Insights into Risk Management

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Defending Malpractice Claims: It's Not Just About the Medicine

By George E. Wakeman, Esq.

Health care professionals involved in malpractice claims frequently are surprised (and disappointed) to learn there is more to evaluating a medical malpractice case than simply reviewing the medicine involved. A number of other factors bear on the overall defensibility of a case, how the facts should be presented in the best light, and how the defense of the case is prepared as discovery proceeds. At the end of the discovery process, including after experts render their opinions, doctors and nurses are often dismayed to learn that the case may have a diminished chance of prevailing, based on factors that have nothing to do with the medicine involved. There are a number of non-medical considerations that significantly impact the evaluation and defense of a case:

The Ineffective Witness: The ability of a physician or nurse to clearly relate the facts at his/her deposition, and subsequently at trial, are critical to successfully defending a case. This requires the defense attorney to assess things unrelated to medical skill, such as personality traits or communication skills. Does the physician or nurse come across arrogant or angry? Is the witness communicating a concept with language a layperson juror can understand? Physical appearance can also be a factor. Evaluation of how off-putting mannerisms (tics, fidgeting, etc.), speaking style, clothing choice, and similar issues may affect the credibility of the witness must be conducted.

The Shocking Outcome: Another consideration is what some might call the "Oh my Gosh" factor. For example, the death of a patient following a simple medical procedure like a tooth extraction, can have a significant impact on the defensibility of a case. Jurors are often not medically sophisticated, and cannot evaluate medical facts that may have factored into the shocking outcome quite the same way a healthcare professional would.

The Wild Card: There is also the vexing issue of the trial judge's impact on the case. Different judges have different personalities and different philosophies, especially when it comes to ruling on evidence. The trial judge has significant discretion in regarding what evidence might be admitted and the scope of expert testimony permitted during trial. This directly affects the quality and nature of the facts the jurors are allowed to consider when developing their verdict.

The Kiss of Death: Altered Records: Any time a healthcare professional alters the records in an inappropriate manner, the case is rendered difficult, if not impossible to defend. Additions to the record that are entered following an adverse event always have a suspect appearance, even when done for the purest of reasons and fully attributed in the record. Lack of documentation in the record regarding a critical event can turn a case into a he said/she said contest between the injured patient/plaintiff and the physician. Finally, even innocent mistakes in dating or timing of events in the chart can be twisted to give an appearance of a cover up. The bottom line is - any time a plaintiff lawyer can create an argument about some other aspect of the case than the medicine for the jury, the case becomes more difficult to defend.

Media Effect: When a case attracts attention in the local media, whether print, radio or television, the impact on a case can be substantial. The evaluation and defense of the case can be significantly impacted, even where there is simply

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potential that the case will create adverse publicity for the hospital. Cumulative stories about an ongoing situation can create a bad perception in the community, potentially creating juror bias that may be difficult to identify during the jury selection process.

Chart Rumor: The style of documentation and choice of words used by the provider in the record has a huge impact on the evaluation of a case, even if the provider/author is not directly involved in the event at issue. "Chart rumor," an issue that keeps recurring note after note, can make cases more difficult to defend, especially where it is subsequently shown to be a mistaken fact. And when "chart rumor" is recognized and corrected, it can give the appearance that the prior record keeping was sloppy. The increasing use of electronic medical record (EMR), with self-populating data fields, is often a set up for inconsistent, conflicting or repetitive incorrect entries in the patient record, and within some templates, can even occur within the same progress note.

The Smoking Gun: Another issue impacting the assessment of a case and its defensibility is when the defense is aware of an actual or potentially adverse piece of information in a case that may not be known to co-defendants or the plaintiff. This creates a "risk factor" that the information could come out during discovery or trial, prejudicing the defense (particularly if revealed for the first time before the jury) and vastly increasing the settlement value of that case.

