Being Sued?

What you need to know

The Legal Process
A Personal Experience
Malpractice Insurance Considerations
Q & A

May 18, 2024

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How this session came about…

A birthday to remember
2016
Getting sued
Becoming a second victim
Getting over it

Making a friend

Many Thanks to Daniel Bell

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Introductions

Jack Schuler, JD
Senior Trial Lawyer, Managing Partner
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The Process

A Video

1.	2.	3.
Intent to Sue **Carrier/ Attorney Involvement** **Investigative Process** **PREPARATION** **Early Meeting of Counsel** **Answer to the Suit/ Complaint** **Written Discovery** **Request for Admission** **DEPOSITION*** **Not the time to "tell your whole story"…** **Standard of Care**	**Risks? Losing?** **Considerations for Settlement** **Settlement Consequences** **Your Malpractice Policy** **Limiits/ Judgement** **Impact of Settlement** **Trial?** **"What a Jury Will do..?"** **Judgement against?** **Other Concerns**	**Avoidance** **Documentation** **Don't allow yourself to be pressured.** ***@ 36:17** **Don't get confused.**

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Malpractice Statistics

- One in three care providers is sued for medical malpractice during their career.
- Misdiagnosis or delayed diagnosis=one-third (32%) of medical malpractice claims.
- Surgical errors account for one-quarter of all claims.
- Prescription errors
  - Harm 1.5 million people annually= $3.5 billion in damages.
- Anesthesia errors=2.7% of medical malpractice claims.
  - National Practitioner Data Bank. Data Analysis Tool
  - 96.9% of successful medical malpractice claims are settled out of court

Medical Malpractice Statistics Of 2024-Forbes Advisor, January 25, 2024

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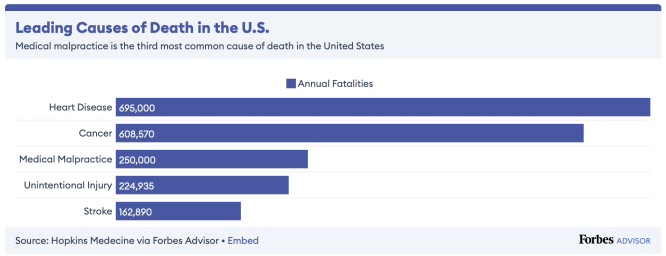

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A Personal Experience

October 2016

What's available as public record?

Alleged complaint

Results

The case, The incident

My actions, My documentation

Mine, The Paramedics.

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Intent to sue received

Within 1 week

Contact with malpractice carrier

put in touch with Schuler & Brown

Anxiety

2nd guessing

Self-doubt

Loss of confidence

Re-living the incident

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2nd Victim Phenomenon

Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that "it will never happen again." Paradoxically, this approach has diverted attention from the kind of systematic improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Sachs CJ, Wheaton N. Second Victim Syndrome. [Updated 2023 Jun 20]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK572094/

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(Providers)-my insert

-continue to expect perfection from themselves and are more often than not denied the time and resources necessary to process feelings and grieve losses when an adverse patient event or mistake occurs. As a consequence, health care workers often suffer life-altering burdens of anxiety, depression, and shame after an adverse patient outcome. Dr. Albert Wu named this burden "second victim syndrome" in his pivotal publication in 2000

Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. BMJ. 2000 Mar 18;320(7237):726-7. [PMC free article] [PubMed] [Reference list]

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SVS-symptoms

- Troubling memories
- Anxiety/concern
- Anger toward themselves
- Regret/remorse
- Distress
- Fear of future errors
- Embarrassment
- Guilt
- Sleeping difficulties

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Differential Diagnosis

SVS symptoms may overlap and be hard to differentiate from other conditions that impair providers' wellbeing. Supportive colleagues and timely professional referral and workplace modifications can still be used to address other similar conditions. Consider these conditions in the differential diagnosis for SVS:

- Burnout
- Depression
- Prolonged grief disorder
- Job stress reaction and fatigue
- Issues with alcohol, medications, or substance use
- Issues with physical health and illness

Prognosis

The last stage of SVS described by Scott et al. involves the ultimate career disposition and has important life-altering provider consequences and institutional impact.

