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Clinical Science

Closed claim review from a single carrier in New York: the real costs of malpractice in surgery and factors that determine outcomes

Jeremy C. Zenilman, Esq.[a], Michael A. Haskel, Esq.[a], John McCabe, M.D.[b], Michael E. Zenilman, M.D.[a,c,*]

[a]*SUNY Downstate School of Public Health, Brooklyn, NY, USA;* [b]*Department of Emergency Medicine, SUNY Upstate, Syracuse, NY, USA;* [c]*Department of Surgery, Johns Hopkins Medicine, Suburban Hospital, Baltimore, MD 20854, USA*

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Abstract

INTRODUCTION: We postulated that a closed claim review of surgical cases would identify not only the quality of care elements but also factors that will predict successful legal outcomes.

METHODS: One hundred eighty-seven closed surgical cases from a single carrier, which insured physicians practicing in 4 university hospitals in New York State, were reviewed, cataloged, and analyzed.

RESULTS: Most suits occurred during midcareer and routine operations. Seventy-three percent of cases were won. The average payment and expenses per case were \$220,846 ± \$38,984 and \$40,175 ± \$4,204, respectively. Poor communication was identified in 24% of cases and was a predictor of a negative outcome (41% lost, $P < .05$), as was inadequate attending supervision (46% lost, $P < .05$). Expert reviews incriminated or exculpated physician defendants in 85 cases, which affected the outcome and cost. The quality of the physician defendant as a witness also affected the outcome.

CONCLUSIONS: Most surgical malpractice claims are won. Although supervision, communication, and aggressive risk management are important, the use of quality experts and establishing credibility of the physician defendant are critical for successful legal outcome.
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In the United States, hospitals require their staff physicians to obtain professional liability insurance.[1] In certain venues, physicians in high-risk specialties consider the commencement of malpractice litigation against them as an adjunct to their practices. As a general proposition, this professional liability litigation is a "cost of doing business."

In New York State, malpractice claims are a substantial part of medical costs. Of the 11,478 claims paid nationally in 2007, New York State ranked first with 1,528, California second with 924, and Alaska last with 9.[2] Of the \$3,710,443,358 paid out in claims nationally in the same year, New York also ranked first with total payments of \$674,683,750, whereas it ranked sixth in the average claim payout (\$441,547).

Although malpractice premiums are an expense of practicing medicine, little data are currently available to subscribing physicians regarding what factors determine the outcomes of litigation. Many closed claim reviews use the cases as a reflection of the quality of care, but whether this

Mr. Haskel is legal counsel to the Academic Health Professionals Insurance Association.

* Corresponding author. Tel.: +1-301-896-3509; fax: +1-301-897-1330.
E-mail address: mzenilm1@jhmi.edu

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is true is debatable.[1,3] Medical malpractice allegations are typically based on poor or unexpected outcomes, and although quality of care issues are sometimes present, extraneous factors such as sympathy, behavior, and hindsight bias[4] contribute as well. Interestingly, Brook et al[5] identified a paradox in which the improvement of medical care is actually accompanied by an increase in medical malpractice claims. New therapies have the potential for producing iatrogenic disease and higher expectations, and he noted that the likelihood of being sued more than once is related to chance just as much as if it were due to being a poor physician.

To date, few publications have offered physicians a picture into their risk of being sued and the nature of the suits or have identified what criteria exist to predict a successful or unsuccessful outcome. In the hope of identifying elements that bear on professional liability claims, this study was commissioned to gather information from closed medical malpractice claims files of a single carrier, the Academic Health Professionals Insurance Association (AHPIA).

AHPIA was formed in 1990 as a reciprocal insurance company (subscriber owned) for physicians practicing at the 4 university hospitals in the State University of New York (SUNY) Medical School System. The hospitals included those for SUNY Buffalo, SUNY Upstate (Syracuse), SUNY Stony Brook, and SUNY Downstate (Brooklyn). These tertiary care hospitals are located in 4 different counties in New York State. AHPIA was organized as a reciprocal, a form of carrier that is sometimes called an insurance exchange and is owned by its insureds. All reciprocals are governed by an advisory committee, which in AHPIA's case is called a Board of Governors (Board). The Board, which consists exclusively of subscribers, is selected at annual meetings by other subscribers. AHPIA's mission has been to provide coverage for physicians in teaching hospitals and is unique in that most of the physicians are medical school faculty members who engage in clinical practice. The staff at AHPIA has been stable for the last 18 years, and the records of each case have been consistently managed by a small group of claims managers.

We postulated that a review of the closed claims in surgery would yield information regarding the demographics of surgeons sued, the nature of the suits, and what criteria led to successful or unsuccessful outcomes. We also used the claims financial data to compare academic physicians with published benchmarks. Finally, we postulated that the review of the cases would yield data that would be useful in analyzing physician behavior.

Materials and methods

Closed claim files for surgical cases were reviewed at the office of AHPIA. Each file contained facts of the case from hospital and physician charts created by claims managers along with their notes from interviews with defendant physicians and conversations with expert reviewers. Documentation of the claims manager's interaction with defense and plaintiff counsel and experts as well as court papers were also included.

A data-intake form was created to input general demographic data about the surgeon and plaintiff; nature of the injury; complexity of the operation; comorbidities; overall outcome; severity of injury; timing of the injury (ie, preoperative, intraoperative, and postoperative); and narratives regarding concerning communication, resident involvement, and supervision.

Cases were classified by AHPIA staff as "closed no payment" for those cases that were closed administratively for inactivity, "settled" for those settled out of court, "settled at trial" for those settled during trial, "won by motion" for those dismissed from court by pretrial motions, and "won at trial." To simplify the subsequent analysis, any case that was settled was considered "lost." Any case that was closed without payment, including won by motion, was considered "won."

All theories of injury were presented in connection with a claim and characterized. For example, a single case may involve an allegation of failure to diagnose, failure to operate, and development of complications. The information was then formatted to allow an overview of issues and to identify trends.

All data were reviewed and entered by the lead author (JCZ) and a 20% sample verified as accurate by a physician (MEZ). Legal issues were reviewed by the attorney (MAH). File summaries were created without identifiers. These data were entered into an Excel file (Microsoft, Redmond, WA), and statistical analysis was performed using Statistica (StatSoft, Tulsa, OK). All data are expressed as mean ± standard error of the mean. The Student *t* test was used to compare means, analysis of variance was used for multiple means, and the chi-square or Fisher exact test was used for frequency analysis. Statistical significance was defined as $P < .05$.

Results

Demographics

From 1991 to 2008, there were 1,202 closed AHPIA claims from all departments within the 4 institutions where the AHPIA-insured physicians practice. There were 225 general surgical claim files that were closed, of which 187 were available for review. Table 1 shows the demographics of the malpractice cases against AHPIA insureds by surgical specialty. Most were general surgical cases with a few trauma and critical care lawsuits. The first and last time of loss (when the alleged injury occurred) were 1991 and 2005, respectively (Fig. 1A), and the last closed claim file reviewed was closed in 2008 (Fig. 1B). The average time

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