Commentary: Serving More, Serving Better

by
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Insured Entities

CRICO is insuring an increasingly diverse population of physicians, hospitals, and organizations reflecting the changing delivery systems of the Harvard affiliated medical institutions. At this point most of the growth has occurred in the *organizations* now being insured while the number of insured *physicians* has maintained a steady increase of five percent per year.

In addition to hospitals and health centers, CRICO insures a variety of physician practice groups, hospices, VNAs, laboratories, imaging facilities, and nursing homes. Managed care organizations have increased fivefold over the past three years due to a formation of a number of physician network organizations at the large institutions. Over the same period CRICO added five subsidiary hospitals, most recently Faulkner Hospital. Physician groups have increased 21 percent primarily due to the growth in Partner's network physician groups. Additional groups are expected to come on board with Care Group's physician network. The impact these organizations will have on the frequency and type of claims made is yet to be seen.

RMF Customer Service

With this change in the makeup of CRICO insureds comes a need to evaluate customer service. RMF will improve its already strong service performance only if its resources are focused on what its customers value the most. This is part of what is, overall, a three-step process:

- Asking CRICO insureds and other customers what satisfies them and what they want,
- Comparing the needs cited against the services being provided, and
- Implementing appropriate actions to provide and improve the delivery of those services.

Currently, RMF teams are working on asking customers what they value.

Coordinating the Effort

Before specific customer service efforts could be properly coordinated, RMF recognized the need to reorganize its staff from a function-based structure into a customer-based structure. In 1997, four multidisciplinary "institutional service teams" were created and trained to serve RMF's customer groups. In turn, those teams began to create a customer service infrastructure with the stated goals of ensuring continuous customer needs assessment, efficient communication, and improved data access.

Growth of CRICO Insureds since 1995

Insured	1995	1998	Growth
Physicians	7,154	7,642	7%
Staff	4,335	5,005	15%
Residents/Fellows	2,819	2,646	-6%
Entities	224	307	37%
Founding Members	13	13	0%
Sponsors			
Subsidiary Hospitals	4	9	125%
Parent Corporations	8	11	38%
Health Care Subsidiaries	13	26	100%
Organizations			
Managed Care Organizations	5	24	380%
Physician Groups	110	133	21%
Joint Ventures	1	4	300%
Non-Health Care Subsidiaries	70	87	24%

RMF's Customer Feedback Team coordinates previously ad hoc efforts to gather and analyze customer comments, complaints, and requests. The team has taken several steps to improve RMF's ability to listen to, learn from, and act upon customer interests and needs.

Participation by CRICO-insured physicians and other customers as advisors is essential for quality improvement projects, educational curricula, and reference materials undertaken by RMF. In addition to ad hoc participation, RMF seeks customer involvement on standing committees such as the Publication and Education Advisory Board, Obstetrics/Gynecology Standards Committee, and Institutional Risk Managers Group.

Responding to Service Gaps

Efforts are currently underway to further strengthen the ability of the institutional teams to respond to "service gaps"—scenarios where physicians or other constituents identify a failure in customer service. The goal is to create an environment that empowers teams to respond immediately to voids in service without creating pockets of inconsistencies across RMF. ■

RMF will improve its already strong service performance only if its resources are focused on what its customers value the most.

Overview of CRICO's Professional Liability Claims Data

by
Maura Keenan

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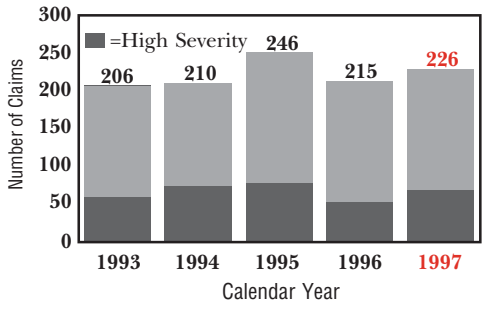
In 1997, 226 professional liability claims naming a CRICO-insured defendant were opened, a five percent increase over 1996 (*Figure 1*). The 1995 high of 246 claims appears to have been an anomaly rather than a new plateau. This experience is consistent with that of ProMutual which reports its volume of claims as steady, and St. Paul which reports a modest increase in claims frequency for 1995 and 1996.

Figure 1

Number of CRICO Professional Liability Claims Opened 1993-97



The rate of defendants per 100 physician coverage years (PCY) was 2.7 for 1997, lower than the 10-year average of 3.2 (*Figure 2*). An increase in the number of insured physicians, principally community-based providers, is a contributing factor to this lower rate. The rate decreased for both staff and house officers (residents and fellows tend to be named in claims less often). House officer insureds are a declining portion of the total CRICO population.

Reflecting the marked expansion of care in the ambulatory setting, outpatient cases represented 60 percent of 1997 claims compared with 40 percent 10 years ago. Diagnosis-related issues are alleged in 30 percent of all outpatient cases and account for 53 percent of losses. One-third of these allege failure to diagnose cancer, and fully one-third of *those* are related to breast cancer.

Figure 2

Physician Specialty Representation in CRICO Claims

MD Specialty	Percent of All CRICO-insured MDs[a]	MDs Named in 1997 Claims	1997 Rate Per 100 PCY[b]	10-Year Rate Per 100 PCY
Anesthesiology	8%	3 (1%)[c]	0.5[d]	2.4
Cardiology	**5%**	**5 (2%)**	**1.4**	**1.7**
Cardio/Thoracic Surgery	1%	4 (2%)	5.7	9.0
Dentistry/Oral Surgery	**2%**	**14 (7%)**	**8.6**	**4.6**
Endocrinology	2%	3 (1%)	2.4	1.4
ENT	**1%**	**7 (3%)**	**8.3**	**8.2**
General Medicine	20%	29 (14%)	2.0	2.3
General Surgery	**4%**	**25 (12%)**	**8.2**	**7.1**
Neonatology	1%	1 (1%)	2.1	2.4
Neurology	**4%**	**5 (2%)**	**1.9**	**2.0**
Neurosurgery	1%	13 (6%)	25.0	14.8
Obstetrics/Gynecology	**4%**	**35 (17%)**	**10.5**	**10.9**
Ophthalmology	2%	4 (2%)	2.4	2.0
Orthopedic Surgery	**2%**	**13 (6%)**	**7.7**	**8.2**
Pediatrics	8%	6 (3%)	1.0	1.1
Plastic Surgery	**1%**	**4 (2%)**	**10.5**	**10.7**
Psychiatry	7%	8 (4%)	1.5	2.7
Radiology	**6%**	**9 (4%)**	**1.9**	**2.4**
Vascular Surgery	<1%	4 (2%)	12.5	9.5
Other	**21%**	**9 (4%)**	**0.7**	**1.3**
All CRICO physicians	**100%**	**201**	**2.7**	**3.2**

a In 1997, CRICO coverage was extended to 7,365 physicians and dentists including residents and fellows.
b Physician Coverage Year. One coverage year is credited for each full year of physician coverage per specialty.
c Percent of all CRICO-insured physician defendants named in cases opened in 1997.
d These rates do not reflect the volume of patient encounters or time devoted to non-clinical activities.

How to Read Figure 2

This table demonstrates claims experience for each listed specialty. For example, anesthesiologists compose eight percent of the MDs CRICO insures. In 1997, three anesthesiologists were named in malpractice claims, representing one percent of 1997's defendant MDs. This represents a rate of 0.5 defendants per 100 anesthesiologists covered in 1997, compared with a rate of 2.4 over the past 10 years.

Severity

Overall severity distribution of claims remains stable, as measured by a widely used scale developed by the National Association for Insurance Commissioners. Unlike CRICO, several other physician insurers have reported rising levels of claims severity in recent years. Typically, the majority of CRICO cases fall in the mid-severity categories; the remainder fit equally into the high or low categories.

Clinical Specialties

CRICO's insured physician population has been growing steadily at about five percent per year. More of the growth in recent years has come from primary care specialties such as General Medicine and Pediatrics than from house staff or other medical specialties. These two specialties represent 28 percent of insured physicians in 1997, up from 24 percent in 1993. Obstetrics/Gynecology continues to be the highest risk specialty accounting for 23 percent of incurred losses but only four percent of the 1997 insured population (*Figure 2*). By comparison, General Medicine represents 20 percent of all insured MDs and 12 percent of losses.

Allegations

Cases involving diagnosis-related allegations have dipped to 17 percent of all cases opened in 1997 from 25 percent in 1994. (*Figure 3*) Despite the reduced frequency, diagnosis-related claims remain costly, accounting for 23 percent of 1997 losses. In contrast, the percentage of Surgical Treatment allegations has been slowly increasing, accounting for 23 percent of 1997 claims and 25 percent of associated losses. Most allegations center around technical issues and postoperative complications.

Diagnosis-related issues are alleged in 30 percent of all outpatient cases and account for 53 percent of losses. One-third of these allege failure to diagnose cancer, and fully one-third of those are related to breast cancer.

Figure 3

CRICO's Professional Liability Claims

Top Allegations	Claims Opened 1992-1996		Claims Opened 1997		Incurred Losses[a] 1997 (millions)	
Surgery-related	191	(18%)	51	(23%)	$15.7	(25%)
Treatment-related	241	(23%)	43	(19%)	$7.1	(11%)
Diagnosis-related	209	(20%)	39	(17%)	$14.3	(23%)
Equipment-related	29	(3%)	17	(8%)	$2.5	(4%)
Safety & Security	48	(5%)	15	(7%)	$0.8	(1%)
Medication-related	65	(6%)	13	(6%)	$4.9	(8%)
Obstetrics-related	51	(5%)	12	(5%)	$9.2	(15%)
Communication	57	(5%)	12	(5%)	$4.5	(7%)
Anesthesia-related	29	(3%)	6	(3%)	$2.0	(3%)
Other	121	(12%)	18	(8%)	$2.5	(4%)
Total	**1,041**		**226**		**$51.7**	

a Indemnity payments, expenses, and reserves for pending claims and suits.

