



AHA Team Training

Teamwork and Malpractice: What's the Connection?

April 13, 2022



Upcoming Team Training Events

Webinars

[Flip Don't Flop! Remodeling Communication Using Deconstructive Feedback](#) – May 11 at 12 pm CT

[Telehealth and Its Emergence During the Pandemic](#) – May 17 at 12 pm CT

Courses & Workshops

In-person [TeamSTEPPS Master Training Courses](#)

- May 16-17 at UCLA
- May 24-25 at Duke
- June 7-8 at Tulane
- June 13-14 at Northwell

[Managing Conflict in Health Care Workshop](#) – Virtual workshop series taking place April 21-May 12

Today's Presenter



David L. Feldman, MD, MBA, CPE, FAAPL, FACS
Chief Medical Officer, The Doctors Company, TDC Group

Today's Objectives

Teamwork and Malpractice: What's the connection?

Define the nature of malpractice risk reduction, and the 3P model

Demonstrate the impact of communication and teamwork on malpractice rates

Utilize malpractice data as a tool to engage hospital leadership in patient safety efforts

Agenda

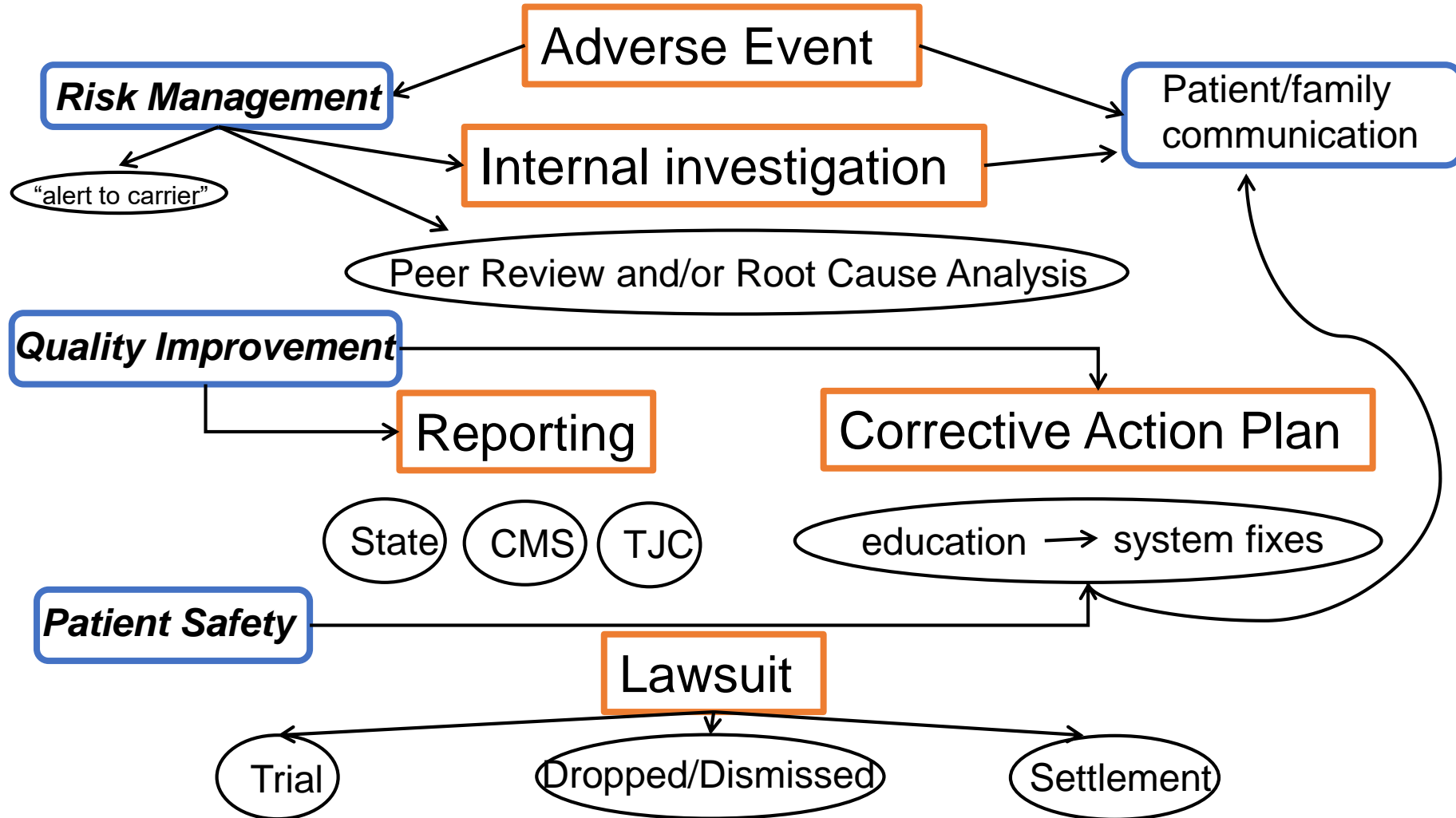
- **Malpractice and risk reduction**
- Malpractice data & the role of teamwork
- Teamwork, the patient & malpractice
- Engaging leadership & insurers

Polling Question #1

How do you feel about the role of malpractice in improving patient safety?

