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

Adverse Event
- Internal investigation
  - Peer Review and/or Root Cause Analysis
- Patient/family communication

Risk Management
- "alert to carrier"

Quality Improvement
- Reporting
  - State
  - CMS
  - TJC
- Corrective Action Plan
  - education → system fixes

Patient Safety

Lawsuit
- Trial
  - Dropped/Dismissed
  - Settlement

Patient Safety → Corrective Action Plan
- education → system fixes

Risk Management → Internal investigation
The ABC’s of Malpractice

• Accept
  o Doctor-patient relationship

• Breach
  o Standard of practice

• Cause
  o “Proximate cause”

• Damage
  o Injury resulting from breach
The ABC’s of Malpractice

• One sentence definition:
  o Malpractice is a violated duty causing harm

• One word definition:
  o 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.

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

Courtesy P. Kolbert, Esq.
Does the Medical Liability System Work?

1452 Claim Files Reviewed

1406 (97%) involved injury
- Error in 889 (63%)
  - Payment in 653 (73%)
  - No payment in 236 (27%)
- No error in 515 (37%)
  - No payment in 370 (72%)
  - Payment in 145 (28%)

37 (3%) no injury
- No payment in 31 (84%)
- Payment in 6 (6%)

Reducing Malpractice Risk

The three “P’s”

• Prevent adverse events
• Preclude malpractice cases
• Prevail in lawsuits
Agenda

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

Rosenbaum, NEJM, 2019.
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 (PARS\textsuperscript{SM})
- Co-Worker Observation Reporting System\textsuperscript{SM} (CORS\textsuperscript{SM})
## Domain Codes

<table>
<thead>
<tr>
<th>Domain Subcategories</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competent Medical Care</td>
<td></td>
</tr>
<tr>
<td>Poor or unsafe care</td>
<td>26</td>
</tr>
<tr>
<td>Scope of Practice</td>
<td>1</td>
</tr>
<tr>
<td>Impairment</td>
<td>1</td>
</tr>
<tr>
<td>Clear &amp; Respectful Communication</td>
<td></td>
</tr>
<tr>
<td>Disrespectful/offensive</td>
<td>60</td>
</tr>
<tr>
<td>Poor</td>
<td>15</td>
</tr>
<tr>
<td>Aggressive/physically intimidating</td>
<td>3</td>
</tr>
</tbody>
</table>

## Domain Codes

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

Martinez, et.al., Jnl Pat Saf, 2018, 1-7.
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,””
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

<table>
<thead>
<tr>
<th>Possible technical problem resulting in known complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor technique</td>
</tr>
<tr>
<td>Misidentified anatomic structure</td>
</tr>
<tr>
<td>Selection of procedure</td>
</tr>
<tr>
<td>Failure to order test</td>
</tr>
<tr>
<td>Failure to appreciate signs/symptoms</td>
</tr>
<tr>
<td>Communication amongst providers about condition/closed loop</td>
</tr>
<tr>
<td>Failure of systems – undergoing/reporting tests, consults</td>
</tr>
<tr>
<td>Clinical environment - Weekend/holiday/busyness</td>
</tr>
<tr>
<td>Supervision of housestaff</td>
</tr>
<tr>
<td>Inadequate response to patient concerns</td>
</tr>
<tr>
<td>Inadequate consent for surgical procedure</td>
</tr>
<tr>
<td>Patient expectations/poor rapport</td>
</tr>
<tr>
<td>Documentation issues – inconsistent, inaccurate, lack of, delayed</td>
</tr>
<tr>
<td>Electronic Health Record</td>
</tr>
</tbody>
</table>

### Adverse event

1. **Surgery**
   - i. Technical Skill
   - ii. Judgment
   - iii. Patient’s Disease
   - iv. Systems

2. **Preclude lawsuit**

3. **Defend**

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**American Hospital Association**

*Advancing Health in America*
## Risk Management Issues in OB Claims

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

- Communication with patient and family
- Supervision of housestaff

### Preclude lawsuit

- Insufficient/lack of documentation
- Inconsistent/inappropriate documentation
- Inaccurate documentation
## Risk Management Issues in ED Claims

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

- 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

### Preclude lawsuit

- Communication with patient and family

### Defend lawsuit

- Documentation issues – findings, rational, delayed, inconsistent
## Risk Management Issues in ED Claims

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

Agenda

• Malpractice and risk reduction
• Malpractice data & the role of teamwork
• Teamwork, the patient & malpractice
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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

- Patient complaints (adjusted for clinical activity) related to:
  - Risk management file openings
  - File openings with expenditures
  - Lawsuits

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.

Hickson, JAMA, 2002.
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

- Malpractice and risk reduction
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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 I: Reactions**
(Like it and Useful)

**Level II: Learning**
(Think, Do, Feel)

**Level III: Behavior**
(Transfer to the job)

**Level IV: Results**
(Organizational results)
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
  o 997,237 Operative Procedures
  o TeamSTEPPS training and RF technology interventions
  o RSI decreased - 11.66 to 5.80 events per 100,000 operations
  o RSI involving RF detectable items decreased - 5.21 to 1.35 events per 100,000 operations
  o Malpractice claims related to sponges and lap pads decreased - 1.6/year to .67/year

Kaplan, JACS, 2022.
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)
Agenda

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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!

www.aha.org/teamtraining

Email: teamtraining@aha.org  •  Phone: (312) 422-2609