Figure 4

CRICO Professional Liability Claims Closed 1993-97

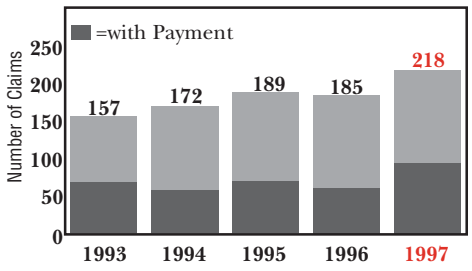
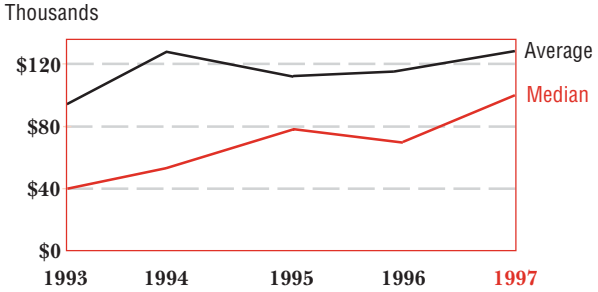


Figure 5

Average and Median Indemnity Payments in CRICO's Closed Claims



Closed Cases

Risk Management Foundation (RMF) closed 218 CRICO cases during 1997, 18 percent more than 1996 (*Figure 4*). RMF's addition of a fourth claims unit may have contributed to the higher closure rate; a similar uptick was seen in 1992 following the creation of the third claims team. The backlog of claims working its way through the court system may have also influenced the higher proportion of claims that closed with indemnity payment in 1997 (44 percent) compared with an average of 39 percent since 1991.

Payments for claims closed in 1997 were up (*Figure 5*), influenced by seven payments made over $1 million. The impact of a few large cases is demonstrated by the fact that 41 percent of associated losses stem from just three percent of cases closed with payment.

Trials

Seventeen cases were tried to conclusion in 1997. Of the 31 CRICO-insured physician, employee, and institution defendants in the tried cases, 26 (84 percent) received a favorable verdict. ■

Note

1 Controlled Risk Insurance Company (CRICO) provides professional liability insurance to health care institutions, their employees, and affiliated physicians.

Medication-related Malpractice Claims

by
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By some accounts, nearly seven percent of hospitalized patients experience an adverse drug event: close to one fifth of all adverse patient events.[1] Media coverage of serious medication adverse events often focuses blame on the individuals involved. Thus, it ignores the context in which these errors occur, one where marked advancements have been made in the field of human factors research that help to explain why good, but fallible, clinicians make errors despite their best intentions, and how systems and processes contribute to the problem.[2]

In light of this, RMF (Risk Management Foundation of the Harvard Medical Institutions) has analyzed 191 medication-related CRICO[3] claims from 1988-1997 to elicit what lessons can be learned. The study examined all claims with medication-related allegations or risk management issues.[4]

Scope of the Problem

Medication-related cases represent 10 percent of all CRICO professional liability claims opened from 1988-1997 and account for 19 percent of the indemnity payments for the same period (*Figure 1*). Compared with CRICO's overall claims experience, medication error claims are closed with payment considerably more frequently, and those payments are substantially higher. The median payment in this set of CRICO claims is $75,000; four of the medication-related cases involved payments of $2 million dollars or more.

Drug Groups

More than 60 percent of alleged errors in liability claims were associated with five drug groups: ***antibiotics, anticoagulants, steroids, narcotics,*** and ***cardiovascular drugs***. Targeting the medication ordering and delivery systems supporting these drug groups may help reduce errors in both inpatient and outpatient settings.

Claims alleging medication errors are closed with payment considerably more frequently, and those payments are substantially higher than the CRICO average.

Figure 1

Medication-related Claims: 1988-1997

	All CRICO Claims	Medication-related
Claims opened	1,868	191 (10%)
Defendant count	3,510	376 (11%)
Percent closed with payment	38%	53%
Total indemnity payment	$151 million	$29 million (19%)
Average indemnity payment	$285,000	$365,000
Median payment	$ 60,000	$75,000

Medication-related Risk Factors

Taken in a broader context, a number of factors are at play in these claims:

- miscalculation of dosage relative to patient weight (particularly serious for pediatric patients);
- medication prescribed prior to reaching diagnosis;
- lack of clinician and patient knowledge of drug side effects, drug-drug interactions, and drug-disease interactions;
- clinicians not immediately available in the event of complications at home;
- clinicians disregarding known warning signs;
- wellness-bias dominating outpatient care despite more inpatients being discharged earlier;
- failure to consider all the evolving clinical data;
- failure to tell patients to discontinue the drugs once side effects were noted;
- dismissing multiple toxic side effects as common side effects;
- failure to counsel patients on the intended effects of prescribed medications so that they'll be better able to detect an *unintended* effect;
- failure to coordinate simultaneous treatment by multiple providers;
- limited time to discuss patient's condition overall, and
- difficulty managing complex diseases in outpatient settings effectively.

Four allegation categories:

- inadequate monitoring,
- wrong dose,
- improper management of medication regimen, and
- wrong drug

accounted for 107 (56 percent) of the 191 claims in this study. Added together, the problems of errors in the use of medications are significant and may result in high-cost malpractice claims. These claims are difficult to defend when what transpired is typically quite clear (i.e., the patient was given too high a medication dose).

Claimant Profile

The median age for claimants in the CRICO cases was 39 years, (range 0 - 94) and 53 percent of claimants were female (*Figure 2*). Examples of cases involving patients ages 30-50 include:

- Preoperative interruption of anticoagulant therapy for a 32-year-old patient was followed by deep vein thrombosis. *Settled/mid range*[5]
- A 47-year-old patient received an overdose of heparin (20,000 units in two hours) when a computation error combined with incorrect infusion pump setting led to an overly rapid infusion. A cerebral hemorrhage followed. *Settled/$1 million*
- After a resident administered adrenaline intravenously instead of subcutaneously, a 42-year-old patient suffered a myocardial infarction. *Settled/mid range*
- A 30-year-old patient developed avascular necrosis secondary to prolonged prednisone use for cluster headaches. *Settled/mid range*

Defendant Profile

Physicians (N=209) were named as defendants in 55 percent of the 191 medication-related cases accounting for $21 million dollars in losses (*Figure 2*). In addition, 31 percent of the cases named a CRICO-insured institution and 13 percent named non-physician defendants. Over the last five years of the study period, the number of house officers named as defendants declined 32 percent while the number of attendings named increased 94 percent.

Outpatient versus Inpatient

Medication-related claims started to shift to the ambulatory setting around 1994, tracking the same trend in patient care. Of the 191 cases in this review, 106 (55 percent) involved an ambulatory setting. More than half of those resulted from care provided in a hospital clinic or physician's office.

Medication-related claims involving inpatient care have significantly higher average indemnity payments ($581,000) compared with those involving outpatient care ($100,000). Although less costly, outpatient claims were more frequent and accounted for 33 percent of the incurred losses[6] for the claims in this study. Since the outpatient setting is providing increasingly complex care, including a variety of new drug therapies, higher percentages of drug complications may be seen in the future.

Figure 2

Medication-related Claims N= 191

Claimants

Age	Claims
Neonatal (<1 month)	6 (3%)
First Year (<1 year)	7 (4%)
Child (1-9 years)	15 (8%)
Teenage (10-17 years)	8 (4%)
Young Adult (18-29 years)	22 (12%)
Adult (30-64 years)	98 (51%)
Senior (65+years)	31 (16%)
Unknown	4 (2%)
Total	**191 (100%)**

Physician Defendants

Specialty	Number
General Medicine	33 (16%)
Psychiatry	23 (11%)
General Surgery	18 (10%)
Hematology/Oncology	17 (9%)
Anesthesiology	16 (8%)
Obstetrics/Gynecology	14 (7%)
Orthopedic	12 (6%)
Neurology	11 (5%)
Pediatrics	7 (3%)
Cardiology	5 (2%)
Other	53 (25%)
Total	**209 (100%)**

Allegations

Claim Category	Number
Inadequate monitoring	33 (17%)
Wrong dose	26 (14%)
Improper management of medication regime	26 (14%)
Wrong drug	22 (12%)
Failure to order	18 (9%)
Adverse reactions	13 (7%)
Wrong route	10 (5%)
Medication inappropriate for medical condition	10 (5%)
Anesthesia-related	10 (5%)
Technical performance	6 (3%)
Failure to obtain consent	5 (3%)
Wrong rate	1 (1%)
Other	11 (6%)
Total	**191(100%)**

Ninety-seven physicians (including 23 residents and fellows) were named in the outpatient medication-related claims. Psychiatry, General Medicine, Neurology, and Pediatrics were the specialties most frequently involved.

Coincidentally, a group of psychiatrists, the most frequently named specialty in outpatient medication-related claims, recently focused attention on coordination issues relative to clinicians sharing treatment. Guidelines for Harvard-affiliated psychiatrists prescribing drugs in conjunction with other clinicians have been published.[7]

Claims Analysis by Alleged Error

Of the 191 medication-related cases reviewed, 106 alleged injury as a direct result of medication use or lack thereof, with antibiotics being the most common medication category. When antibiotics *were* involved, selection of the wrong antibiotic, too short of a course, delayed onset of treatment, and failure to use antimicrobial therapy were the top allegations. In some situations, wrong antibiotics combined with treatment delays resulted in increased morbidity.