- a. I'm already using malpractice data, want to use it more
- b. Malpractice data is probably useful, but I don't have access
- c. Malpractice is too rare an event to make the data meaningful
- d. Malpractice is too arbitrary to make the data useful
- e. I don't know enough to answer the question

The Path to a Lawsuit

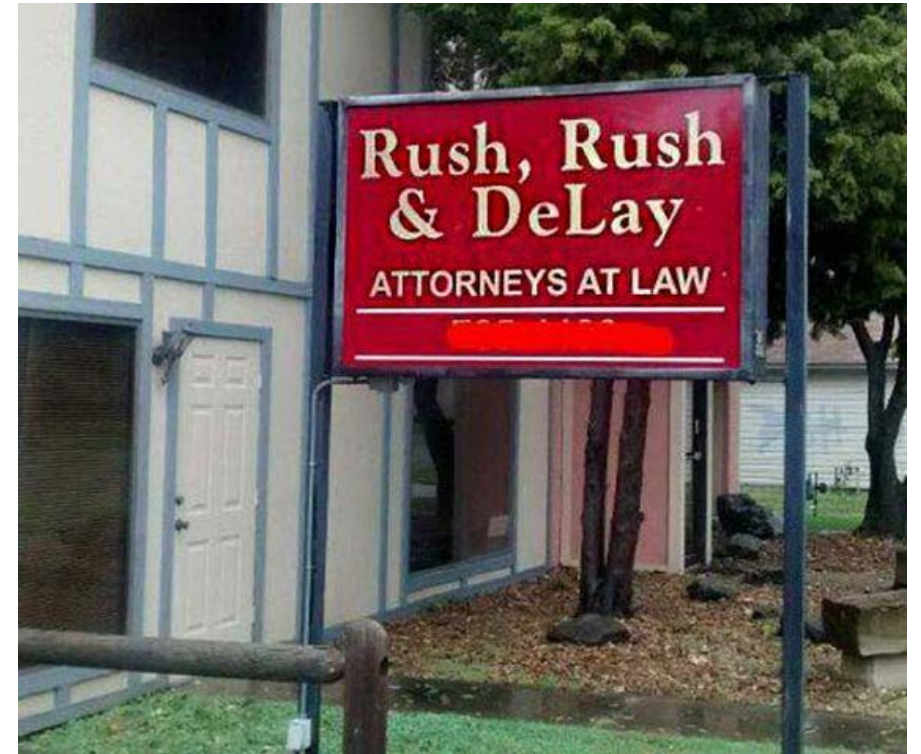


The ABC's of Malpractice

- Accept
 - Doctor-patient relationship
- Breach
 - Standard of practice
- Cause
 - “Proximate cause”
- Damage
 - Injury resulting from breach

The ABC's of Malpractice

- One sentence definition:
 - *Malpractice is a violated duty causing harm*
- One word definition:
 - *Unreasonableness*

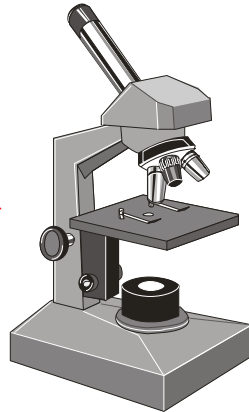


Medical Malpractice Litigation

What does it involve?

