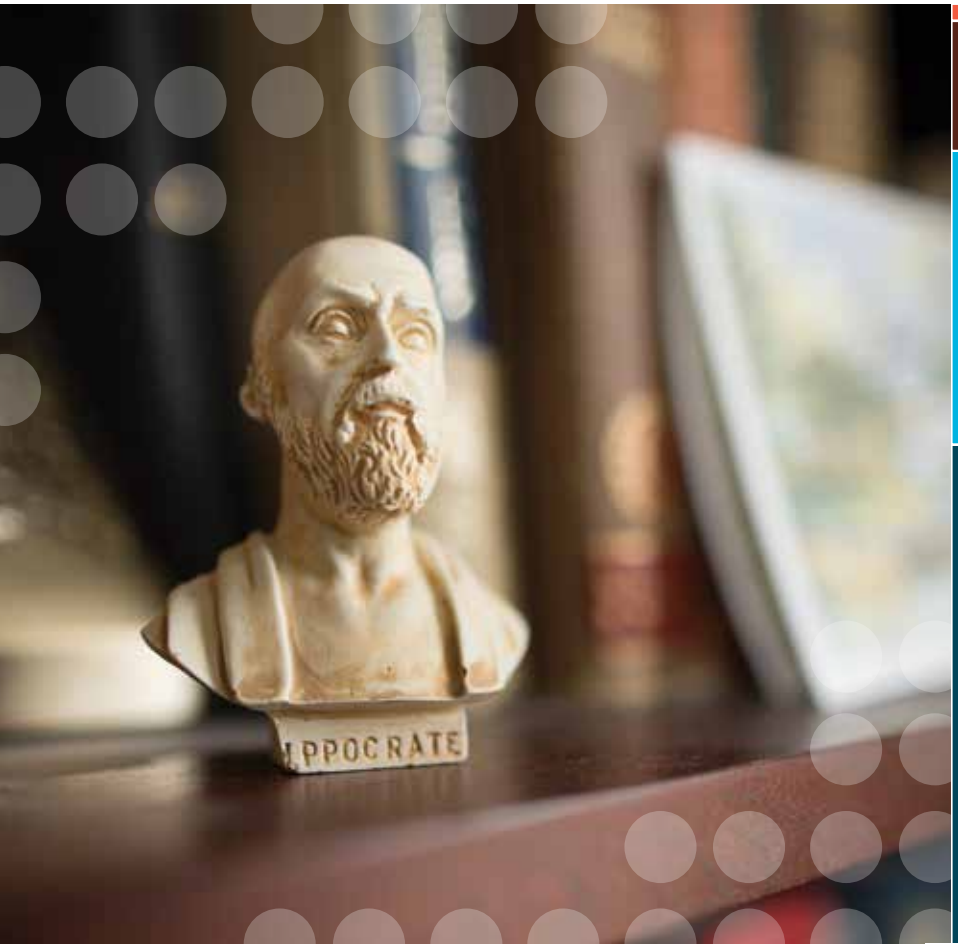
Insight

into Claim Management

crico

2013



CRICO Results
2,351 cases closed 2003–2012

2%
Plaintiff verdict

14%
Defense verdict

31%
Settled

53%
Dropped, denied, or dismissed

Protecting Providers

Protecting Providers. Promoting Safety. As a newcomer to CRICO—still seeing it with an "outsider's" eyes—I'm impressed at how well this tag line distills CRICO's mission and commitment to the well-being of our community: to the clinicians, the organizations, and the patients.

Externally, CRICO is known for its pathbreaking efforts to promote safety: for its use of data to identify areas of needed improvement and its willingness to proactively invest in patient safety improvement efforts. We are less well known for the work that we do to protect providers, but this is central to who we are. We pride ourselves on what we can do to protect and support providers in the most difficult circumstances.

This issue of Insight explores what happens when a provider faces an allegation of malpractice. What happens to physician defendants? How do they cope? In what ways does CRICO endeavor to support and protect providers? We hope you never become one of the few to experience this first hand, but want you to know we are here should you need us.

Mark E. Reynolds
President, CRICO

Insight

Protecting Providers

Helping Providers Protect Themselves

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Chronology of a Malpractice Case

Claire Cronin, MD, FACS, MBA

I am generally an enthusiastic supporter of CRICO. At a time when most of my colleagues still recoil from the idea of voluntarily talking to a malpractice claims representative, I have mine on speed dial. I have no qualms about sharing a bad outcome or reporting the actions of a litigious family. In fact, I find it liberating to have someone else besides me worry about a potential claim, sort of like the feeling one gets after confession. Despite my earnest reporting efforts, it came as a big surprise when I was named in a suit that I didn't see coming. CRICO put together a cracker jack team and after five years of living with the fear and embarrassment of a medical malpractice case, I was exonerated.

Recently I was looking through the CRICO website and came upon the Chronology of a Malpractice Case and realized that for a corporation in the med-mal business, CRICO got it all wrong. Steps 1 through 4 more or less occurred, but the algorithm doesn't really capture the whole process from a physician's point of view. I have with much thought and no research, come up with my own chronology of what really happens during a malpractice case and have outlined the stages below.

Stage 1 DENIAL: A physician usually first becomes aware of a medical malpractice suit when the sheriff drops by the office with the gift of a Summons. The actual filing of the Complaint in the Superior Court goes by without our knowledge (or consent). Despite the

Chronology of a Malpractice Suit

...according to CRICO...

Your suit may be dropped or dismissed shortly after the original filing, or it may take years to go through the entire trial and appeal process. In Massachusetts, the majority of suits take at least three years after the filing date to reach trial.

If you find yourself being named as a defendant in a malpractice suit, it may well be your first exposure to civil litigation. While you will probably wish it would just go away, you cannot ignore it no matter how you feel about the merits of the claim.

Every case follows its own path to conclusion, but this illustration depicts common steps in the process. Understanding what your involvement is likely to be along the way helps strengthen your ability to cope with what can be a long and drawn out course of events. While you will face occasional spurts of activity related to your case, you may not hear anything new about the proceedings for extended periods of time. Of course, for case-specific information, contact your CRICO claim representative or defense attorney.

