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Concurrent and overlapping surgery: Addressing the risks

By Kathleen Shostek, RN, ARM, FASHRM, CPHRM, CPPS
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Concurrent and overlapping surgery has been described as when a surgeon begins a second operation, leaving the rest of the first procedure to another surgeon or practitioner to complete.[1] Long a common practice in teaching hospitals, concurrent and overlapping surgery has been thought of as an acceptable way to optimize surgeons' skills, reduce delays, and allow surgeons in training or assistants to complete routine procedures. However, the practice came under scrutiny when Boston Globe reporters published an investigative report on the topic, spurring state and federal investigations. The report detailed patient-related events and subsequent complaints and lawsuits, and described concerns that had been raised by surgeons to hospital administration about the practice.[2] Professional and public outcries prompted the American College of Surgeons (ACS) to address concurrent and overlapping surgery by revising its Statements on Principles to address the practice.[3] With patient safety as a primary consideration, and the desire to avoid claims and lawsuits, hospitals where concurrent or overlapping surgery is performed are reexamining their surgical policies and practices.

Definitions: What's the difference?

In its Statements on Principles, ACS makes an important distinction between **concurrent** surgery and **overlapping** surgery by ascribing the term "simultaneous" to concurrent surgery. The ACS statement notes that when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time, it is considered simultaneous. ACS goes on to state that the primary attending surgeon's involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is inappropriate.

Continued on page 2

The term overlapping surgery is used by ACS to describe surgeries performed by the primary attending surgeon in two situations. One situation is when the critical elements of the first operation have been completed by the primary attending surgeon, who then starts a second operation in another operating room. In this circumstance, a qualified practitioner completes the noncritical components of the first operation, such as wound closure. The second situation is when the key or critical elements of the first operation have been completed and the primary attending surgeon is performing key or critical portions of a second operation in another room. ACS notes that, when this occurs, the primary attending surgeon must also assign immediate availability in the first operating room (OR) to another attending surgeon.

In both situations, the critical or key components of an operation are to be determined by the primary attending surgeon. An approach by one hospital to define critical components, described in the Senate Finance Committee White Paper, *Concurrent and Overlapping Surgery*,[4] uses Current Procedural Terminology (CPT®) codes for hip procedures; the critical portions identified include finalizing bone cuts or bone preparation, implant trialing, and final placement of implants.

Considerations for risk management

There are a number of ethical, risk management and patient safety issues surrounding concurrent and overlapping surgery. Sedgwick healthcare risk management consultants have encountered several of these issues and concerns while performing surgical risk assessments and making observations in the OR. We have also received calls from our clients asking for information, resources and advice on the topic. Some of these issues and concerns have included the following:

- Longer anesthesia time for patients waiting for the attending surgeon, when delayed in the first procedure
- Lack of patient awareness (consent) regarding what portions of the surgery are being performed by which surgeons or practitioners involved in the procedure
- Inadequate supervision of surgical residents and surgical assistants, and scope of practice creep when the primary surgeon leaves the OR for a second procedure
- OR nurses reporting fears of "patient abandonment"
- Inadequate pre-procedure briefings and the absence of surgical debriefs

In general, ethics and informed consent, regulatory compliance, professional practice guidance, and surgical department policies are all areas that deserve special risk management attention when considering your own organization's concurrent and overlapping surgeries.

Informed consent requirements and compliance

It is common in academic and teaching facilities for patients to give general consent during their admission to have students and residents participate in their care. More specific consent forms, obtained later, often contain language permitting the attending surgeon and his or her assistants or delegates to carry out procedures related to the planned surgery. However, there is often inconsistency regarding the amount and type of information provided to patients regarding the involvement of those other than the attending surgeon. One study reported that, while patients preferred having detailed information about resident participation in their procedures, consent rates declined significantly when such information was provided.[5]

When addressing informed consent, the ACS Statements on Principles guide the surgeon to include, "a discussion of the different types of qualified medical providers who will participate in their operation and their respective roles." The Centers for Medicare & Medicaid Services (CMS) does not specifically address informed consent for concurrent or overlapping surgery. However, CMS' interpretive guidelines include a statement about the elements of a well-designed informed consent process that includes, "whether physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, ... and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner." CMS also includes recommended patient discussion items for surgeries in which residents will perform important parts of the surgery.[6] In addition, various statutory requirements for informed consent apply.

