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NOVEMBER 2021 Vol. 43, No. 11; p. 121-132

INSIDE

Relias Media
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Post-COVID Could Bring Surge in Med Mal Cases

The COVID-19 pandemic still has many hospitals and healthcare facilities straining to maintain anything like normal operations. But that pressure will eventually ease, and more patients will return for routine care and elective surgeries. Some risk managers and healthcare leaders worry this will prompt an increase in medical malpractice cases.

Claims could grow as hospitals perform more elective surgeries, possibly even at a higher volume than before to make up for revenue lost during the pandemic. That increase in the number of procedures could produce its typical number of claims per procedure, but that could be even higher if hospitals push their surgical teams too hard in search of revenue.

Delays in diagnosis are another worry. Failure to diagnose cancer is one of the most common medical malpractice allegations. With patients hesitant to enter a healthcare facility during the pandemic or unable to schedule an appointment, the number of cancer screenings has decreased sharply, according to the National Cancer Institute (NCI). A December 2020 summary of NCI research and other studies revealed decreases of up to 85% in cancer screenings, like mammograms and colonoscopies, during the

WITH PATIENTS HESITANT TO ENTER A HEALTHCARE FACILITY DURING THE PANDEMIC OR UNABLE TO SCHEDULE AN APPOINTMENT, THE NUMBER OF CANCER SCREENINGS HAS DECREASED SHARPLY.

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HEALTHCARE RISK MANAGEMENT™

***Healthcare Risk Management™*, *ISSN 1081-6534, including Legal Review & Commentary*,™ is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Healthcare Risk Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**

GST Registration Number: R128870672

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pandemic. Those delays could result in an additional 10,000 breast and colorectal cancer deaths over the next 10 years, the researchers suggested. *(The report is available at: https://bit.ly/3BsdPxL.)*

Hospitals and physicians probably should prepare for a wave of malpractice lawsuits, says **Emily L. Fernandez**, JD, partner with Wilson Elser in White Plains, NY. In addition to any increase in elective surgeries and delayed diagnoses, malpractice allegations stemming from COVID-19 care could arise.

"I believe the most immediate influx of lawsuits to come down the pike will be cases arising from care and treatment in 2020 and 2021 that courts did not dismiss under more recently enacted immunity statutes relative to the COVID pandemic, such as the PREP [Public Readiness and Emergency Preparedness] Act," Fernandez says. "Despite federal and state governmental efforts to provide a degree of immunity to protect healthcare providers during such an unprecedented time, courts have been reluctant to dismiss cases pursuant to immunity statutes."

Those matters must now be litigated, she says. A primary inquiry will be the standard of care during that unique time.

"Even though I believe many healthcare providers will ultimately prevail, the cases will still require time and expense to resolve," Fernandez says.

More Elective Procedures

Healthcare facilities will handle more elective procedures as COVID-19 cases wane. That would be good for hospitals, which generate revenue from elective procedures, Fernandez says. Increased demand for elective procedures should lead to increased supply, but does not and should not translate into a greater incidence of malpractice lawsuits if the standard of care is followed.

"I believe policies can be put in place with an aim toward smarter, more streamlined hospital visits when it comes to elective surgeries to address the demand and result in benefit to hospitals, insurance providers, and patients," Fernandez says. "Particularly with respect to surgical admissions of private patients, policies may be implemented to emphasize more robust and regimented outpatient care both pre- and postoperatively."

For example, before admission, a hospital might choose to require comprehensive documentation of diagnosis, evaluation, pre-testing and clearance, insurance information, and informed consent, most of which could be completed electronically and already available

EXECUTIVE SUMMARY

Hospitals could see a surge in medical malpractice cases after the pandemic ends. An increase in elective surgeries, along with delays in diagnosis and treatment, may prompt part of the increase.

- Delayed cancer screenings could bring claims of failure to diagnose.
- Plaintiff attorneys will test federal immunity laws.
- Depend on solid risk management policies and procedures.

in the patient's electronic medical record.

After surgery, patients should be discharged promptly and properly to free up space and staff for the next patient. A hospital might require patients to be discharged when stable; discharge instructions might include a short interval follow-up visit scheduled for a specific date with a specific provider or primary care doctor identified pre-admission.

Safely shortening admission times benefits everyone. This could allow for a greater volume of elective surgeries and, thus, increased revenue for hospitals. The key is to create policies and procedures that maintain the standard of care and optimize patient safety while shortening admission times, Fernandez says.

Patient Reminders Needed

There also is a concern that patients need more in-depth, complex care due to a lack of preventive care in recent years. More advanced care can bring higher malpractice risks, Fernandez notes. It is unclear if this would lead to more claims.

More care, complex or not, likely will be needed because of the dearth of patient willingness to seek routine, preventive care during the height of the pandemic. Fernandez says hospitalization is unlikely, except for advanced cases.

"We lost a significant amount of time — about one and a half years at this point — but for many it is not too late to get back on track through outpatient measures. Encouraging primary care treatment through portals, texts, emails, letters, and clinic notices will be the best line of defense," she says. "Electronic reminders can be powerfully effective. In an effort to reduce hospitalization for emergencies such as a heart attack or stroke due to uncontrolled or poorly controlled underlying conditions during the pandemic, hospitals with clinic offices or affiliates should join in the effort to encourage primary care or maintenance treatment."

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Risk managers should implement specific policies with respect to COVID-19 and elective surgeries, Fernandez says. First, she urges strong consideration for a COVID-19 consent form, which would be a separate, standard informed consent form for vaccinated and unvaccinated patients that clearly and simply reflects these three main ideas:

- The patient is aware there is an ongoing pandemic of a highly transmissible respiratory virus causing COVID-19, which can cause life-threatening complications, including death.
- The hospital is actively engaged in treating patients with COVID-19.
- The patient is aware of and accepts the risks of exposure to COVID-19 while at the hospital despite the hospital's efforts to prevent exposure.

In addition, Fernandez says health-care risk managers should consider limiting elective surgeries only to individuals who provide proof of proper and up-to-date vaccination. Even then, a COVID-19 consent form still would be necessary because of the growing incidences of breakthrough infections and understudied ability of a vaccinated person to transmit the virus.