Chronology of a Malpractice Suit

...according to Dr. Cronin...

1 Denial

2 Anger

3 Bargaining

requirement that an officer of the court deliver the Summons, it turns out that once he arrives in the office, he can hand the darn thing to anyone standing around. So not only do I get sued, I get cheated out of the chance of meeting a real life sheriff. My billing person, Kathy, was the lucky recipient of the Summons and Complaint and out of fear of stage 2 (see above), decided to let someone else give it to me three days later.

Come Monday morning, I was asked to take a seat in a partner's office. "It's nothing to be worried about," I was told. "It will go away." Despite an immediate physical reaction that felt like a bowel obstruction with a side of a heart attack, my mind remained calm and I said, "This is a mistake. This can't be happening. Nothing went wrong." My partner nodded sympathetically.

> Despite an immediate physical reaction that felt like a bowel obstruction with a side of a heart attack, my mind remained calm...

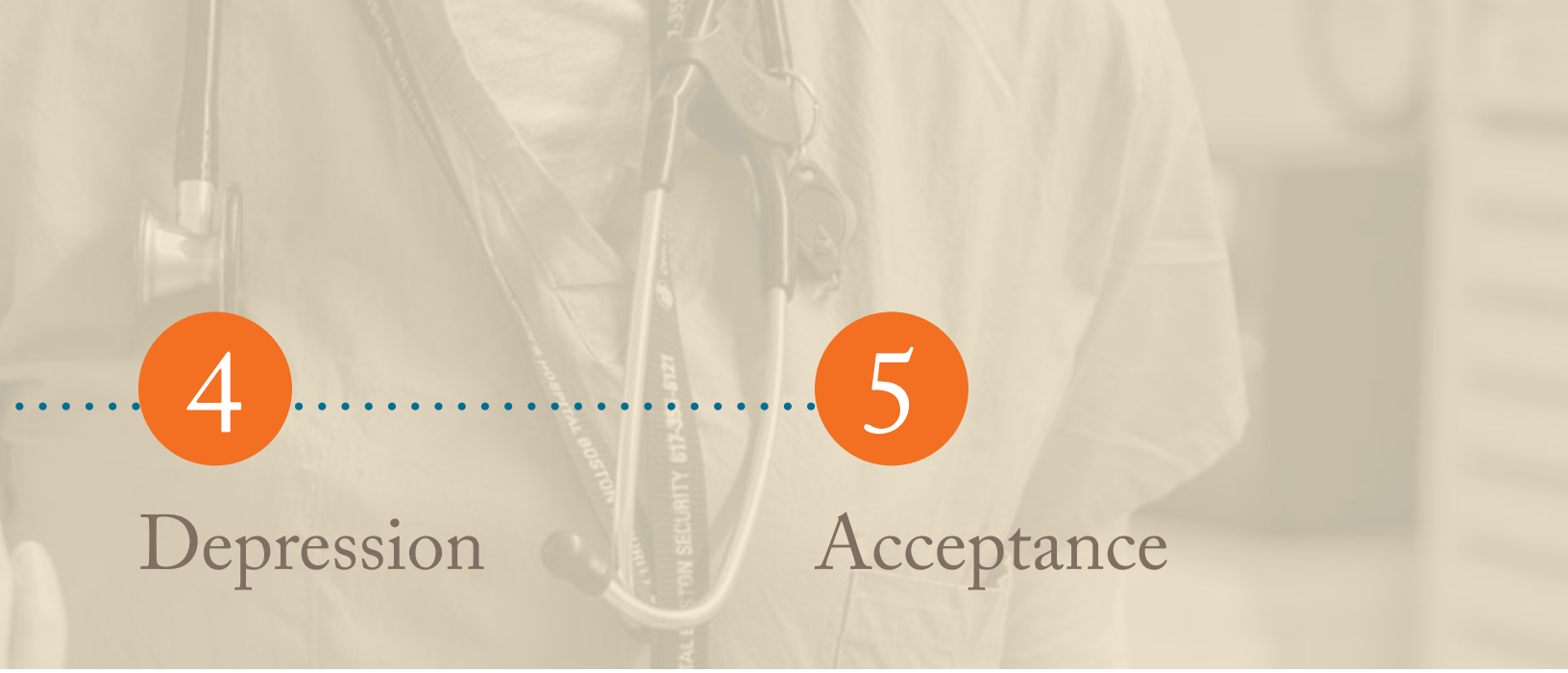
What I consider to be the signature reaction of Stage 1 came next: the immediate need to call the patient and family and explain everything. I was convinced that once they understood the medicine behind what had happened, we would reconcile over the misunderstanding and they would drop the case. My office manager, who is experienced in matters of this kind, tackled me on the way to my phone and after pinning me down, told me that I cannot contact the plaintiffs (as the family now preferred to be known). It made no sense to me to not take care of this unfortunate situation with openness and honesty right now. The office staff took turns sitting on me until all the phones in my office were removed. To this day, I still can't fully grasp the concept of not being allowed to contact the plaintiffs without the interference of lawyers. Deep down I believe it is a conspiracy introduced by the trial lawyer lobby.

I was advised to not discuss this case with anyone but my attorney and my husband, who is wonderful but absolutely no help in matters such as this, and then five years of a Mafia-like omerta ensued. The rules of conduct were introduced to me similar to Emily Post's Rules on Etiquette. I quickly slipped from the denial of stage 1 to stage 2.

Stage 2 ANGER: After berating the office staff for keeping secrets from me, I lit into the hospital risk manager for not letting me know that records were requested from an attorney for the patient in question. I was miserable and willing to take everyone down with me. I hated patients. I didn't trust any of them. I barely smiled and refused to console them when they cried. I may not have used as much local anesthesia during that time as I could have.