Examples of statements in surgical policies that address disclosure include:

- "If the surgeon will not be present for any portion of the surgical procedure, the patient must be informed"
- "Overlapping surgery should be disclosed to the patient during the informed consent process"

In December 2016, a U.S. Senate Finance Committee published its report on concurrent and overlapping surgeries, calling for additional measures and oversight of the practice.[4] The report noted that just half of the hospital policies reviewed by the committee included a requirement to inform patients that their procedure would be scheduled as an overlapping one. Also, experience with medical malpractice claims shows that, in cases involving residents or surgical assistants, the plaintiffs have often claimed they were unaware of the roles and responsibilities of providers involved in their procedures. It was only during discovery and record review that they became aware of who performed what part of the surgery.

More on regulations and compliance

CMS permits providers to bill the Medicare program for up to two simultaneous or overlapping surgeries, but the regulations note that the surgeon must be available for "critical" portions of both operations. CMS does not define what is meant by critical.[7] The Medicare rules include requirements for another surgeon to be immediately available when the attending surgeon leaves to begin a second procedure and note that the attending surgeon must document his or her presence for the surgery.

At the state level, the Massachusetts Board of Registration in Medicine recently approved a rule to regulate the practice of concurrent surgery that mirrors CMS' rules.

According to a 2015 Boston Globe report, a Wisconsin medical school paid $840,000 to settle a lawsuit alleging that neurosurgeons illegally billed Medicare for simultaneous spine surgeries largely done by unsupervised medical residents. Similar settlements have been made by other facilities and providers.[8]

ACS guidelines

The ACS principles note that when the primary attending surgeon is not present, nor immediately available, another attending surgeon should be assigned as being immediately available. This is in keeping with the Medicare requirements that the surgeon be available for critical portions of both operations, which cannot occur simultaneously.

In the case of operations where several surgical specialists are involved, each may only be present for the component of the operation for which he or she is responsible. The ACS principles state that, in these operations, an attending surgeon must still be immediately available for the entire operation.

Within the ACS principles, "critical or key" portions of an operation are defined as "segments when essential technical expertise and surgical judgment are required, as determined by the attending surgeon"; "physically present" means that the attending must be in the same room as the patient; and "immediately available" means he/she must be reachable and able to return to the OR immediately.

The U.S. Senate Finance Committee report on concurrent and overlapping surgeries noted above compares the guidance provided by CMS and ACS. The report can be found here: http://www.finance.senate.gov/imo/media/doc/Concurrent%20Surgeries%20Report%20Final.pdf.

Surgical department policy considerations

It is important to consider a number of things when developing policies or reviewing existing policies on concurrent or overlapping surgery, including the applicable regulations and professional practice guidelines discussed above. Also, it is key to review available studies on the safety and efficacy of the practice as support for your own decisions. For example, a recent study published by the Mayo Clinic on over 10,000 overlapping surgeries revealed no difference in the rates of postoperative complications or deaths within a month after surgery.[9] One earlier study involving 3,000 simultaneous cardiothoracic surgeries at the University of Virginia found no negative impact on surgical complications, length of hospital stay, or operative mortality.[10]

As there has been a general dearth of information in the literature on concurrent surgery and its effect on patients and outcomes, surgical departments must define practices and policies with patient care and safety at the forefront.

Once developed, it is essential to communicate policies to the surgical, teaching, scheduling and nursing staff. Implement a process to review surgeon compliance and provide feedback to physicians and department chairpersons. Establish a clear means of communication and chain of command for OR nurses and surgical support staff to ask questions and voice concerns.

Recommendations for addressing concurrent surgery risks include:

- Have the surgical executive committee define concurrent or overlapping surgery, identify what surgeries are acceptable for concurrent or overlapping performance, and specify the "critical parts" of the operation.
- Implement a comprehensive informed consent process – the process should include a discussion about which surgeons and other surgical practitioners will perform what parts of the operation; consent practices and forms should be reviewed with medical staff and legal counsel.
- Establish a process to ensure that a surgeon is immediately available to return to the OR as necessary.
- Ensure all surgeons' entry and exit times from the OR are documented, noting the portions of the procedure when the surgeon was present and the extent of their involvement.
- Address application of standard safety procedures such as the universal protocol for prevention of wrong patient, procedure or site surgeries, and responsibility for conducting pre-procedure briefs and post-procedure debriefs.
- Review any unexpected outcomes in cases involving concurrent performance or overlaps, as well as any extended anesthesia times while awaiting a surgeon's arrival.

Healthcare risk managers can work with surgeons and clinical staff, legal counsel and administrators to proactively address the patient safety, clinical and regulatory issues that currently surround the practice of concurrent or overlapping surgery. Bringing the topic to an appropriate decision-making body or committee, with related guidelines and regulations for review and recommendations for action, can foster the development of policies that aim to protect patient safety, set guidance for providers, and mitigate risks for the organization.