"It also may be advisable to obtain a general release of any and all claims and causes of action arising from or relating to exposure or contraction of COVID-19 during a hospital visit for an elective procedure," Fernandez says. "Obviously, the hospital does not want to impose measures that will cause patients to seek treatment at other facilities with less demanding preconditions to elective procedures, so perhaps this could be a voluntary option until patient response can be assessed."

Patients Could Be Sicker

In addition to the pandemic's tremendous strain on providers, and patients forgoing routine health screenings, there appears to be an increase in sedentary behaviors, obesity, and likely diabetes, says **Elizabeth L.B. Greene**, JD, partner with Mirick O'Connell in Worcester, MA. There likely will be an increase in delayed diagnosis of cancers and cardiovascular diseases — caused by the pandemic, not the providers.

A focus on or return to the basics of risk management and quality of care will continue to be important, Greene says. Good documentation, appropriate patient education and assessment, referrals to specialists, and

attention to following guidelines in patient care will lower any liability risk.

"Risk managers will also want to pay attention to the providers, some of whom may be suffering from post-traumatic stress syndrome secondary to COVID-19 or other mental or emotional challenges as we come out of this pandemic," she says. "Risk managers will want to familiarize themselves with the signs of burnout and trauma in providers."

There is a significant amount of anticipation in the healthcare community about a potential increase in claims in the coming months, says **Aaron Richard**, president of Argus Risk Advisors, an insurance broker based in New York City. It is unknown whether COVID-19 treatment issues will prompt a wave of claims.

"The early impression by our people on the liability side is that they are cautiously optimistic," he says. "But that could all change very quickly in the next six to 24 months as all of this opens up."

The biggest determinant will the federal immunity laws and how they are tested in court, Richard says. Plaintiffs' attorneys will try to find a way around the immunity laws. If early attempts are successful, that will prompt more claims.

"They will be looking at things like willful misconduct, which is a common exclusion in those laws, but it's also a common policy exclusion," Richard says. "That could be a potential workaround for a small number of cases."

However, the COVID-19 immunity laws likely will offer no protection for malpractice claims unrelated to COVID-19 treatment, such as those arising from more elective surgeries after the pandemic. However, Richard is skeptical about a surge in elective surgeries, at least in some specialties. In plastic surgery and bariatric surgery, physicians are unlikely to take on such a volume of elective surgeries that the liability risk is higher.

"I know from speaking to our surgeons and anesthesiologists in those fields that they are not going to accept an increase that threatens their quality of care," Richard says. "They're busy and getting back to normal levels, but I don't think there will be an increase where they will go much over the levels they were pre-COVID." ■

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Surveillance Video Can Make or Break Med Mal Defense

A medical malpractice claim against a hospital in New York City may hinge on what is depicted in the surveillance camera footage of the hospital's emergency department (ED). That is unusual because surveillance footage is routinely destroyed after a short period and long before a malpractice claim is filed, attorneys say.

In this case, a man died in the ED waiting area. His family alleged staff failed to act on obvious signs of distress. They immediately filed a complaint with the state department of health, and investigators seized the surveillance video.

Surveillance video can be useful to either the plaintiff or defendant — or even both, depending on the circumstances, says **Adam Peoples**, JD, partner with Hall Booth Smith in Asheville, NC. As a theoretical example, he says, the surveillance video from an ED might show the area was quite busy and other patients were more obviously in need of help than the plaintiff.

It is unusual for surveillance video to be used in malpractice litigation because there are few requirements that it be kept for any period, Peoples says. Most healthcare facilities keep the video for a relatively short time, often weeks or a month, before routinely erasing it when there has been no indication to preserve it. Because it usually takes longer than that for a medical malpractice case to be filed, any related surveillance footage usually has been erased.

"It often is a tradeoff in terms of the cost and network resources required to save video. Storage needs can be enormous, especially for something like a hospital that will have cameras everywhere," Peoples says.

The question of whether to create video should not be determined by

trying to predict whether it might be helpful or harmful in future litigation, says **Chad Young**, JD, with The Law Office of Chad Young in New York City. It can go either way, and there is no way to predict the answer. Instead, rely only on practical considerations of the need to ensure a safe environment for patients, staff, and visitors.

"I've personally been involved in cases in which the video totally made my case, and I've been involved in cases where I wish there had never been a video," he says. "In this New York case, maybe the video shows that they did not neglect this man and his death, however unfortunate, was not due to any neglect by the hospital. The family may think the wait was unreasonable, but maybe the video shows someone in there taking his vitals every 20 minutes, or whatever the case may be."

In his experience, Young has never seen a facility routinely preserve video for more than a month. He has seen some that kept it only 24 hours.

When video is available, it might dissuade some plaintiffs from pursuing litigation. Young recalls one client who told him she slipped in a hotel's laundry facility and broke her wrist. He completely believed her explanation of why the facility was liable, and immediately requested surveillance video.

"They had footage, but unfortunately it revealed that she had climbed onto a chair to reach something and fell off the chair, which was not consistent with what she had claimed," he says. "Obviously, I did not feel she had a case anymore after I saw that footage, and I let her know that in no uncertain terms."

Even if the video footage supports the plaintiff's allegations, that still can be advantageous to the defendant if it prompts a quick settlement offer that prevents five years of costly litigation, Young says.

Often Better for Defense

Video usually will help the defendant more than the plaintiff, says **Mark Seitelman**, JD, of Mark Seitelman Law Offices in New York City. He is a plaintiff's attorney and has handled many claims against hospitals, including some involving video.

"In our experience, video imaging can cut both ways. Many times, it will defeat a claim," he says. "From our experience in representing injured people, most of the time, the video hurts our client. The old saying that 'a picture is worth a thousand words' holds true. If the videotape is damning to the plaintiff, it is almost impossible to explain it away. Assuming that the video is neither phony nor doctored, a plaintiff's explanation will be feeble."

Seitelman notes two relevant cases. In one, a client claimed she fell on a defective sidewalk that would have been the responsibility of the adjoining property owner, a mosque. The adjoining property owner provided video surveillance of the accident. It showed the client actually fell in the roadway. Hence, the property owner was not liable. The video provided a definitive defense.

