Notable Grand Rounds
of the
Michael & Marian Ilitch
Department of Surgery

Wayne State University
School of Medicine

Detroit, Michigan, USA

John Webber MD, FACS

MEDICAL MALPRACTICE FOR THE SURGEON

March 9, 2022

About Notable Grand Rounds

These assembled papers are edited transcripts of didactic lectures given by mainly senior residents, but also some distinguished attending and guests, at the Grand Rounds of the Michael and Marian Ilitch Department of Surgery at the Wayne State University School of Medicine.

Every week, approximately 50 faculty attending surgeons and surgical residents meet to conduct postmortems on cases that did not go well. That "Mortality and Morbidity" conference is followed immediately by Grand Rounds.

This collection is not intended as a scholarly journal, but in a significant way it is a peer reviewed publication by virtue of the fact that every presentation is examined in great detail by those 50 or so surgeons.

It serves to honor the presenters for their effort, to potentially serve as first draft for an article for submission to a medical journal, to let residents and potential residents see the high standard achieved by their peers and expected of them, and by no means least, to contribute to better patient care.

David Edelman, MD
Program Director
The Detroit Medical Center

and

Professor of Surgery
Wayne State University School of Medicine

MICHAEL & MARIAN ILITCH
DEPARTMENT OF SURGERY
WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE

Medical Malpractice for the Surgeon

John Webber MD, FACS

Professor of Surgery
Wayne State University
School of Medicine

This paper is based on Dr. Webber's Surgical Grand Rounds presentation on March 9, 2022

Introduction

This paper discusses medical malpractice as it relates to surgeons and what surgeons should know about it, especially residents just starting to practice. Seasoned surgeons have all been through malpractice lawsuits many times and know that it is not much fun. This paper may not make it any more fun but at least make it less daunting.

This paper does not in any way constitute legal advice or the practice of law and is not intended to replace legal counsel. But all surgeons should have some knowledge of the legal system because they *will* participate, willingly or unwillingly, in it. All surgeons are likely to be sued. Knowledge is empowering and helps the surgeon transition from fearful victim to proactive prevention, to do the things that will hopefully protect them from, or during, lawsuits.

It has always seemed to me that "malpractice" is a misnomer, because it really isn't about malpractice. "Mal" means bad, so malpractice means bad practice. But most surgeons are not bad practitioners—most are in fact good practitioners who are sued for complications that occur during cases. "Maloccurrence" is really what's going on.

Liability

To prove that a surgeon is liable for a patient's injury or death, it must be shown that:

1. A physician-patient relationship existed ("Duty"), *and*
2. The physician failed to meet the required standard of care ("Breach of duty"), *and*
3. The physician's breach caused the patient's injury ("Actual and proximate causation"), *and*
4. The patient incurred medical expenses and/or pain and/or suffering and/or lost wages as a result of the breach ("Injury and damages")

Standard of Care

All surgeons will all be asked to define "standard of care" when deposed in lawsuits therefore it is critical to know it. It is the legal term for the duty owed by one person to another and applies to non-medical as well as medical situations. It is defined as what a surgeon of ordinary skill, learning, experience, and judgement would or would not do, given a similar set of circumstances. Note especially the word "ordinary" and do not be tempted to replace it with "prudent"—the success or failure of a suit may depend on it. Violation of the standard of care is defined as failure to exercise the level of skill, diligence and judgement that a reasonable surgeon would have exercised under the same or similar circumstances.

Incidence

Figure 1 its an indication of the likelihood of being sued for medical malpractice in the US, given that 120,000 deaths result from medical error, far surpassing motor vehicle accidents, deaths from falls, drowning deaths, and airplane crashes.

