

System Failure: Issues of Medical Malpractice

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ACCORDING TO RESEARCH done at Johns Hopkins University, diagnostic error kills 40,000 to 80,000 hospitalized patients annually, based upon autopsy studies conducted over the past 40 years. The Institute of Medicine updated report indicates that as many as 200,000 people die in the United States annually due to medical malpractice. According to Brennan et al., a Harvard medical practice study indicates that the incidence of adverse events and negligence in hospitalized patients is much greater than once believed.

Errors in medication administration account for 770,000 adverse events annually where patients are either killed or injured. No matter what research is referenced, the message is clear – medical malpractice and the resultant injuries are epidemic.

Medical malpractice is professional negligence by act or omission by a health care provider in which the care provided deviates from accepted standards of practice in the medical community and causes injury or death to the patient.

Medical Injury Compensation Reform Act (MICRA)

The Medical Injury Compensation Reform Act of 1975 (MICRA) was enacted by California in 1975 as a means to cap the rising costs of medical malpractice insurance. It limits recoverable damages in California for noneconomic losses (e.g., pain and suffering) to a \$250,000 aggregate

cap no matter how many plaintiffs or defendants are named in a case. Additionally, the damages recovered by an injured patient are reduced by the amount of any collateral source benefits, such as health insurance. MICRA also allows the defendants to pay out over time all future damages in excess of \$50,000.

In addition to the constraints set by MICRA, punitive damages cannot be included in a professional negligence claim unless a court order is obtained first. Therefore, the court must first assess whether it believes there is enough evidence to include a punitive damage claim.

Assessment of a medical malpractice case first requires a careful review of the facts of the case. When evaluating a malpractice case for merit, or strategizing a defense, one must analyze the facts of the case and compare that to the standards of practice specific to the field at issue. For example, if the potential breaches are related to nursing care in a post operative patient, then nursing standards in the area of medical surgical nursing would apply.

If the case is regarding a wrong site surgery, operating room standards would apply. Standards of care arise from different sources: licensing bodies, federal and state regulations, professional organizations, State Practice Act and a facility's policy and procedure manuals. Because of the complex nature of most cases, it is prudent to have an experienced legal nurse assist in the evaluation of the matter.

The practice of professional nursing has become increasingly complex as medical and technical advances in science, medicine and health care occur. With the development of subspecialization and advanced practice in nursing and medicine come greater expectations of the health care consumer and a greater need for nurse experts to play a part in assuring the correct standard of care was (or was not) applied. This will prove to be more important as health care reform is approached, and as more and more primary care is delivered by advanced practice nurses. By having a legal nurse consultant review the case initially, there will not only be an assessment of a specific area of practice, but of the overall case, evaluating both medical and nursing care.

Unlike a physician who will look at a case in their own area specifically, nursing is better prepared to provide an overview of all disciplines. The skilled legal nurse consultant will know if they need to get additional specialty opinions, physician or otherwise, in the initial phase of evaluating a case. Clearly, medical support for the case, whether plaintiff or defense, will be required as the case develops.

The duty of the healthcare provider is to have the knowledge and skill ordinarily used in like cases, by trained and skilled members of the same profession in the same or similar locality and under the same circumstances.

A breach of duty occurs and the care provider is negligent if

the error in judgment or lack of a positive outcome is due to a failure to perform in accordance with similar professionals acting under the same or similar circumstances. This needs to be differentiated from a procedure or care delivered within the standard that just has an unfortunate poor outcome.

Medical malpractice may result from numerous situations. Some examples of the most common include: delay or failure to diagnose or properly treat a condition or disease; leaving foreign objects in the body during surgery; surgical or anesthesia errors; or medication administration errors in terms of using the wrong drug or incorrect dosage. Other medical malpractice issues are often related to healthcare's staff failure to follow the facility's policies and procedures.