- "Drop out": Providers leave their current job, specialty, or clinical care altogether. This may cost institutions upwards of $500,000 per physician to replace.
- "Survive": Providers stay in current employment but are haunted by the event and adverse outcome and continue to have long-lasting SVS symptoms.
- "Thrive": Providers adopt a growth mindset, choosing to turn the experience into one that improves systems processes to benefit future patients and providers, such as quality improvement initiatives or improved support systems for providers after an adverse event.

Though these career disposition categories provide a convenient frame of discussion, not all affected providers fall within a discrete category, nor are the categories mutually exclusive. For instance, a provider may leave clinical practice for a period of time (dropout) but later return and thrive. Or a provider who appears to thrive and learn from the experience may still have moments of self-doubt and intrusive reflections of the adverse outcome.

Complications

Research has shown that SVS after adverse events impairs provider cognitive functioning, with approximately 79% reporting difficulty concentrating.[Providers with SVS were twice as likely to report burnout and a desire to leave their jobs.[

One study of nurses suffering from second victim symptoms found an increased intention to leave their current job and increased absenteeism in this population. However, it is important to note that these risks were decreased if the nurses perceived that their organizations supported them through the response.

Most concerning of all, severe or long-lasting symptoms of SVS are associated with subsequent depression and suicide. Surgeons with lawsuits due to an adverse outcome in the prior two years are 1.64 times more likely to consider suicide in the subsequent year.In addition, those who consider suicide are 3.4 times more likely to report a self-perceived medical error in the prior 3 months.

Second Victim Syndrome-Carolyn J. Sachs; Natasha Wheaton. Last update: June 20, 2023

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What we need...What we get.

Unconditional sympathy and support

rarely forthcoming

Norm of not criticizing, BUT-

reassurance grudging or qualified.

We criticize that which we fear in ourselves.

Discussion? Discouraged

Passively-lack of appropriate forums

Actively by risk managers and hospital lawyers.

Discussed at M&M?

Facts rather than the feelings.* (NOT DISCOVERABLE)

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Not Unique Responses:

"contact with the family ceased. But life continued. I was able to see patients again, but not concentrate. I began to "enjoy" alcohol. It would have been easy to go down that route. My family was wonderful—I don't know how someone without a caring partner would have coped. Reactions from colleagues were mixed. One valued friend went through the whole event with me—carefully going over each step without passion. Slowly we made some sense of the events. I received lots of telephone calls. Some support was clumsy: someone asked me how I was getting on in the middle of a crowded room at a conference. Others simply offered useful support—such as locum assistance if I needed to get away. Others just ignored me—as though I might taint them with my failure."

"As the days stretched into weeks, people ceased to be interested. I realised that for them it was now old news, despite the fact that I still dreamt about it. It was time to move on. My thoughts about the incident changed with time. Regardless of the actual events, I realised that it was my fault. I could not avoid the fact that I was responsible for the patient's death. But did responsibility mean that I was negligent? Interestingly, suicide never entered my mind. If it had, however, would it have been an inappropriate response? I'm not sure. ***Surely there is a price for the responsibility we handle."***

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A Recognized Issue

Initially discussed the second victim in relation to patient harm after an error

Since expanded to include

Burdens of anxiety

Depression

Shame :

"any healthcare provider feels after any traumatic adverse and/or unexpected patient care experience"

Seys D, Wu AW, Van Gerven E, Vleugels A, Euwema M, Panella M, Scott SD, Conway J, Sermeus W, Vanhaecht K. Health care professionals as second victims after adverse events: a systematic review. Eval Health Prof. 2013 Jun;36(2):135-62. [PubMed] [Reference list]

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Prevalence

25% of emergency physicians

27% of emergency nurses

22% of ICU nurses

22% of surgery residents

15% of trauma surgeons

17% of anesthesiologists**----CRNAs probably not included= Suspected higher incidence

"report extreme and pervasive distress. These severe SVS can lead to true "second victim syndrome," which, if unchecked, can lead to the diagnosis of true posttraumatic stress disorder"

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Stages

1. **Chaos and accident response** – The adverse event is noted, and the provider performs required emergent patient care tasks to stabilize the condition.
2. **Intrusive reflections** – After the patient has stabilized, the provider worries, ruminates, and mentally "replays" the incident for days, weeks, months, or even sometimes years. This often interferes with providers' personal and professional lives.
3. **Fear of rejection *versus* seeking confirmation** – The provider worries about others' perceptions of what happened and that others may doubt their competence. They may confide in trusted peers, seeking affirmation that the poor outcome was not entirely their fault, and may try to identify other factors that contributed to the adverse outcome.
4. **Enduring the inquisition** – Administrative or legal parties may investigate the incident, such as peer review, quality improvement review, licensing boards investigations, or lawsuits. Providers perceive these reviews as inquisitions of their competence.
5. **Emotional first aid** - The provider connects with a colleague, mentor, and/or mental health professional to assist in processing the event.
6. **Final disposition** -In the long term, a provider may "drop out," "survive," or "thrive" after the event.

