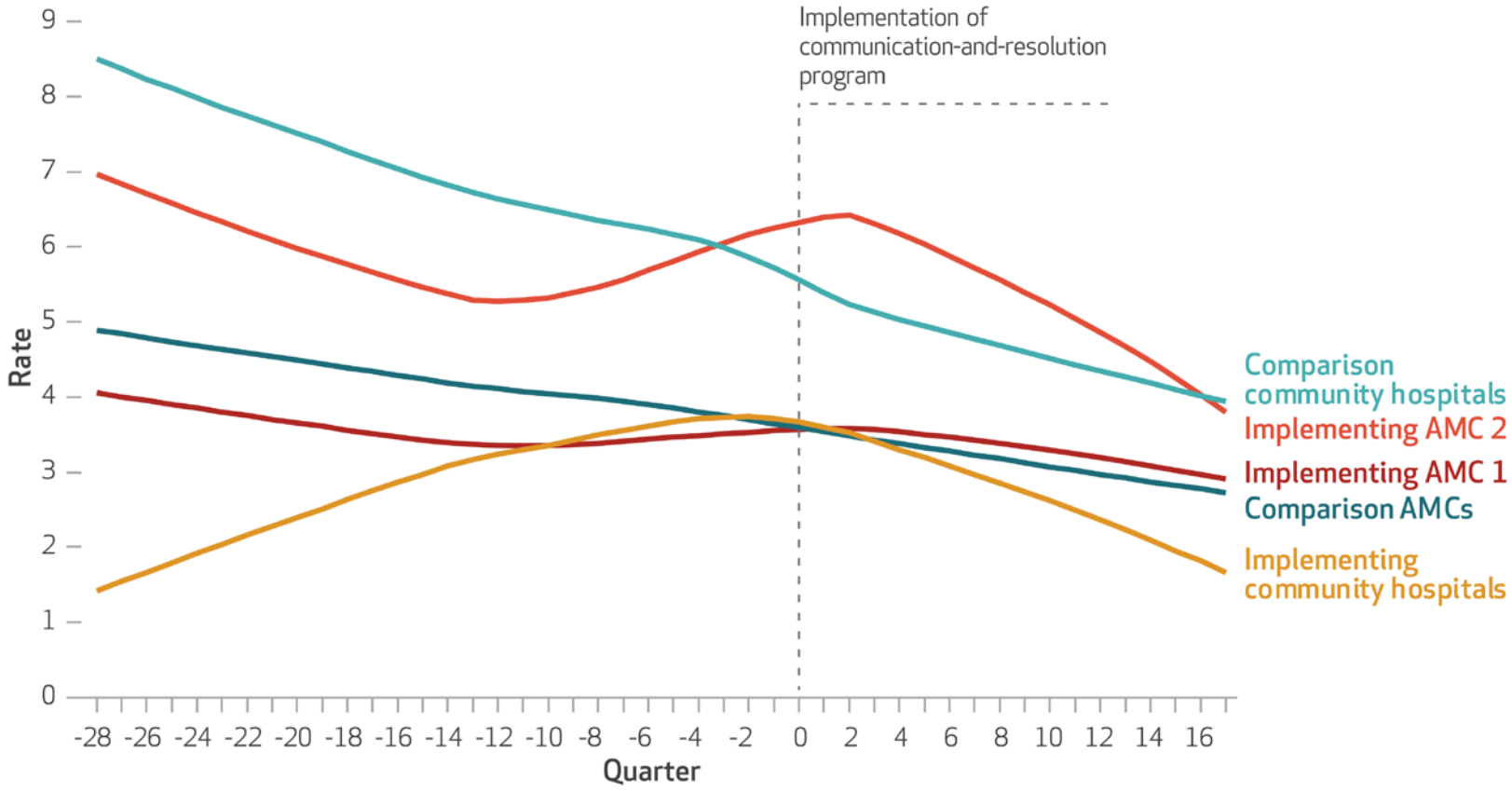
  - 36% decrease in monthly rate of new claims
  - 30% decrease in time to resolution
  - Decreased costs (total liability, patient-related, legal-related)

Ann Intern Med 2010;153:213-221.

Disclosure and Offer: The Massachusetts Experience

EXHIBIT 2

Time trends in rates of new malpractice claims at implementing and comparison hospitals



Source: Kachalia A, et al. Effects Of A Communication-And-Resolution Program On Hospitals' Malpractice Claims And Costs. Health Aff (Millwood). 2018 Nov;37(11):1836-1844.