In the second, a client claimed she slipped on oil in a supermarket. The video established that another customer spilled the oil about one minute before the plaintiff crossed the aisle and fell. The video proved that the supermarket did not have notice of the spill and could not have prevented the fall.

If a hospital wanted to be extra cautious in preserving video data for its defense, Seitelman suggests one year would be adequate. Plaintiff's counsel usually will send a letter of representation to the hospital within one year of the incident.

"The statute of limitations for regular negligence cases like slips and falls is three years, so you could save it that long," he says. "Of course, it may not be practical to save so much data. I would say that one year is being very safe."

Most Ban Delivery Video

The use of video in medical malpractice cases gained attention years ago when cameras became smaller and more affordable — at the same time that it became more common for family members to be present during childbirth, notes **Roger Harris**, JD, partner with Swift Currie in Atlanta. Cases arose

EXECUTIVE SUMMARY

Video surveillance data can be either helpful or harmful in defending a malpractice claim. Healthcare organizations should strictly adhere to their policies on the preservation of video.

- Surveillance video can be erased routinely after a prescribed period.
- Deviating from a video preservation policy can be considered destruction of evidence.
- Once a lawsuit is filed, any related video should be preserved.

in which amateur video was used to allege negligence causing birth injuries, and hospitals debated whether to allow cameras in the delivery room.

Harris was the defense attorney in such a case, in which a father recorded the difficult birth of his child. The video showed the obstetrician struggling and grunting as he tried to deliver the breech birth, and the baby was left with severe neurological issues.

"Of course, the video made the difference in settling the case vs. the hospital being able to defend it because the optics were so bad," he says.

Most hospitals now prohibit recording deliveries, Harris notes. Although videos might help the defense, certain footage could negatively influence juries that might only see disturbing visuals without understanding the entire medical context.

For surveillance video and similar recordings, it is typical for hospitals to overwrite videos in 30 to 60 days, but sometimes sooner depending on the storage limitations of the technology, Harris says. Whatever the typical overwrite period is, video should never be intentionally deleted because the hospital fears the contents could be used against it. Even if no lawsuit has been filed, it is never a good idea to delete video because it might be used against you.

Surveillance video can be necessary and beneficial to everyone involved, particularly in a potentially volatile area like an ED waiting room, Harris says. In that case, following the hospital's own policies is paramount, and avoiding spoliation must be a major concern. *(See the story on in this issue for more on spoliation.)*

Recently, Harris was involved with a premises liability case for a client who received a preservation letter from the plaintiff's attorney, but it did not reach the right person. The video recording was allowed to expire.

"We clearly had a duty to preserve, and we didn't. It became a big challenge to us," he says. "The plaintiff filed a motion for spoliation. The judge held a big meeting where she said we had to go to mediation, or if we went to trial, the plaintiff was going to be allowed to enter all the evidence on the destruction of the video. It was a nice way for the judge to tell us to settle, which we ultimately did." ■

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Spoliation Instruction Is Major Risk to Avoid

When dealing with video that might be used in a malpractice or premises liability case, the risk of spoliation arises when the owner of the evidence knows it could be relevant to the case and destroys it anyway, says **Adam Peoples**, JD, partner with Hall Booth Smith in Asheville, NC.

When that happens, the court may order the jury to assume that whatever was on the video was damaging to the party that destroyed it.

"That can be a fatal blow when you get a spoliation instruction in a civil case," he says. "Every facility is going to be destroying video on a regular basis, but you have a duty to preserve evidence when you have knowledge that it could be relevant to any investigation or litigation."

However, the loss of the video does not automatically create a spoliation issue. If the hospital can convince the court that it had no reason to suspect litigation involving the video, the court might not issue the spoliation instruction.

But the bar for anticipating litigation is low. Any communication from a potential plaintiff's counsel, even hinting that a lawsuit might be filed, could be enough to trigger the need for preservation, Peoples says. He recalls one example in which an employer was charged with violations by the Equal Employment Opportunity Commission.

"No lawsuit had been filed, no letter had been received, but the duty to preserve arose based upon other pertinent facts," he says.

Generally, the duty to preserve information arises when litigation is reasonably anticipated, or you know or should have known there is a credible threat of litigation.

"At that point, your in-house counsel would send out a message to everyone involved, telling them not

to change or delete any evidence — and that would include surveillance video," Peoples says. "You would tell your IT department to save the video along with the metadata."

If there was nothing to trigger the preservation of the video before it would be erased under the organization's policies, the court probably will not accept the plaintiff's claim the footage would have supported his or her allegation. But following policy is extremely important. If policy states videos should be deleted after one month, but it is not performed routinely and video is available from the past year, the one-month policy cannot be used to delete old video when litigation arises.

"You cannot go back and delete that video because it's past the date at which you should have deleted it. It doesn't work that way," Peoples says. "I've seen organizations that were negligent in following their own policy, and then when litigation was imminent, their local counsel wanted to delete, delete, delete. They say, 'You've never done it before, but you have to do it now.' That creates an exception to the policy, and the spoliation instruction goes to the intent of the party destroying the evidence."

Courts often look to the culpability of the party destroying the evidence. If an IT vendor deleted video as part of a routine process, there likely is no culpability.

"It's different from the risk management team rushing into the IT department and ordering them to delete that video now," Peoples explains. "If the IT vendor has no knowledge of any reason to not follow the deletion policy as a routine matter, it's unlikely anyone would conclude it was done in bad faith."

The risk of spoliation is not to be taken lightly. The federal rules of civil procedure were recently eased to reduce the need to show culpability, no longer requiring courts to find "exceptional circumstances," Peoples says. The resulting sanctions can be significant.

If a court finds electronic information should have been preserved, but is gone, it can instruct the jury to presume the missing information was unfavorable to the party that lost it, dismiss the entire case, or enter a default judgment.

"The default judgment would be really bad for a hospital. That would be a default finding of liability, leaving the only question to be the amount of damages," Peoples says. "That would be the worst-case result, and a pretty severe case in the world of medical malpractice where the damages can be so high." ■

Medical Simulators Can Prevent Med Mal Claims

Using medical simulators for obstetrics training can lower the incidence of medical malpractice claims, according to recent research from CRICO/Risk Management Foundation of the Harvard Medical Institutions, Brigham and Women's Hospital, Harvard Medical School, and the Center for Medical Simulation.