Never Events

Simply put, "never events" are adverse events that should never happen. Effective July 1, 2007, California Health and Safety Code 1279.1 became effective. This requires health facilities to report adverse events to the California Department of Public Health (CDPH, formerly known as DHS) no later than five days after the adverse event has been detected or if that event is an ongoing urgent or emergent threat to the welfare, health or safety of patients, personnel or visitors, not later than 24 hours after the adverse event has been detected.

Adverse or never events can include surgery performed on the wrong patient or wrong body part, infant discharged to the wrong person, or accidental death situations such as death occurring during a surgical procedure or up to 24 hours after induction of anesthesia on a normal, healthy patient.

The health facility is also required to inform the patient or the party responsible for the patient of the adverse event by the time the report is made. The adverse event reporting law contains specific penalties for failure to report. A hospital that fails to report an adverse event may be assessed a civil penalty in an amount not to exceed \$100 per day for each day that the adverse or never event is not reported following the initial five day period or 24 hour period, as applicable. If the hospital disputes a determination by CDPH regarding an alleged failure to report an adverse event, the hospital has 10 days to request a hearing pursuant to Health and Safety Code Section 100171.

With regard to never events, one can see how important it is to verify if proper reporting has been done when there is an allegation of medical malpractice. This is important for both defense and plaintiff as the defense attorney will need to know what the internal root cause analysis was (if in fact there was a breach in the standard of care) and what was done about it.

On the plaintiff side, it will assist them by knowing what the CDPH investigation cited. Both sides should make contact directly with the CDPH field office and request a copy of the 2567 surveys and all surveyor notes for two years before and one year after the alleged incident. Defense counsel will need this as they do not want to



The mistakes are all there, waiting to be made."

**– Savielly Tartkower, chessmaster
1887 - 1956**

find out information about their facility from plaintiff counsel. They will also want time to strategize how they will address these variances in care if in fact there were any. This information will also assist defense counsel in putting together an offer of settlement, if exposure exists. Conversely, defense counsel can use stellar surveys to support their case in defense of their facility.

For the plaintiff, this information will validate their case of negligence (if there are findings and plans of correction). If prior similar incidents have occurred, it will help the plaintiffs' case in establishing a pattern of negligent care and the knowledge that management was aware of the poor care yet may have knowingly chose to put profits over patients.

In California, the statute of limitations for medical malpractice is one year from the time one knew or should have known a breach in the standard of care occurred or three years after the date of injury. In no event shall the time for commencement of legal action exceed three years unless tolled for any reason per CCP 340.5.

Where to Look for the Breaches in the Standard of Care

Most errors do not have a single cause – the "rule of three" seems to consistently apply. Most often there are at least three errors or communication deficits that cause an adverse event to occur. It is rarely, if ever, just one specific error or mistake that causes an issue.

The Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations) has found that communication is the number one contributor to patient injury. Communication is affected by fatigue, prior life experience, accents, socioeconomic level, values, cultural framework, environmental distractions, workload, sleep deprivation, relationships between healthcare providers, ethics and prejudices.

This is compounded by our multicultural society wherein both language and cultural differences can easily lead to misunderstanding, miscommunication and failure to take action. An influx of foreign trained nurses brought to the United States to help with the nursing shortage, and the large number of foreign trained physicians, has exacerbated the communication challenges. Not only does this bring language difficulties, but cultural ones as well. All of this plays into the complex process of communication and unfortunately can adversely affect patient outcomes.

The Ten Most Common Reasons for Nursing/Medical Liability list areas of breakdown in care that can usually be found which lead to patient death or disability. Each of these reasons for liability contains steps which should allow multiple opportunities to assure the standard of care is met, yet become missed opportunities. This represents areas that should be carefully reviewed when evaluating medical malpractice cases as the majority of matters will fall into these categories.

All patients are at risk of receiving substandard care. Patients 20 years ago who would be on the general nursing floor are now treated at home by lay family and friends and, if lucky, a home health nurse a few times a week. Patients who 20 years ago would have been treated in the intensive care units (ICU) are now on general nursing floors and many who are in the intensive care unit today are there due to the advances in medical treatment and are much sicker than those of years ago. Yet still, they are kept in the ICU's much less time, often

being discharged to home directly from ICU whereas historically they would have always gone to a general nursing floor for at least a few days for further monitoring.