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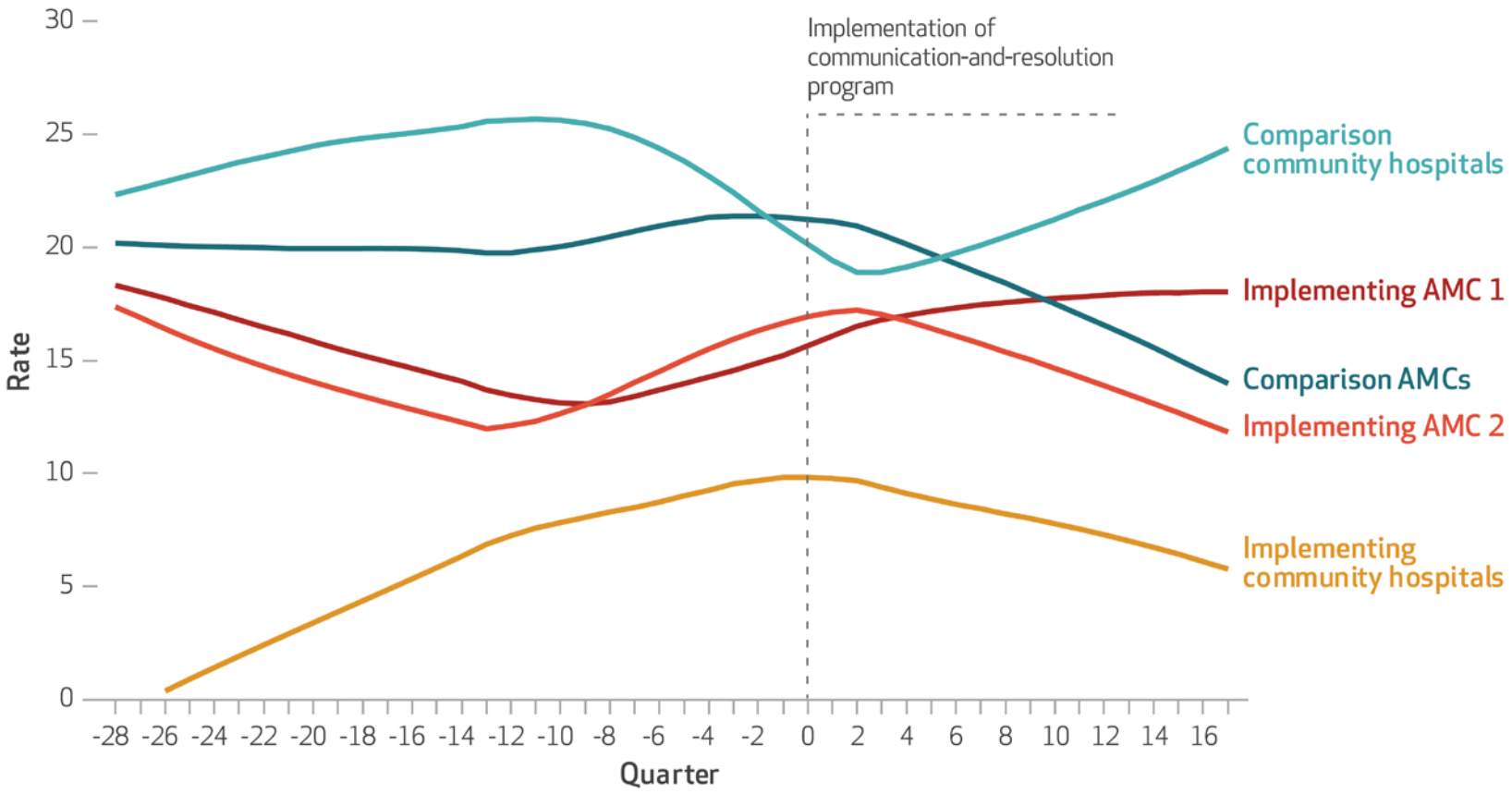
HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Disclosure and Offer: The Massachusetts Experience

EXHIBIT 3

Time trends in total malpractice liability claim cost rates at implementing and comparison hospitals



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BRIGHAM HEALTH
BWH BRIGHAM AND WOMEN'S HOSPITAL

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Disclosure: U Illinois Chicago

Responding to patient safety incidents: the "seven pillars"

T B McDonald,[1,2] L A Helmchen,[3,4] K M Smith,[1,2] N Centomani,[5] A Gunderson,[1] D Mayer,[1,2] W H Chamberlin[5]

Table 1 Guiding principles of the comprehensive process for responding to patient safety incidents at the UIMCC

1.	"We will seek to provide effective and honest communication to patients and families following patient safety incidents involving patient harm."
2.	"We will apologise and provide rapid compensation when inappropriate or unreasonable medical care causes patient harm and defend vigorously care that we believe was appropriate."
3.	"We will learn from our mistakes."
4.	"Reckless behaviour will be subject to corrective action."
5.	"We will provide support services for providers involved in patient safety incidents (the "second patient"(13))."

Qual Saf Health Care 2010;19;e11.