Unable to sleep, I came up with the scathingly brilliant idea that captures the true essence of stage 2; I was going to sue the plaintiffs for ruining my life. I would calculate all the time spent out of the office in depositions and court days and demand to be made whole. This did not even come close to the pain and suffering that I was going through. My "worry lines" were going to need their own trust fund for plastic surgery as they grew deeper and increased in number. After spending four and a half painful hours in my deposition debating everything including my gender, I added the plaintiff's attorney to the list of people who contributed to my pain and suffering. Not surprisingly, the "rules and regs" of malpractice cases don't really go in for that kind of retaliation so after awhile I moved on to stage 3.

Stage 3 BARGAINING: After the initial shock of being named in a suit wears off, everything sort of goes back to normal. Everyone goes back to their corners and nurses their wounds (OK just me) and then life goes on. I remember walking the corridors in the hospital wondering if everyone could tell that I was being sued. Sort of like you do after you lose your virginity. No one noticed and I found out later that, at any one time, 60 doctors are walking around my hospital feeling like they are the only ones involved in a malpractice suit. I wish I knew that back then.



4

Depression

5

Acceptance

So with the reprieve due to an overcrowded court system, I continued on with my practice. I stopped blaming every patient for the plaintiff's actions. In fact, I became a better but more expensive doctor. I listened to patients and their families and explained everything four or five times. My documentation got longer as I included every possible complication of care that I could spell. I ordered every study our radiology department offered. In retrospect, I am probably solely responsible for the health care crises in the United States.

By practicing so thoroughly I was ensuring that I would never end up in a claim again. By living such a "clean" life I would make amends for whatever oversight led to me getting sued in the first place. I was bargaining with God. In response, I got Obamacare.

Stage 4 DEPRESSION: As the date of the trial came closer and nothing I was allowed to do could stop it, I became resigned to the fact that I was going to court. The denial, anger and bargaining were gone and I was left with sadness. The only good part of this stage is that those last five pounds of baby weight finally melted away.

I couldn't turn to my colleagues at work because of the gag order. I did have the impulse once to tell everyone in the hospital lunch room and my relatives in Holland just to see if the plaintiff's attorney would subpoena them all during the trial, but I didn't. I thought about other careers and actually started looking at online job advertisements. Not many companies were looking for ex-surgeons. I was depressed by the whole situation.

Stage 5 ACCEPTANCE: I went to trial because I had to. It wasn't because I had any epiphany of acceptance. In fact, I still don't acknowledge that this is the best way to resolve medical injuries or disputes. I was fortunate to make it out the other end without a verdict against me. I'm glad because the Massachusetts Board of Medicine has just sent me an email informing me that all verdicts will remain on their website in perpetuity instead of the customary 10 years.

I propose that CRICO adopt my new algorithm for the Chronology of a Malpractice Suit as displayed above. Uh-oh, scratch that, as they like to say in the biz. On a second look for copyright privileges, it appears that Dr. Kubler-Ross came up with these in 1969 to describe

> My "worry lines" were going to need their own trust fund for plastic surgery as they grew deeper and increased in number.

the stages of grief when patients were faced with impending death or other extremely awful fates. I have no insight as to whether or not she ever experienced a medical malpractice claim but it is fair to say that from a physician's standpoint, a med-mal case definitely falls into the "extremely awful" category. CRICO does a great job of representing physicians during a malpractice claim, but the legal stages of a trial are very different from the emotional ones.

I propose that we never get comfortable enough to accept this process as the right path to resolving claims. It is not fair for the patient who suffers a minor injury that does not attract large rewards for the attorneys and therefore cannot find representation and it's not fair to the health care providers. Even a winning verdict is a losing proposition for the physician and the health care system as a whole. The process needs to change so we never get to stage 4 in either algorithm.

Claire Cronin, MD, FACS, MBA, is a general surgeon at Newton-Wellesley Hospital.

Supporting Disclosure & Apology

Jessica Bradley, MBA

Since 2011, the Disclosure & Apology Consortium, representing multi-specialty clinical leaders from each of the CRICO-insured organizations, has convened quarterly to discuss instances when a disclosure and apology discussion took place. Participants advance their skills in this discipline by sharing actual scenarios. Exploring what went well, what went poorly, and the outcome of the conversation, these sessions provide education for disclosure and apology coaches, and providers. Added value is delivered through validation of the emotional impact these conversations can have on patients, families, clinicians, and other employees.

More recently, CRICO has provided funding for projects at two organizations to explore the effective implementation of disclosure policies and their impact on clinicians and patients:

Beth Israel Deaconess Medical Center (BIDMC)

BIDMC and its affiliate institutions (Milton and Needham) have launched "A Pilot Assessment of the Communication, Apology, and Resolution (CARe) Approach to Preventable Adverse Events." Formerly referred to as the Disclosure, Apology and Offer program, this initiative is part of a broader coordinated pilot in a variety of clinical and malpractice insurance environments within Massachusetts. The pilot leverages existing patient safety and risk management programs. BIDMC is evaluating the impact of the pilot implementation in the dimensions of safety, satisfaction, and cost, using a formal assessment of clinical and financial outcomes.

Brigham and Women's Hospital (BWH)

The ultimate goal of "Operationalizing the Disclosure & Apology Program at Brigham and Women's Hospital" is for clinicians at BWH to disclose all significant errors in an empathetic, transparent, and timely fashion. This project supports the creation of a robust process whereby all clinicians receive timely disclosure coaching and adverse events are routinely reported. The cornerstone of the program provides easily accessible, widely available disclosure coaching and support to all clinicians at any time.

Program offerings include:

- 24/7 availability and usage of disclosure coaching
- Access to and widespread adoption of disclosure and apology educational tools as developed by CRICO
- Integration of disclosure and apology training into departmental grand rounds and M&Ms
- Cohesion and integration with patient safety efforts, especially with regard to using adverse events to make both individual and systems changes
- Development of a robust set of process measures to evaluate the impact on providers, as well as patients and families
- Seamless integration with the peer support program to promote clinician growth after involvement in an error

Jessica Bradley is grants manager for CRICO's Patient Safety Department.

Our Approach to Disclosure of Medical Error and Compensation

Elizabeth Cushing, Esq.