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Robin Maley joins Sedgwick

Sedgwick is pleased to welcome Robin A. Maley, RN, MPH, MS, CPHRM, CPHQ, who has joined our professional liability and healthcare risk management team as SVP, Healthcare Risk Management and Patient Safety. Robin is an industry-recognized expert in risk management and patient safety with 30 years of experience. Prior to joining Sedgwick, she gained experience as a hands-on clinician and held executive leadership positions within the healthcare divisions of leading medical malpractice insurance companies and a highly regarded insurance broker. Robin also led risk management, patient safety, insurance and regulatory affairs at major academic medical centers. Additionally, she managed her own successful risk management consulting firm for many years.

At Sedgwick, Robin is responsible for overseeing and providing innovative consultative services to improve patient safety and risk management programs at healthcare organizations and among healthcare practitioners. Sedgwick's expertise in education, tool development and project management supplements a vast array of consultative services offered to acute care, long-term care and specialty-specific healthcare organizations, as well as clinical provider groups.

Robin received her Bachelor of Science degree in nursing from Skidmore College, Saratoga Springs, NY, a Master of Public Health degree from Columbia University, New York, NY and a Master of Science degree in healthcare delivery leadership from the Mount Sinai School of Medicine, New York, NY. She also attended the Columbia University Graduate School of Nursing, majoring in adult psychiatry. She holds both the CPHRM and CPHQ professional designations. Robin is on the Board of the American Society of Healthcare Risk Management, New York Chapter and served on numerous ASHRM committees. She also served on the Board of the Columbia University School of Public Health and was a faculty member there teaching risk management, quality and healthcare finance for several years. Robin has been a frequent speaker at national forums on risk management and patient safety issues and authored several award-winning articles on these topics.

Reducing risks in magnetic resonance imaging

By Robin Maley, RN, MPH, MS, CPHRM, CPHQ, SVP, Healthcare Risk Management and Patient Safety

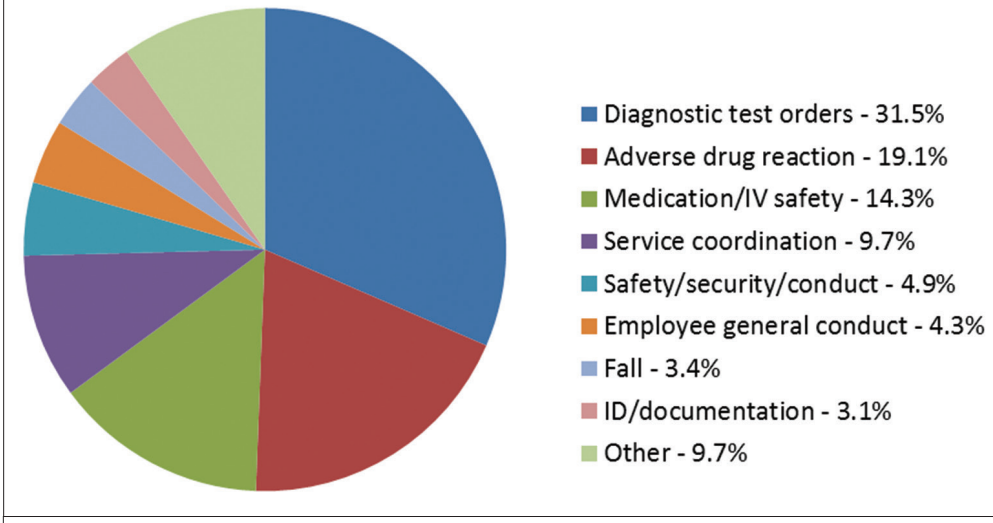
Magnetic resonance imaging (MRI) was introduced in 1977 as a groundbreaking technology that uses electromagnetic waves to differentiate healthy tissue from diseased tissue in three-dimensional images. MRI results have created numerous opportunities for healthcare practitioners to monitor, prevent, control, and cure a broad range of healthcare conditions and improve both the quality and length of life. Over 35 million MRI scans are performed per year in the United States and this number is increasing.[1]

MRI-related risks

The MRI magnet weighs 10 tons and has a magnetic force 30,000 times as powerful as the earth's magnetic field. As a result, there is great risk for harm related to the MRI magnet's ability to cause ferromagnetic objects to be projected toward it, possibly striking and killing persons in their path. An example occurred in 2001, when an oxygen tank was introduced into the MRI scan area at a New York hospital. The tank was propelled toward the magnet

and struck the skull of a six-year-old boy, killing him. This case was settled for $2.9 million in 2010. Additional fines were levied against the hospital for safety violations.[2]

These powerful magnets also have the ability to displace metal objects implanted within the body, such as pacemakers and aneurysm clips, potentially causing severe or fatal injuries. Other well-documented MRI-related risks include errors in diagnostic test orders, adverse drug reactions, thermal burning, contrast agent reactions, medication/IV safety issues, and complications from poor or interrupted clinical monitoring. Percentages of incidents by risk description may vary by organization. Collecting and analyzing incident data increases awareness of trends, helps to pinpoint corrective actions to be taken, and allows for both internal and external benchmarking. This pie chart shows distribution in percentages of incidents collected during a study conducted over a six-year period.