OB/GYNs who participated in medical simulation training experienced fewer claims in the retrospective analysis. The researchers compared malpractice claim rates for 292 OB/GYNs who were insured by the same company and attended at least one simulation training session over 17 years.

The malpractice claim rate was 11.2 claims per 100 physician coverage years before simulation training. After training, that number fell to 5.7 claims per 100 physician coverage years. Looking specifically at two-year periods before and after simulation training, claim rates fell from 9.2 claims per 100 physician coverage years before training to 5.4 claims per 100 physician coverage years after simulation training. *(An abstract of the study is available at: https://bit.ly/2Yv4lmV.)*

The simulation training in the study focused on teamwork and crisis management, says lead author **Adam C. Schaffer**, MD, MPH, of Brigham and Women's Hospital. Other OB/GYN simulation training focuses on more technical skills of delivery, such as responding to shoulder dystocia.

"It was a low-frequency, high-acuity training scenario, addressing situations such as a mother going into cardiac arrest around the time of birth due to severe postpartum bleeding," he says. "The simulation focuses on how the team works together, how to have a functional hierarchy so that everyone works well together to provide effective, coordinated care."

Schaffer suggests the reduction in malpractice claim rates probably can be tied to the simulation training addressing two of the most common factors that contribute to adverse events in obstetrics: poor communication and a dysfunctional hierarchy.

The research also revealed a dose response relationship. The more simulation training a physician participated in, the more that physician's claim rate dropped afterward. That

supported the conclusion that the simulation training was responsible for the drop in claims, Schaffer says.

For a risk manager seeking a robust simulation training program, Schaffer advises starting with a risk assessment.

"Consult with your clinical leaders to find out what are the scenarios that keep them up at night. Then, you can tailor your simulation program to the needs of your clinician workforce," he explains. "Part of the challenge is getting people to participate in the simulation training. Even though people often are enthusiastic about it, as a practicing physician there are many demands on your time. By tailoring the simulation to what your clinicians are most concerned about, you can encourage participation."

Risk managers also might consider other incentives for participation, such as protected time off from a scheduled clinical shift, rather than asking physicians to add the training on top of their regular duties.

"In our research, the malpractice insurer offered a premium reduction to clinicians who participated in the simulation training. That creates a financial incentive that motivates people to participate," Schaffer says.

A good outcome of the study would be for medical malpractice insurers to offer more incentives for participation in simulation training, suggests **Ziad Rouag**, CEO of Biomodex, a medical simulator company in Quincy, MA. Insurers offer discounts for organizations and individual practitioners who demonstrate adherence to best practices and participation in advanced education. Rouag suggests a similar certification could be developed for simulation training.

"We think the technology could be used in the same fashion, because the insurance companies benefit from the reduction in claims that was demonstrated in this research," he says. "There is value there."

Address Emotional Effect

One factor to consider is the emotional effect of simulation training. Administrators should be prepared to offer emotional support to participants, Schaffer says, because the training can be realistic enough to generate the same kind of stress that comes from treating real patients in high-risk scenarios.

"That's part of the point of simulation training. It feels real in every regard and the simulation is designed to immerse the practitioner in a way that feels very realistic," he says. "It can be intense and emotionally draining, even for those who are just observing."

It is important for training programs to incorporate a post-course briefing that serves two functions. First, it allows a discussion of what went well and what did not, allowing participants to learn from their mistakes in a safe way.

"But it also is important to let people talk about their experience, to share their reactions and some of their emotions related to the intensity of the clinical situation," Schaffer says. "I observed one session in which the participants weren't able to figure out what went wrong, and the simulated patient died. That's a very emotional experience. One objective of the post-simulation briefing is to give people a chance to talk about their reactions."

Can Alleviate Physician Stress

Researchers confirmed the importance of simulation training for OB/GYNs in particular, says **Laura Fortner**, MD, an OB/GYN and life coach in Newark, OH, who counsels physicians involved in medical malpractice cases. She notes other research shows that by the age of 45, 36% of doctors in low-risk specialties and 88% of those in high-risk specialties have been subjected to a malpractice claim.

By the age of 65, those numbers jump to 75% for low-risk and 99% for high-risk specialties. OB/GYN is in the high-risk category. *(The research is available at: https://bit.ly/2YHX7f7.)*

"Unfortunately, when a physician gets sued, even if it does not have any merit, emotional injury is real. Ninety-five percent of physicians will

EXECUTIVE SUMMARY

Results of recent research show a direct correlation between simulator training for OB/GYNs and a reduction in medical malpractice claim rates.

- Claim rates declined from 11.2 claims per 100 physician coverage years before simulation training to 5.7 claims.
- Similar effectiveness can be expected from simulation training in other areas of medicine.
- A simulation training program should accommodate the emotional needs of participants because the scenarios can be so realistic.

go through litigation stress, and they report feelings of isolation, anger, shame, negative self-image, self-doubt, and fear for the future," she says.

The effects of litigation stress range from burnout, poor patient communication and care, increase in medical errors, defensive medicine, divorce, family problems, and suicide.

"If simulators do, in fact, cut down on medical malpractice lawsuits, they literally could save not only patients' lives but physicians' as well," Fortner says. "We should incorporate simulators as a must in the training process."

Medical simulators could improve the safety of healthcare in general, especially patient safety, Fortner says. They allow healthcare practitioners to acquire valuable experience, in a variety of clinical settings, without putting patients at risk.

"The more physicians practice, the more competent they become. This especially is beneficial at the resident or fellow level," she says. "With the time restrictions in resident training programs across this country, the number of patients they see and evaluate is less than in the years past. Simulators would definitely enhance their skills and help with competency to combat this issue."

The best way to optimize the benefits of simulation is to incorporate it at the beginning of medical school. "If we started at this level, we could truly see the impact of lowering medical malpractice claims, lowering medical errors, increasing patient safety, and increasing physician well-being, and possibly decreasing physician suicide," Fortner says.