When clinicians are faced with the disclosure of medical error, CRICO's goal is to help them maintain trust and support their patients. CRICO urges clinicians to undertake these uncomfortable conversations not simply to avoid lawsuits, but because it is the right thing to do. To date, CRICO has been able to resolve every claim presented after disclosure and apology without protracted litigation, although we sometimes have to pay a premium on the fair indemnity amount to do so. In fact, many of these situations are handled without court involvement.

The length of time required to determine causation related to medical error varies greatly. The process of evaluating all contributing factors can result in a protracted discovery period needed to establish whether negligence was a factor, or if the standard of care was met. Sometimes, obvious instances of negligence can be identified (e.g., wrong site surgery or wrong patient). In such cases, immediate payment will be made. For cases that take longer to determine, once negligence or causation has been established, we will offer compensation. In all cases regardless of outcome, CRICO provides support to insured clinicians from the time we are informed of an adverse event.

CRICO takes the position that the best approach to compensation following disclosure of a medical error is one that respects the need of patients to be self-directed and move at their own pace. During this time, CRICO claim managers will collaborate with institutional risk managers to respond to these situations and will be responsible for all discussions of financial compensation. No physician should have to engage in financial negotiations with his or her patient. Not only is it terribly awkward, but physicians have no frame of reference for what is fair and just compensation in any particular circumstance. Similarly, we encourage patients to consult legal counsel before accepting a settlement of their claim.

CRICO has partnered with the Institute for Professionalism & Ethical Practice to compile a list of guidelines for disclosure physicians can reference following an adverse event.

CRICO staff and your institutional risk managers are available as needed to provide any additional clarification or answer any questions you may have. Our interest is in protecting your needs as well as assisting you in the delivery of the safest care possible to your patients.

Elizabeth Cushing is vice president of Claims for CRICO.

View CRICO's *Guidelines for Disclosure.*
RMF.HARVARD.EDU/DISCLOSURE

Case Volume

CRICO cases, 2003–2012

2,351
Cases closed

1,530 | 65%
Cases involved physicians

22%
of cases invovling physicians went to trial or arbitration

31%
of cases involving physicians resulted in a payment

2.4
MD defendants per 100 insured physicians

Accuracy at Issue in the New Massachusetts Disclosure Law

Tom Augello

Health providers in Massachusetts have new protections and new rules to follow, after a state medical error disclosure and apology law went into effect in November 2012.

The rules for the Health Payment Reform Act were crafted to improve communication between providers and patients after an unexpected adverse outcome:

- **First**, the Act attempts to add protections for providers who apologize to patients, and
- **Second**, the Act requires a "cooling off" period before a patient can bring a lawsuit. It also requires that hospitals and doctors reply to the patient's request for information during that time.

John Ryan is a medical malpractice defense attorney with Sloane and Walsh in Boston and has represented clinicians and hospitals during malpractice suits for nearly 40 years.

"Physicians have to be mindful that there is now a statutory mandate that this form of full disclosure take place. As a result, physicians have to be more attuned to making certain that the information they are relating is accurate, that is, that they can be comfortable that they've looked at the facts and the information and what the health care provider is telling the patient is accurate."

> *"...when you're in that moment, you need to step back and be sure that the information that you are giving to that patient and family at the time is absolutely 100% correct and verifiable."*
>
> —Elizabeth Cushing, CRICO

The law requires disclosure of unanticipated outcomes with a significant medical complication. Apologies are given additional protection under the new law; the charitable immunity cap on health institutions was raised from $25,000 to $100,000; and the interest rate on dollar awards was lowered.

Beth Cushing is vice president of Claims for CRICO. She points out that CRICO has worked closely with its insured hospitals to teach clinicians how to appropriately talk with patients after a bad outcome or medical error, and apologize.

"The central part of the education that we did in disclosure and apology was to help clinicians understand that their words have great meaning in that situation, and also that they should not be discussing anything that they don't know to be absolutely certain. Those of us who work in this area know it's often difficult to be certain about anything in the immediate aftermath of an adverse event. So a lot of our training has been around helping people understand that, despite all the emotions they are having and their desire to make things right, when you're in that moment, you need to step back and be sure that the information you are giving to that patient and family at that time is absolutely 100% correct and verifiable."

The new rules offer even more incentive to be accurate in these discussions. Under the new statute, apologies and expressions of sympathy cannot be admitted later as evidence in a lawsuit—with one exception. If a provider who apologizes, later contradicts his/her statements to the patient or family, under oath, the original apology and associated statements may be brought in.

"You do not want to be in the position of changing your story from one day to another," Cushing says, "or having subsequent information come to your attention later that now changes the opinion that you rendered a few days ago. But in the practice of medicine, that's often the case. Test results as well as other issues need to be explored in order to get the full clinical picture of what happened. We need to measure the conversation, not to hold back and create a story or create a reason for why something happened. You need to be sure that you are not adding insult to injury for a patient who is seeking factual information."

Attorney Ryan says some physicians may have a difficult time with uncertainty immediately after a bad outcome, including what may have happened before they saw the patient:

What should I do after a serious adverse event?
RMF.HARVARD.EDU/ADVERSEEVENT

"There's a great natural instinct in highly intelligent people—of which the medical profession is filled—to drive towards a composite impression of what is the answer to a given question. It is going to be important to be careful about that, because physicians may be inadvertently in these statements tying other people down. And they might find out gee, that isn't what happened on the last visit before they came to see you."

Patients should also benefit from the law's new requirement for a cooling off period and time to share information. Patients or their survivors are required to notify their provider at least 182 days before filing a lawsuit. The provider must in turn reply within 150 days of a notice from a patient or his/her representative regarding an incident covered by the law.

According to Beth Cushing, this earlier exchange of information about the contours of a negligence claim will help resolve questions and claims earlier in the process.