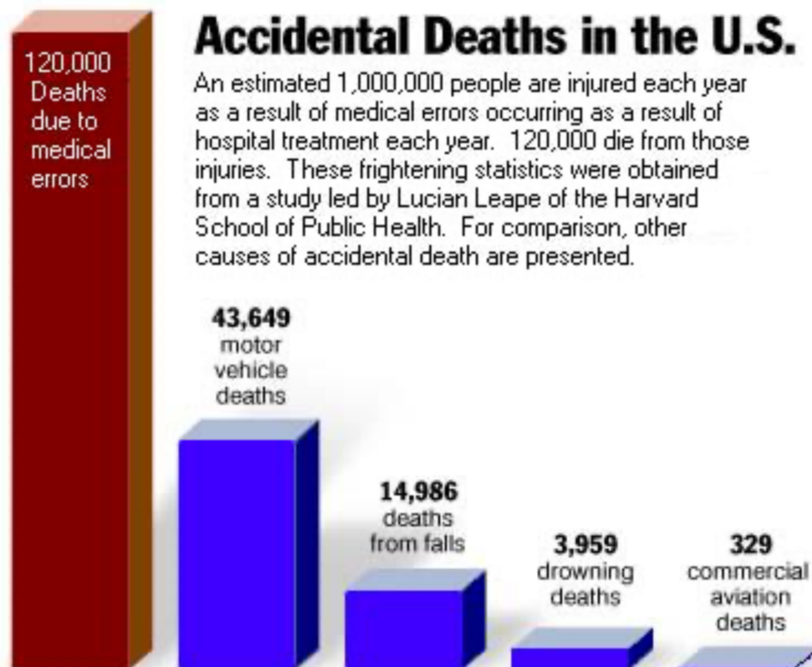

Figure 1. Accidental Deaths in the US.
Source: National Safety Council 1995

A study at Harvard, also dated but still much quoted, found that 4% of patients suffered medical error resulting in prolonged stay or disability, and 14% of those injuries resulted in death—a figure equivalent to 3 plane crashes every dav.

The Saks study of the extent of malpractice litigation found that 3% of negligent injuries result in litigation *versus* 1.3% of non-negligent acts, and that for every suit in response to negligence, 30 victims do not bring suit, while 5 non-negligently injured patients do.

These studies also found that the nature of lawsuits was 28% diagnostic errors, 27% surgical errors, and 26% improper medical treatment.

Table 1, from the Harvard study, shows the percentage of adverse events by degree of disability ranging from minimal impairment to death, with the majority (56.8%) being minimally disabled yet a substantially proportion (13.6%) dying. The reasons people choose to sue are shown in Table 2.

Category of Disability	Adverse Events (%)
Minimal impairment, recovery 1 mo	56,042 (56.8%)
Moderate impairment, recovery >1 to 6 mo	13,521 (13.7%)
Moderate impairment, recovery > 6 mo	2,762 (2.8%)
Permanent impairment, < 50% disability	3,807 (3.9%)
Permanent impairment, > 50% disability	2,550 (2.6%)
Death	13,451 (13.6%)

Table 1. Adverse Events by Degree of Disability
Source: Harvard Medical Malpractice Study

	Percent Expressing Concern
Advised to sue by influential other	32
Needed money	24
Believed there was a cover-up	24
Child would have no future	23
Needed information	20
Wanted revenge, license	19

Table 2. Reasons Why People Sue Their Doctors

Medicine as a field is particularly susceptible to lawsuits because of systems constraints including staffing problems (especially today), fatigue (to combat which, the 80 hour rule was introduced), the enormous knowledge required of a surgeon, communication and the continuity of care, and poor documentation.

Communication

Poor communication is not listed anywhere as an official cause of medical malpractice claims, although it underlies almost every malpractice action and is a contributing factor in 80% of lawsuits. It is the combination of long wait times and short visits with the physician that yields the most negative results on patient satisfaction surveys.

In our own clinic, the average patient wait is an hour or even two. I may see 30 patients in three hours, which works out to six minutes per patient. Patients who have short wait times and adequate patient doctor exam room time are much more positive about their physician.

Documentation

Why do we document at all? We document in order to get paid—payers will not pay for an undocumented procedure, so we send an operative report with our bill or the insurance claims adjuster will deny it. Hospitals require documentation because they also want to get paid for services rendered.

Even more importantly, documentation is also needed to memorialize a treatment for the benefit of future providers or for yourself, so that when you look back at the patient's record you know what you did. You are otherwise not going to remember a case from possibly years ago. Documentation is also necessary for patient purposes: Patients will often request their medical records and you need to be able to give them something. Not least, we document for medical-legal purposes.

Too many surgeons dictate short and vague operative reports, believing that this might forestall a suit or help if suit is brought. In most cases, that is wrong. More detailed and descriptive operative reports are better protection against litigation. Operative reports should memorialize the rationale for a procedure, especially when unintended complications arise during it.

For example, the initial entry site—the first port—of a laparoscopic procedure is a blind entry. The other entry sites are not blind. That must be documented, to protect against a lawsuit. Think about whether, five years later, your operative record will provide an accurate picture of the care delivered or whether what is missing will speak louder than what you noted. For sure, you won't remember the case even three years later, when most lawsuits are brought, and then you're stuck with what you have documented.

