WiscRisk
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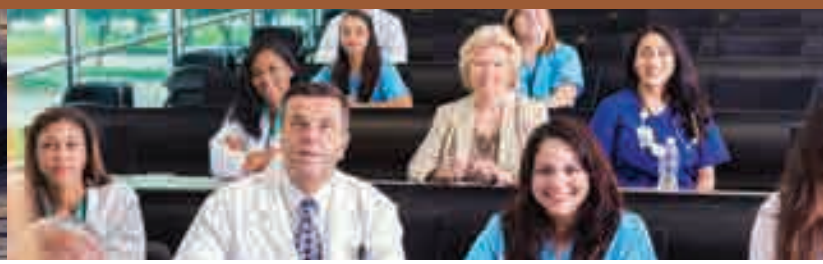

MALPRACTICE CLAIMS UPDATE: ANATOMY OF A CLAIM, AND FUND'S LOSS EXPERIENCE

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Introduction

This article provides two types of claims information. It first presents a case study of a single claim and discusses the risk management lessons learned. It then describes the Fund's overall claims experience, to give a general perspective on claim values.

ANATOMY OF A CLAIM

Medical malpractice claims are often complex, and the eventual outcome may be affected by a variety of factors. Similar issues do come up in a number of cases, however. We discuss a hypothetical case study below that illustrates some of these common issues. Identifying these factors may help risk managers to focus their efforts in reducing medical errors, and may also help claim personnel to resolve claims favorably.

Case Study of a Hypothetical Claim

A patient had elective surgery which was to involve moderate sedation. The physician's order set out a range for the sedative agent, from 12.5 mcg to 100 mcg. However, the order did not say what the initial dose of the sedative should be, what the incremental doses should be, or when or how often additional doses should be given. Further, the order did not expressly say that the highest dosage in the range was the total maximum amount of sedative that the doctor meant to give over the entire course of the surgery; and the nurse who administered the sedative instead interpreted the order as allowing her to administer up to the highest dosage in the range as many times as needed.

There was some uncertainty as to whether the nurse verbalized the initial and subsequent dosages before administering them, because this was not charted in the record. There was also some confusion as to the total amount of sedative that was given, because the medication and administration sections of the record reflected different amounts. Both total amounts, however, were more than the highest number in the range ordered by the physician.

Further complicating the case, neither the monitoring equipment nor the electronic health record software recorded any vital signs for several minutes after the medication was given. Despite this, the equipment was not set aside or tested to determine why it had stopped working.

The patient suffered anoxic brain injury and died several days later. The family brought suit alleging negligent administration of excessive anesthesia, inadequate monitoring, failure to timely identify deteriorating vital signs, and failure to reverse the excessive sedation.

Lessons Learned and Risk Management Tips

As the case study shows, clear communication is critically important. Orders and notes should effectively convey the writer's intended meaning, so as to avoid possible misinterpretation by other health care providers. From a risk management perspective, clear communication promotes appropriate care and helps to prevent mistakes that could arise from ambiguous or incomplete instructions or documentation. From a claim perspective, precise medical record entries strengthen the defense, especially since a number of years may pass between the time of treatment and when a suit is filed, and memories may fade in the interim.

- TIP: Risk managers should encourage providers to be clear and explicit in their communications, and should provide training to help caregivers reach this goal.

Having a complete medical record is also essential to the defense of malpractice claims. Thorough documentation can help to show that the provider complied with the standard of care. On the other hand, lost, missing, or incomplete records may allow the plaintiff's attorney to create doubt as to the care received, or to argue that if something was not charted it was not done, even if the treatment itself was in fact appropriate.

- TIP: Risk managers should make providers aware of the importance of maintaining a complete medical record, not only for purposes of patient care, but also for helping claim personnel in their investigation and efforts to favorably resolve a case.

The case study also highlights the need to investigate possible equipment or software malfunction as soon as possible after a problem occurs. From a risk management perspective, promptly addressing the issue may prevent other patients from being harmed. From a claim perspective, there might have been a defense if the monitoring equipment suddenly stopped working without prior warning, causing a delay in recognizing deteriorating vital signs. But without contemporaneous testing of the machine, it would be extremely difficult to disprove that the providers relied on defective equipment in making their treatment decisions.

- TIP: Risk managers should investigate possible equipment malfunctions as soon as possible after an event.

Lastly, risk management best practices should include written policies and procedures regarding topics such as monitoring and documentation of vital signs during surgery, and preservation of potentially faulty equipment. Such policies and procedures should be clear, concise, and consistent, and should be reviewed periodically. In addition, health care providers should be trained about the policies and procedures. If policies and procedures are adhered to, they can be a shield against malpractice claims, as providers can show that they acted in compliance with hospital practices. But if they are not followed, the plaintiff's attorney could try to use deviation from the institution's own guidelines as a sword in litigation, even though such policies and procedures are not the standard of care by which a claim is to be evaluated.

- TIP: Risk managers should develop clear policies and procedures, and ensure that providers are aware of them.