Inadequate Monitoring of Medication Regime—which included failure to monitor for drug levels, failure to monitor for drug effects and side effects, and failure to use laboratory data to assess patient response—was the most frequently alleged error in the claims studied, accounting for 17 percent of all medication-related claims and 11 percent of incurred losses (*Figure 3*).

Continued on next page

Case Examples

- A 72-year-old patient died from Macrodantin-induced pulmonary fibrosis after taking the drug for four years to treat recurrent urinary tract infections. The patient's periodic complaint to her clinician of a persistent cough was attributed to post-nasal drip. Abnormal chest X-rays were noted during the first year of Macrodantin therapy. *Settled/mid range*
- A 41-year-old patient alleged that she developed permanent neurologic injuries as a direct result of prolonged Reglan use. The medication was first ordered by a specialist who documented the risk of central nervous system damage, then was continued by the patient's internist over a two-year period. During this time, the patient repeatedly sought medical attention from multiple providers for a variety of involuntary facial movements. The physicians involved in the patient's care did not evaluate continuing the Reglan nor did they refer her to a specialist regarding the continued use of the drug. Her claim against the internist was primarily based on a lack of informed consent with regard to her risk of developing a movement disorder. *Settled/mid range*

Wrong Dose was alleged in 26 cases (*Figure 4*). More than half of these involved computation errors. Two claims involved misuse or malfunction of infusion pumps; two others involved insufficient premedication with Thiosulfate prior to chemotherapy, which precluded completion of the chemotherapy course. Two patients in an experimental protocol for treatment of breast cancer received excessive amounts of Cytoxan when the total four-day dose was instead administered on *each* of the four days. The error went unnoticed by physicians, nurses, and pharmacists for several days. One patient died and the other patient developed cardiac complications.

When circumstances heighten the public's concern about safety, reaction can be swift and severe. In more than half of the cases, the adverse drug event seemed preventable.

Case Examples

- An infant received 4.0mg (instead of 0.4mg) of morphine and arrested. His condition was reversed with Narcan. *Settled/low range*
- An incorrectly set pump resulted in a patient receiving 20mg of morphine instead of 2.0mg. *Settled/low range*
- An 82-year-old woman was rushed to the hospital from her home after a pharmacy error resulted in her receiving 25mg per cc of morphine via PCA pump instead of 25mg per 500cc, as ordered. Narcan was administered. *Settled/low range*
- An 8-day-old infant received 10 times the intended dose of Phenobarbitol due to a misplaced decimal point. Severe neurologic injuries followed. *Settled/> $1 million*
- An infant born at 37 weeks received potassium supplementation despite high serum potassium and arrested. *Settled/> $1 million*

Improper Management of Medication was associated with the highest losses in this study (*Figure 5*). The management of anti-coagulation therapy before and after surgery with the possibility of unstable angina reactivation or stroke was a recurrent factor, as was failure to timely recognize and treat complications. Among this group of claims, six cases involved questions about the selection and duration of antibiotics to manage infection.

Figure 3

Medication-related Claims

Inadequate Monitoring N=33

Claims closed w/payment	5
Indemnity payments	$760,000
Average payment	$152,000
Incurred loss	$5.6 million
Top location	Non-hosp. based
Physician defendants	48
Top Physician Specialties	
Psychiatry	
General Medicine	
Claimants	
Neonatal-Child (2)	
Teen-Young adult (2)	
Adult (22)	
Senior (7)	

Figure 4

Medication-related Claims

Wrong Dose N=26

Claims closed w/payment	21
Indemnity payments	$1.4 million
Average payment	$66,000
Incurred loss	$16 million
Top location	Patient's room
Physician defendants	31
Top Physician Specialties	
Hematology/Oncology	
General Surgery	
Pediatrics	
General Medicine	
Claimants	
Neonatal-Child (13)	
Teen-Young adult (3)	
Adult (6)	
Senior (4)	

Figure 5

Medication-related Claims

Improper Management of Medication N=26

Claims closed w/payment	9
Indemnity payments	$6.5 million
Average payment	$722,000
Incurred loss	$13.4 million
Top location	Non-hosp. based
Physician defendants	27
Top Physician Specialties	
Obstetrics/Gynecology	
General Medicine	
Psychiatry	
Claimants	
Neonatal- Child (3)	
Teen-Young adult (6)	
Adult (14)	
Senior (3)	

Case Examples

- Blood cultures of a 13-year-old burn victim were positive for *Staph aureus*. The patient was placed on an eight-day course of antibiotics. Follow-up blood cultures were negative. Six days later, positive blood cultures dictated an additional eight-day course of antibiotics. Nine days after completing the antibiotics, the patient returned with fever and chills; gastroenteritis was suspected. Twenty-four hours later, he was admitted with endocarditis requiring mitral valve replacement. The duration of the antibiotic regimen was central to the case. *Settled/mid range*
- A female who was 23 weeks pregnant was seen for nausea, vomiting, and diarrhea; viral gastroenteritis was suspected. She underwent an appendectomy for acute necrotizing appendicitis with abscess formation. Nine days later, after five days of intravenous antibiotics, she was discharged. Less than a week later, she was readmitted in premature labor with chorioamnionitis and peri-appendiceal abscess. Her 2lbs./2oz. infant was born with *E.coli* sepsis and brain injury. *Settled/>$1 million*

Wrong Drug claims accounted for 22 cases; four involved prescribing medication to which the patient was allergic (*Figure 6*).

Cases Examples:

- A patient was given a paralyzing agent instead of an antibiotic. Respiratory arrest followed. *Settled/low range*
- A patient, whose last name was similar to another patient, received Trilafon instead of Enalapril. *Settled/low range*
- A six-year-old patient received eight doses of an antineoplastic alkylating agent by three different RNs who thought *Busulfan* was the generic name for *Buspar*, the anxiety medication he was supposed to receive. *Settled/low range*
- A woman was given her father-in-law's prescription (same last names) for anti-anginal medication instead of gastric secretion medication. *Settled/low range*

Health care is a human activity in which occasionally occurs a tragic collision of chance, circumstances, and decision making.

Conclusion

Health care is a human activity in which occasionally occurs a tragic collision of chance, circumstances, and decision making. And when that concurrence involves medication error, a convergence of law and medicine may also occur. On one side is the patient's or family's need for compensation and recognition, and on the other side a well-meaning physician deeply committed to his or her field of study, perhaps at the mercy of a flawed system, process, or technology.

At their best, medication ordering and delivery systems work fine. But when things go wrong in an isolated incident, the resultant harm to an individual can also damage the public's perception about medical safety. At the end of the day, patients still look for a level of personal involvement on the part of the physician that will comfort them. To that end, people on both sides of the equation need to identify and improve the systems involved.

The facts of a malpractice case only offer a retrospective view on the issues raised by the plaintiff. More important are less visible factors related to inflexible systems: failures of expertise; lack of communication, coordination, and teamwork; inadequate information; fatigue; and other conditions with multiple root causes contributing to the likelihood of error.

Given the broader context, staying the course will not be the right action. Aggressive solutions in medication safety must be placed on the fast track. A forward-looking sense, such as the innovative work of Leape, Bates and others, is essential for safety to prevail. ■

Figure 6

Medication-related Claims

Wrong Drug N=22

Claims closed w/payment	15
Indemnity payments	$551,000
Average payment	$37,000
Incurred losses	$899,000
Top location	Non-hospital, Pharmacy
Physician defendants	30
Top Physician Specialties	
Anesthesiology	Gynecology
Neurology	Neurosurgery
Pediatrics	Psychiatry
Radiology	
Claimants	
Neonatal-Child (4)	
Teen-Young adult (2)	
Adult (13)	
Senior (2)	

Notes & References

1 Bates DW, et al. Incidence of adverse drug events and potential adverse events. Journal of the American Medical Association. 1995;274:29-34.

2 Leape LL, et al. Systems analysis of adverse drug events. Journal of the American Medical Association. 1995;274:35-43.

3 Controlled Risk Insurance Company (CRICO) provides professional liability insurance to health care institutions, their employees, and affiliated physicians.

4 Limitations of the study: In this review, data analysis was based on review of case abstracts which may not fully reflect insights into the specific causes of an adverse event.

5 Low range = < $99,999;
Mid range = $100,000 - $499,999;
High range = $500,000 - $999,999.

6 Incurred losses includes expenses, payments on closed cases, and reserves on open cases.

7 Sederer L, Ellison J, Keyes C. Guidelines for prescribing psychiatrists in consultative, collaborative, and supervisory relationships. *Psychiatric Services*. 1998; 49(9):1197-1202.

Arbitrating/Mediating Medical Malpractice Cases

An interview with Hon. James P. Lynch, Jr. (Ret.)

Judge Lynch is a Senior Mediator with J.A.M.S./ ENDISPUTE and former chief justice of the Massachusetts Superior Court.

At times, the civil court system may not completely serve the real interests of either the claimant or defendant in a medical malpractice dispute. As a result, alternative dispute resolution is gaining ground as a more efficient and satisfying alternative to litigation. In this regard, *Forum* turns to one of Massachusetts' most respected adjudicators, for insight into the arbitration/mediation process.

Judge Lynch, in medical malpractice litigation, what options are available as an alternative to a jury trial?

Arbitration and mediation. In each, qualified, experienced persons, "neutrals," are available to help resolve disputes between patients and physicians.[1]

What are some advantages of arbitration and mediation that may lead a defense team to seek one of these procedures, if available?