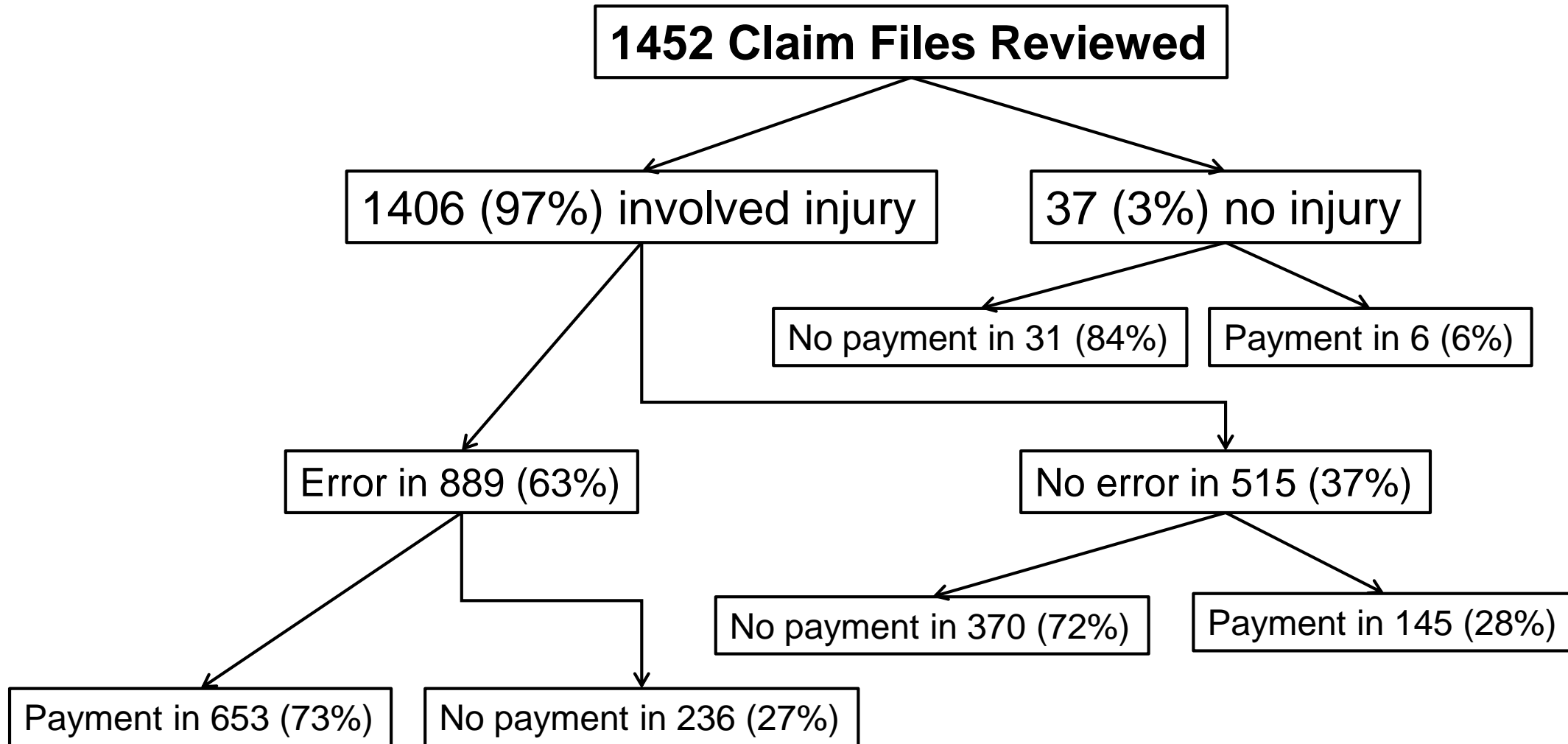
Plaintiff attorneys, with the aid of experts, try to make a case starting with a bad outcome and working backwards.

Retrospectroscope



The principal piece of evidence in virtually every medical malpractice case is the patient's **medical record**.

Does the Medical Liability System Work?



Reducing Malpractice Risk

The three “P’s”

- Prevent adverse events
- Preclude malpractice cases
- Prevail in lawsuits

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Polling Question #2

What is the biggest reason for malpractice cases?

- a. Poor clinical judgment
- b. Unintended adverse events
- c. Bad teamwork between patients and providers
- d. Bad communication between providers about patients
- e. Poor documentation

Teamwork – Still a problem

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

TEAMWORK — PART 1
Debra Malina, Ph.D., *Editor*

Divided We Fall

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

TEAMWORK — PART 2
Debra Malina, Ph.D., *Editor*

**Cursed by Knowledge — Building a Culture
of Psychological Safety**

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MEDICINE AND SOCIETY

TEAMWORK — PART 3
Debra Malina, Ph.D., *Editor*

The Not-My-Problem Problem

Lisa Rosenbaum, M.D.

