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Risk Management in Ambulatory Anesthesia – Reducing Liability Exposure

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Agenda

- A near miss
- Serious patient harm events – dealing with them and the aftermath
- Disclosure – benefits and risks
- "I'm sorry…"
- Some specific risk reduction thoughts for the ambulatory environment

A Near Miss

February 20, 1981

- Argentine Boeing 707 entered NYC airspace and requested approach to JFK
- Ceilings were low with poor visibility and fog
- ATC asked the plane to descend to 1500 feet and enter a holding pattern
- The pilot descended as instructed
- Radar alerted ATC of a dangerous situation and the plane was instructed to turn right immediately and climb to 3000 ft

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February 20, 1981

- What actually happened…
- The plane was instructed to descend to 2700 ft but the pilot heard 1500 ft and questioned the request - but received no verbal confirmation from ATC
- The pilot did not pursue further confirmation which resulted in the aircraft headed toward the WTC north tower which stood at 1749 ft
- A newly installed radar system alerted ATC that the plane was below minimum safe altitude and a collision was averted
- Based on an interview afterwards, the ATC employee said based on a scale of 1 to 10 (best), ease of communication with the pilot was a 4

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Defining the “Event”

- Complication
  - An infrequent but known occurrence as a result of a disease condition or treatment
  - Is something you tell the patient during informed consent
- Unanticipated Outcome
  - Not the expected outcome from a treatment or procedure
  - Is not always something you tell the patient may happen during informed consent
  - May or may not be due to medical error
- Adverse Event
  - An event during the care of the patient that has the potential to harm (“near miss” or “near hit”) or in fact harms the patient
  - Spectrum of events (minor harm through Sentinel Event)
    - A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response (Joint Commission).
  - May or may not be due to medical error
- Medical Error
  - Inaccurate or incomplete diagnosis or treatment

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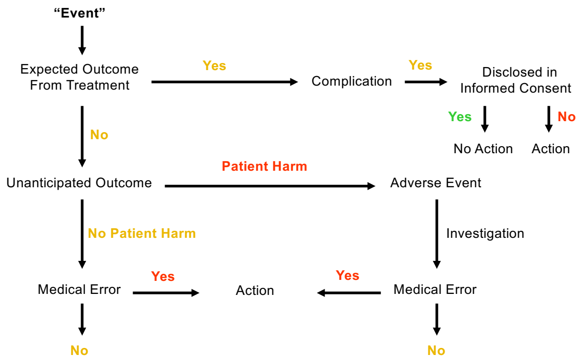

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Determining the Cause of a Serious Harm Event

- Rapid assessment / investigation
- Root Cause Analysis
  - Data collection / chart review
  - Interviews
  - Group interview
  - Error identification
  - Analysis of errors
  - Determine error frequency and type
  - Assemble responsible parties for intervention
  - Action plan
  - Audit

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Common Themes from RCA

- Communication gaps
- Inadequate or ill-defined process
- Environment
- Lack of education / knowledge
- Lack of training
- Equipment / technology malfunction

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Event Documentation

- Remember, what you write in the medical record is your legal interpretation of the event(s) that occurred
- DO be accurate and detailed
- DO state what you knew and did at the time of the event
- DO NOT speculate
- DO NOT engage in the "blame game"
- If you make a "late entry" into the medical record, clearly date and time the note and include the purpose of the entry
- DO NOT alter or delete previous entries made either by yourself or others in the medical record

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Who Can You Talk You?

- Privilege – entitlement or immunity granted by the government to a restricted entity or circumstance that can be revoked under certain conditions
- Most states recognizes 2 types of privilege as it relates to the practice of medicine
  - Attorney–client privilege (includes attorney work product)
  - Privilege as it relates to quality efforts and peer review
- When is privilege lost or revoked?
  - When information that is protected is discussed or transmitted outside the confines of the protected relationship or committee

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Frontline Communication

- Either poor or a lack of communication with patients and their families results in the majority of law suits
- Physicians are not always good communicators in the face of an adverse event / poor outcome
- Often caregivers are still dealing with critical situations arising from a poor outcome while others are communicating with family members
- Not being present while others represent the care you rendered places one at risk
- What about follow-up communication?

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How is the Caregiver Affected ("the second victim")?

- Guilt
- Fear
- Isolation – can be compounded by both legal and institutional advice to remain silent about the event
- Doubt
- Distraction
- Increased risk for another event due to preoccupation

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Does An Adverse Event / Poor Outcome Always Mean Litigation?

- In many instances, how the event is initially handled determines the pathway a case may eventually take
- What leads patients and their families to medical malpractice attorneys after an event is an "aggravating circumstance"
  - 80% of claims arise from poor communication
  - 70% of those who sued felt their questions were devalued or ignored or that the physician simply deserted them
- Often times, litigation cannot be avoided
- What can be done following a poor outcome that may reduce the risk of litigation?