Unlike court proceedings, arbitration and mediation are conducted out of public view under confidential conditions. Court proceedings are inevitably more expensive than arbitration; mediation is the least expensive of all. Traditional medical malpractice litigation in court is subject to protracted pretrial procedures (motions and discovery) and other delays before the case ever reaches trial. Since a verdict favors one side over the other, a protracted appeal often follows. If early finality of outcome is desired, arbitration is much more effective than traditional litigation. If an early settlement of the controversy is the prime object, mediation seems to be the vehicle of choice.

Disposition of CRICO Professional Liability Cases: 1993 - 1997

	Cases Closed in Calendar Year 1993-1996		1997	
Dropped/denied/dismissed	352	(50%)	102	(47%)
Defendant verdict at trial	63	(9%)	14	(6%)
Binding arbitration - defense	20	(3%)	3	(1%)
Total closed without payment	**435**	**(62%)**	**119**	**(55%)**
Settled prior to trial	228	(33%)	86	(40%)
Settled during trial/appeal	17	(2%)	3	(1%)
Binding arbitration - plaintiff	8	(1%)	5	(2%)
Plaintiff verdict at trial	11	(2%)	3	(1%)
Total closed with payment	**264**	**(38%)**	**97**	**(45%)**
Total Closed	**699**	**(100%)**	**216**	**(100%)**

Can a physician be forced—by the court or otherwise—to arbitrate or mediate his or her case?

No, both sides must agree to have their dispute arbitrated or mediated before that can happen. A judge may strongly suggest arbitration or mediation once the case is pending in court, but has no power to impose it upon the parties.

Does the physician have a voice in the selection of an arbitrator or mediator?

Certainly. Both parties usually agree on the identity of the neutral who will be involved. The physician's attorney will ordinarily know the neutrals who are available, and who would be acceptable for the assignment. In addition, providers of alternative dispute resolution services are able to suggest qualified neutrals experienced in medical malpractice litigation. Because mediation is non-binding in the absence of a settlement, the choice of a mediator, while important, is usually less critical than the selection of an arbitrator who will decide the controversy with finality.

If early finality of outcome is desired, arbitration is much more effective than traditional litigation.

What is the difference between arbitrating and mediating a medical malpractice claim?

In arbitration, the arbitrator receives evidence, finds the facts, applies the law, and renders a binding decision on the merits of the malpractice claim presented. In mediation, unlike arbitration, there is no decision reached on the merits of the dispute; the objective is to reach a final, financial settlement of the dispute.

Under arbitration, the arbitrator hands down a decision—called an award—on the merits of the patient-physician dispute after receiving evidence from both the patient and the physician and after hearing oral arguments from the attorneys for both parties. The evidence presented usually consists of 1) oral testimony of witnesses, who may include the patient and the physician, and experts called by each side, 2) affidavits of unavailable witnesses (if the arbitrator agrees), 3) hospital and medical records, and 4) other writings and exhibits. The testimony of witnesses is subject to cross-examination. The rules of evidence apply, but may be somewhat relaxed at the discretion of the arbitrator. The arbitrator's decision is in writing and is binding on the parties (unless, in rare cases, the parties have agreed otherwise).

Arbitration has the advantage of bringing finality to the dispute. It is, however, a more formal proceeding than mediation, may take several days to complete, and may involve scheduling problems for the physician, who normally attends, and for his experts.

Even so, it is much more flexible in that regard than a court trial. Mediation is quite informal by comparison, and usually takes less than a day to complete.

If either party is disappointed with the arbitration award, is an appeal still possible?

No. The only "escape" from a disappointing arbitration result is a motion made in court to vacate the award. But the grounds for allowing such a motion are statutory and extremely narrow—principally corruption, fraud, evident partiality, or other undue means. An award will not be set aside even if the arbitrator in reaching a decision may have committed an error of law or fact. Courts rarely vacate arbitration awards.

Other than being less formal, how does mediation work?

Rather than being a fact finder or decision maker, the mediator's role is to assist the patient and the physician to identify the controlling issues in the case, to assist in their discussions and negotiations, and to aid them in developing a mutually acceptable settlement. Mediation is a confidential proceeding. It is not intended to be confrontational.

No testimony or other evidence is received, so there is no pre-mediation discovery or depositions. Neither the parties nor their supporting witnesses have to be present. If the mediation process does not result in a settlement, neither party is bound in any further court proceedings by any admissions, concessions, demands, or offers made during the mediation session. If, however, the parties do reach a settlement, that is binding on them, and may be enforced.

If an early settlement of the controversy is the prime object, mediation seems to be the vehicle of choice.

What happens at a typical mediation session?

The participants gather, in a conference room, for a "plenary" session. The mediator introduces everyone, explains the process, then requests the attorneys to present a brief overview of their respective client's claim and defenses, and why that attorney believes that his or her client will prevail before a jury if the matter is tried in court. Suit may have been commenced, but mediations can occur before formal court proceedings have been instituted.

The presentations usually cover both liability and damage issues. During the oral presentations, the mediator may ask questions to clarify issues and assertions and may ask about the history of settlement discussions, if any, and the status of the case in court, if action has been commenced.

The plenary session is designed to set the informal tone of the proceedings as well as to educate the mediator and the parties as to the strengths and weaknesses of each side's position. When the presentations have been completed, the settlement negotiations are ready to commence. Of course, other mediators may follow other protocols or procedures.

Arbitration Profile

Defendants: General Surgeon, Urologist

Plaintiff: 70-year-old male

Result: Arbitration (Defense Verdict)

The family of a 70-year-old male patient alleged delay in diagnosing and treating signs and symptoms of an anastomotic leak, resulting in peritonitis and death due to complications of septic shock. This patient, who had a diagnosis of renal cancer (Stage IV) underwent radical nephrectomy with colon resection and anastomosis. Six days postoperatively, the patient was diagnosed with small bowel obstruction for which treatment was observation. His vital signs, abdominal exam, and WBC were normal. Nine days postoperatively, the patient developed severe abdominal pain with sudden changes in vital signs. An emergency laparotomy was performed revealing anastomotic leak. The arbitrator found no clear evidence of peritonitis until the morning of the emergency laparotomy, at which time appropriate action was taken.

How is the negotiation started?

The mediator determines with which party he or she will first confer to obtain an opening offer to settle the case. Acting in the role of a facilitator—in a totally objective fashion, expressing no thoughts or observations on the merits of either party's position—the mediator transmits offers, counteroffers, and information from one party to the other. In short, he or she shuttles from room to room, essentially in the role of messenger.

The mediator continues to act solely as a facilitator so long as the negotiations appear to be fruitful and headed toward settlement. If, as often occurs, the parties are unable to narrow their offers and counteroffers to a point of agreement, the arbitrator then changes his or her participation from a facilitator to that of an evaluator.

How is that role different?

At an appropriate time in the process, by request or assent of the parties, the mediator may evaluate for each party in confidence what he or she believes to be the strengths and weaknesses of that party's position as to each issue of liability and damages, and may express an opinion on the probable outcome of that issue if tried to a jury. Based on that evaluation, the mediator may also express an opinion as to a fair range for settlement, or a fair settlement figure.

Neither party is in any way obliged to agree with the mediator's evaluation of the issues or any settlement suggestions; and the mediator has no power to force agreement. Often, however, the evaluation and settlement suggestions of an objective mediator, experienced in the risks and outcomes of medical malpractice litigation, carries considerable weight with the parties and leads to a settlement within the mediator's suggested range.

Continued on next page

What happens following the mediation session?

If they settle, the agreement will be written up and the attorneys will thereafter draft the releases and other closing documents. There is no publicity.

If no settlement is reached, the case proceeds on in court; if no suit is pending, a civil action may commence. What often occurs, however, is that the seeds for settlement have been sown and thereafter the case is settled before trial often at or close to the mediator's suggested solution. Neither the mediator nor the participants in a mediation that does not reach settlement may disclose what transpired at the session; no settlement negotiations or mediator evaluations or suggested settlement figures may be used for or against any party in court or otherwise. ■

Note

1 For convenience, the term "physician" is used throughout in the singular and is intended to include physicians, surgeons, nurses, and other health providers. Some arbitrations and mediations may include more than one physician.

Arbitration from the Claims Professional's Perspective

by
Kathleen Dwyer, M.S.N.

Kathy Dwyer is a Loss Prevention Consultant for Risk Management Foundation of the Harvard Medical Institutions.

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The resources involved in malpractice litigation, in terms of dollars, time, and distraction, are enormous. Lawsuits are protracted, generate negative publicity, adversely affect morale in the provider's setting, and frequently are resolved with both sides dissatisfied. All of these factors are incentives for both sides to seek an alternative to a jury trial.

Avoiding Trial

In short, arbitration provides that alternative—an early opportunity for opposing sides to better express and understand their differing viewpoints. It also offers greater control over the dynamics of the proceeding. Both parties agree upon the arbitrator, usually a retired judge experienced in sorting complex facts and deciding a case's merits. With arbitration comes an ease of scheduling as both parties agree in advance to a specific date and length of the proceeding—in direct contrast to the less predictable civil court system, where delays and postponements are common. And at the end of the process—unlike litigation, in which the losing party can exercise their right to appeal—arbitration is final and binding.

RMF considers arbitration as an option for all suits that face the potential for trial.

The combination of these factors guides both sides to fair, fast, and economic resolution of their dispute via arbitration. Today, as a matter of course, claim representatives at Risk Management Foundation of the Harvard Medical Institutions (RMF) consider arbitration as an option for all suits that face the potential for trial. As each case progresses, the defense team determines whether or not to raise the arbitration option with plaintiff's counsel.