Vanderbilt University Medical Center

Center for Patient and Professional Advocacy

- Professional Conduct Policy
- Training for faculty in
 - Commitment to *Credo behaviors*
 - Feedback to students & residents
 - Behavior policy
- Patient Advocacy Reporting System (PARSSM)
- Co-Worker Observation Reporting SystemSM (CORSSM)

Vanderbilt Co-Worker Observation Reporting SystemSM

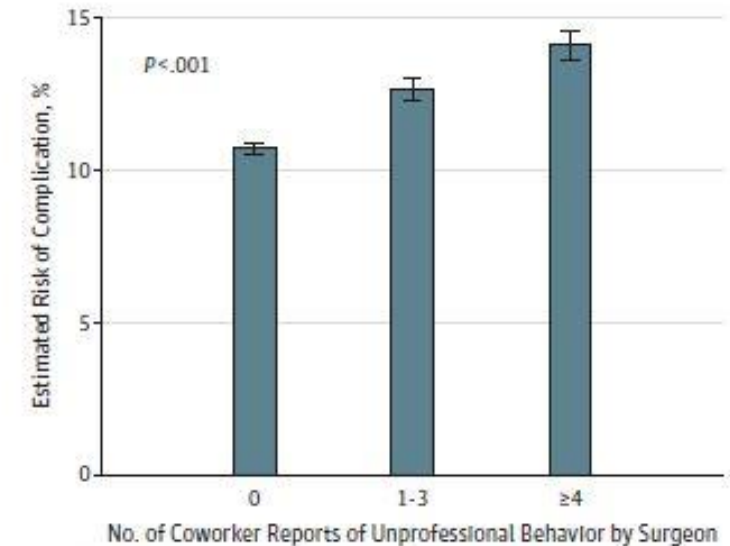
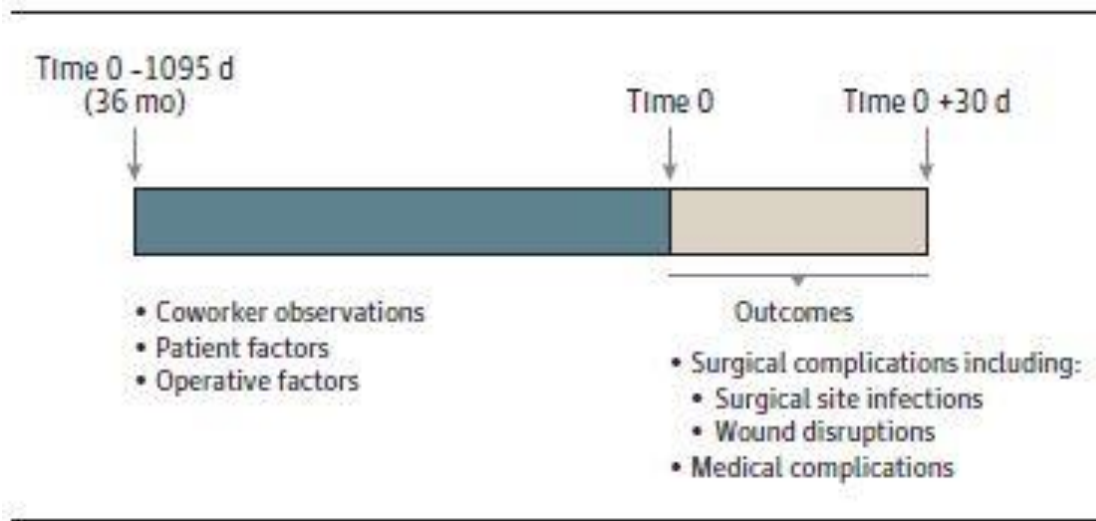
Domain Codes	Domain Subcategories	Prevalence
Competent Medical Care		
	Poor or unsafe care	26
	Scope of Practice	1
	Impairment	1
Clear & Respectful Communication		
	Disrespectful/offensive	60
	Poor	15
	Aggressive/physically intimidating	3

Domain Codes	Domain Subcategories	Prevalence
Responsibility		
	Access/availability	20
	Failure/reluctance/refusal to complete role-related tasks	15
	Failure to accept feedback	3
Integrity		
	Violation of stated organizational values	12
	Breach of patient/family confidentiality	4
	Conflict of interests	1
	False documentation	1