The Sympathy Factor: All cases involve a degree of sympathy, based upon the fact that a patient, the parent, or child of a family sustained an injury or complication, and such a reaction by the jury is reasonable. However, some cases are inherently more sympathetic than others. Cases involving babies or young children, the loss of a young parent, complications involving permanent or distasteful sequelae such as quadriplegia/paraplegia requiring bowel/bladder care, colostomy, loss of a testicle or particularly difficult scarring, will impact the evaluation of a case even if the way the medicine was practiced is defensible.

No Good Reason Why: The inability of the defense to explain why a particular complication occurred other than saying it was "not due to the doctor's negligence," can leave an insurmountable hole in the defense. Defending a case solely based upon a lack of causation, (i.e., conceding breach of standard of care), or promoting the idea that there was no difference in the outcome even if there was a breach in the standard of care, can present a risky element to defending the case.

The Trial: At trial, a number of factors can affect the assessment of a case. The composition of the jury (e.g. a predominantly female jury in a breast cancer case or male jurors in a loss of testicle case, predominance of young college students during summer vacation, etc.) can have an impact. In addition, trials are "organic" and unforeseen developments during trial can affect the evaluation of whether to proceed further or not. Witnesses sometimes say things that are unanticipated and prejudicial to that individual's defense. Even actions or events off the witness stand can affect the defensibility of a case such as a client's inappropriate laughter, or act of falling asleep during testimony.

Also beyond the actual medicine and given substantial weight, the defense attorney will consider additional factors such as past jury verdicts, local and national trends related to the value of similar cases, and the current legal climate with regard to issues such as tort reform. Unfortunately, our experience defending medical malpractice lawsuits reveals there is a great deal more to the assessment, evaluation and defensibility of a case beyond simply defending the medicine.

2015 Risk Management Grant Program : Our 13th Year Creating Change!

Did you know? Entering its thirteenth cycle in March, 2015, the Risk Management Grant Program has awarded funding to over 50 recipients who have implemented projects related to loss prevention, patient safety and claims reduction.
Watch the Lifespan Intranet front page for our Risk Management Grant notice and
For more information, see our grant website at: http://www.lifespan.org/risk/grant

Raising the Bar: A Guide to Behavioral De-escalation Intervention

Developed by Bradley Hospital,
Departments of Behavioral Education and Quality, Risk and Regulatory Compliance

Raising the Bar is an e-training tool that has been developed for use at Bradley Hospital to provide a quick reference for staff on a specific clinical intervention, technique or practice. Following the successful implementation of ***SafetyCare*** throughout Bradley Hospital and other locations throughout the system where patients with behavioral health issues are treated, this ***Raising the Bar*** provides a guidance to the reader about elements required to assess, adapt and attend to the patient requiring de-escalation in a behavioral health environment.

The De-Escalation Process

	Individual	Environment	Tools
Assess	*Cognitive functioning* *Risks* *Trauma* *Intensity of emotional dysregulation*	*Assess for actual and potential environmental safety concerns*	*Access to safety equipment* *Support staff*
Adapt	*Adapt or modify approach so that it is appropriate to the individual in crisis.* *Be aware of non-verbal communication*	*Clear unsafe items: modify environment* *Modify body positioning and awareness* *Move to safer environment if needed*	*Think of alternative means of de-escalation* *Switch-off with staff* *Help/prompt/wait strategies* *Think outside the box!*
Attend	*Attend to patient needs* *Provide support encouragement active listening*	*Remove distractions* *Reduce stimulation* *Encourage patient to move to safer location*	*Offer patient appropriate coping strategies* *Use sensory tools* *Utilize safety tools as needed*

When working with an individual in crisis and using the de-escalation strategies taught in SafetyCare, staff should continuously monitor the effectiveness of their approach. Staff can accomplish this by constantly assessing, adapting and attending to the situation at hand.

Remember that all crisis situations are different and will require team work and flexibility.
Slow down. If you feel yourself becoming frustrated, switch off with another staff.

Delivering health with care.