Percentage of incident reporting categories (Mansouri Study, April 2006-2012)

Frequency and severity of MRI-related events

Overall, MRI-related incidents are infrequent in comparison to the number of images taken and often don't result in patient harm. Upward of 7,000 events and near misses involving MRI are reported per year, with report frequency increasing over recent years.[3] One study reported a 500% increase in MRI-related events since 2000, while MRI use increased 112% during the same time period.[4] The Food and Drug Administration (FDA), a recipient of MRI event data, suspects that events are underreported.[5]

MRI safety was cast into the limelight, and a Sentinel Event Alert released by the Joint Commission in 2008, following five reports of MRI-related deaths. One event was caused by a projectile, three cases related to cardiac events and one event was due to a misread MRI that resulted in delayed treatment.[6] Of note, there have been no sentinel events reported to the Joint Commission since the release of this report.[7] Data contained within other databases indicated a need for a focus on MRI safety. For example, an analysis of the FDA's Manufacturer and User Facility Device Experience (MAUDE) database revealed 389 reports of MRI-related events over a 10-year period, including nine deaths. Three of the deaths were related to pacemaker failure, two to insulin pump failure and the others were due to implant dislodgement, a projectile and asphyxiation from a cryogenic mishap during installation of the MRI imaging system. Statistical analyses revealed that more than 79% of the 389 reports were related to burns and 10% were projectile-related.[8]

Most reported errors have led to less serious consequences than death or permanent injury. Nonetheless, events such as burns from thermal heating, dislodged implanted devices, or allergic reactions to contrast can have serious consequences. Both serious and less serious events have led to claims of medical malpractice and negligence against providers, staff and institutions.

MRI scans have been in increasingly high demand by consumers and clinicians and, in order to meet demands and maximize workflow, screening has sometimes been rushed or incomplete. Contributing to the risk has been the improper use of MRIs due to patient demand, referring physicians' lack of knowledge of the proper medical imaging modality for the patient's condition, and/or lack of standardized guidelines for MRI diagnostic use. Efforts to enhance the patient experience, at the forefront of most healthcare organizations' goals, have sometimes been prioritized over adherence to best practices, compromising standards in favor of maintaining patients' perception of quality care. For example, some facilities have encouraged patients to wear sportswear for examinations to decrease changing time and increase comfort. However, there are metallic particles in some clothing that can cause burns. Use of facility-issued garments is now a recommended best practice.

Low tolerance for error

Most MRI-related events are preventable. Liability and negligence claims related to MRI-related adverse events are extremely hard to defend. Further, claimants are not reticent to sue radiologists and other radiology department staff, as they generally have not developed a personal relationship with them.

Best practices

The American College of Radiology (ACR) was the first

organization to take a hard look at developing MR safety best practices when they developed and issued the Guidance Document on MR Safety Practices in 2002,[9] followed by the Joint Commission's 2008 Sentinel Event Alert.[10] The two documents, considered the premier guidance documents for best MR safety practices, were initially confusing as to which guidelines should take precedence. Thus, they were subsequently cross-referenced for ease of use and compliance. The latest ACR guidelines, issued in 2013, are compatible with the Joint Commission's recommendations and Environment of Care standards.[11] These resources are invaluable and should be well-known to all involved with MRI.

Key risk management and patient safety considerations

There are many actions that can be taken to eliminate or significantly reduce the likelihood of adverse events related to MRI. Several of these are outlined under the topics that follow. These key considerations, summarized largely from published guidance documents, are not all-inclusive. ACR, Joint Commission and other guidelines by experts should be consulted (see resources).

» ***Plan MRI sites with experts***

For MR installation, consider access, patient flow, security, cryogen and vent locations, and proximity to other locations. Those involved in planning must be experienced in MR facility design. Further direction can be found within Appendix 3 of The ACR Guidance Document on MR Safe Practices: "MR Facility Safety Design Guidelines."[12]

» ***Limit and restrict access to MRI areas***

Zone 1:	Freely accessible to the general public
Zone 2:	Location where patients are greeted and screened; people are not free to roam in this area and must be supervised by MR personnel
Zone 3:	Strictly supervised and controlled by MR personnel under the authority of a physician, with no exceptions; parents, guardians and support staff, such as anesthesiologists who have been appropriately screened and determined to be free of ferromagnetic items, may be allowed to enter, but must be supervised closely by MR personnel.
Zone 4:	Where the MRI magnet is located and "live;" signs identifying the area must be prominent and illuminated at all times, supported by backup power.