Co-Worker Complaints & Outcomes

NSQIP data from Stanford and Vanderbilt

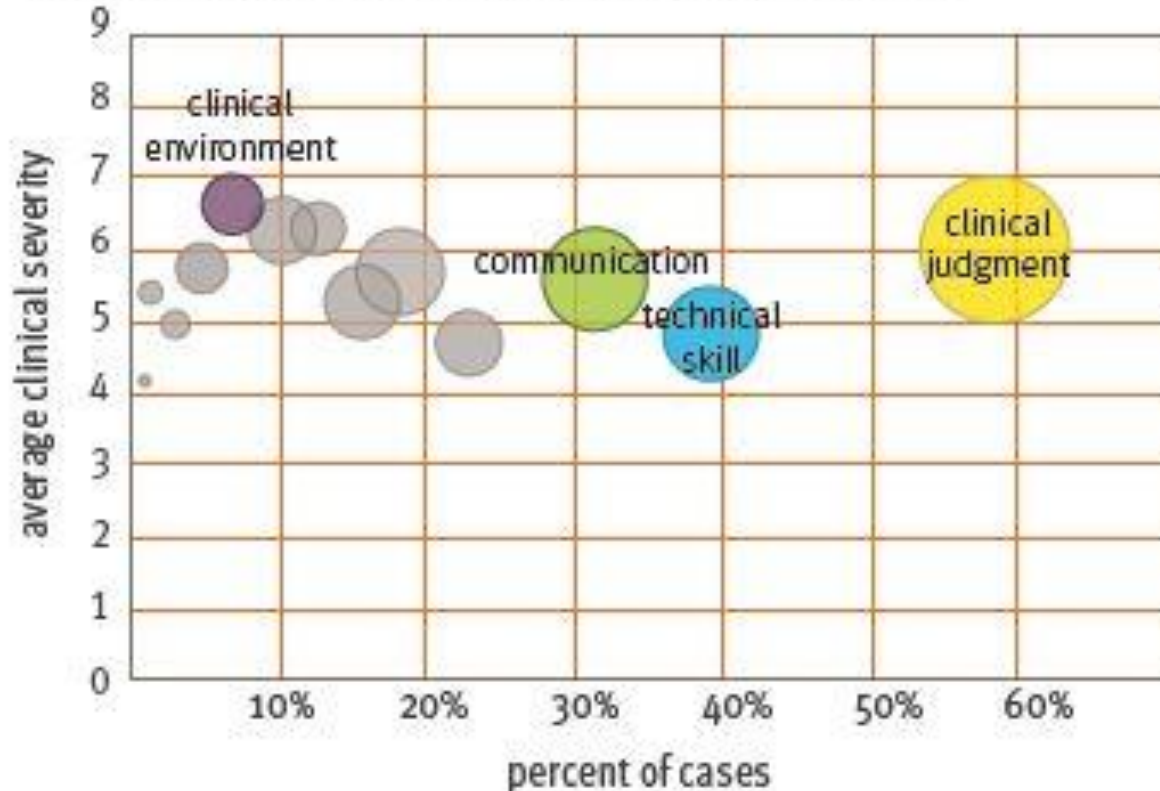
Patients whose surgeons had higher numbers of coworker reports about unprofessional behavior in the 36 months before the patient's operation appeared to be at increased risk of surgical and medical complications.



“...nurse [who] reports, “I asked for the procedure time out. Dr X said, ‘Look, we’re all on the same page here. Let’s get going without all this time out nonsense,’”

CONTRIBUTING FACTOR CATEGORIES

SIZE REPRESENTS (RELATIVE) TOTAL INCURRED LOSSES



Teamwork Communication & Malpractice

- Ambulatory Care – 22%
 - Unprofessional
 - Responsibility unclear
- Inpatient Care – 18%
 - Reading the EMR
 - Reaching consensus
- ED Care – 19%
 - Hierarchical issues

Risk Management Issues in Surgery Claims

		Contributing Factors Category	Claim Count
<i>Adverse event</i>	Surgery i. Technical Skill ii. Judgment iii. Patient's Disease iv. Systems	Possible technical problem resulting in known complication	
		Poor technique	
		Misidentified anatomic structure	
		Selection of procedure	
		Failure to order test	
		Failure to appreciate signs/symptoms	
		Communication amongst providers about condition/closed loop	
		Failure of systems – undergoing/reporting tests, consults	
		Clinical environment - Weekend/holiday/busyness	
		Supervision of housestaff	
<i>Preclude lawsuit</i>		Inadequate response to patient concerns	
		Inadequate consent for surgical procedure	
		Patient expectations/poor rapport	
<i>Defend</i>		Documentation issues – inconsistent, inaccurate, lack of, delayed	
		Electronic Health Record	

Risk Management Issues in OB Claims

	Contributing Factors Category	Claim Count
<i>Adverse event</i>	Selection/management of therapy	
	Patient assessment issues	
	Patient monitoring	
	Failure/delay in obtaining a consult	
	Technical performance	
	Communication among providers	
	Clinical environment	
	Clinical systems	
	Patient non-adherence with treatment	
	Non-insured issues	
<i>Preclude lawsuit</i>	Supervision of housestaff	
	Communication with patient and family	
<i>Defend lawsuit</i>	Insufficient/lack of documentation	
	Inconsistent/inappropriate documentation	
	Inaccurate documentation	