Proven Effectiveness

Research has proven the effectiveness of simulation training, says **James Archetto**, vice president of U.S. direct sales for Gaumard Scientific, a medical simulator company in Miami. A study published by the National Council of State Boards of Nursing (NCSBN) revealed training nursing students with simulation is as effective as clinical training with a patient. NCSBN concluded up to 50% of the students' clinical time could be performed via simulator in an optimally designed simulation training program. *(The study can be found at: https://bit.ly/3Bo9pbh.)*

This latest research showing the direct linkage to a reduction in claims is consistent with the previous research on effectiveness, Archetto says. He notes the use of simulation training for high-risk, low-frequency scenarios in medicine is similar to what the airline industry uses with pilots who train in simulators for potentially deadly situations that rarely occur.

"Malpractice claims are the byproduct of medical errors. The objective in simulation is to reduce errors, to ensure that the healthcare practitioner is skilled and has the ability to perform these very important procedures that they may encounter very infrequently," he says.

While the most recent research focused on OB/GYNs, Archetto says the effect on reducing errors and claims is seen in other areas of medicine just as strongly. For example, simulation training is highly effective in practicing intubation because it is a challenging procedure that is difficult to practice on real patients.

The use of simulation training has increased significantly in recent years, and will continue to grow as research shows the effectiveness and linkage to reduced claim rates, Archetto says.

The simulation industry is growing due to the evidence of its effectiveness, says **Eric Gantwerker**, MD, MMSc, FACS, vice president and medical director at Level Ex, a company in Chicago that

provides medical training games for physicians. The fact malpractice insurance carriers often fund these programs is a testament to their efficacy, he says, and CRICO has been leading the way in this arena.

"There is mounting evidence that skills learned during simulation training can be transferred to the clinical realm. However, the effect of these improved skills on patient outcomes has historically been very difficult to demonstrate due to countless confounding variables and, often, the time delay from education to patient care," Gantwerker says. "Studies like this go a long way to show that patient care improves when healthcare practitioners train on simulators, validating long-held beliefs that we have always had problems proving."

Gantwerker says all aspects of simulation, from physical task trainers to software-based simulation, can produce similar effects. Video games, although they are not always simulative in the truest sense, also can help physicians learn a variety of skills using similar methods to simulation.

"There is strong evidence that video game skills can be transferred to the real world in a variety of domains, including medicine. A well-designed program can utilize all these types of solutions, in addition to traditional experiential learning," Gantwerker says. "Stronger evidence will lead to more funding for these programs and ultimately improve patient safety, patient outcomes, and, hopefully, reduce costs."

Many types of simulators exist, including physical simulators, task-trainers, and software-based solutions.

Virtual reality and augmented reality (VR/AR) have been the subject of a lot of hype and significant funding increases, but Gantwerker says it has not yet proven its worth.

"Unfortunately, VR/AR implementations often are solutions looking for problems to solve, and the development of technology for technology's sake," Gantwerker says. "Best practice continues to require evidence that these solutions can do what they say they do. Existing proof shows that people enjoy them more than traditional learning only go so far. We need better evidence that these programs actually improve healthcare practitioners' cognitive, affective, and psychomotor skills, that those skills transfer to the patient bedside, and that, ultimately, they improve patient outcomes." ■

SOURCES

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Hospital Successfully Addresses Medication List Errors in ED

Many patients' medication lists contain errors when they are admitted through the ED. South Shore Hospital in South Weymouth, MA, addressed the problem by changing its electronic health record (EHR) software and more directly involving pharmacy staff. The hospital improved patient safety by recognizing more errors on the lists.

With about 300 patient visits per day in the ED and approximately 100 of those patients admitted, the risk of adverse events from errors on medication lists was substantial, says **Rachel Blum**, PharmD, clinical pharmacy manager. Typically, up to 70% of patients' medication lists contain errors when they are admitted through the ED. More than half of those errors can cause harm.

"We had several pretty significant medication safety events around the medication reconciliation process, and we realized that the pharmacy team were the best people to do this work," Blum says. "We found that these errors were stemming from an incomplete medication history or an inaccurate home medication list."

The hospital needs an accurate medication history on all admitted patients so it can perform medication reconciliation during the admission process. But that can be difficult in the ED, especially with high-risk patients.

Medication histories of high-risk patients collected by nursing and hospital staff contained an average of eight medication errors by the time the patient is admitted to inpatient care, Blum says. To improve the process, South Shore pharmacy leaders sought to accurately update

each patients' medication history using a reliable electronic source and efficient process. They also used a complexity score to prioritize patients whose medication history should be completed by the pharmacy team.

Previously, two pharmacy technicians during the day and two at night assisted with assessing medication histories. South Shore now employs five during the day and five at night. Even the 10 full-time equivalents are not enough for the pharmacy technicians to assess the medication history of each patient admitted through the ED, Blum says, so the hospital also tweaked its EHR to include a complexity score that identifies high-risk patients whose medication histories should be directed to them.

In the first five months, South Shore staff caught thousands of high-risk medications during the admission process that would not have been received previously:

- 7,712 abuse-related medications;
- 2,962 cardiovascular medications;
- 1,515 thyroid disease medications;
- 1,499 anticonvulsants;
- 1,274 steroids and immunosuppressants.

"Having the software that identifies these high-risk patients allows us to get our professionals in there to talk to the patients and clarify these discrepancies faster than we normally would have," Blum says. "It is a challenge for these technicians, especially during COVID, but they have a tremendous impact on patient safety when we can get them in there to do what they do best." ■

SOURCE

- **Rachel Blum**, PharmD, Clinical Pharmacy Manager, South Shore Hospital, South Weymouth, MA. Email: rblum@southshorehealth.org.

CME/CE QUESTIONS

1. **What does Emily L. Fernandez, JD, suggest should be one component of a COVID-19 consent form?**

   a. The patient is aware there is an ongoing pandemic of a highly transmissible respiratory virus causing COVID-19, which can cause life-threatening complications, including death.
   b. The patient is aware it is highly likely that by entering this facility, he or she will contract the respiratory virus causing COVID-19, which can cause life-threatening complications, including death.
   c. The patient certifies he or she is fully vaccinated against the respiratory virus causing COVID-19.
   d. The patient certifies he or she will accept full vaccination for the respiratory virus causing COVID-19 during treatment.