"The more information we get up front, the more quickly we can move on whatever the theory or issue is that we are being presented. Cases that go directly into lawsuits have a track of their own, and it can take a very long time due to the litigation process to really be able to focus in on the heart of the issue. Hopefully, with these letters written by plaintiff attorneys or the patients themselves, we will get a better insight into that sooner and can, therefore, focus our investigation and evaluation on those points that have been raised."

Cushing believes the biggest impact of these changes may be on the insurer or the physician's attorney, rather than the clinician's themselves. John Ryan says the notification letter from the patient is likely to come from an attorney, and might go to several individual doctors involved in the case. He recommends that practices and hospitals have a protocol whereby the patient letters are forwarded to and processed by a central office at the hospital, probably the risk manager or general counsel. Ryan says that, in the end, the new rules are based on a myth that hospitals and clinicians are not trying to be forthcoming. In this sense, he thinks the Act mostly structures something that's already taking place.

"I'm a great believer that the medical profession at the end of the day—and here comes the naiveté of a 38-year trial lawyer—ought not to be driven by legalisms and by fear of litigation, it should be driven by the natural ethical and wonderful instincts of health care providers, which is to care for the patient. A lot of these activities would typically be in the ebb and flow of the relationship with patients particularly in these outpatient primary care settings where there is a good relationship that's built up over time. It's not a profession of hiding. It's not a profession that's covert, at least in my experience."

Tom Augello manages multi-media content and production for CRICO.

Write It Right

Entries should be...

...OBJECTIVE

- Document your clinical rationale at critical decision points, e.g., a new finding or change in the patient's condition
- Record the risk-benefit analysis of important decisions
- Don't chart a symptom without documenting your response
  - response should meet the standard of care
- Describe actions of the patient rather than labeling behavior
  - "pt has not kept scheduled appointment with GI" rather than "pt is difficult and non-compliant"
- Avoid comments that could be viewed as disrespectful or prejudicial, e.g., "attention seeking", "histrionic", "dramatic"
- Include socioeconomic information only if relevant to care
- Document communication with other clinicians
- Document patient education, instructions
- Consider the "audiences" that may have access to patient records, e.g., insurance companies, regulatory agencies
  - remember, patients often request copies of their medical records, particularly if there has been a bad outcome
- Avoid hearsay: do not record what someone else said, heard, felt, or smelled unless information is critical; use quotations and attribute remarks accordingly

DOCUMENTATION BEST PRACTICES PROTECT YOUR PATIENTS, YOUR TEAM, AND YOURSELF

...SPECIFIC

- Avoid vague terms; e.g., write "9 x 5 x 1 cm wound" rather than "medium wound"
- Beware copying and pasting in electronic medical records

...TIMELY

- Notes should be recorded contemporaneously with medical care; a long time lapse before entry diminishes credibility

Avoid chart wars

- Do not joust in the record
- Avoid criticizing other staff—current or former caregivers
- Be aware that all relevant facts about prior care may not be available
- Patient's perceptions of care may be inaccurate
- Conflicting chart entries undermine your credibility
- Patient awareness will lead to loss of trust in hospital/caregivers
- Use appropriate chain of command, not medical record, to address conflicts with other providers or administration
- Don't prompt patients to consider litigation
- Do not make assumptions; if something is not clear, get clarification
- Do not amend or alter entries in the record without using the appropriate process

Addenda

- Late entries are appropriate for information that is missing or incompletely documented
- Mark with time/date of late entry, refer to original event
- Do not make an addendum in anticipation of a claim or legal action
  - may be characterized as an attempt to falsify or change the record of fact
  - may appear to be "self-serving" rather than providing information that is needed for patient care
  - appears defensive, does not contribute to the care of the patient, and should be avoided

Corrections

- Paper: draw a line through incorrect entry with initials and the date. Provide corrected information.
- EMR: add a clearly marked addendum to the original entry with the corrected information
  - state the reason for the correction
  - do not delete or make original information inaccessible

Read case studies of documentation failures
RMF.HARVARD.EDU/DOCUMENTATION_CASES

Helping Providers Protect Themselves

Mark Horgan, Esq

CRICO successfully defends its insured in most cases, only paying on about a third of malpractice claims. However, the average size of these payments has grown in recent years consistent with the national trend of seven percent. This growth, together with media reports of shockingly high jury awards in medical malpractice trials from around the country, has some physicians worried about the adequacy of their insurance coverage. They worry that if they are sued, and a jury award exceeds the limits of their malpractice coverage, their personal assets are at risk. It's a legitimate concern.

Physicians, even those employed by a hospital or practice group, bear individual legal and financial responsibility for malpractice claims, including amounts that exceed the available insurance coverage. Some consider purchasing additional coverage in excess of the underlying CRICO policy. Before doing so, it is important to assess the actual risk in context. First, CRICO coverage limits are among the highest in the country. Indeed, in the local market, only the captive University of Massachusetts insurance program equals the $5 million per claim, $10 million in annual aggregate offered by CRICO. The limits of most insurers are much lower, typically $1million/$3 million or $2 million/$6 million.

The corollary is that CRICO's coverage has proved sufficient to pay every settlement made in the company's 30-year history, and has been exceeded in only about a dozen jury trials during that period. Even where a jury award has exceeded the available coverage, defense counsel has in every instance negotiated post-trial agreements relieving CRICO providers of personal responsibility. So, the higher limits offered by excess insurance have not yet been necessary, nor is there any guarantee those enhanced limits would not be exceeded in any particular case.

The most prudent approach is for each provider to perform a risk mitigation assessment. For example, some specialties—such as surgery and obstetrics—are at risk for higher awards than others. Similarly, some commonly held assets—such as equity in a principal residence and ownership of federally-insured retirement funds—are partially or wholly protected by law from the reach of creditors. Where there are substantial, unprotected personal assets at risk, consultation with an estate planner or other financial advisor may be indicated. In cases where we anticipate such risks to our insured, CRICO claim managers suggest they retain personal counsel to advise them during the litigation. The range of risk mitigation options available is much broader before a particular exposure has arisen than after an injury that could give rise to a claim has occurred.

As always, CRICO remains committed to supporting providers before and after serious events.