Staffing crises, as well as multicultural differences, demanding stressful assignments, fast changing technology, an emphasis on more cost effective managed care and a lack of management support feed into feelings of frustration and not being able to provide the care the nurses want to give. This leads to more staff turnover with experienced nurses leaving the profession.

For physicians, managed care has impacted their practices as well. Many experienced practitioners have been unable to continue to provide the level of care both they and their patients enjoyed. With insurance companies now driving which physicians patients see, most people no longer have the same physician for years. As insurance rates increase, companies change their plans and their employees are forced to go to new healthcare providers. This breakdown in continuity of care also increases the risk of missed diagnoses, creates a lack of relationship between physician and patient, and promotes losing patients to follow up.

Medical malpractice is at epidemic levels and does not appear to be decreasing – even with quality care organizations, regulations, and well known standards of care all supporting increased patient safety. As progress seems to be made in one area, other areas increase in adverse events.

Be clear, patients do not go into a hospital in hopes of striking it rich as the result of a medical error. And the reality is that the vast majority of patients who have been malpracticed do not sue. Those that do sue know that a plaintiff verdict cannot change the catastrophic damage that has been done. What patients want most often is to know that the same thing will not happen again to someone else. 🐾

Tricia West is a pioneer in the field of legal nurse consulting. Along with her clinical work, she has worked in the medical legal arena since 1980. West has experience as a registered nurse and administrator, having worked in intensive care, quality care, acute and chronic dialysis. She can be reached at twest@pjwa.com.



Santa Clarita Valley Bar Association



PAULETTE GHARIBIAN
SCVBA President

A Year in Review

EXACTLY ONE YEAR AGO this time, Brian Koegle was elected to serve as president of the Santa Clarita Valley Bar Association. It was an exciting and successful year for the association. Koegle set out to grow membership and to implement new and improved membership benefits; he was successful at both.

In past years, surveys distributed among the membership revealed an interest in the hard-to-obtain continuing education courses, on the topics of substance abuse, ethics and elimination of bias as well as an interest in networking opportunities. The focus of Koegle's presidency included meeting the stated needs of the membership by providing more opportunities for networking among the members of the association as well as organizing and providing continuing education classes on the requested topics.

Koegle served his term alongside a dedicated and hard working board, including past president Robert Mansour, treasurer Jane McNamara, secretary Amy Cohen, members-at-large Barry Edzant, April Oliver and Mark Young and San Fernando Valley Bar Association liaison Caryn Sanders.

In order to minimize the Santa Clarita Valley Bar Association's financial liability associated with organizing this year's meetings, the bar's leadership was successful in securing sponsorships for all of the year's events. All meetings were well attended and were a great success, allowing those who attended to network, enjoy great food and drinks,

as well as earn the credits for their continuing education.

2010 also marked the redesign of a new and improved website. Through the efforts of past president Robert Mansour, as well as the Scorpion Web Design team, the SCVBA launched a new face on the web (www.scvbar.org). The site provides for easy navigation, lists local attorneys by practice areas, as well as allows members to pay for dues and sign up for events online.

Looking to the year ahead, the SCVBA is excited to continue its success and to take on new ventures and commitments. The association was founded by and nurtured through role models for leadership. These individuals were leaders of action who were courageous and determined to make a difference.

The planning of the next term will be collaborative, reflective and diverse. The SCVBA hopes to inspire and learn from one another and the membership-at-large. At the core of its service, the association will hold onto our passion for substantive growth and continuous improvement in our community involvement.

The SCVBA leadership looks forward to soliciting more involvement from members and encourages an open door policy during this upcoming year. Open communication, feedback and discussion about any matter is important to the association. Stay tuned for more news ahead and the exciting new events coming up in the 2011 term. 🐾

For more information, please visit www.scvbar.org.

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