Unlike litigation, with its ever-escalating adversarial nature, arbitration affords a more informal, less intimidating environment. Since the arbitrator is both fact finder and decision maker, an element of certainty exists for both sides.

Before arbitration can occur, the defense team faces a major hurdle: the plaintiff must agree to this type of resolution. Initially, many plaintiffs resist the idea. For this reason, RMF claim representatives play a key role preparing a compelling argument to soften the initial resistance towards arbitration.

Case Selection

From the defense perspective, the emotional or technical nature of the case can make it a strong candidate for arbitration. In this regard, experienced arbitrators make their decisions based on the facts of the dispute and the law, recognizing, but putting aside, sympathy to focus on the question of liability.

Arbitration can also involve an element of creativity for the defense team. "Winning" is not always the goal of taking a case to arbitration. In some cases, for example, all of the parties agree that a case has some merit, but they cannot agree on the value in terms of indemnity. In these situations, the parties in arbitration may negotiate a "high-low" arrangement. This requires a payment of the low figure even if a defense verdict is returned, with a cap on the payment at the high number if the verdict exceeds that amount.

CRICO Results

For malpractice cases involving CRICO-insured providers, arbitration is becoming a mainstream option.[1] Over the past five years, RMF has successfully shifted 36 cases from trial to binding arbitration (*see Page 8*). Of the 75 defendants involved, 48 received defense verdicts. In several other of the cases, the amount awarded was limited as described above. ■

Note

1 The attraction of arbitration varies by state. While Massachusetts' caseload prolongs the trial process, other states have shorter schedules. The binding nature of the decision also varies; in Rhode Island, for example, arbitration decisions are not binding.

Defending Cases Involving Catastrophic Injury

An interview with John P. Ryan, Esq.

John Ryan is a Partner with the law firm of Sloane & Walsh in Boston, Massachusetts.

Mr. Ryan, with the stakes so high in malpractice claims involving a very bad outcome, many people might be surprised at how effectively they are defended, even when the complaint appears to have some merit.

A malpractice trial is not simply compensating a person because of a bad medical outcome, but rather judging the liability of a clinician based on the medical practice he or she employed. Even when the complaints or the allegations might appear to have merit, most jurors understand that they're going to hear a defendant's explanation of the outcome—that they'll hear the defendant's answer to the plaintiff's allegations—and they reserve judgment until they've heard the whole case. Even when cases involve a bad outcome, it's not entirely surprising that jurors, generally, are able to come to an appropriate conclusion once they've heard all of the evidence.

What do you tell defendant physicians named in catastrophic cases?

"Put aside the laudable and appropriate emotion of empathy for the patient and concentrate on an intellectual and academic review of the medicine." That's very difficult for fine physicians to do because it runs somewhat counter to their whole mission. But once they realize that the lawsuit is being propelled by a plaintiff's lawyer who will be analyzing and engineering the theory of the allegation against the physician, they get on to an academic, intellectual track of explaining the medicine in the case.

What aspects of this are within control of the defendant clinician?

First and foremost, mastery over the details and facts of the case. Rather than focus on the horrible horribles that might be residing in presently unopened closets, I direct them toward the known facts: the treatment they provided to the patient. By having mastery over the facts, they will invariably produce a good deposition.

Second, they have control over responses to written questions in the course of the litigation, to the degree they spent the time mastering the detail, mastering the facts, and quite frankly, assisting counsel in getting prepared for the case.

Third, they have control over their presentation. Ultimately, the information is going to have to be taught to a group of lay people. The defendant's demeanor has to convey respect for the intelligence of the jurors as opposed to being curt, obtuse, or argumentative. The whole area of communicating credibility is very much in the defendant's control.

What aspects are not within their control?

Scheduling is not within their control. Cases get scheduled, the doctors make arrangements, the court gets occupied on another matter, and the case gets rescheduled. Although it sounds mundane, the anxiety over having cases scheduled and rescheduled is very frustrating.

Second, the selection of the juries in Massachusetts is not a highly controlled activity, so that can be a bit frustrating. Fortunately, jury reform has eliminated most of the traditional rules for being excused from jury duty and has put more highly educated people on juries, including even physicians, lawyers, and in fact, several judges. But again, it's an item over which defendant physicians don't have much control.

Third, they don't have control over the sequence of the presentation of the case. The plaintiff always goes first. While that sounds like a simple point, having to sit through a jury trial and listen to the presentation against you for a day or two is difficult. The defendant has to remain unflappable even when major accusations are being lodged.

And last, when cases proceed all the way to jury deliberation, physicians don't have control over the outcome. They have to presume that the jurors have listened to the evidence. It is disquieting to have a group of strangers listen to your case for a week or two and then deliberate for a day or two with no control over what they are doing.

In addition to the actual evidence entered into a malpractice trial, what influences a jury's decision?

One of the major influences is a juror's personal experience. The second thing that works in a juror's mind today—perhaps more than in the past—is the amount of simplified medical knowledge that's now in the popular media or the popular press. It's not uncommon to see on the science pages of the *Boston Globe*, for example, extensive articles on common medical conditions that are in people's minds—breast cancer, stroke, prostate cancer, etc. There's no way to determine which jurors might be bringing along some preconceived notions or some pre-acquired knowledge from the popular press about various medical conditions. And, while there is constant reinforcement to the jury that it is only what takes place in the courtroom that can be the proper subject of their deliberations, you have to take a jump of faith that they will follow those instructions.

Continued on next page

With sympathy being one of the strongest human emotions, how do you address that element to a jury in cases with a catastrophic outcome?

The single most important aspect is what I call the doctrine of acknowledgment. Right in the opening statement to the jury, I like to acknowledge the severity of the outcome of the case, to speak about the details of the severity of the outcome of the case—even in situations where the plaintiff may have glossed over it in his or her opening statements. I like to inform the jury that the outcome—the catastrophic injury, sympathy, empathy for the plaintiff—is not the issue.

The second thing I like to do is to comfort the jury. It is foolhardy not to believe that jurors hearing about a catastrophic outcome aren't going to have great empathy for the family and for the plaintiff. Consequently, you have to comfort the jury by acknowledging how devastating the outcome is. Thus, when the defendant is presenting evidence on the medicine, the jury has advanced notice that the doctor is empathic to the outcome We're conveying that we understand what the plaintiff or family is going through. But again, if that were the issue there would be no need to have a trial.

The third thing I like to deal with in the courtroom is that the care that was rendered was appropriate despite the outcome. I have seen jurors be reduced to tears in the trial of cases, and nevertheless come back with defendant verdicts. They can separate intellectual and emotional responses even though they may experience both of them during the course of the trial.

How do you address elements of the patient's behavior that may have factored in the outcome?

Prudently, so not to create the impression that you are victimizing the plaintiff. Appropriate intellectual development of the patient's conduct as it may relate to, for example, not following medication regimes or not coming back for follow-up visits can be woven into the case without falling into attacking the patient—which is never productive.

Let's assume we have an extremely likeable patient (who we know as a matter of record missed appointments) and opportunities were lost for an earlier diagnosis of the condition. The defense still has to politely put those questions to that witness. "Mr. Smith, I noticed a moment ago you were speaking about this event on December 15, 1996. Would I be correct that on October 15, 1996 you had a scheduled appointment that you didn't keep?" There is nothing offensive about that question.

So one is to treat them with respect, but not to coddle them. Keep in mind that jurors are going to be instructed at the end of a case that it is within their purview to assess the credibility and overall presentation of a witness, that is, whether or not you believe that person is telling the truth. The best counteractions to likeable plaintiffs are presentable and likeable physicians who are direct, forthright, and who answer the questions that are put to them, with a level of comfort that indicates they know the information and aren't afraid to be there.

Given that delay in diagnosis is a common allegation of malpractice claims, what do you do with the misconception that early detection equals cure?

Two large questions that come up in virtually all delayed diagnosis cases are 1) whether or not the delay made any difference, the so-called causation issue, and 2) why there was a delay.

On the causation issue, the question always arises, if the diagnosis had been made earlier, would it have made any difference. Causation is the connection between the alleged malpractice, i.e., failure to diagnose, and the ultimate outcome. Often defendants are so caught up in the standard of care that they practiced, that they lose sight of this very fundamental element of malpractice: without causation there is no malpractice.

The best counteractions to likeable plaintiffs are presentable and likeable physicians who are direct, forthright, and who answer the questions that are put to them, with a level of comfort that indicates they know the information and aren't afraid to be there.

The second aspect is what I call the interval question. That relates to the nature of the treatment that was rendered during the period that the diagnosis was not being made or another diagnosis was being entertained. The point is to explain the interval of activity so that the jury understands that while the physician may not have made the ultimate diagnosis quickly, he or she was clearly on the job doing his or her best.

How do you console physicians who actually made a mistake?

I tell them that they have a unique and substantial responsibility in the demanding profession they are in. I let them know at the outset that jurors understand they have a tough job. With that tough job comes bad outcomes. The medical malpractice arena is only one small aspect, unpleasant as it may be, to a much grander and honorable professional calling, and I like to emphasize that to them. I tell them, "Go back to work. Keep helping your patients. Keep performing your responsibilities and duties because you do good work."

After the case is underway and they find out the world isn't going to fall in and that many of their colleagues have been in the same boat, they are, for the most part, able to move beyond it. ■

The Impact of Malpractice Litigation on Physicians

by
Kenneth M. Settel, M.D.

Dr. Settel is in private practice of psychiatry and at Harvard Medical School. He provides clinical support for physicians going through malpractice litigation.