Risk Management Issues in ED Claims

	Contributing Factors Category	Claim Count
<i>Adverse event</i>	Ongoing assessment: monitoring of clinical status	
	Ordering of diagnostic tests	
	Failure/delay in obtaining a consult	
	Communication among providers about condition/failure to read EMR	
	Clinical environment - busyness	
	Clinical environment – Weekend/holiday/night shift	
	Performance of diagnostic tests	
	Administrative – EMR/staffing/policies	
	Technical skill	
	Supervision of house staff	
<i>Preclude lawsuit</i>	Communication with patient and family	
<i>Defend lawsuit</i>	Documentation issues – findings, rational, delayed, inconsistent	

Risk Management Issues in ED Claims

ED Process of Care	% of cases	Average indemnity
1. Patient notes problem and seeks care	6%	\$529,000
2. Initial assessment: history and physical exam	11%	\$816,000
3. Ongoing assessment: monitoring of clinical status	30%	\$653,000
4. Ordering of diagnostic tests	65%	\$525,000
5. Performance of diagnostic tests	5%	\$670,000
6. Interpretation of diagnostic tests	22%	\$463,000
7. Transmittal of test results to (ED) provider	7%	\$576,000
8. Consultation management	26%	\$566,000
9. Development of discharge plan	43%	\$499,000
10. Post discharge follow-up (includes pending test results)	9%	\$488,000
11. Patient adherence to plan	5%	\$220,000

Communication & Handoff Failures in Medical Malpractice Claims

- 498 random claims - Candello malpractice database
 - Communication errors in 244 (49%) – 130 (26%) among staff
 - Patient severity of illness 61 (54%)
 - Handoff errors (53%)*
 - Patient contingency plan 51 (45%)
 - Patient diagnosis 39 (34%)
 - Medication plan 16 (14%)
- Mean cost/case \$359,000 (v. \$130,000 staff & patient/family)

*77% likely preventable with a handoff tool

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Polling Question #3

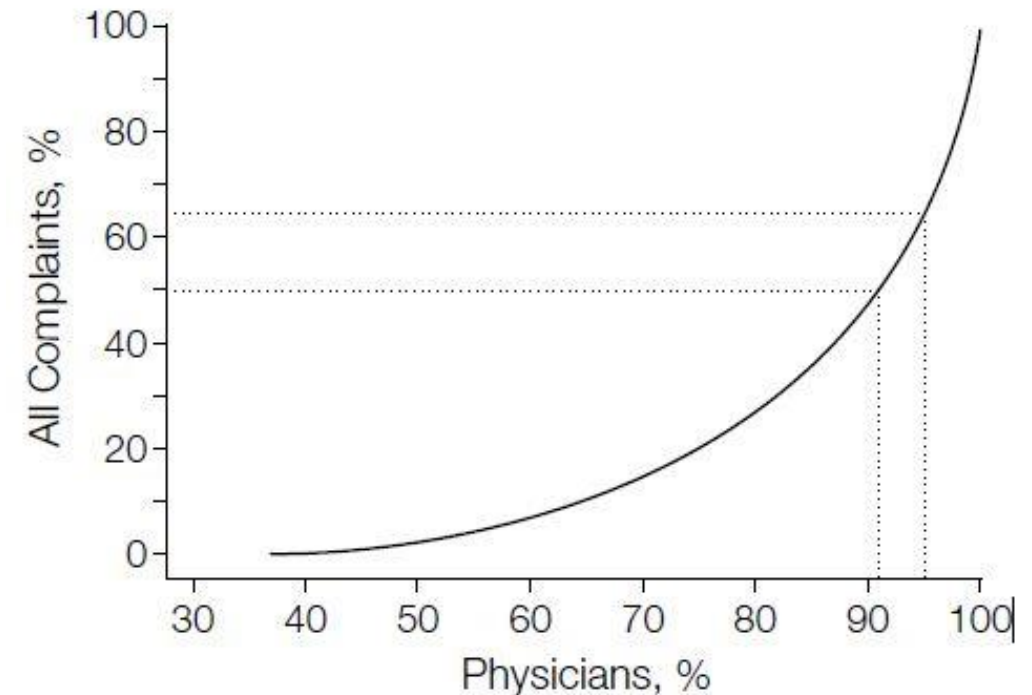
What's the best way to engage with patients to avoid malpractice?