FOCUS on Nursing - The Power of Words on a Jury

The purpose of this section is to share summaries of closed cases that have occurred in the New England area and represent real life issues that provide proactive risk management educational opportunities. The cases used may come from Lifespan affiliates, or other institutions or practices, or may be composites of several cases with very similar fact patterns. We present these cases because we believe they have some relevance to situations that you may encounter.

Not Just About the Medicine...

***ISSUE*: The appearance and unusual testimony of a key witness can often distract a jury away from the medically defensible facts of the case, leading to an unexpected verdict.**

FACTS:

♦Mr. W was a 45 year old, married man with three adult children. He worked as a general manager of a small local business.
♦One evening, the patient was out drinking and dancing at a party, when he passed out. He was taken to the ED by EMS for treatment.
♦He was evaluated by Nurse 1 in triage, where he remained for one hour before being transferred to the Urgent Care area.
♦The patient was cared for by Nurse 2 in the Urgent Care area where she observed the patient had unstable VS, was ashen in color and had a L eye droop. The patient was in the Urgent Care area for 20 minutes before being transferred to Trauma Room Two.
♦In Trauma Room Two, the patient was cared for by Nurses 3 and 4. Nurse 3 was given a report by the Urgent Care Nurse (Nurse 2), who repeated the findings as indicated above. Trauma Room Nurse 3 handed care off to Nurse 4, leading her to believe the patient was generally stable by using a generalized statement (below).
♦A surgical consult was called and a decision was made to do an exploratory laparotomy. After significant delay, the patient was taken to the OR. His abdomen was stable, but a large PE was found, causing *cor pulmonale*, and the patient died on the OR table before the cardiac surgeon arrived.
♦Experts in the case were supportive of the care, and opined that the patient's presentation was consistent with his treatment and inconsistent with a diagnosis of PE. They also stated this sort of PE had a 90% mortality rate, despite best medical rescue efforts.
♦Based on the medical facts, Attorneys defending the case predicted a greater than 60% likelihood for a Defense verdict.

♦During the trial, Nurse 3 made quite an impact on the jury:

1. Nurse 3 appeared for trial wearing a short, tight, wildly patterned dress and army boots.
2. When asked to tell the jury what she told Nurse 4 during the handoff, she stated: "...this is a drunk guy who passed out at a club, and he suffers from "HHS: *Hysterical [culturally insensitive word] Syndrome."*
3. In response to being told by the patient, "I don't know what is wrong," Nurse 3 offered to the jury, "I should have known something was up with this patient. Patients always end up dying when they say, 'I don't know what's wrong.'"
4. She also told the jury, "The ED was overwhelmed that night."

♦The jury determined the nurse and the hospital who employed the nurse was liable for the patient's death. In after-trial interviews, the jurors stated their decision was based on the poor appearance and unusual testimony of Nurse 3.

Insights is published by Lifespan's Department of Risk Management. Submissions and ideas are welcome and may be submitted to **Suzanne Duni @ sduni@lifespan.org** or **Deborah Randall @ drandall1@lifespan**, or by fax to **401-444-8963.**

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Fostering a Positive Patient Relationship

Can physician behavior reduce the likelihood of being sued?

A failure to properly communicate is known to be one of the prime factors inherent in almost every malpractice case. Inadequate communication with a provider is a notorious trigger for a patient with an adverse outcome to allege malpractice, and the decision to sue is often influenced by the extent and quality of communication between the patient and physician. It is well established that the role of effective physician-patient communication is critical in achieving the best medical outcomes and a high level of patient satisfaction.

- **Characteristics found in physicians who *have* been sued include being less accessible, less communicative.**
- **Conduct found in physicians who *have not* been sued include spending more time with patients, skillful use of humor, openness and honesty, candid disclosure, and guiding patient expectations with orienting statements during encounters:**

  "First, I'll examine you and then we will talk the problem over."

  "I will leave time for your questions."

Physicians may impact their risk of being sued by changing certain behaviors while interacting with patients. A good relationship can influence the patient's perception of physician competence.