Mark Horgan is senior vice president and chief operating officer for CRICO.

Where Are You When Things Go Wrong?

William Berry, MD

Sometimes things in medicine go terribly wrong for a patient. Medicine is practiced by humans and, as an unfortunate consequence of our humanity, patients are hurt by our mistakes. Even the very best health care practitioners can make mistakes.

Surgeons sometimes cut things that they shouldn't cut; internists sometimes miss diagnoses; radiologists sometimes misinterpret X-rays; and nurses sometimes hang the wrong type of IV medication. Why is that? It is because our eyes are not cameras, our ears are not tape recorders, and our brains are not computers. Marvelous sensors of reality, they are flawed because the messages our eyes, ears, and brains take in have to be interpreted by a distractible, fallible intellect. We know that the eyes used to perform intricate surgery and interpret complex diagnostic studies are the same eyes that "see" optical illusions and that are deceived by a quick hand in a magic show. Ears that hear the soft murmur in a baby's heart are fooled by the ventriloquist. And our brains, more complex than the largest computers on earth, help us put it all together but are ever subject to error from fatigue and emotion. Unfortunately and in spite of our tremendous strengths we are vulnerable to seeing, hearing or thinking it "wrong."

So what are we as physicians and nurses to do? The first thing is to recognize our humanness and understand that some accidents are not preventable. The second is to acknowledge the need to fairly compensate patients who are injured as a result of that humanness. The third is to do everything we can to learn from our mistakes and build a system of care that is resilient enough to absorb, correct, and minimize these errors. And the fourth and final thing to do is much more difficult and challenging than the rest: to learn how to forgive ourselves for our imperfections.

We now recognize formally that there is a victim besides the patient when there is a medical mistake. Doctors and nurses pay a tremendous price when they are responsible for what has gone wrong. The nurse or physician who makes a mistake may leave clinical practice entirely, and/or suffer for a long period of time with guilt; both are tragic outcomes for everyone concerned, since time, skills, and talent get wasted, and committed healers walk away from a calling.

Perhaps the answer here is to better support each other when bad things happen. The tendency is to think, "Well at least I didn't make the mistake," and to move on, instead of thinking, "That could have happened to me." Think about working at your own hospital or in your own practice to build a program to help and support each other and end the isolation. When things go wrong, none of us should be alone.

William Berry, MD is a surgical consultant to CRICO.

In Defense of the Jury System

By Elizabeth Cushing, Esq

CRICO's purpose is to protect the reputations and assets of our insured institutions and clinicians. Fundamentally, we do this by steadfastly defending good medical practice against unjustified claims, thereby upholding the good names of our doctors, nurses, and hospitals; and fairly compensating patients and families when they are harmed by care that departs from accepted standards of practice.

A small number of cases reported to CRICO each year involve adverse events that are the result of clear negligence; e.g., operating on the wrong limb or administering the wrong medication to a patient. When these errors occur in CRICO institutions, by and large, thoughtful disclosure and apology takes place, CRICO professionals are engaged, and the matters are resolved without protracted litigation. In fact, many cases resolve without court involvement at all. The process isn't pain free or perfect, but CRICO makes every effort to ensure that we understand the situation and can do the right thing for our insureds and their patients.

Most cases presented to CRICO, however, involve complicated circumstances in which patients question whether they received proper care. CRICO professionals, together with institutional risk managers, the involved clinicians, experts in the specialty at issue, and plaintiff and defense counsel (if retained), evaluate these cases in depth, seeking to determine if the care deviated from accepted practices, or if the patient experienced an unfortunate medical result, despite quality care. It is an important process that patients and clinicians alike need to be able to rely on for a consistent, objective, and fair review of the case.

Our evaluations over the past 30 years have proven to be very reliable. Generally speaking, on average, 229 claims and suits are received by CRICO each year: one-third (about 74) are identified as matters of liability for which compensation is appropriate, and the matter is settled. More than half (53%) of the cases are ultimately dropped by the patient. We are studying this group of cases for insight into why the patients brought the claims and then abandoned them. Since these cases do not typically involve any malpractice, ideally we will identify some opportunities to address patients' issues before they file a claim they won't fully pursue.

The remaining 16% of cases proceed to trial or arbitration. These are cases that are pursued by a patient and his or her attorney despite the fact that CRICO has determined—through investigation and expert analysis—that the care provided was proper and that the matter is one to defend on behalf of the involved insured. CRICO is committed to protecting the reputation of its insureds and we prevail in more than 90% of these contested matters. Despite the variability of juries, it is the system we have, and for the most part it works well.

Elizabeth Cushing is vice president of Claims for CRICO.

CRICO DEFENDANTS' REACTIONS TO BEING SUED...

Why did this happen to me?

I must be guilty.

I'm mad as hell.

They have finally found me out.

I don't trust my own judgment.

As long as I keep busy, I won't feel anything.

This will forever change the way I see patients.

I see everyone staring at me; they know I've been sued.

I can't get away from this; it keeps coming back.

The standards and demands make this job intolerable.

This is what medicine is like today.

I can't empathize with patients. I see them all as potential lawsuits.

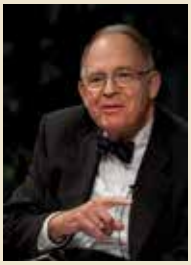
This is an entirely predictable outcome of the work I do.

I should never have gone into medicine.

I can't get closure or resolution.

I have made it through other traumas before, and will make it through this one today.

Hear a CRICO defendant's tale
RMF.HARVARD.EDU/DEFENDANT



from the Bench

Hiller B. Zobel

After a half-century of practicing law, teaching it, presiding over trials (for 26 years), talking with medical people, and co-authoring a book on malpractice litigation, I have yet to meet any health care provider who thinks the court system deals intelligently, logically, or fairly with patients' claims.

Boiled down, the litany comes to this:

The system is rigged by lawyers and judges.

It puts dedicated, concerned doctors at the mercy of opportunistic individuals out for a quick buck.

It encourages suits by patients whose results weren't as successful, prompt, or painless as they were supposed to be.

