The Trauma Professional's Blog

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Emphasis: Medical Malpractice II Subscribe: www.TraumaMedEd.com July 2015

Open Discussion At M&M: Does It Increase Lawsuits?

Errors occur in medical care. And banking. And car manufacturing. The key to managing errors is to have a robust system of identification and correction. The morbidity and mortality (M&M) process is supposed to provide this for trauma professionals.

There are many individual services involved in trauma care, each with their own M&M. These include prehospital care, emergency medicine, trauma service, surgical subspecialties, radiology and others. In US trauma centers, there is also a multidisciplinary trauma performance improvement (PI) committee that brings together principals from many services to discuss more complex cases on a regular basis.

But does open, frank discussion in multidisciplinary groups increase the risk of lawsuit? Do we need to worry about so-called "tattletale lawsuits"? Should the fear of a lawsuit be allowed to compromise the transparency needed to keep the same problem from occurring again?

A single, self-insured Level I trauma center reviewed its experience over an eight year period. Cases were discussed at an open M&M conference that was attended by physicians, nurses, allied health professionals, midlevel providers, prehospital providers, residents and students. Honest and open discussions were encouraged.

All lawsuits filed during the study period were cross-referenced with names of patients discussed at Trauma M&M. Here are the factoids:

- 20,479 trauma patients were admitted, and only 7 lawsuits were served
- 1 suit was dismissed and 1 was granted a summary judgment
- 3 of the 7 were discussed at M&M, the others were not
- 3 were settled with payment to the patient
- The hospital paid a total of **$2.1M in liability** and another **$704K in legal fees**

Bottom line: The authors did not find any significant increase in risk of lawsuit in patients discussed at M&M. The numbers are small, and there are other limitations to this study that the authors fully disclose. However, it does appear that the trauma professionals involved (even students!) are very sincere in their effort to improve patient care and not blab to their friends. However, before you consider doing something like this, check with your hospital counsel! States vary on their peer protection statutes, and you must abide by hospital policy! And BTW, the

Trauma Calendar of Events

Trauma Education: The Next Generation III
Location: St. Paul, Minnesota
Date: September 17, 2015

American Association for the Surgery of Trauma
Location: Las Vegas, Nevada
Date: September 9-12, 2015

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attorneys appear to do very well regardless of outcome.

Reference: Transparent and Open Discussion of Errors Does Not Increase Malpractice Risk in Trauma Patients. Annals of Surgery 243(5):645-651, 2006.

Family Presence In Trauma Resuscitation: A Lawsuit Risk?

Nearly two decades ago, the Emergency Nursing Association (ENA) resolved that family presence during resuscitation and invasive procedures was a patient right. They thought that it was beneficial both to the patient and their family members.

As you might imagine, this was hotly contested by emergency physicians and trauma surgeons for years. Shortly after the release of the resolution, a survey was sent to members of the American Association for the Surgery of Trauma (AAST, trauma surgeons) and the ENA (nurses). This survey was designed to gauge the attitudes and beliefs of their members with respect to family presence during trauma resuscitation.

Here are the factoids:

- The entire AAST membership (813) and a random 10% of the ENA membership (2988 were polled
- Response rate was 43% overall, not bad
- AAST members tended to be male, older, and had more trauma experience (duh!)
- **98% of AAST members thought that family presence was inappropriate, vs 80% of ENA members**
- A similar proportion of members believed that family presence would interfere with patient care, increase stress on the trauma team, and **increase malpractice risk**
- All differences were statistically significant (sort of)

Bottom line: This was a weird study. If you look closely at the numbers, it appears that the same surgeons and nurses answered all the questions exactly the same way. The n for each question is virtually the same, plus or minus five respondents.

And a lot has changed in the past 15 years. This study took place when the family presence concept was relatively new. Attitudes have changed considerably, and family presence, especially parents of children, is much more routine.

There is still little data, but anecdotal experience would indicate that there is probably less likelihood of lawsuits when family is present. It is the ultimate good communication, and in cases resulting in death, the family member can see that the team is doing everything possible for their loved one.

But remember, don't just throw family members into your resuscitation room. Assign a nurse as a "medical interpreter" to explain what is going on, make sure they do not impede the team, and keep them from keeling over on the floor and getting hurt.

Reference: Family Presence during Trauma Resuscitation: A Survey of AAST and ENA Members. J Trauma 48(6):1015-1024, 2000.

Emergency Medical Services Liability Litigation

We know that in-hospital trauma professionals are at risk for litigation. But what about prehospital providers? Unfortunately, there is painfully little literature for us to go on. In this case, I was only able to dig up **a single 20 year old paper** to help provide a little guidance.

A retrospective review was conducted of data from a computerized database (note that I did not say *online*; this was from the birth of the internet) of court cases filed against EMS agencies nationwide. It specifically looked at ambulance collisions and patient care incidents.

Here are the factoids:

- **Only 76 cases were identified** over a 6 year period (!!)
- Collision and patient care suits were divided nearly 50:50
- In ambulance collisions, the other motorist was likely to sue (78% of cases)

- With patient care issues, 93% of the plaintiffs were the patient *(who were the other 7%??)*
- The most common collision occurred in an intersection, or was a rear-end accident
- The most common patient care issues were **arrival delay, inadequate assessment, inadequate treatment, patient transport delay, or failure to transport**
- About half named an EMT or paramedic as codefendant
- **41% of suits were closed without any payment to plaintiff**, but there were 5 cases with awards greater than $1M US (and this is in 1994!)