Best Disclosure Practice

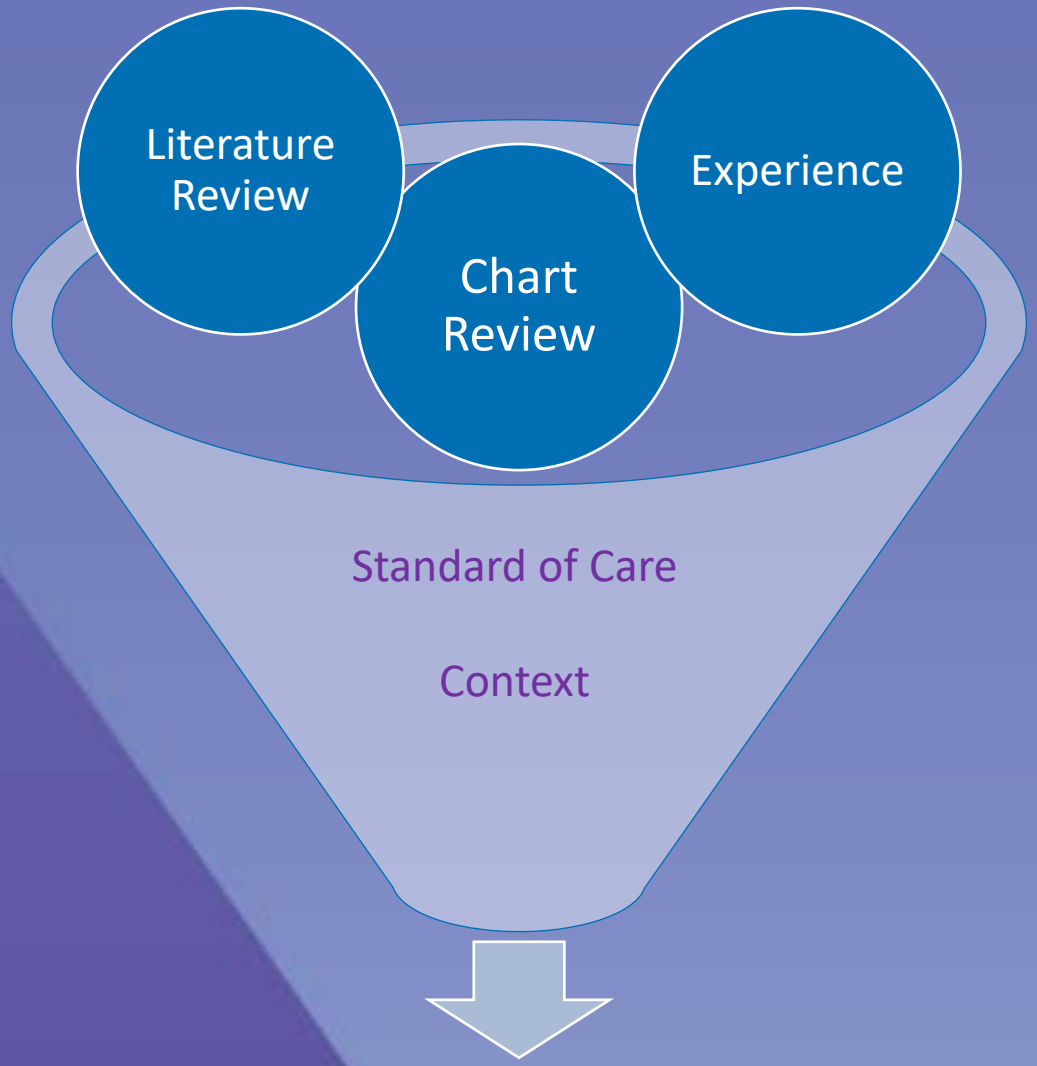
- **Immediately** see the patient +/- family in person.
- **Admit** an adverse event and associated harm has occurred.
- Reiterate that any outcome of harm was unintentional. **Apologize** for the harm.
- **Defer** all judgments regarding culpability or preventability.
- Make a **personal commitment** to:
  - investigating for causes and fixable remedies to prevent similar events for other patients in the future.
  - exploring how best support can be provided.
  - ultimately telling the patient what you find.

  "**I** don't know, but **I** will find out, and **I** will let you know when I do."
- Leave the patient. Immediately engage your **support resources** (Risk/Legal). **ERROR REPORT AFTER**.

Personal Mitigation of Risk

- After being served:
  - Little/no chance for you to speak for your own clinical reasoning with the plaintiff side.
  - Documents will speak for you.
  - Deposition of you: primarily as a “material witness” → verifying who you are, what you wrote, who you spoke to and what was said, etc.
  - Your trial questions and testimony are shaped by your **deposition.**
    - “No surprises” after deposition.
  - Arguments for/against justification of your clinical actions will come from *expert witnesses*.

Expert Witness: The Opinion



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The Most Important Tip

- **Practice what you document, document what you practice, and document what you think.**
  - Clinical care documentation:
    - Real-time context and engagement
    - Documentation read and understood in context
  - Legal documentation:
    - Real time context is gone
    - Documentation is used to reconstruct context
    - *CHART-CONTEXT RELATIONSHIP IS REVERSED*
    - ***Was the documenting provider engaged?***

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Brief Post-test

Audience Questions

Submit questions via the chat or Q&A feature in Zoom.

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THANK YOU