You will likely be asked in a deposition whether you have any independent knowledge or recollection of the procedure or the patient. Most surgeons will not. And then the lawyer will ask if you plan to base your defense on the medical record. At that point, that's all you've got, and you have to answer that yes, you will go by the medical record. If you've got nothing in the medical record, you're in trouble.

Since a*pproximately 90% of settlements and litigation are caused by inadequate documentation,* this is obviously the place to focus on prevention. Malpractice activity is disproportionate among physicians, with 75% to 85% of awards and settlement costs over a five year period made on behalf of 1.8% of internists, 6% of obstetricians, and 8% of surgeons who get sued.[1] (Surgeons, anesthesiologists, OB-GYN and emergency room doctors are the four fields that get sued the most.)

[1] Source- Sloan, 1989, Bovbjerg, 1994

Risk Management Strategies
The chief ways to manage risk are to dictate operative notes in a timely manner, to avoid amending the record, and to call for help.

Timely Dictation: A thorough and timely medical record is the preeminent risk strategy. By "timely," I mean that the sooner you dictate the procedure the better. It will be fresher in your mind, you'll include more detail, and you'll probably be more accurate The medical record is a witness whose memory never fades, Surgeons have been known to forget to dictate a procedure and try to catch up a year and a half later.

Don't Amend: The minute you get notified of being sued, never alter the medical record. Everything in the medical record is timestamped, and alterations will not go unnoticed and unquestioned. Once notified of pending litigation don't even access the chart at all—period—unless a lawyer asks you to. If you do see an error, just draw a line through it.

Who To Call: When you get notified of a suit, you should call risk management at the hospital or physician practice group, or both.

How Lawsuits Work
All lawsuits in the state of Michigan begin as a Notice of Intent (NoI). Michigan imposes a 182-day waiting period after the NoI is filed before a formal Complaint (Legal term for the lawsuit) can be filed with the appropriate court. The NoI is a letter detailing the problem, explaining why it is being filed, and giving the defense and surgeon a chance to prepare themselves to show up in court.

The formal complaint—the actual lawsuit—with the accompanying affidavit of merit from qualifying medical experts cannot be filed until the 182-day waiting period is up. By the end of 182 days, the complainant will either have filed a complaint or they won't file a complaint. Most of the time they won't file a complaint and there is no case—the statute of limitations will have expired.

The statute of limitations in Michigan is two years after the date of negligent act or omission or six months from the date when the claimant discovered—or should have discovered—the existence of the claim.

For example, a retractor left inside a 14-year-old was only discovered when he was 29 and suffering from multiple issues that led, within the 6 month statute, to the discovery of the retractor, which turned out to be the cause of all his problems.

NoI's often arrive within days of the end of the statute of limitations, but that's enough to stop the clock, allowing the lawsuit to proceed. The statute of limitations is a little fuzzy today because COVID stopped all civil suits for about a year. Wayne County and Oakland County courts dealt only with criminal matters, and civil issues were put on the back burner.

Once an NoI is issued, it is assigned to a claims supervisor at the defendant's insurance company. <u>Never "go naked"—never be uninsured</u>. It's a really bad idea and hospitals and practice groups don't usually allow a physician to practice without malpractice coverage, but it happens. A local surgeon ended up having to pay $125,000 out of his own pocket for that very reason.

After receiving the NoI, a response letter is then sent to the policyholder and the plaintiff's attorney and a claims supervisor investigates the claim over the next several months. That investigation includes collecting and reviewing the medical record and referring the case to independent medical consultants for evaluation. During this time, the case may become a lawsuit or it may remain a claim.

The Battle of Experts
If it gets to trial, much hinges not just on the testimony of expert witnesses but also on who's more believable, who's more likable, who impresses the jury more. It used to be that local

experts in the community would engage in a conspiracy of silence to protect one another, but today, due to the wide availability of national journals and databases, experts tend to be recruited nationally, not locally.

The American College of Surgeons has published on its website recommended guidelines for behavior of the physician acting as an expert witness:[2]

- Physicians have an obligation to testify in court as expert witnesses when appropriate. Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.

- The physician expert witness should review all the relevant medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the physician expert witness may be called upon to draw an inference or an opinion based on the facts of the case. In doing so, the physician expert witness should apply the same standards of fairness and honesty.

- The physician expert witness should be prepared to distinguish between actual negligence (substandard medical care that results in harm) and an unfortunate medical outcome (recognized complications occurring as a result of medical uncertainty).