- **Even in the face of a severe outcome, patients with positive physician interactions are less likely to sue the physician, and more likely to focus the liability elsewhere.**

The purpose of communication is for the physician to understand the patient's concerns and make mutually agreeable decisions with the patient. It is not to convince the patient to do what the physician wishes. Effective communication results in many benefits: enhanced patient recall of information, compliance with medical regimens, greater satisfaction and psychological wellbeing, and improved outcomes. Paramount in achieving these benefits is the most basic behavior of effective listening.

"No word was ever as effective as a rightly timed pause."
— Mark Twain

One effective practice is to ask the patient at the end of a conversation if there are any other questions. At that point, patience is a virtue! Wait for your patient to respond. Suppress the urge to interrupt if the patient is having difficulty getting to the core of the matter. Cutting off the exchange by talking or walking away may cause the patient to not articulate important health concerns. Unexpressed questions or worries can leave the physician unaware of important information and the patient dissatisfied by the inability to communicate concerns. Taking a reasonable amount of time to listen to and acknowledge patient concerns, probing a bit, and proposing follow-up measures, assures the patient that a two-way communication took place. A less attentive approach may be perceived as disinterest, and will likely be a point of contention if the patient's unspoken concern becomes an unaddressed health problem.

- **Barriers to effective communication may result if patients feel that they are wasting the physician's valuable time and result in:**

  * Omission of details in their history which they deem unimportant
  * Not understanding medical terminology with regard to diagnosis, plan of care, follow up instructions, education
  * Embarrassment due to things they think will place them in an unfavorable light
  * Belief the physician has not really listened and, therefore, does not have the information needed to make good treatment decisions

Continued on reverse →

The following attributes have been shown to directly impact the physician-patient relationship, either culminating in trust and a strong relationship or stifling communication and diminishing positive rapport

Skill	Benefit	Positive Behavior	Negative Behavior
Engagement	* **Diagnostic ability improved** * **Patient's perspective understood** * **Physician/ patient partnership developed**	* Sit down, establish eye contact, show attention with nonverbal cues such as leaning forward and nodding. Avoid crossing arms. * Acknowledge and legitimize feelings * Listen to what is not said, nonverbal response to questions * Observe body language, voice inflection, appropriateness of complaints; listen without interrupting * Allow silences while patients search for words * Explain and reassure during examinations * Adapt medical terminology to the level of the patient * Acknowledge patient statements; explain which symptoms are most important or pertinent * Ask explicitly if there are other areas of concern "Is there anything else you would like to talk about?"	* Interrupting * Using technical/ medical terminology or jargon * Not facing the patient while entering data in the EMR.
Empathy (verbal and non-verbal) & *Compassion*	* **Patient anxiety lowered** * **Compliance increased** * **Patient (and provider) satisfaction higher**	* Use a 5 step process to gather information: **BATHE** * **B**—Background "What is going on in your life? * **A**—Affect "How do you feel about that" or "How does it affect you?" * **T**—Trouble "What about the situation troubles you the most?" * **H**— Handling "How are you handling that?" * **E**—Empathy; Show understanding — "That must be very difficult for you." * Show acceptance ("I know how important it is for you to get back to work.") * Balance concern for patient's emotional needs with objectivity	* Using inhibiting behaviors (sitting behind desk, holding & reading medical record/ report)
Education	* **Information needs of patient satisfied**	* Anticipate/answer basic general questions about procedures and outcomes * End visit by asking "What other questions do you have?"	* Minimizing questions with cursory answer
Enlistment & *Continuity*	* **Improved adherence to instructions** * **Patient-physician relationship that endures over time** * **Risk of lawsuit reduced**	* Arrive at agreed-upon diagnosis though open communication; the patient and their wellbeing must be the primary concern and take precedence over the physician's personal interest. * Keep regimen as simple as possible * Provide written instructions * Allow the patient to correct or add to your response until his/her understanding is confirmed * Motivate with benefits, goals, ability to achieve * Discuss risks, side effects, costs, alternatives - patients want choices	* Assuming patient understands * Failing to appreciate patient's specific concerns about a regimen or procedure