- a. Use good informed consent before treatment/procedures
- b. Be sure to console patients after an adverse event
- c. Explain treatment options in detail with patient and family together
- d. Apply shared decision making to all treatment decisions
- e. Maintain an ongoing relationship with patients before, during and after treatment

Patient Complaints & Malpractice Risk

- 645 general and specialist physicians, January 1992 - March 1998; 2546 physician-years of care.
- Patient complaints (adjusted for clinical activity) related to:
 - Risk management file openings
 - File openings with expenditures
 - Lawsuits

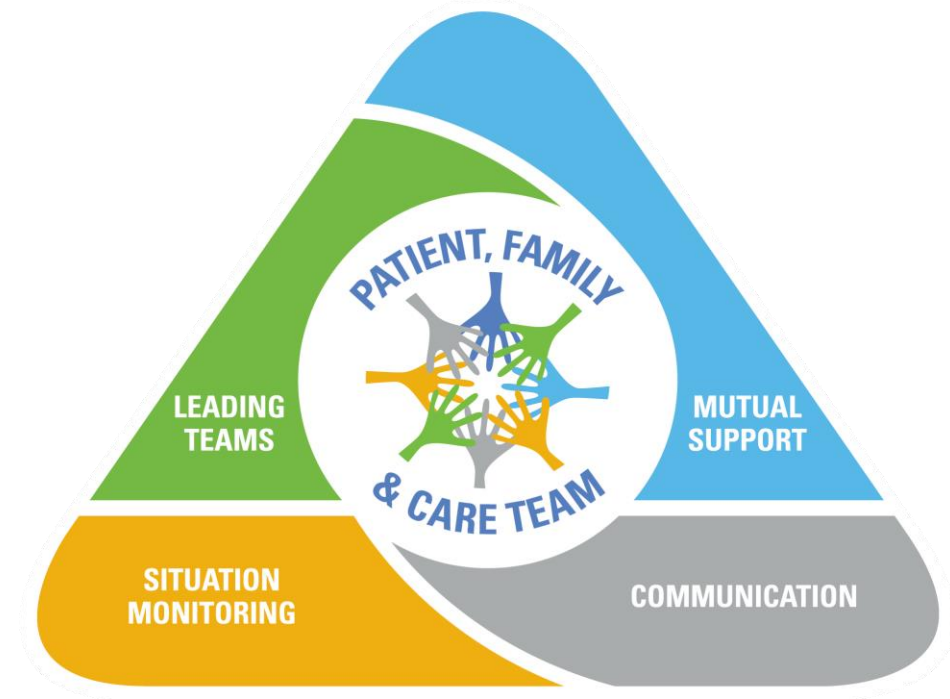
Figure. Cumulative Distribution of Physician Cohort Members and Unsolicited Complaints



The dotted lines illustrate that 9% of cohort members were associated with 50% of patient complaints and 5% were associated with approximately one third of all complaints.

Communication Issues with Patients/Families Seen in Malpractice Claims

- Patient contingency plan
 - Patient diagnosis
 - Patient severity of illness
 - Medication plan
 - Radiologic result
 - Procedure or test result
 - Laboratory result
 - Specialist recommendations
 - Need to see specialist or primary care physician



Partnering With the Patient

Strategies for involving patients in their care

- Include patients in bedside rounds
- Conduct handoffs at the patient's bedside
- Provide patients with tools for communicating with their care team
- Involve patients in key committees
- Actively enlist patient participation

Patient and Family Responsibilities

- Provide accurate patient information
- Comply with the prescribed plan of care (e.g., schedule and attend appointments as directed)
- Ask questions and/or voice any concerns regarding the plan of care
- Monitor and report changes in the patient's condition
- Manage family members
- Follow instructions of the clinical team