- The physician expert witness should review the standards of practice prevailing at the time and under the circumstances of the alleged occurrence.

- The physician expert witness should be prepared to state the basis of his or her testimony or opinion and whether it is based on personal experience, specific clinical references, evidence-based guidelines, or a generally accepted opinion in the specialty. The physician expert witness should be prepared to discuss important alternate methods and views.

- Compensation of the physician expert witness should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. It is unethical for a physician expert witness to link compensation to the outcome of a case.

- The physician expert witness is ethically and legally obligated to tell the truth. Transcripts of depositions and courtroom testimony are public records and subject to independent peer reviews. Moreover, the physician expert witness should willingly provide transcripts and other documents pertaining to the expert testimony to independent peer review if requested by his or her professional organization. The physician expert witness should be aware that failure to provide truthful testimony exposes the physician expert witness to criminal prosecution for perjury, civil suits for negligence, and revocation or suspension of his or her professional license.

An earlier version said income from expert witnessing should be no more than 5% of a physician's gross income. Today, there are physicians who make almost their entire living from expert witnessing. (Incidentally, you can only be an expert if you were actively in practice *at the time of the alleged malpractice*. Therefore, a retired physician can still serve as an expert witness for up to about three years after retirement, because most cases occur some three years before a lawsuit is filed.)

The website for United States Courts says that "Any party may challenge the admissibility of expert testimony offered by another party. The party seeking to challenge the admissibility of expert testimony shall do so by motion as soon as possible; preferably well in advance of the Final Pretrial Conference. In the motion, the moving party

[2] Source: Bulletin of the American College of Surgeons Vol.96, No. 4, April 2011

shall identify the specific opinion(s) that the movant seeks to exclude and the legal basis for exclusion, together with sufficient background information to provide context. The movant shall electronically file, in a searchable format, the relevant expert report(s) and, if the expert was deposed, the full transcript of the expert's deposition."[3]

Remember that all your depositions made throughout your career will go to a deposition repository that is searchable by any lawyer for the plaintiff or the defense in discovery. So *stay consistent*. If caught in an inconsistency, your testimony will likely be thrown out and your credibility is lost. Even if you are consistent, a loss of credibility is possible and can be devastating.

A patient of mine went to the floor after mid-week surgery and was doing well until Sunday night, when she developed high blood pressure and suffered a hemorrhagic stroke. I was blamed for the stroke because I was the surgeon. Of course I had nothing to do with her blood pressure management, and her pressure after PACU was normal. But they blamed me anyway, even though I wasn't even working that weekend.

On deposition, my attorney asked the plaintiff's expert where he went to medical school. It turned out to be a small, remote, island medical school and that the physician had not applied to any US medical school. He continued to stay consistent with his testimony but his credibility was damaged and his deposition got thrown out. He is no longer hired as an expert witness.

Experts are expensive, charging a minimum $300 an hour to review charts and talk to lawyers, $600 an hour to be deposed. Neurosurgeons charge almost $1,000 an hour to review charts and $2,000 an hour for depositions. They cannot attract such rates if they are not credible, however.

As well, it is no longer sufficient as an expert to state that something is your opinion. You must be able to provide a factual basis for your opinion, mainly in the form of relevant literature. Any expert who states he or she is relying on no literature is at risk of having his or her testimony and expert status challenged in a Daubert hearing—a hearing to test the very admissibility of an expert's testimony. The bottom line is whether the expert is qualified to be an expert.

One case, thrown out by a circuit court judge on the basis that the plaintiff's expert admitted he relied on no literature, was overturned by an appeals court. However, the Michigan Supreme Court reversed the appeals court decision, saying:

> "We hold that, under the facts of this case, in which [the expert] admitted that his opinion was based on his own personal beliefs, there was no evidence that his opinion was generally accepted within the relevant expert community, there was no peer reviewed medical literature supporting his opinion, plaintiff failed to provide any other support for [the expert]'s opinion, and defendant submitted contradictory, peer-reviewed medical literature, the circuit court did not abuse its discretion by excluding [the expert]'s testimony. The Court of Appeals clearly erred by concluding otherwise. We therefore reverse the judgment of the Court of Appeals and reinstate the opinion and order of the Oakland Circuit Court."