2016 FUND UPDATE

The Injured Patients and Families Compensation Fund (Fund) provides excess medical malpractice insurance to Wisconsin health care providers. Since the Fund's establishment in 1975 through June 30, 2016, there have been 6,090 claims filed in which the Fund was named. Of these, the Fund has paid on 670 claims in a total amount of approximately $ 861 Million. In addition, 5,290 claims have been closed without payment by the Fund. Another 130 claims are currently open.

Claims may be closed with no Fund payment for various reasons including:

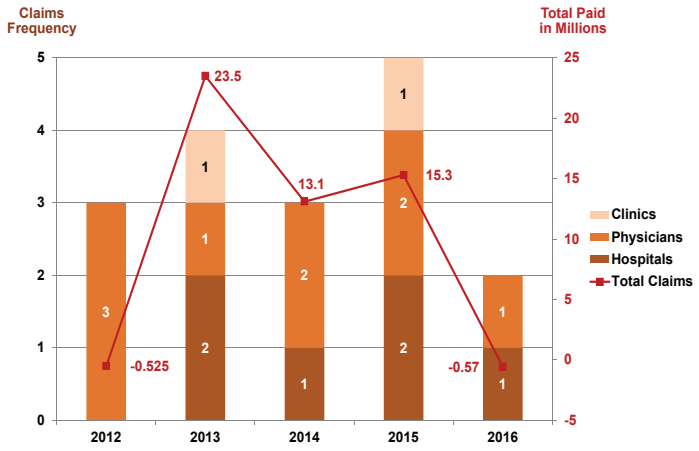
- Dismissal of claims, lack of negligence or causal negligence, or plaintiffs did not pursue the case
- Defense verdicts at trial
- Claim settlements negotiated within the underlying insurer limits

The Fund's settlement history and trial experience for claims over the last five fiscal years is reported below. Settlements represent cases negotiated to resolution out of court. Trials with plaintiff's verdicts may result in no Fund payment if the verdict is within the primary carrier's limits.

Claims	Settlement
13	Settled with Fund money
14	Settled within Primary Limits
34	Tried, Defense Verdict
13	Tried, Plaintiff Verdict

Fund claim payments can vary widely due to various factors, including the unlimited amount of coverage provided by the Fund, the severity of the patient's injuries, and the primary insurance limits available for the incident.

Number and Amount of Losses Paid by Fiscal Year



** Please note that some numbers are negative, because calculations are done on a gross basis that takes into account such things as recoverables and reductions in anticipated future medical payments.

The following table summarize claims paid during fiscal years 2012 – 2016. The payments reflect Fund payments only and do not include payments made by primary carriers.

Fiscal Year 2012 Claims Paid		
$1,011,185	Verdict	Alleged failure to diagnose impending stroke/informed consent
$280,269	Verdict	Alleged failure to diagnose resulting in stroke
$85,000	Settled	Alleged medication error/overdose - adult
Fiscal Year 2013 Claims Paid		
$11,978,490	Verdict	Alleged negligent management of birth - brain damaged infant
$6,891,000	Settled	Alleged improper performance - brain damaged adult
$4,500,000	Settled	Alleged failure to timely perform C-section - brain damaged infant
$200,000	Settled	Alleged failure to treat fetal distress - brain damaged infant
Fiscal Year 2014 Claims Paid		
$9,000,000	Settled	Alleged failure to diagnose colloid cyst – brain damage
$3,500,000	Settled	Alleged delay in performing C-Section – brain damaged infant
$1,000,000	Settled	Alleged failure to timely diagnose cancer – death
Fiscal Year 2015 Claims Paid		
$7,722,045	Verdict	Alleged failure to timely diagnose – amputation of all four limbs
$6,000,000	Settled	Alleged lack of oxygen during C-Section delivery – brain injury
$1,500,000	Settled	Alleged misdiagnosis and intraoperative error – spine injury
$500,000	Settled	Alleged failure to timely deliver baby – death of baby
$465,438	Verdict	Alleged failure to timely diagnose and treat compartment syndrome
Fiscal Year 2016 Claims Paid		
$1,100,000	Verdict	Alleged delay in diagnosing compartment syndrome – leg amputation
$2,750,000	Settled	Alleged failure to timely diagnose and monitor – brain injury

From print to electronic delivery

The Fund is pleased to advise that we will be moving to a new electronic communications platform later this year. The Fund is currently developing a curated site, based on LinkedIn, which will allow us to provide more timely content and permit two-way communications between the Fund and members in real time. The next newsletter (which will be the last one to be published as a hard copy) will provide more information including instructions on how to access the site.

About WiscRisk

WiscRisk is published quarterly and circulated to more than 15,000 healthcare providers statewide. Designed to keep readers informed of trends in liability claims and loss prevention, this publication is prepared by the Risk Management Steering Committee for the Injured Patients and Families Compensation Fund.

Articles published in WiscRisk contain the expressed opinions and experiences of the authors and do not necessarily represent the position of the Injured Patients and Families Compensation Fund. Authors are required to make disclosure of any relevant financial relationships, which may be related to the subject matter discussed. Authors have made proper disclosure and have no relevant financial relationships that exist now or in the past 12 months.