Agenda

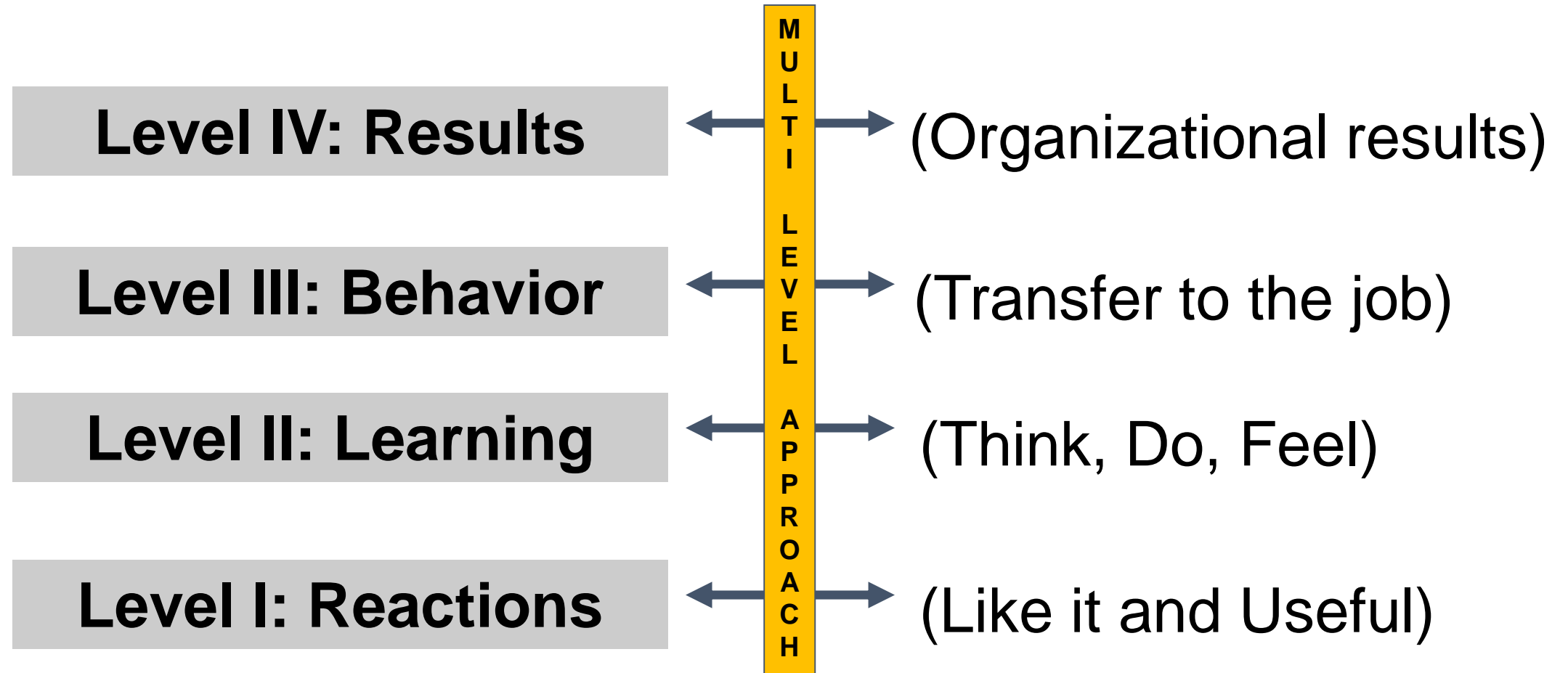
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Polling Question #4

Which is the best approach to get hospital leadership buy-in for patient safety programs?

- a. Present malpractice data to the patient safety committee of the hospital board
- b. Use a well thought out business plan with a defined ROI for all patient safety expenses
- c. Have the CFO attend all root cause analyses
- d. Be sure the hospital performs well on all publicly reported hospital metrics
- e. Create a dedicated hospital committee to ensure top HCAHPS performance

How to Measure – Kirkpatrick



Level IV: Results

- Patient Outcome Measures
 - Examples: Complication rates, infection rates, measurable medication errors, and patient perceptions of care and satisfaction with their care
- Clinical Process Measures
 - Examples: Length of patient wait time, time to intubate, medication administration delays, compliance with preventive screenings, number of misdiagnoses, number of structured handoffs used
- **Malpractice Data!**

Retained Surgical Items

- Prevention - Counting, Teamwork, Radiography, New technology
- **Risk Reduction Strategies to Decrease the Incidence of Retained Surgical Items**
 - 997,237 Operative Procedures
 - TeamSTEPPS training and RF technology interventions
 - RSI decreased - 11.66 to 5.80 events per 100,000 operations
 - RSI involving RF detectable items decreased - 5.21 to 1.35 events per 100,000 operations
 - Malpractice claims related to sponges and lap pads decreased - 1.6/year to .67/year

Value of Malpractice Data

- Qualitative details
- \$\$\$
- “Tip of the iceberg”
- Combining with other data sources
 - Adverse events
 - Patient/staff complaints
 - Outside data bases – NSQIP, STS

Using Malpractice Data to Drive Safety

- Determine your professional liability insurance carrier
 - Individual physicians
 - Hospital
- Understand state-based laws
 - Charitable immunity
 - Caps on non-economic damages
 - Pricing of premiums
- Get the data!
 - Your carrier
 - National sources – Candello (CBS), MPLA (DSP)

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Key Takeaways

1. Malpractice data can be useful as a tool to identify events and the associated costs can be a driver for investment in patient safety efforts.
2. Poor teamwork can be identified in malpractice analyses along with its specific impact on payment.
3. Risk managers and patient safety leaders in healthcare institutions should understand the nature of their malpractice program to help them reduce the costs incurred by poor teamwork and communication.



Questions? Stay in Touch!

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