A plaintiff's expert in a gallbladder injury case opined that the injury was egregious because the surgeon did not recognize the injury at the time of the surgery—it was only recognized a few days later and the patient was sent to another hospital for a repair that was successful. They asked the expert what should have been done. He replied that they should have considered:

[3] https://www.ilnd.uscourts.gov/judge-cmp-detail.aspx?cmpid=952

(1) Getting the Critical View of Safety (CVS) (a method of target identification in the cystic duct and the cystic artery),
(2) Ordering a cholangiogram,
(3) Calling in another surgeon, and
(4) Opening the patient up.

Those four things, he claimed, would have met the standard of care.

However, the defense lawyer had done her homework and brought out that the expert himself had been successfully sued in 2013 and in 2017, and had done none of those four things.

In support of his contention, the expert then presented 11 articles, while the defense expert (myself) presented only five, and 11 seems more credible than five. However, some of the 11 were published only after the incident occurred, and since a surgeon cannot be expected to have knowledge of future literature, these articles could not be used against the surgeon.

Some of the articles that were published before the alleged malpractice were published in foreign journals which, I argued at the Daubert hearing, were inadmissible since they did not adhere to the US national standard for scholarly publication. We won that Daubert hearing and the case was dismissed.

Investigation

If a lawsuit is filed (which can occur at any point in the NoI phase) then an attorney is assigned to the defendant. The insurance policyholder will receive a letter advising of the attorney assignment, and under the direction of a claims supervisor (usually an insurance adjuster), the defense attorney prepares the case for trial by conducting discovery, which means locating expert witness testimony and taking depositions. The claims supervisor, the attorney, and the policyholder then work together to develop the defense strategy.

Settlement

After the investigation, the policyholder, attorney, and claims supervisor may decide to settle the case. It is important that you, if you are a defendant, determine if your carrier requires a policyholder to consent to settling. There are some insurance clauses that do not that require that the surgeon consent to settlement. Some insurance companies don't care what the surgeon thinks—they will settle anyway if they want to.

In that case, if you want to defend the case, you're on your own. I would not recommend doing that. If the insurance company settles, you would probably be better off to settle along with them rather than take on the personal liability.

If a settlement is warranted and physician consent (if needed) is granted, negotiations begin. If acceptable terms are reached during the negotiations, the case is settled. (In Michigan, 80% are settled.)

If all parties agree, a case may go to mediation, in which independent mediator (usually a retired judge) helps the parties resolve the case among themselves.

If the case proceeds to trial, its length varies according to the complexity of the case and number of parties or witnesses called.

If the defense wins at trial (a finding of “no cause”) the insurance carrier may be able to close the claim file; however, the plaintiff *may* appeal (though they often do not).

If the plaintiff wins at trial, the insurance carrier and defense counsel will evaluate the case to determine if there is a legal basis to appeal (again, there usually is not). Usually, the defendant personally is not going to appeal either. If the claim is closed with an indemnity payment to the plaintiff, the case is then reported to the National Practitioner Data Bank.[4]

[4] https://www.npdb.hrsa.gov

Deposition
The plaintiff (the person who was injured, or surviving family if the patient died), treating physicians, defendant surgeon/s, plaintiff's experts, and defense experts are deposed in that order.

A big question is whether a surgeon should serve as a prosecution witness, as plaintiff's expert, against a fellow surgeon. I would say the answer is unequivocally "YES!" You should serve as a plaintiff's expert if called upon to do so. The patient is entitled to an expert opining on their behalf, and there *are* legitimate cases of malpractice.

The vast majority of my expert testimony has been given for the defense, but I have taken a couple of plaintiff cases where there was legitimate malpractice. In general, though, if you're going to work for the plaintiff, do so in another state—"don't take a dump in your own backyard" as the saying goes.

Working as a plaintiff's expert and working as a defense expert adds credibility. When (as happens) you are asked at deposition whether you would you ever testify on behalf of a plaintiff and answer "No," then you are not credible and your testimony will get thrown out. Do not say "No".

Be consistent in your testimony, because all your depositions are discoverable by any attorney, and your previous testimony can and will come back to haunt you. Even though you don't remember your previous testimony, it will be out there, in the National Practitioner Data Bank, for someone to find, and someone *will* use it to try to trip you up during your deposition.

To Err Is Human
Finally:

> "Physicians and nurses need to accept the notion that error is an inevitable accompaniment of the human condition, even among conscientious professionals with high standards. Errors must be accepted as evidence of system flaws not character flaws."[5]

* * *

L L Leape . Error in medicine. JAMA 1994 Dec 21;272(23):1851-7. PMID: 7503827