Bottom line: Yes, EMS providers do occasionally get sued. It is probably more likely today than it used to be given the legal climate in the US. Providers need to be familiar with the common reasons for lawsuits involving them, and always practice within their scope and in compliance with protocols and medical direction. Whether specific individual liability insurance is needed is a local and regional thing, and should be negotiated with your particular employer.

Reference: Emergency medical services liability litigation in the United States: 1987 to 1992. Prehosp Disaster Med 9(4):214-220, 1994.

Nursing Malpractice: The Basics

Back in the old, old days, there was really no such thing as nursing malpractice. Nurses had little true responsibility, and liability largely fell to the treating physicians. But as nursing responsibilities have grown, they have become an integral part of the assessment, planning, and management of their patients.

As all trauma professionals know, our work is very complex. And unfortunately, our understanding of how the human body works and responds to injury is still incomplete. So unfortunately, undesirable things happen from time to time.

But does every little adverse event or complication mean that someone is at fault? Or that they can/should be sued? Fortunately, **the answer is no**.

The law is complex, at least to professionals outside the legal field. **Following are the basics of malpractice as it relates to nurses.**

There are **four elements** that must be present for a malpractice case to be brought forward:

1. **The nurse must have established a nurse-patient relationship.** Documentation provided by the nurse or other providers in the medical record must demonstrate that they were in some way involved in care of the patient.
2. **A scope of duty must be established within the relationship.** For example, an ICU nurse will have duties relating to examining the patient, recording vital signs, reporting significant events to physicians, etc. The exact duties may vary somewhat geographically and even between individual hospitals. Written policies help to clarify some of these duties, but often, experts are required to testify to what the usual standards of care are when not covered by policy.
3. **There must be a departure from what is called "good and accepted practice.**" The definition of this leaves a lot of wiggle room. It is defined as the care that an ordinarily prudent nurse would have provided in the given situation. It does **not** need to be the optimum or best care. And if there is more than one approved choice, a nurse is not negligent if they choose either of them, even if it later turns out to be a poorer choice.
4. **Finally, there must be a cause-effect relationship between the nurse's action and the patient's alleged injury.** This linkage must be more than a possibility, it must be highly probable. For example, wound infections occur after a given percentage of operations, and it varies based on the wound classification. It's a tough sell to bring suit for improper dressing care in a grossly contaminated wound that is likely to become infected anyway. Typically, expert witnesses must attest to the fact that the patient was, more likely than not, harmed by the nurse's action or inaction.

What are common sources of malpractice complaints against nurses? The most common event is **medication error**. Most people worry about common errors like wrong dose, wrong drug, and wrong route of administration. But one less commonly considered drug-related responsibility is assessment for side effects and toxicity of medications administered.

Other common reasons include failure to adequately monitor and assess the patient, and failure to supervise a patient that results in harm. Significant changes in patient condition must be reported to the responsible physician. However, doing so does not necessarily get the nurse off the hook. If the physician's response leads the nurse to believe that they have misdiagnosed the problem or are prescribing an incorrect drug or course of action, the nurse is obligated to follow the chain of command to notify a nursing supervisor or other physician of the event.

And finally, one of the most common issues complicating malpractice cases of any kind is documentation. Lawsuits must typically be filed within two years of the event that caused harm. Once that occurs though, several more years may pass before significant action occurs. Collection and review of documentation, identification of experts, and collection of depositions takes time. And unfortunately, our memories are imperfect after many years go by. **Good documentation is paramount!** *"Work not documented is work not done,"* I always say. And poor documentation allows attorneys to make your good work look as bad as they want and need it to.

Reference: Examining Nursing Malpractice: A Defense Attorney's Perspective. Critical Care Nursing 23(2):104-107, 2003.

Forensic Nursing

Forensic Nursing combines nursing science with the investigation of injuries or deaths that involve accidents, abuse, violence or criminal activity. Sexual Assault Nurse Examiners (SANE nurses) are one of the most recognized types of forensic nurses, but they have special training in one type of injury. Forensic nursing programs typically involve a broader set of skills, encompassing some or all of the following:

- Interpersonal violence, including domestic violence, child and elder abuse/neglect, psychological abuse
- Forensic mental health
- Correctional nursing
- Legal nurse consulting
- Emergency/trauma services, including auto and pedestrian accidents, traumatic injuries, suicide attempts, work-related injuries, disasters
- Patient care facility issues, including accidents/injuries/neglect, inappropriate treatments & meds
- Public health and safety, including environmental hazards, alcohol and drug abuse, food and drug tampering, illegal abortion practices, epidemiology, and organ donation
- Death investigation, including homicides, suicides, suspicious or accidental deaths, and mass disasters
- Forensic nurses find that their additional training improves their basic nursing skills, and allows them to derive greater career satisfaction from helping patient in another rather unique way.

Approximately 37 training programs exist, ranging from certificate programs that require a specific number of hours of training, to degree programs (typically Masters level programs). Many of the certificate programs are available as online training.

Source: International Association of Forensic Nurses (http://www.iafn.org/)

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