The various zones must be clearly demarcated. Remember that magnetic fields may reach to areas such as rooftops and storage areas and warnings must extend to those areas. Ferromagnetic detectors should be used to supplement other screening processes.[13]

» ***Know where MRI is being performed and identify persons at risk***

MRI safety guidelines must apply to not only diagnostic settings, but also research, interventional, intraoperative and ambulatory settings where MRI may be performed. MRI, CT and PET scans done during ambulatory visits continue to increase (see chart, opposite page).[14]

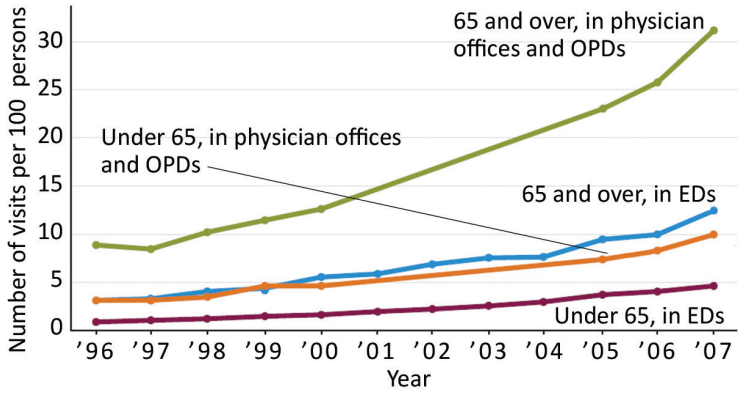
Populations requiring special attention

- High-risk patients, including those:
  - Coming from non-intensive care units with comorbidities and vital sign alterations prior to arrival
  - Requiring respiratory support
  - Receiving sedatives around the time of medical imaging

  Patient distress encountered is most often cardiac (41%), respiratory (29%) or neurological (25%).[15] Suggestions for preparedness include:
  - Utilize standardized handoff protocols.
  - Perform vigilant vital sign monitoring.
  - Establish sound policies and procedures describing actions to be taken when patients arrive in MRI, during the MRI and in the event of an emergency and/or transfer to an alternate location.
  - Require emergency response drills several times per year within all MRI locations.
  - Review the availability and location of MRI-compatible equipment in the event of an emergency.
  - If EKG leads are present, all must be MRI-conditional leads and removed and repositioned as possible throughout the procedure to avoid heat buildup (consider the use of pulse oximetry with an MRI-compatible device for patients with poor oxygenation).
- Other special populations
  - Pregnancy-related
    - › Pregnant employees can help position patients. They should not remain in the MR scanner bore or Zone 4 during scanning.
    - › Pregnant patients should be screened and consideration given to whether the MRI is medically necessary during the pregnancy or could wait until after pregnancy. All risks and benefits should be explained and documented if imaging proceeds. Contrast should not be used.
  - Pediatrics
    - › Provide special attention to temperature monitoring, especially for neonates and small children.
    - › Adhere to standards of care established by the American Academy of Pediatrics, American Society of Anesthesiologists, the Joint Commission and individual

state laws and institutional policies and procedures.

- Persons with tattoos
  - 1/5 of all Americans have at least one tattoo. The ink used to create tattoos may contain iron oxide or other substances that may react to the MRI and cause burns.[16] Tattoos may also distort images.
  - Determine the location, size and age of all tattoos – large tattoos and older tattoos are more likely to lead to untoward reactions. Tattoos in sensitive areas such as the face, including permanent makeup, will react faster and more severely.
  - During MRI, watch for swelling and irritation around the tattooed area. To decrease risks of adverse events, cold compresses may be applied pre-scan.



Ambulatory care visits with MRI/CT/PET scans ordered or provided within the visit, by age and location of care: United States, 1996-2007. OPD = hospital outpatient department, ED = emergency department.

» ***Establish, implement, and maintain policies and procedures***

- Maintain a current MR safety policy and procedure manual that pertains to all MR clinical and research sites.
- Review policies and procedures concurrently whenever there are any changes to the MR environment.
- Be familiar with and comply with all applicable national standards, state laws, professional guidelines, accreditation and institutional requirements.

» ***Assign accountability for the oversight of MRI operations***

- For each site where MRI is performed, name a medical director responsible for assuring MR safe practices guidelines.
- Establish written guidelines describing the roles and responsibilities of the MR medical director, safety officer, physicist, managers and all MR staff.