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Disclosure

- "Patients and, when appropriate, their families are informed about the outcomes of care, treatment, and services that have been provided, *including unanticipated outcomes*"

JC Standard RI.2.90

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Disclosure

- Applies to ALL unanticipated outcomes of a procedure regardless of whether or not there was an error
- Has a direct relationship to the informed consent process (biological variability in diagnosis and treatment)
- Informed consent is comprised of
  - Procedure
  - Risks
  - Benefits
  - Alternatives
  - Personnel
  - Acknowledgment
  - Questions
- Is an ethical obligation

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Benefits of Disclosure

- Patients and their families are more likely to negotiate for fair settlement when told upfront about errors resulting in potentially compensable injuries
- Can reduce cost per claim for an organization
- Emotional benefit for the caregivers
- Emotional benefit for the patient and family
- Removes the stigmata of professional indifference or the perception of wrongdoing and a "cover-up"

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Multidisciplinary Issues with Disclosure

- Who's patient is it anyway?
- Conceptualized as a doctor-patient conversation
- If we practice as a team, and we make an error, should we disclose as a team?
- Team disclosure complicated by power dynamics

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The Risks of Disclosure

- No patient injury - there is little risk in disclosing
- Patient injury – greater risk in disclosing
  - An unanticipated outcome (injury) could arguably qualify as one of the 4 elements of malpractice
  - Departure from SOC with a proximate cause defense can be challenging
  - Departure from SOC with no ability to defend causation is the most dangerous scenario
- From the time of "injury" onward, everything said or written in the medical record is potential evidence
- If it qualifies as evidence, it will be revealed at trial
  - Damaging information or facts that are indefensible
  - Punitive damages can be sought by the plaintiff if they can prove you were untruthful or deceptive

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What about just saying "I'm sorry?"

- Apology
  - Expression of contrition and remorse for having done something wrong
  - It is an acknowledgement of responsibility
- Saying "I'm sorry" isn't an apology
  - Expresses empathy
  - Should be placed in context
- Does saying "I'm sorry" work?
  - Evidence points to multiple institutions that have been successful taking this approach
  - Only in the context of rigorous risk management programs that evaluate whether the care rendered was satisfactory

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Wisconsin Healthcare Provider Apology Law

- Under the Wisconsin law, healthcare providers are allowed to apologize to patients and their family members without having the apology be admitted in legal proceedings as a party admission
- For an apology to be excluded as evidence under Wisconsin's apology law, two requirements must be met
  - First, the apology must occur before the commencement of a civil action, administrative hearing, disciplinary proceeding, mediation, or arbitration
  - Second, the healthcare provider's words or conduct must express "apology, benevolence, compassion, condolence, fault, liability, remorse, responsibility, or sympathy to a patient or his or her relative or representative." The apology may be in the form of "a statement, a gesture, or conduct" and does limit the specific means of the apology chosen by the provider

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How Does Saying "I'm sorry" or Making an Apology Make an Impact?

- No impact on minor injuries
- Settlement values for serious injury cases reduced
- Time to settlement for serious injury cases reduced

Boothman RC, et. al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. Health & Life Sci. L. 125, 133 (2009).

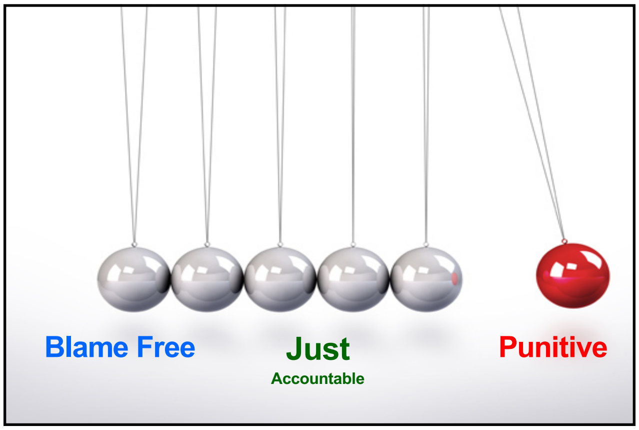
Elaine Liu and Benjamin Ho, *Does Sorry Work? The Impact of Apology Laws on Medical Malpractice*, Johnson School Research Paper Series, No. 04-2011 (October 2010).

Anatomy of a Malpractice Lawsuit

- 4 elements comprise a claim of medical negligence
  - Duty – the defendant had a duty to comply with the standard of care (SOC)
  - Breach – the defendant breached his/her duty
  - Injury – the claimant sustained an injury that is compensable under the law
  - Breach caused the injury – the breach proximately caused the injury being claimed
- To prevail at trial, the claimant's attorney must prove all 4 elements

Human Error

- To err is human…
- First, we blame the individual
- Second, we identify other 'factors'
- Why does this occur?
  - It is human nature to blame someone else
  - Our legal system supports blaming someone else
  - It is easy for management to blame individuals
  - Companies often blame individuals rather than take responsibility for faulty systems or products



Human Error in Healthcare

- Non-punitive event reporting
- Spectrum of attributable causes
  - System design
  - Process design
  - Human error
  - Negligence
- Just culture concept
  - Requires quality, patient safety, CRM, and HR

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Specific Risks in Ambulatory Anesthesia and Surgery

- Most ASC's don't have a designated individual trained in risk management and patient safety
  - If ASC is affiliated with a larger entity, ask them to consult and provide guidance
  - If ASC is independent, your facility insurer and / or medical malpractice carrier(s) may provide consultation services

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Risk Reduction Strategies in Ambulatory Anesthesia and Surgery

- Where ASC's can fall short and create risk –
  - Patient selection
  - Preoperative evaluation
  - Patient education
  - Staff onboarding and education
  - Physician credentialing
  - Informed consent
  - Discharge planning
  - Patient follow-up

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Additional Risk Reduction Strategies in Ambulatory Anesthesia and Surgery

- Use safety events as an educational opportunity and change the process
- Make sure the informed consent matches the procedure and patient expectations
- Patient identification is like communication – if you think you've done it enough, do it again…
- Emergency preparedness is no longer just about codes and malignant hyperthermia

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