When Dr. Jones entered his office after lunch, a man holding an envelope directly confronted the 41-year-old physician, handing him the envelope before quickly departing. The surprised Dr. Jones anxiously opened the envelope. He froze in his tracks with the shock of a summons for a malpractice suit. He broke into a cold sweat.

Who was this patient? The name did not sound familiar. What had he done wrong? What did it all mean? What should he do now? How was he going to continue his day seeing patients, going to his son's Little League game? Certainly his staff and waiting patients must know that something unusual is going on. His assistant interrupted his reverie, a patient was waiting in the exam room, and a specialist was on the phone, returning his morning call.

Confrontation with the threat of malpractice litigation can be a most shocking and devastating event. One sampling of physicians sued for malpractice revealed that more than 20 percent viewed the experience as the most stressful event in their entire lives.[1]

Physicians often come to choose medicine not only out of scientific interest, but also out of a deep personal drive and commitment. Caring for the sick and vulnerable can serve as a meaningful and successful way to satisfy strong emotional needs such as mastery of helplessness, illness, and vulnerability.

Combining that with one's intellectual interests offers a challenging, stimulating career with financial rewards and social respect. This winning combination of satisfactions can often serve as a successful compensation for underlying vulnerabilities while creating a great sense of personal satisfaction and pride.

Pushing the Stress Limits

Physicians deal with stressful situations on a daily basis. In addition to dealing with the worries and pain experienced by anxious, sick, and dying patients (and their families), the structure of medical practice is itself highly stressful. Pressured schedules are continually interrupted and intruded upon by clinical, business, and personal demands. Many physicians make little room in their lives for relaxation and respite.

The norms of the medical profession are for highly driven self-sufficient individuals to work at or beyond their limit. They find little opportunity for peer support, with many busy doctors maintaining their full work lives in isolation and racing off to family or community as soon as they are done. In this context, a malpractice lawsuit comes as another challenge to an already marginally compensated, highly stressed system.

Challenging One's Sense of Competency

A malpractice suit threatens the very heart and soul of what drives physicians to practice medicine. It challenges one's sense of competency, responsibility, and desire to do good rather than to do harm. The wording of the complaint casts the physician in the role of a malignant "harmer," who has breached his or her responsibility to the patient. To the sued physician, it is a shameful matter of incompetence and deceit that has created pain and done harm to the patient he or she intended to care for. In addition, the seeming randomness and unpredictability of the challenge are an affront to the physician's sense of control and mastery of one's universe. The level of impact a malpractice allegation has on a particular physician is determined by many factors:

- The lack of control and sense of helplessness over the challenge.
- The degree to which the event is perceived as a challenge to the physician's sense of pride and mastery.
- The extent that life experience has prepared the physician to handle this kind of stressful experience.
- The physician's degree of self-criticism, self-demands, high expectations, and willingness to accept personal limitations.
- The physician's cognitive ability to perceive the malpractice suit in the greater social context of a highly litigious society, and the patient's desire for redress and compensation for an unfortunate outcome.
- The physician's preexisting vulnerabilities from the past that were never fully resolved and are stirred up by this perceived challenge to competence and motives.
- The social and peer support available.

A Chronology of Physicians' Responses to Being Sued

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

"I must be guilty"

"I can't practice medicine anymore"

"This will hang over me forever"

"No one should ever find out"

"Everyone will eventually know"

"I'm incompetent"

Continued on next page

"They have finally found me out"

"I'm an impostor"

"My children will be hurt"

"My spouse will be shamed"

"My colleagues will judge me"

"I'm mad as hell"

"I'm forever second guessing myself"

"I can't make decisions or take risks"

"I can't listen to my patients with the same sense of sympathy"

Overwhelmed by the Experience

Most physicians experience the threat of litigation as extremely disruptive to their lives and sense of well being. Those who are overwhelmed by the experience suffer significant emotional morbidity. One study revealed that nearly 40 percent of sued physicians developed a constellation of symptoms suggestive of a full-blown major depressive disorder, while an additional 20 percent were subject to symptoms of an adjustment disorder. Two thirds of the sued physicians experienced significant symptoms of anger, change in mood, inner tension, depressed mood, and frustration. Half experienced fatigue, insomnia, and irritability. A quarter experienced difficulty concentrating, feelings of worthlessness and guilt, decreased sex drive, low self esteem, indecision, and decreased appetite.[1]

From the moment of the initial subpoena to the final outcome, physicians experience a series of stressful challenges. Each subsequent progression of new challenges—requests for records, interrogatories, depositions, lawyer meetings, and trial—reawakens the initial trauma and stirs up some of the initial reactions to the summons.

Five Stage Process

Physicians who have been sued for malpractice typically progress through five stages of reacting to and working through the situation, much as they would process grief.

The ***initial impact*** stage lasts for a period of hours following receipt of the summons. It is marked by the experience of numbness, denial, and confusion. The summons arrives without warning, the patient may be familiar and meaningful to the physician—or perhaps not even remembered. Physicians recall feeling numb and lost, with no sense of what to do, who to call, or what to say. They are usually in the middle of some activity such as seeing patients or taking care of children or family with no opportunity to stop what is going on and respond.

At that moment, the physicians who are now defendants may experience transient physical symptoms such as sweating, dizziness, and palpitations as well as confusion, flight, or paralysis. They continue their daily activity, putting aside as best they can, any reaction to the threat of a lawsuit.

The next phase, ***disorganization,*** begins shortly after the initial phase and may last for days or weeks. The event has become a reality and the physician experiences the first sense of being overwhelmed. This phase is marked by intense anxiety with consequent insomnia, loss of appetite, weight loss, rage, difficulty concentrating, repetitive non-productive activity, and fear of losing control.

The realization of what has happened can lead to feelings of shame and doom. Physicians feel uncomfortable walking around the office and awkward returning to the hospital. They feel all alone. The desire for support is inhibited by shame and exacerbated by the warnings not to talk to anyone.[2] At this point, physicians both desire and fear going back to the record to see what really happened and what was documented.

The third phase is one of ***reattachment,*** marked by a progression from anger to sadness as equilibrium is reestablished and recovery begins. This usually lasts two to four months. During the initial period of anger, physicians often experience difficulty sleeping, increased rumination, and preoccupation with the malpractice case. They are risk averse, order more tests, and are reluctant to see patients and perform risky procedures. Physicians finds themselves increasingly alienated from their patients and the way they practice medicine. At times they come to dislike their patients and resent their obligation to care for them.

Anger is gradually supplanted by a sense of sadness. This is characterized by a slowing down, increased preoccupation, mind wandering, and persistent problems sleeping and eating. Physical symptoms such as decreased resistance to illness, stomachaches, and headaches are common. At this stage, many physicians contemplate a life without medicine and wonder about other careers.

The fourth and fifth stages: ***reorganization and reconstitution*** continue through the first and second year following the stressful trauma. At best, the physicians will become successful at coping with the stress. They are better able to distance themselves, develop more intellectually based coping styles, and stop perceiving the lawsuit as a personal attack. The focus shifts from what happened to them to how they will manage their lives in the future. They come to see the malpractice suit as an inherent risk of the profession, not as a measure of personal competence or clinical ability. They will try to see the patient in a different light—trying to imagine things from their perspective. At best, the physician can now take a more active approach to his or her own malpractice defense, reducing their sense of helplessness. Contact with family, friends, and colleagues improves.

Getting Stuck

Physicians who get stuck in the process of adapting to this stress will often show continued withdrawal and emotional detachment from family and friends, continued isolation, suspicion and rage at patients, withdrawal from medicine, continued anxiety and depression, and difficulty in effectively defending themselves in the malpractice lawsuit.

Assisting distressed physicians is a challenge for friends, colleagues, family, and the litigation support team. Seeking and receiving help is out of character for many physicians who are more comfortable in the role of the helper. Yet help is what is needed to both reduce the morbidity and pain of this process and to help physicians reestablish coping skills needed to effectively defend and advocate for themselves in the litigation process.

Getting Unstuck

The goal of helping physicians cope with malpractice litigation stress is to improve self-esteem, and to allow the physician to reestablish his or her previous sense of control and mastery. Sued physicians must overcome the sense of hopelessness and helplessness by getting involved in active coping styles such as participating in and planning the defense strategy and actively protecting themselves and others from future events. This often cannot happen until the physician has sufficiently talked about and worked through the trauma of the lawsuit. Professional counseling may be useful in helping the physician understand the meaning of the lawsuit in light of past life experiences and vulnerabilities. These vulnerabilities threaten to derail the "working through" process that leads to successful coping and mastery.

Physicians trying to cope with the stress of malpractice litigation need help similar to what others going through any traumatically stressful situation need. They need increased social support, contact, interest, and empathy from their community. They may even need an opportunity to distance themselves from the scene or source of the stress by having a less pressured schedule and often a respite from the particular medical setting where the event took place.

At the same time, they need to reinforce their identity as a competent professional, and as a supportive spouse, parent, or community leader. Recuperation and renewal through vacation, contact with family, friends, religion, hobbies, and community are important. In addition, physicians need information, coaching, and preparation to guide them and help them with mastery and control. When people are prepared for what they are facing, they feel less alone, less overwhelmed and more in charge.

Conclusion

Medicine has always been a stressful profession. Recent changes in the structure of medical practice along with the stress of malpractice litigation have contributed to a strikingly higher rate of physician morbidity, disability, and early retirement. Preparing physicians ahead of time for the potential traumatic impact of a malpractice summons and subsequent litigation may "normalize," and foster greater acceptance of, the universal vulnerability and need for support through the stress reaction sequence.