2. **Which is true concerning the preservation of surveillance video?**

   a. Surveillance video can be erased whenever the owner chooses on a case-by-case basis.
   b. It is best to erase video once you are notified of potential litigation in which the video may be used by the plaintiff.
   c. Surveillance video can be erased routinely after a prescribed period.
   d. Federal law requires surveillance video to be preserved for three years.

3. **Which of the following is not one of the court's options if spoliation is discovered?**

   a. It can instruct the jury to presume the missing information was unfavorable to the party that lost it.
   b. It can dismiss the entire case.
   c. It can enter a default judgment.
   d. It can impose criminal penalties on the individual who destroyed the information.

4. **Which was a finding of recent research from CRICO/Risk Management Foundation?**

   a. Claim rates declined from 11.2 claims per 100 physician coverage years before simulation training to 5.7 claims.
   b. Claim rates increased from 5.7 claims per 100 physician coverage years before simulation training to 11.2 claims.
   c. Simulation training did not affect claim rates.
   d. Simulation training affected claim rates only for the most experienced OB/GYNs.

CME/CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. describe the legal, clinical, financial, and managerial issues pertinent to risk management;
2. explain the impact of risk management issues on patients, physicians, nurses, legal counsel, and management;
3. identify solutions to risk management problems in healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

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DocuSign Envelope ID: 5F171521-F613-46F5-90E4-D7D71FD38E8C

Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

UNITED STATES POSTAL SERVICE®

1. Publication Title	2. Publication Number	3. Filing Date
Healthcare Risk Management	1 0 8 1 – 6 5 3 4	10/1/2021
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$299

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4®)*
1010 Sync St., Ste.100, Morrisville, NC 27560-5468.

Contact Person: Sabrina Johnson
(919) 459-9495

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
1010 Sync St., Ste.100, Morrisville, NC 27560-5468.

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*
Relias LLC, 1010 Sync St., Ste.100, Morrisville, NC 27560-5468.

Editor *(Name and complete mailing address)*
Jill Drachenberg

Managing Editor *(Name and complete mailing address)*
Leslie Coplin

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
Relias LLC	1010 Sync St., Ste.100, Morrisville, NC 27560-5468.
Bertelsmann Learning LLC	1745 Broadway, New York, NY 10019

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☑ None

Full Name	Complete Mailing Address

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

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DocuSign Envelope ID: 5F171521-F613-46F5-90E4-D7D71FD38E8C

13. Publication Title

14. Issue Date for Circulation Data Below: September 2021

15. Extent and Nature of Circulation			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*			87	73
b. Paid Circulation *(By Mail and Outside the Mail)*	(1)	Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	70	60
	(2)	Mailed In-County Paid Subscriptions Stated on PS Form 3541 *(Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)*	0	0
	(3)	Paid Distribution Outside the Mails Including Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid Distribution Outside USPS®	1	1
	(4)	Paid Distribution by Other Classes of Mail Through the USPS (e.g., First-Class Mail®)	5	2
c. Total Paid Distribution *[Sum of 15b (1), (2), (3), and (4)]* ▶			76	63
d. Free or Nominal Rate Distribution *(By Mail and Outside the Mail)*	(1)	Free or Nominal Rate Outside-County Copies included on PS Form 3541	0	0
	(2)	Free or Nominal Rate In-County Copies Included on PS Form 3541	0	0
	(3)	Free or Nominal Rate Copies Mailed at Other Classes Through the USPS (e.g., First-Class Mail)	0	0
	(4)	Free or Nominal Rate Distribution Outside the Mail *(Carriers or other means)*	2	2
e. Total Free or Nominal Rate Distribution *(Sum of 15d (1), (2), (3) and (4))*			2	2
f. Total Distribution *(Sum of 15c and 15e)* ▶			79	65
g. Copies not Distributed *(See Instructions to Publishers #4 (page #3))* ▶			8	8
h. Total *(Sum of 15f and g)*			87	73
i. Percent Paid *(15c divided by 15f times 100)* ▶			97%	97%

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Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

UNITED STATES POSTAL SERVICE®

16. Electronic Copy Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Paid Electronic Copies ▶		
b. Total Paid Print Copies (Line 15c) + Paid Electronic Copies (Line 16a) ▶		
c. Total Print Distribution (Line 15f) + Paid Electronic Copies (Line 16a) ▶		
d. Percent Paid (Both Print & Electronic Copies) (16b divided by 16c ⨯ 100) ▶		

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17. Publication of Statement of Ownership

☑ If the publication is a general publication, publication of this statement is required. Will be printed in the November issue of this publication. ☐ Publication not required.

18. Signature and Title of Editor, Publisher, Business Manager, or Owner

DocuSigned by: kay kraft 400740A3CF8246E...

Chief Executive Officer

Date: 29-Sep-2021

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LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Misdiagnosis of Infection Leads to Injuries and $500,000 Award

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UCLA School of Law, May 2021

News: A patient underwent a knee replacement surgery, which resulted in an infection. However, despite subsequent visits to the hospital, the infection remained undiscovered for a substantial period. By the time the infection was discovered, it significantly worsened, and the patient required amputation.

The patient filed a lawsuit against the medical facility, alleging the delayed diagnosis caused the patient's injuries and amputation. The defendant facility denied liability. An arbitrator awarded the patient more than $500,000.

Background: In April 2019, a 73-year-old man underwent a total knee replacement at a medical facility. One week later, the patient returned with symptoms of an infection on the same knee. A physician evaluated the patient and diagnosed cellulitis. The physician promptly discharged the patient. The next day, the patient's condition dramatically worsened, prompting him to visit the ED of the same medical facility.

The patient was evaluated again and received the same diagnosis. Two days later, the patient underwent an irrigation and debridement surgery, at which point physicians changed the diagnosis from cellulitis to necrotizing fasciitis. The patient's condition had continued to significantly deteriorate because of the incorrect diagnoses. Approximately one week after the irrigation and debridement, the patient required an above-the-knee amputation.