» ***Assure that staffing of MRI areas is optimal***

- Level 1 MR personnel must have at least minimal safety education to work in Zones 1-3.
- Level 2 MR personnel must be provided with more extensive education involving recognition and treatment of thermal injury and neuromuscular excretion from rapidly changing gradient. No level 2 personnel may assign responsibility to supervise non-MR personnel still in Zone 3 or Zone 4 until they formally sign off to another Level 2 MR person.

Those who have not been trained within the past 12 months are considered non-MR personnel, regardless of their professional designation.

Except in emergencies, there must be a minimum of two MR techs or one MR tech and one other person with the designation of MR personnel within the Zone 2 to 4 environments. In an emergency, an MR tech can scan a patient without another individual in Zone 2 to 4 environments, but there must be a radiology attending or house staff member in-house and available to respond in the event of an emergency.

» ***Conduct thorough screening of patients and MR personnel***

- Persons undergoing non-emergent MRI must be screened by a minimum of two people. One of the screening processes must be verbal and interactive and performed by Level 2 MR personnel.
- Emergent patients may undergo only one screening but it must be performed by Level 2 personnel.
- In preparation for MRI:
  - Advise patients to remove all metallic personal belongings. Note: some cosmetics include metal and, thus, makeup should also be removed. Clothing can contain some metallic substances. Facility-issued garments are recommended.
- Patients with a history of ferromagnetic foreign objects must undergo further investigation:
  - Take detailed patient history regarding the object(s).
  - Obtain plain films of area(s) in question.
  - Acquire prior CT or MRI films of the area in question.
  - Obtain written documentation of type, model and maker of implant.
  - Check product labeling.

Note: Above also applies to anyone with a history of orbit trauma by a potential ferromagnetic object.

- Non-emergent patients must complete screening before entry to Zone 3.
- If the patient is unconscious or unreliable, a family member or guardian must complete the screening on their behalf. Check patients for scars that indicate a possible implant and perform a plain x-ray prior to MRI. If no prior films are available, a plain skull and orbit x-ray should also be done to exclude a metallic foreign body.

- The person completing the screening as well as the MR staff member must sign the form, which then becomes part of the medical record. Leave no blank spaces on the form.
- The final determination to scan a patient with an implant should be made by a Level 2 designated attending radiologist.
- Occasionally an object is found that was not identified during screening. This may be detected upon review of the images taken. In these cases, the medical director should be notified immediately and determine next actions.
- Prisoners or parolees with RF bracelets should have the restraining devices removed by the authorities.
- In the event of a fire, firefighters should be met by MR personnel and only MR-compatible equipment should be used. If the fire is in Zone 4, quenching the MRI should be seriously considered. All non-MRI people must be excluded from the area until it has been determined that the static field is no longer detectable.

» ***Use only MRI-approved equipment***

- NEVER assume that equipment is MRI-compatible unless it is specifically noted to be so.
- Equipment should be audited on a routine basis to assure that it is MRI-safe and that staff is aware of its location and safe use.

» ***Track and review adverse occurrences***

Learning from adverse events and near misses is important so that improvements can be made and future adverse events eliminated and minimized.

- Hold debriefs immediately following any adverse event or near miss to determine the surrounding facts, and decide whether a root cause analysis is indicated. Also establish whether the event needs to be reported to any outside authorities.
- Examine the processes that led to the event to determine whether protocols were followed and, if so, what gaps in the process need to be addressed.
- In the event that a root cause analysis is required or desired, assure that all parties with expertise to add to the analysis of the event are invited to attend. This may include radiologists, nurses, technicians, administrators, pharmacists, MR staff and ancillary staff. Those directly involved should not attend to eliminate potential bias.
- Keep a log of MRI-related events for internal trending to explore and address common contributing factors, and to make improvements.
- Share information obtained with key staff so they are better prepared to address MRI-related issues in the future.

Conclusion

MRI has become a widely used technology in the U.S. and its use is expected to grow. While adverse events and near misses are not frequent, increasing reports of both have been made in recent years. Information from such reports provides all involved in MRI with opportunities to make improvements that will enhance patient safety and allow patients to reap the benefits of improved and precise diagnoses.

Resources

- ACR Guidance Document on MRI Safety Practices 2013: http://onlinelibrary.wiley.com/doi/10.1002/jmri.24011/pdf
- ACR MR Safety Website: http://acr.org/Quality-Safety/Radiology-Safety/MR-Safety
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10 STRATEGIES FOR SUCCESSFULLY RESOLVING A MEDICAL MALPRACTICE CLAIM

By Jayme T. Vaccaro, J.D., Vice President, Specialty Claims Operations

From never being afraid to try a case, any case, to knowing what ultimately motivates the plaintiffs, thinking outside the box and utilizing creativity can be a mantra for successfully resolving medical malpractice claims. In a series of ten articles, Jayme T. Vaccaro shares time-tested strategies for resolving a medical malpractice claim.