Ideally, information and preparation will better allow physicians to seek the help and support they may need later on. Risk management education—beginning in medical school and continuing through residency—is a valuable opportunity to address the issues of identifying and managing stress in oneself and in one's colleagues. ■

Notes & References

1 Charles SC, Wilbert JR, Kennedy EC. Physicians' self-reports of reactions to malpractice litigation. *American Journal of Psychiatry.* 1984; 147:563-565.

2 Conversations with one's spouse, personal physician, psychotherapist, clergyman, attorney, risk manager, and liability insurance company representative are protected from legal discovery. Conversations about the case with colleagues (outside the peer review process) are discoverable by the plaintiff; those colleagues could be subject to deposition and could later be called to testify based on those conversations.

"This will forever change the way I see patients"

"I should never have gone into medicine"

"Why did this happen to me?"

"The standards and demands make this job intolerable"

"This is what medicine is like today"

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

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

Peer Review in Practice: *Carr v. Howard*

by
Robert P. Powers, Esq.

Bob Powers is a member of the law firm Melick & Porter, LLP. He argued the Carr appeal before the Massachusetts Supreme Judicial Court.

Medical care providers in Massachusetts who maintain an organized system of peer review should feel more secure about the confidentiality of their proceedings following the Commonwealth's Supreme Judicial Court decision last spring in the case of *Carr v. Howard*.[1] The *Carr* opinion is of great significance because it addresses at length the protections afforded to peer review pursuant to Massachusetts law.[2] The opinion provides guidance for medical care providers concerned about maintaining the fullest possible measure of confidentiality for their peer review process, as well as for providers faced with a plaintiff's request for protected material.

Factual Background

The *Carr* case arose from the death of Stanley Howard, who broke away from an escort and jumped from the roof of a hospital parking garage, landing on John Carr. Carr sued Howard's estate, which in turn, sued New England Deaconess Hospital.[3] Carr sought records from the hospital relevant to Howard's treatment, including any incident reports. The Deaconess agreed to produce a security guard's report, but reports created by a nurse manager, an emergency department nurse, and the department of psychiatry were withheld as privileged peer review materials.

Carr asked a Superior Court judge to require the hospital to disclose the documents. The judge asked the Deaconess to provide the documents for his personal review so that he could determine whether the peer review privilege applied. The Deaconess refused. It argued that even this would improperly breach confidentiality.

The displeased judge declared that the hospital's "bold" decision to withhold the documents was not "beyond review by an independent judiciary." He ordered the hospital to comply with his request. The Deaconess sought appellate relief from his order and threat of sanctions. It successfully persuaded the Massachusetts Supreme Judicial Court (SJC) to review the propriety of the order.

The Opinion

The SJC recognized that the medical profession has historically regulated itself through internal peer review, and that the Massachusetts Legislature intended to bolster peer review by enacting the various statutory provisions now contained in Chapter 111. These provisions require, as a condition of licensure, that hospitals participate in risk management programs to review past performance and prevent future harm to patients. To promote candor and confidentiality in the review process, the Legislature created strong protections against discovery and use of peer review materials in civil malpractice actions. The statute states plainly:

> "the proceedings, reports and records of a medical peer review committee shall be confidential and shall not be subject to subpoena or discovery."

The SJC, in *Carr*, ruled that plaintiffs "must not be permitted to disregard the policies embedded" in this statutory prohibition.

The SJC agreed with the Deaconess that determining whether a document is protected by the peer review privilege requires examination of its purpose and the process by which it was created, not its content. The SJC directed trial judges to first examine a discovery request to determine whether on its face it seeks information clearly within the scope of peer review. If doubt exists, the SJC said, trial judges should next consider the evidence proffered by the medical care provider. The SJC stated that a party seeking to protect peer review materials must produce evidence tending to show 1) that the materials are "necessary to comply" with required risk management and quality assurance programs and 2) are necessary to the work product of medical peer review committees. The SJC concluded that a provider need not show that a particular record was submitted to and used by a specific peer review committee, only that the record at issue is of a type that is generally used by peer review committees.

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Notwithstanding the broad discretion granted to trial courts on issues of discovery and evidence, the SJC stated that judges are not at liberty to substitute their judgment for that of the Legislature, and that any order that violates the confidentiality granted by the peer review statute would be an abuse of discretion. Reviewing the materials and affidavits which the hospital had provided to the judge below, the Supreme Judicial Court concluded that the Deaconess had successfully shown that the incident reports were protected peer review materials. This was sufficient to sustain its burden. The Court therefore vacated the trial court's order.

Putting The Decision Into Practice

Perhaps the most significant point to observe about the *Carr* decision is how important the existence of a formal peer review program was to its outcome. As exemplified by the lower court's order, judges tend to view the discovery process as a means of uncovering the "truth," and will favor the legal principle that the public has a right to every person's evidence. Claims of privilege will often be met with skepticism because of the broad legal concept of "relevance" which leads judges to favor the admissibility of any matter that might bear on any issue in a given case. To overcome this inclination, medical care providers must be able to demonstrate for the court that a formal peer review program exists and be able to explain the process.

Review of the *Carr* opinion will afford health care providers and risk managers a clearer understanding of the types of supporting materials that are necessary to sustain a claim of peer review privilege in Massachusetts. These may be grouped into two categories. First, hospital bylaws, internal rules, and applicable regulations should always be provided. These must show the existence of a formal, organized peer review process in compliance with the requirements of the Board of Registration in Medicine. Second, affidavits from knowledgeable individuals within the institution should be obtained. These should include affidavits from medical staff personnel involved in the peer review process, but may also include individuals from the general counsel's office or department of risk management.

Review of the Carr opinion will afford health care providers and risk managers a clearer understanding of the types of supporting materials that are necessary to sustain a claim of peer review privilege.

An affidavit from the chief of the department from which the peer review document is sought is very effective. Such individuals are highly sensitive to the importance of maintaining confidentiality in the peer review process. Their sensitivity to this issue can result in an exceptionally persuasive and forceful affidavit. Keep in mind that the judge to whom the materials are submitted will not have anywhere near the familiarity with peer review as will the chief of a department. Affidavits are key to providing education and understanding.

Affidavits should track the language of the statutory requirements. They should demonstrate the purpose for the materials and the process by which they were created or used. They should contain strong language detailing the importance of peer review to the institution and the impact disclosure will have on the effectiveness of peer review. Affidavits stating that the subject materials generally are necessary to comply with regulations of the Board of Registration in Medicine are acceptable. However, affidavits that specifically attest to this are preferable. Affidavits need not *specifically* show that the documents were submitted or used by a particular peer review committee within the institution. They need only to show that information sought to be protected is necessary to the peer review committee's work product generally. However, when the *specific* document in question has been submitted to and/or used by a peer review committee, include this information in the affidavit since it bolsters the argument in favor of confidentiality.

Concluding Observations

Peer review is absolutely critical to the teaching and advancement of medicine. In the provisions of Chapter 111, the Massachusetts Legislature sought to advance the important purpose of aggressive peer review in the Commonwealth's hospitals, health maintenance organizations, and nursing homes. Although prior case law explained the strong public policy which underlies the need for protecting the confidentiality of peer review, these decisions provided little guidance to medical care providers and trial courts on how the peer review privilege should be established. The *Carr* decision fills this gap. *Carr* provides health care providers with guidelines on how to protect from disclosure in malpractice cases the deliberations of peer review committees, their work product, and the materials upon which that work product is based. It will be of great help in preserving the confidentiality which is essential to maintaining peer review as a critical tool in the delivery of health care. ■

1 426 Mass. 514 (1998)

2 General Law c. 111, §§ 204 and 205

3 Today, part of Beth Israel Deaconess Medical Center.

Skillful Action in Language: Commitments, Trust, and Medical Malpractice

by
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We live in a network of commitments, the source of our unique human capacity to design the future. But when things don't go well, we are often blind to the nature and consequence of the commitments that have been made and received. The manifestations of this blindness and lack of competence are serious and pervasive in health care.

Patients sit by the phone waiting for test results. They don't comply with their care instructions. They wonder whether their doctor is committed to them or to the insurance company. They don't trust their physician or their care system. They are dissatisfied.

If these simple questions had been asked, then the patient's death may have been avoided.

Breakdowns in the network of commitments can lead to miscoordination, waste, bad outcomes, and even death. Understanding the network of commitments can reduce the risk of bad outcomes for patients, the frustration and dissatisfaction for caregivers, and the burden of malpractice for everyone.

A Case Example

A medical malpractice action is typically a manifestation of betrayal, a broken promise. For example:

A 45-year-old woman undergoing chemotherapy for breast cancer was admitted to a hospital with a pulmonary embolism. She was treated with heparin and discharged, on Warfarin, to the care of her internist. She was seen several days later in the gynecology clinic for a vaginal infection and treated with metronidazole. Her internist reduced the Warfarin dose to counter the potentiating effect of metronidazole. Several days later, her prothrombin time was in the therapeutic range. She asked her internist if she could have her next prothrombin time drawn at the hospital oncology clinic for her convenience. He agreed. Several days later the prothrombin test was drawn at the clinic and was subtherapeutic. The patient wasn't contacted about the result. She died a week later from massive pulmonary embolism.

What happened?

Common sense leads us to think A) someone didn't do his or her job, B) our systems don't work, C) life and work are too pressured and complex, and D) her internist forgot. These explanations lead only to blame and powerlessness. If they are true, then our only options are to A) force people to do their jobs, B) get better systems, C) make life slower and simpler, and D) be sure to remember. Given the apparent difficulty or impossibility of fixing all these problems, we fall into resignation and accept the fact of failure. We pay our malpractice premiums and call them part of the cost of doing business.