The patient filed an arbitration action against the hospital's medical group, alleging the incorrect diagnosis of cellulitis and failure to diagnose necrotizing fasciitis caused the patient's injuries, including the required amputation. The defendant medical group denied liability, and argued it was reasonable at the time to conclude the patient suffered from cellulitis. Furthermore, the defendant medical group alleged that even if the necrotizing infection had been diagnosed sooner, the severity of the infection would have necessitated the amputation; as a result, the delayed diagnosis did not cause more severe injuries.

> ACCORDING TO THE PATIENT'S EXPERTS, IF THE STANDARD OF CARE WAS FOLLOWED, THE NECROTIZING FASCIITIS COULD HAVE BEEN DIAGNOSED SOONER AND THE PATIENT WOULD NOT HAVE REQUIRED AMPUTATION.

Each side presented two expert physicians during the arbitration: one orthopedic surgery expert and one infectious disease expert. The patient and his experts testified his initial symptoms were consistent with a necrotizing infection, requiring further evaluation to rule out that possibility, rather than simply conclude it was cellulitis. According to the patient's experts, if the standard of care was followed, the necrotizing fasciitis could have been diagnosed sooner and the

patient would not have required amputation. However, based on the incorrect initial diagnosis, the fasciitis was allowed to grow and spread uncontrolled, which severely worsened the patient's injuries.

The defendant and its experts presented contradictory evidence and testimony, arguing the healthcare provider's initial diagnosis was reasonable at the time. According to the defendant's experts, the diagnosis of necrotizing fasciitis was not required or possible until the patient underwent the irrigation and debridement surgery. Causation also is a critically important aspect of medical malpractice cases, and the defendant's experts challenged the patient's experts' claims the delayed diagnosis directly contributed to the patient's condition. The defendant's experts argued that with this specific type of necrotizing infection, containment and control is difficult. Even if the infection had been diagnosed a few days earlier, the patient's injuries would have been the same, they argued.

Before arbitration, the patient made an offer to the defendant to accept $275,000 to settle the arbitration; the defendant did not appear to make any offer to pay any sum for settlement. A practicing attorney served as the arbitrator. The arbitrator agreed with the patient's claims experts' assessment, awarding damages. The arbitrator awarded $32,500 for economic damages because of the patient's expected future medical care, and $500,000 for non-economic damages for the patient's pain and suffering.

What this means to you: This case presents interesting lessons in both substance of medical malpractice cases and in procedures for resolving allegations of medical malpractice. On the substance, the primary issues in this case revolved around the delayed diagnosis: whether the delay fell below the applicable standard of care, and whether the delay directly caused the patient's injuries. A patient alleging medical malpractice has the burden of demonstrating both of these elements, among others.

If a defendant care provider can adequately rebut a single necessary element, then the patient will be unsuccessful. This presents multiple options for care providers to honestly evaluate the underlying events and strategize about which elements to challenge — and which elements to potentially concede. Attacking every single aspect of the patient's case may stretch resources and credibility. By contrast, picking one or two of the patient's weakest elements will enable a focused attack. Depending on the facts and circumstances present in each case, it might be worthwhile to concede less disputed elements. For example, when a complete failure to diagnose results in a patient's death, and there are no other factors contributing to the patient's death, a defendant care provider might look foolish by challenging the causation element and arguing an unknown cause.

A surgical site infection is a complex risk that should be reviewed with the patient before proceeding with surgery. Most postoperative infections are superficial and result in serous or purulent drainage from the incision line. Necrotizing fasciitis is a much more serious and extremely virulent infection that can result from any perforation in the skin. It is not common and not easily recognized because it can manifest itself like the more typical wound infections, such as cellulitis. There might be drainage or redness at the surgical site. It can develop just below the surface of the skin or deep within the tissue, depending on the organism causing the infection. What makes it different is the unrelenting pain it causes. Usually, patients will seek medical assistance continually because pain relief is difficult. A rapid return to the physician's office or ED is a red flag for necrotizing fasciitis. Surgical intervention early is critical, along with IV antibiotics. Unfortunately, many physicians and surgeons look to the most common cause rather than stepping back and looking for reasons why it might be something else.

In this case, the defendant attempted to challenge both the claim that the diagnosis was improperly delayed, and the claim that the delayed diagnosis caused the injuries. While the defendant managed to secure multiple medical experts to support its contentions, the arguments were ultimately unsuccessful, as the arbitrator did not agree with the defendant's experts. Instead, the arbitrator concluded that under the applicable standard of care, a reasonable physician in the same or similar circumstances would have performed further testing and evaluation earlier to determine the precise nature of the infection. Thus, the failure to do so in this case constituted malpractice, and that delayed diagnosis enabled the infection to worsen and significantly harm the patient.

Another interesting lesson from this case involves the method for this dispute resolution. This case proceeded through an arbitration, an alternative dispute resolution process that forgoes the public forum of a civil court. Arbitration is a creature of contract, and it is likely the patient signed an agreement as part of his receipt of medical services

whereby he agreed to arbitrate any issues. There are advantages and disadvantages to arbitration vs. standard litigation. Some advantages can include a more expeditious process, greater privacy compared to public court filings (although not complete privacy as certain arbitration cases are newsworthy and become public), and the absence of jurors, which can prevent runaway adverse verdicts.

At the same time, arbitration is not without its drawbacks, as arbitration itself is a more expensive forum since the parties have to pay for one or more individuals to serve as arbitrator. Typically, they are practicing attorneys or retired judges who charge substantial hourly rates. Arbitration's attempt to streamline proceeds also might limit the parties' efforts to secure information from third parties through discovery, including limiting the number of depositions. Care providers should consult risk managers and counsel to consider the multitude of advantages and disadvantages, and whether requiring patients to resolve disputes through arbitration is best for each care provider. ■

REFERENCE

- Private arbitration, decided April 19, 2021.

Severe Brain Injuries Caused by Postnatal Negligence Results in $35 Million Verdict

News: A pregnant woman gave birth to premature twins. Following delivery, one of the twins struggled to breathe and suffered three seizures. The child was subsequently diagnosed with significant brain injuries and cerebral palsy.