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What we're taught vs. Reality

Documentation will save us

- We all need our illusions

"Experts"

- Available to us also

Attorneys know the chart

- NOT the significance*

Errors in communication---rampant

Anyone can be named…

- Their legal actions affect you
  - ***Even if you are not at fault***

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The Deposition

Almost 1 year after the incident…Right before Thanksgiving

Plaintiff's attorney not a medical malpractice specialist

- Questionably interested in actual facts
- Specifically interested in an "emotional trigger"

Good Charting

"Yes, No, I don't remember, I don't know, it's on the chart."

Plaintiff's attorney may fixate on one particular issue.

"The worst day of your professional life…just another day at work for us."

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The Settlement

A completely defensible position

Counseled that "no one can predict what a lay jury will do"

62 years old, 32 years of practice and teaching.

Had been going on for 2 years…

No Claims before

No impact on future work/ credentialing

Much, much less than my 1m/3m limit

Still a huge emotional "point of impact"

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The Settlement

- Highest settlements
  - unnecessary procedures
  - failure to treat fetal distress.

- In 2019, the largest payout in a medical malpractice claim was $205 million in a case resulting from a brain injury during childbirth.

- Between 80 and 90% of defensible malpractice claims are dismissed with no settlement.

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Malpractice Insurance Considerations

2 different kinds

Occurrence:

More expensive

Doesn't matter when the claim is made

No tail required

- Limits do NOT accrue
  - Per- Mr. Schuler
  - Per-Clifton Insurance agency

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Malpractice Insurance Considerations

Claims Made:

Coverage only if claim is made during the period of coverage

Premium paid for 2024

Claim must be made in 2024

Much less expensive than Occurrence:

Avg: Occurrence-7K, Claims Made: 2k

*Many carriers offer endless coverage after 5 years

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Malpractice Insurance Considerations

Consent to settle?

1. You want to fight, carrier wants to settle:
   - Assigned attorney's first responsibility is to you.
   - You may be liable for any judgement amount> your limits

2. You want to settle, carrier wants to go to trial:
   - Assigned attorney's first responsibility is to you.
   - Carrier is responsible for any monies d/t judgment against.

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Malpractice Insurance Considerations

Carriers Reservations of Rights:

"There is No Potential for Coverage for the Battery, Fraud/Intentional Misrepresentation, Concealment, Negligent Misrepresentation and Aiding and Abetting Causes of Action to the Extent They Are Based On or Arise Out of Your Alleged Dishonest, Fraudulent, or Deliberately Wrongful Acts."

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Malpractice Insurance Considerations

Board of Nursing Actions

- Does carrier cover attorney costs for this?
  - Mine did

Witness depositions

- Does carrier cover attorney costs for this?
  - Mine did

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Check EVERY piece of information

From the AANA malpractice insurance website:

"Occurrence coverage offers greater limits of liability than claims-made. Each occurrence policy provides the policyholder with a separate set of limits. During the annual policy term, a policyholder with occurrence coverage will typically have limits of $1 million per claim and $3 million in total. If that same individual has an occurrence policy in force for five years, there would be $15 million (3 million X five years) in total limits available."

*Probably not so.

*Unlikely any carrier would do this

*Neither Mr. Schuler, nor Clifton Insurance Agency has ever heard of such a thing…

DISCLAIMER: I CANNOT DEFINITIVELY PROVE (at this time) THAT NO CARRIER PROVIDES THIS.

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Take HOME

May you never be named in a suit

Communicate completely & often with your lawyer

Main Suits in Anesthesia:

- Airway
- Positioning-nerve

Document

Understand your coverage

Prognosis after SVS: Drop out, Survive, Thrive

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