Ten strategies:

1. **Never be afraid to try a case – any case**
2. **Always be aware of the plaintiff's attorney vulnerabilities – leverage**
3. **Always know where your codefendants lie and wait – friend or foe**
4. **Use your tools – from high/lows to bifurcation**
5. **The courtroom is sometimes not the place – alternative forums**
6. **Know when to hold – and know when to fold**
7. **Know what the plaintiff wants out of the case – the sweet spot, and it may not be money**
8. **Back to basics – know your case inside and out, legal, medical and the like**
9. **Anyone can help you mediate – from the judge to the structured settlement representative**
10. **Understand risk appetites – client/insured/defendant**

Read strategies 1 and 2 in our recent *Risk Resource* newsletters, archived at: http://www.sedgwick.com/news/Pages/newsletters.aspx. In this issue, we will explore Strategy 3.

Strategy 3: Always know where your codefendants lie and wait – friend or foe

In malpractice actions, the codefendants attempt to avoid pointing fingers at one another to maintain a unified defense. The theory is once you start attacking your codefendant you make the case for the plaintiff. This can result in letting the plaintiff's attorney sit back and have the jury sort out the exposure between the codefendants. Even better, robust finger-pointing can lead to a jury finding all defendants liable.

Knowing the strengths and weaknesses of your codefendant(s) can facilitate a more favorable resolution. While understanding how to effectively deal with the plaintiff's attorney is important, working with a codefendant can be just as challenging and, if done successfully, render more acceptable outcomes. A major factor with a codefendant is allocation and apportionment. If codefendants disagree on how much each party contributes to the eventual settlement, it can tear them apart. This friction can also increase the value of the settlement for the plaintiff as he observes the discord.

Take the codefendant with a large policy limit vs. the codefendant with lower limits. Even if the lower limit defendant has the lion's share of the exposure, many times the plaintiff's attorney will take their limit and pursue the remaining codefendant with the larger limits. Why? It's much easier to go after the larger limits than go into the personal assets of the other codefendant. Also, most plaintiff's attorneys don't want a reputation of bankrupting physicians or medical groups. Taking the easier target streamlines the process and ruffles fewer feathers – unless you are the codefendant with large limits.

In addition to policy limit tensions, consider the other types of business relationships that may exist between the individual physicians, their groups and the hospital where the incident took place. For example:

- A codefendant in contract renewal with their codefendant hospital
- A codefendant that is a general partnership and, due to how it is legally formed, all partners are individually exposed in the event of a mega verdict
- A codefendant medical group that is incorporated, where the physicians are shareholder employees and the entity is exposed through labor code for excess losses
- A codefendant that has experienced an adverse verdict and is apprehensive about trials
- A codefendant hospital system that is experiencing negative publicity or is risk adverse and wants the case to just go away

Knowing more than the facts of the case can help you navigate the business and political agendas of the codefendants to your advantage.

EXAMPLE A

A physician and his group are named in a case involving the failure to diagnose a spinal abscess. There are three other codefendant physicians and their groups named. Throughout the litigation, one attorney represented the co-defendants. At the end, just prior to the first settlement conference, separate counsel is assigned to the five codefendants – three physicians and two groups.

If you are the claims person for our physician and his group, how do you play your hand with your codefendants?

Conflict often arises when codefendants suddenly get separate counsel. Strategize accordingly; the pressure this may create for the conflicted codefendant(s) could reduce your share. Many of us have had the opposite result and were left the last man standing, only to pay more at settlement.

In our example, the conflicted codefendants paid three times more than the non-conflicted codefendant. The reason being a good temperature was taken on their "panic" as well as effective dealing with the plaintiff's attorney. The non-conflicted codefendant achieved the best outcome.

EXAMPLE B

The case involves a catastrophic injury with high medical and loss of earning damages. Your codefendant is a physician and his group. The group is an "asset-rich, intentionally underinsured mega entity." It also happens to be a general partnership. The codefendant physician is refusing to consent, thereby putting great pressure on you, a large self-insured program, to settle the case.

How can you put pressure as a codefendant in such a scenario? Is the entity concerned, given they are exposed with their low limits, assets and legal makeup? Under a general partnership, the partnership is exposed, as well as all individual partners. Is the one physician keeping his partnership hostage exercising the right to control the consent over the settlement decision?

Physicians and groups continue to maintain lower limits not withstanding their assets or legal makeup. Plaintiff's attorneys may not go after a physician or group's assets, especially if there is an easier dip into a codefendant's larger policy limits. The plaintiff may opt to go after the defendant's hospital or healthcare system. As the codefendant with more to lose (if you are the hospital or even a doctor with significantly higher limits), getting your codefendants in agreement to contribute their fair share is crucial.