The malpractice tribunal scheme, ostensibly designed to screen out worthless claims, is a joke. All a plaintiff's lawyer needs is a letter from a doctor—not even one qualified in the defendant's specialty—saying that the defendant erred, and the case and the torture continue.

Cases take unconscionably long to reach resolution, even cases that are so meritless that the plaintiff ultimately drops the claim before trial.

The excruciating delay affects not only the doctor's professional life but perhaps more important, her or his personal life, as well.

The discovery process (particularly the deposition) seems designed to intimidate and embarrass the doctor, besides taking him or her away from patient care.

The trial, once it comes, is a bad joke. Twelve people selected at random have to evaluate scientific evidence that even experienced physicians struggle to understand. Beyond that, the rules of evidence prevent even experts from testifying to the "whole truth."

Outrageously high verdicts and the costs of even successful defenses drive up malpractice insurance premiums.

Perhaps worst of all, constant fear of being sued affects (and infects) a physician's clinical judgment.

Although certainly overstated, this sputtering litany of epithets and exaggerations expresses a valid discontent with the way the judicial system handles physician errors. Indeed, I know no judge or lawyer with any courtroom experience in medical malpractice litigation who regards happily or even calmly the process of administering justice to injured patients and accused doctors. They all would like to see a better method; yet, I've not heard anyone suggest a reasonable plan of improvement. Rather than deal here with each of the complaints, I think it would be more useful to focus on the central problem of how the system should decide three basic issues:

Was the physician's performance unacceptably deficient?

Did that performance injure the patient?

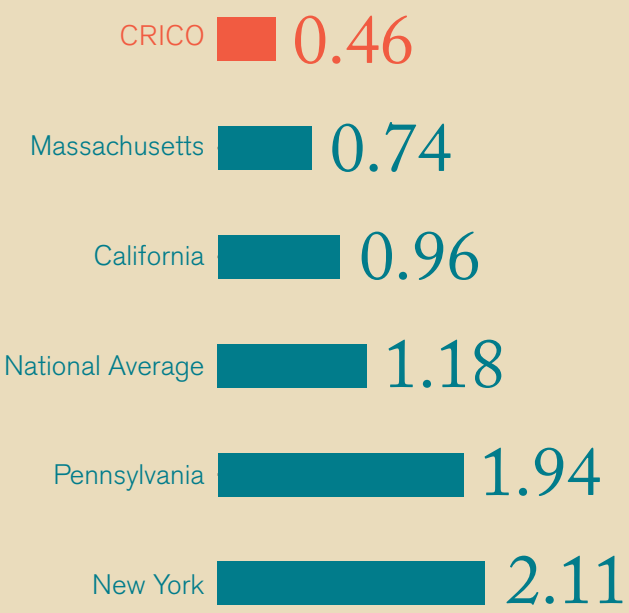
What amount of money fairly compensates the plaintiff?

The apparatus which has evolved (admittedly in a haphazard manner) is the jury. We have come to believe that a group of ordinary citizens hearing the evidence is the best or, if you prefer, least bad way of determining factual issues including damages and the underlying liability. So we ask 12 laypersons to decide whether the doctor was negligent and whether the negligence caused the patient's injury.

Here is the heart of the medical profession's contempt for malpractice litigation. Given the technical nature of medical evidence, putting the issues to a group of non-specialists is indeed asking the ignorant to use the incomprehensible to decide the unknowable.

Paid Claims per 100 Physicians

2011



31%

of the cases closed over the past 10 years that named physician defendants resulted in a payment.

> "I know no judge or lawyer with any courtroom experience in medical malpractice litigation who regards happily or even calmly the process of administering justice to injured patients and accused doctors."
>
> Hiller B. Zobel

How else could we resolve the dispute? Submit the matter to a panel of the defendant doctor's co-specialists? If you were suing your stockbroker would you want the decision to rest with a group of stockbrokers? For that matter, if you were a physician-plaintiff (believe me, such outliers do exist) would you want the decision to rest on a panel composed of doctors sharing the defendant's specialty certification? Is it fair to have any case decided by people in the same business as the defendant?

Well, wouldn't a judge be at least as competent as a jury to decide liability and damages? Speaking frankly, and from experience, I doubt it. Twelve people, hearing and seeing the evidence the parties want to put before them, tend to achieve a fairer result than one person, however impartial and intelligent.

Thus we are left with a deeply-flawed, plainly imperfect system, which in my observation works because juries generally reach the right result—which is of course just another way of saying that I usually agreed with the verdict.

Still, I too wish we could develop a simpler way of achieving justice in malpractice litigation. Perhaps the devil we know is no worse than the devil we don't. As Winston Churchill once remarked in a somewhat different connection: "It has been said that democracy is the worst form of government except all those other forms that have been tried from time to time."

Hiller B. Zobel is a retired associate justice of the Massachusetts Superior Court, and the author, with Stephen N. Rous, MD, of *Doctors and the Law*.

from the Bar

Ellen Epstein Cohen, Esq.

The right to trial by jury dates back to the signing of the Constitution. The Seventh Amendment provides: "in suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law." Most, physicians, nurses and other health care providers have a healthy dose of skepticism about leaving the ultimate decision in a complex medical malpractice case in the hands of 12 lay people. After all, none of the people on the jury is likely to have any medical training or experience, yet *all* of them have experienced health care as patients. It makes sense to assume that lay jurors will be biased in favor of a patient suing her doctor for malpractice—but it turns out not to be true. In actuality, jurors are skillful at identifying what really happened, and they want to believe health care providers are providing good care. Give them credible witnesses and good reasons, and jurors properly conclude the vast majority of the time that the medical care provided was not negligent.