The mother filed a lawsuit on behalf of her child, alleging the hospital's actions constituted malpractice. The hospital denied liability. After a two-week trial, a jury awarded the patient nearly $35 million.

Background: In August 2007, a woman gave birth to twins at a hospital. The twins were born approximately one month early. Soon after birth, one of the babies experienced difficulty breathing. The child required breathing assistance from a bag valve mask ventilator before he could breathe on his own. In the early morning hours following the birth, the child was admitted to the special care nursery and eventually could breathe by himself. However, approximately 15 minutes later, the child suffered an apneic episode and again struggled to breathe. Hospital staff proceeded with the "blow-by oxygen" technique, which involves blowing oxygen near the child's face. Hospital staff also attempted other techniques to stabilize the child's condition.

Unfortunately, these efforts were not entirely successful. Nearly 30 minutes later, the child's condition severely deteriorated, with oxygen readings at dangerously low levels. The child turned blue due to oxygen deprivation. Hospital staff intubated and placed the child on a ventilator, at which point he had high levels of acid in his body fluids. The child suffered three seizures in a short period. He was transported to a newborn ICU at a different hospital, where a CT scan confirmed the child suffered a brain injury that likely resulted from lack of oxygen. The child was diagnosed with cerebral palsy, a seizure disorder, and other disabilities.

The woman and her child, now a teenager, filed a lawsuit against the initial hospital, claiming the hospital's actions caused the child's brain injuries and permanent disabilities. Because of his disabilities, the child requires around-the-clock care. The plaintiffs alleged the hospital staff mishandled the initial indications of the child's difficulty breathing, and failed to promptly contact the on-call physician. The plaintiffs focused on a 10-minute period, during which hospital staff failed to act to address the child's lack of oxygen. After this period, the child suffered an apneic episode.

The plaintiff's expert argued it was highly likely the child suffered from the apneic episode several minutes before the nursing staff acted. Furthermore, the expert opined that had staff acted promptly, including by notifying a pediatrician, the child's injuries would have been far less severe, or could have been prevented.

The defendant hospital presented experts who attempted to contradict these claims. They argued it was likely the child suffered the brain injury days or weeks before the delivery. These contentions were refuted by the patient's witnesses, including the obstetrician and pediatrician who monitored the child at birth and immediately after. Both witnesses stated the child was

in a stable and healthy condition before the transfer to the special care nursery. Thus, the injuries must have arisen because of action or inaction after the delivery.

The trial lasted two weeks. After 11 hours of deliberation, the jury found in favor of the plaintiff. The jury awarded $35 million, allocating $32.2 million to the child's future medical expenses. The remainder was awarded for lost future earnings ($1.3 million) and past medical expenses ($1.2 million).

What this means to you: One of the major takeaways from this case relates to the substantial adverse verdict imposed by the jury here: Nearly $35 million dollars, primarily allocated to the lifetime of anticipated medical expenses. Past and future expenses are a critical component that medical malpractice patients seek to recover. When the patient is an injured child, a lifetime of injuries can cascade into massive damages through projections and estimates of permanent or extensive medical care.

Care providers might consider using settlement techniques or vehicles to mitigate the potential for a runaway jury verdict with excessive damage awards. One such technique is a "high-low" agreement that guarantees the patient receives a minimum monetary amount regardless of the verdict, but also imposes a maximum monetary award to limit the defendant's exposure.

This type of agreement is not disclosed to the jury, and does not hinder the defendant's ability to generally challenge the allegations. A defendant could continue to argue they have not committed any malpractice, or could choose to admit liability but simply dispute the damages. Depending on the specific facts and circumstances of the case, such an approach may inure to the benefit of the defendant, making them appear reasonable and accepting of their fault, while also reducing burdensome costs of challenging the entire case.

For example, the parties in this case could have reached a high-low agreement of $2 million/$10 million. From the patient's perspective, that would have guaranteed recovery of at least $2 million dollars, while the defendant would have limited its maximum exposure to $10 million. As a result, the jury's award of nearly $35 million would have only entitled the patient to $10 million. High-low agreements can be reached at any time, even once the jury has begun deliberations. Depending on how negotiations and settlement discussions proceed generally with medical malpractice plaintiffs, defendant physicians and care providers could consider exploring a high-low agreement to mitigate the inherent risk of litigation.

In this matter, the defendant hospital's liability arose because of the staff's failure to monitor the newborn and failure to promptly contact an on-call physician for further evaluation. The jury found these inactions constituted malpractice as the hospital had a duty to the mother and child. These shortcomings by staff constituted a breach of those duties, and caused the child's permanent and significant injuries.

It is essential for hospitals without NICU facilities to make arrangements with hospitals that do. All premature births should be evaluated by a neonatologist, especially twin births. A transfer via ambulance with neonatal staff and neonatal resuscitation equipment is a standard procedure, the cost of which will be easily worth spending as these types of cases can easily become multimillion-dollar lawsuits. Although staff might be well trained to intervene, the fact is, unless they see this condition in neonates frequently enough, they will not look for it or recognize it in time to mitigate harm.

While the parties presented conflicting expert testimony, the patient's experts presented more compelling testimony, and the jury rejected the defendant's argument the injuries existed before the delivery. However, had the defendant succeeded, the jury could have concluded the injuries were pre-existing, and the staff's inadequate monitoring and follow-up would have been irrelevant.

Another lesson from this case is that entities, such as hospitals, surgery centers, or medical practice groups, may bear liability for the actions of their employees or agents — a legal doctrine known as "respondeat superior." Hospitals and other entities are legally responsible for the wrongful acts of their employees or agents; this applies with great force to issues arising out of actions by staff. This doctrine does not apply to independent contractors. Depending on a hospital or entity's particular state of operation, it might be harder to determine whether a physician is an employee or independent contractor. Nevertheless, from an entity's perspective, it might be necessary or beneficial to argue the individual wrongdoer was acting outside the scope of their employment, or was not even an employee at all. Entities should carefully craft and evaluate their relationships with physicians when considering issues about such ascribed responsibility. ■

REFERENCE

- Decided Aug. 19, 2021, in the Circuit Court for Baltimore City, Massachusetts, Case Number 24-C-19-005417.