Coordination of Action

Another interpretation is revealed when we ask the question: "How does action happen?" A beehive or an ant colony demonstrates that animals are capable of highly complex coordination of behavior. But, to our knowledge, insects cannot decide "next year, we'll build our colony over there." That capacity—to design the future—emerges with language. This is distinguished from coordination of behavior and is called "coordination of action."

We are always coordinating action. When someone asks for an appointment and keeps it, we have coordinated action. When someone misses an appointment, the coordination does not happen. Effective coordination produces satisfaction while breakdowns in coordination produce dissatisfaction. A lack of awareness and skill in linguistic coordination led to a fatal outcome in our example case.

The Four Actions in Language

We can examine how the example case was impacted by the four actions in language: requests, promises, assessments, and declarations.

A ***request*** initiates an interaction between two people to address some need or concern via five elements:

1 *speaker* (in this example, the patient),
2 *listener* (the internist),
3 *shared background* (the test and its importance),
4 *conditions of satisfaction* (adjustments in the dosage),
5 *time* (when the test would be done).

The ***promise*** also has five elements:

1 *speaker* (internist),
2 *listener* (patient),
3 *shared background* (the test and its importance),
4 *conditions of satisfaction* (internist would adjust the Warfarin dosage to maintain patient safety),
5 *time* (when the internist would contact the patient).

What was the breakdown in the network of commitments that led to the patient's death? What future was being designed? What was the patient's request? What was the internist's promise? What was the condition of satisfaction? What actions were committed? Was it the lack of a clear commitment, lack of performance of the commitment, or blindness to the actual commitment that led to the breakdown in care and the patient's death?

The conversation may have proceeded something like this:

"Doctor, would it be OK if I got my next Protime at the oncology clinic during my chemotherapy?"

"That would be fine."

From this imagined conversation, it appears that the request was to get the test at the oncology clinic. In examining this case more closely, however, we see that what appears to be the request is not really the request. Asking to get the test at the clinic was *really* a request for the internist to make appropriate adjustments in the medication dosage based on a test drawn not in the office, but in the clinic. "That would be fine," is not a promise, but the patient experienced it as the internist's promise to get the test result and contact her to make appropriate dosage modifications.

Breakdowns in the network of commitments can lead to miscoordination, waste, bad outcomes, and even death. Understanding this network can reduce the risk of bad outcomes for our patients.

The blindness to the phenomenon of how we invent the future in language and our incompetence in making and managing promises can have trivial or tragic consequences. In this case, the internist was held accountable for the tragic outcome.

A Note About Trust

Language invents the future, and in the invention of the future, trust emerges. To see this, consider the question: "When is a promise real?" The common sense is that a promise is real when it is *fulfilled*. But when a promise is made, we design our lives differently. For example, when the internist approved the test at the oncology clinic, the patient made different plans from those she had prior to his approval. A promise is real when it is *made*.

Trust is an assessment made by the person receiving the promise of the person making the promise. ***Assessments*** are the third action in language. The assessment "trust" answers the following questions: Does this person (making the promise) care about me and my concerns? Is this person sincere in making the promise, competent to carry it out, and are they generally reliable in keeping their promises? These are assessments we make about caring and fulfillment that enable us to live with others.

In health care, trust is critical to improve satisfaction and compliance. Patients who are fearful, vulnerable, or embarrassed, however, are compromised in their ability to make requests or to receive promises in a way that produces desired results. It is therefore imperative that clinicians, clinical team members, and leaders listen carefully to patients to assure that the commitments are being made and managed effectively to build the highest levels of satisfaction and trust and effectiveness.

Partnerships in Health Care

Can tips and techniques lead to better outcomes? Success is obviously more complicated than that. While the distinctions presented here are simple, they can be hard to do. The breakdowns that lead to ineffectiveness and malpractice are the result of habits. Awareness of the way that language designs the future, and the willingness to develop the skills and behaviors to make and manage commitments, is only one part of the task.

None of the distinctions presented here will fulfill our hopes without a context and purpose. Purpose is declared, and ***declarations*** are the fourth action in language. Like the *Declaration of Independence*, they invent new realities. We are in the midst of a health care revolution that requires us to invent new realities. As we invent new practice organizations, what purpose are we committed to? What traditional values do we declare will continue? What kinds of relationships do we want with our patients?

Partnerships are based on caring for the person as well as fulfilling commitments. If we know that patients often cannot make requests because of fear, vulnerability, or embarrassment, then part of our caring for them is to help them manage their end of the commitment.

Although some transactions in health care are simple, like getting an annual flu vaccination, often much more is at stake. If we declare that caring is part of our purpose, then we are concerned about trust and mutual understanding and satisfaction. Even in a simple transaction, a request and promise, the clinician asks the following questions at the end of a patient interaction:

- Have I addressed your concerns?
- Do you know what to do next?
- Do you know what I'm going to do next?
- Do you know what to do if things don't go as planned?

If these simple questions had been asked in the sample case—not as part of a mechanical routine, but as a manifestation of a deeper level of caring and partnership—then the patient's death may have been avoided.

Summary

The phenomenon of language is invisible to us because we are creatures of language. Language is to us as the water is to the fish and the air to the bird. We live in language but we are blind to it. By developing linguistic competence in making and managing commitments, by developing high levels of trust and satisfaction, by declaring a commitment to the highest level of personal caring in partnerships for care, we can improve our effectiveness and satisfaction and reduce suffering. ■

Closed Claim Abstract

Communication and Coordination of Care Among Providers

A patient who had been treated with Clozapine for 16 months for chronic paranoid schizophrenia died of peritonitis three days after an elevated white blood count was reported.

Clinical Sequence

A 48-year-old male presented to a psychiatrist to be treated with Clozapine, which required regular visits and weekly blood counts due to the relatively high incidence of agranulocytosis as a side effect. The risks of this treatment were discussed with the patient, who decided to proceed. Overall, the patient appeared to be motivated and compliant. On the few occasions when he did miss an appointment with the psychiatrist, he would be seen by his internist, who would order the blood work and fax the results to the psychiatrist.

Sixteen months after starting Clozapine, the patient presented to the emergency department complaining of lower abdominal pain and urinary retention. He was admitted, treated for fecal impaction, and released the next day. Three days later, he cancelled his psychiatrist's appointment because of his continued bowel problem, which he reported was being followed by his internist. The patient said he would reschedule his appointment for later in the week, but two days later phoned the psychiatrist again, stating he did not feel well enough to come in for his weekly blood work. He was instructed to have his internist order the test. The same day, the patient phoned his internist's office to report a reduced appetite, use of magnesium citrate, and a small bowel movement that day.

Upon examination the next morning, the internist found the patient's abdomen protuberant and diffusely firm; he was unable to palpate the liver or spleen. He noted in the record that the patient was still suffering from fecal impaction. He instructed the patient to restart the magnesium citrate, call in three days to discuss his status, and schedule an appointment for the next week. The internist also ordered a CBC with WBC, the results of which were to be faxed to the psychiatrist. A practice partner provided the internist coverage until the office closed, at which point coverage was provided by a physician from another practice.

That same day, the psychiatrist received a fax from the internist's office showing an elevated white count (21,500). He immediately notified the patient, instructing him three times to see his internist immediately. The psychiatrist explained that, if untreated, the infection could be fatal. The patient said he felt better and did not have a fever, but on the three occasions he was instructed to see his internist, the patient said he would do so. When he did call, his physician was not in the office.

One day later, a mental health aide visited the patient at his home and encouraged him to go to the hospital. The patient reported he felt better and did not go to the hospital. Two days later, while en route to the hospital with his brother, the patient died of sepsis secondary to peritonitis.

Claim Sequence

The patient's estate sued the psychiatrist, internist, and the internist's practice group, alleging failure to diagnose and wrongful death.

Disposition

The psychiatrist was dismissed from the case by the plaintiff following settlement with the internist.

Discussion Points

Patient Education: The psychiatrist used the consent process appropriately to communicate the benefits, risks, and requirements of Clozapine treatment, and properly documented the specific issues addressed. With this information, the patient was compliant and cognizant of the importance of weekly blood counts.

Consent forms that detail the issues discussed with the patient demonstrate that the consent task was not perfunctory.

Narrow Diagnostic Focus: The internist apparently did not consider any causes for the patient's problem other than previously diagnosed fecal impaction.

Relying on a previous diagnosis, without considering others, risks following too narrow a diagnostic path, especially if the current clinical information indicates that prior diagnoses were incorrect. The basis for confirming or ruling out diagnoses that were considered should be noted.

Staff Education/Office Systems: The internist's receptionist faxed the Clozapine report to the psychiatrist because she thought he was the covering physician. Thus, the actual covering physician did not receive the report.

Clearly written standard procedures and office systems for identifying the covering physician and handling clinical information that requires immediate attention will reduce miscommunication and potential adverse outcomes.

Documentation: While the psychiatrist's documentation of the phone call demonstrated that he had communicated to the patient the lab results and urgency in seeing his internist, he did not record telling the patient the infection could be fatal.

Documenting all critical information, such as urgency or seriousness, that is communicated to a patient will prevent having to rely on memory to recall facts several years later.

Coordination of Care: After receiving a copy of the lab work revealing an elevated white blood count, the psychiatrist urged the patient to contact his internist's office immediately. The patient followed did so, but his internist had already left the office, and the back-up system of notifying the covering physician failed.

With abnormal clinical information, the level of response needs to be commensurate with the level of concern. Relying too much on the patient to transmit abnormal test results can pose serious risks. In these situations, members of the health care team need to have direct communication amongst themselves.

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