In cases with a legitimate complaint about the treatment provided, the resolution is settlement, often using alternative dispute resolution options. It is the strongly contested cases, where despite a poor patient outcome the defense is certain the medical care was appropriate, which go to trial. It has been my experience as an attorney who defends health care providers that jurors really do want to be fair to all parties, and they do an excellent job evaluating the evidence presented at trial. The word "verdict" comes from the Latin veritas dictum, meaning to speak the truth. Jurors are asked to reach a conclusion about what really happened between doctor and patient —to find where the truth lies regarding the contested issues in the case. Jurors do not need any medical training or expertise to be able to identify a reasonable fact pattern recounted to them by a credible witness, compared with an embellished story by someone less credible. This applies to lay witnesses and physicians alike. Jurors are able to tell when a health care provider, who has made tremendous personal sacrifices in order to dedicate her life to helping others, is accurately explaining in meticulous detail why the course of treatment provided was appropriate and reasonable at the time it was provided; jurors are equally savvy when it comes to identifying a patient trying to take advantage of an unfortunate outcome despite appropriate care. Jurors can identify expert medical witnesses who have made a business out of selling their expert opinions, when compared to a well-qualified expert with significant experience relating to the issue in question, who has performed a full and fair, objective review of the medical treatment and can explain why that care was proper and appropriate. Based only on their life experience of identifying who is credible and who is not, jurors are able to recognize the truth from the evidence.

Contrary to common belief, sympathy alone does not cause jurors to award money to a plaintiff when the outcome is devastating but proper medical care was provided. The applicable law favors health care providers. Jurors are instructed that a physician or nurse is entitled to exercise professional judgment in caring for a patient, and if that judgment was reasonable at the time then it was not negligent, even if the outcome was not as intended or expected. A bad outcome alone is not evidence that the treatment provided was negligent.

22%

of the cases closed over the past 10 years that named physician defendants went to trial or arbitration.

Jurors want to believe that doctors and nurses are providing quality care, as this makes them feel confident in the care that they are receiving. Jurors understand that if a doctor takes the time to sit in a courtroom throughout trial, and to testify under oath to defend her care of the patient, then she must feel very strongly about it—which has a strong impact on a juror's ability to trust and believe the defendant. Taking the suit seriously, being present throughout trial, being prepared and able to explain the treatment in an understandable way, all contribute to the jury's ability to find in favor of the health care provider.

The goals of the defense in a medical malpractice case are to be able to explain the complexity of the care provided in a simple, understandable and believable way. Most jurors are genuinely very interested in learning about the medical issues. While only some lay jurors may actually understand the medicine at the end of the trial, as long as they have a reason to "vote" their confidence in the defendant health care provider(s), they find in favor of the provider. The track record of medical malpractice cases reflects defense verdicts in the 90 percent range, which should give providers a strong reason to have confidence that our jury system is effective in seeking out the truth.

Ellen Epstein Cohen, JD, is a partner with Adler, Cohen, Harvey, Wakeman & Guekguezian, LLP.

Our Juries: Partners in Justice

William J. Dailey, Jr., Esq. and John P. Ryan, Esq., Sloane & Walsh, LLP

Each year, between 650 and 750 medical malpractice cases will be filed in the Massachusetts courts. Each case will involve health care providers being named as defendants. The great majority of these professionals will experience significant emotional distress and will feel challenged professionally. Many will be angry.

It is common for these defendants to question the jury's ability to understand and sort through the nuances of complex and controverted medical issues. Contrary to commonly held beliefs, experience has taught us that jurors have the commitment, discernment, and judgment to fairly determine even the most complex medical malpractice cases. It is important for defendants to see themselves and jurors as partners in the jury process, partners in justice—rather than adversaries.

Jurors want to believe in physicians; they are looking for evidence that practitioners cared for their patients and did their best. It is very unusual for a jury to find against a health care professional who measured up to those standards. At its best, the jury trial is a teaching experience for the physician and a learning experience for the jury. Looking at it this way increases the likelihood of effective interaction between defendants and jurors, which can lead to successful outcomes.

Jurors become very interested in the cases being tried before them. It has become common practice to provide them with notebooks containing copies of the pertinent medical records, peer-reviewed literature, and other evidentiary exhibits. It is equally common to allow jurors to take notes during the trial. Several members of the Massachusetts judiciary have adopted the practice of allowing jurors to ask questions of the witnesses after the lawyers have completed their respective examinations. It has even become acceptable for the defendant's attorney to invite the defendant to step out of the witness box, center him or herself in front of the jury box, and explain the medicine using anatomical models, or illustrations. Jurors want to learn, just as they want to make an informed decision.

ABOUT INSIGHT

Insight examines the issues impacting health care providers' ability to provide safe care and practice in an environment where they are supported by a proactive medical liability insurance program.

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GLOSSARY

Allegation is the plaintiff's assertion of what led to the patient's injury.

Assert year is the year in which a malpractice claim or suit is filed.

Case: a malpractice claim or lawsuit. CRICO counts each case as a single entity regardless of how many defendants are named.

Defendants in malpractice cases are named by the plaintiff. In some CRICO cases, providers not insured by CRICO may also be named.

Loss year is the year in which the event precipitating a malpractice claim or suit occurred.

Physician coverage year (PCY) is one year of coverage for a full-time physician or part-time physicians in full-time equivalents.

Responsible service is the clinical service determined to have been responsible for the patient at the time of the events triggering a malpractice allegation.

Total incurred losses reflects money reserved for open cases, money paid on closed cases, and the costs incurred defending insured organizations and providers.

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Meet your claims defense team.

Patty Hanks, master claims representative, CRICO

"We want our physicians to get back to the good work they do taking care of patients, while we're taking care of their lawsuit…"

Physician defender interviews
RMF.HARVARD.EDU/DEFENSETEAM

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"The key to vindicating clinicians without unnecessarily exposing them to the personal and financial trauma of an adverse event is reflected in our rigorous claim management process."

—Mark Horgan, COO, CRICO

Protecting Providers. Promoting Safety.

CRICO, a recognized leader in evidence-based risk management, is a group of companies owned by and serving the Harvard medical community. For more than 30 years, the CRICO companies have provided industry-leading medical professional liability coverage, claims management, and patient safety resources to its members, proudly serving more than 12,000 physicians (including residents and fellows), 22 hospitals and more than 200 other health care organizations.