Large systems/programs continue to have larger limits. Adjusting their deep-pocket outcomes is increasingly important to stay financially healthy. This is especially true when facing a strategically underinsured, legally vulnerable codefendant. There is a belief among physicians and defense attorneys that you do not want to stand out among codefendants with higher policy limits. Hospitals and health systems have high limits to protect their assets and their employees and stakeholders. As a result, entities need to strategically consider their alternatives. Use of indemnity agreements, bylaws of hospitals that increase minimum limits and other pre-litigation measures also may assist in having your codefendant contribute their fair share. Medical groups can consider having partners waive their right to consent through their partnership agreement.

Step up your strategy as you attempt a more acceptable apportionment among your codefendants. This would include putting safeguards in place prior to litigation, but once in litigation, using all the tools in your toolbox and considering the intangibles.

Word to the wise: if a business relationship is valued, negative interactions during a claim need not develop and threaten the relationship. Building collaborative relationships with your potential codefendants well in advance of an incident should be an objective. After all, in the end it will come down to people sitting across the table from one another. In the heat of negotiations, professionalism and respect are critical. For example, if you and your codefendants disagree on apportionment, but you do agree the case should be settled and for how much, then settle the case. Take your differences on apportionment to a separate arbitrator or mediator. Let someone else be the bad guy.

Before closing, consider this checklist:

- ✓ Know your codefendants' legal structure
- ✓ Learn about your codefendants' insurance coverage
- ✓ Think through the economic and political implications for everyone involved
- ✓ Learn about your codefendants' settlement philosophy
- ✓ Above all, remain professional and respectful – long-term relationships matter

In the end, while a case may not go as planned, you can work to raise awareness of the need to redefine the allocation/apportionment found in a claim. Many would say tensions are best dealt with not in the heat of a medical malpractice claim, but in the boardroom, long before and certainly after the claim is resolved. Doing your homework with insight and perception, while being mindful of the short-term and long-term implications to business relationships, is the best approach to working with codefendants.

Next time, strategy 4: Use your tools – from high/lows to bifurcation.

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Unit-based champions promote risk management culture

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Today, leading-edge organizations systematically share internal control knowledge across their organization, departments and functions to promote best practices and to minimize loss. Healthcare organizations, especially larger systems with multiple hospitals, clinics, freestanding outpatient surgery centers and urgent care units, are leading the way with this new approach using risk champions. "Risk Champions" help to create and maintain a system-wide risk management culture in all of their activities and departments using an embedded risk management framework to promote decisions that align with their overall risk tolerance strategy. Institutions such as the University of California and New York University have implemented such a program under their enterprise risk management programs and published their successes.[1,2]

The goal for creating such a system-wide risk-aware culture from a multidisciplinary staff is to identify, assess, and control risk, and then review the controls in place. The objectives are also to prevent and reduce loss, improve quality of care, maximize patient safety, reduce liability, and highlight risk management strategies.

Formation of a risk champion steering committee, consisting of loss control/risk managers, is critical to a risk awareness culture. The steering committee encourages risk management strategies to be shared throughout their healthcare system with the participation of facility-based risk managers and facility-based risk champions – the existing personnel/staff of each department. Embedded unit risk champions become the "boots on the ground" as well as the "eyes and ears" for the facility risk manager and the steering committee. A risk-aware culture can also help nurture a pool of potential future risk managers from existing facility staff.

Program creation process

The process of creating such an awareness culture initially should come from leaders at the highest level who incorporate the program into clearly defined annual goals. The risk champion steering committee should define the charter for the risk champion program. The charter should include the mission of the program, as well as the roles of the steering committee, facility-based risk managers and unit-based risk champion staff.

The steering committee oversees the strategy, tactics and logistics of creating and maintaining a risk management culture, proposes risk initiatives to implement, and monitors a metric tool for program assessment. Additionally, the steering committee creates a common language for managing loss and reducing risk.

Once the charter and general strategy of the implementation phase is well-defined, the steering committee members communicate this information to the respective facility risk managers. By doing so, the culture of system-wide risk awareness and management is communicated from the top down.

The goal for risk managers of each facility within a large healthcare system is to create a network of risk champions from the existing staff in every unit/department, including the emergency department, operating room, medical and surgical units, pharmacy, respiratory, etc. Risk managers would advocate for risk initiatives, communicate and educate champions, and encourage risk issues to be communicated from the specific units/departments.

Risk champion staff members can be volunteers or nominees within each unit/department who are interested in taking on the role of a risk management/loss control advocate. They are not experts in the field of risk management, but should be influential and respected staff members within the departments they represent. They should possess teamwork skills, effective communication skills, be allotted time to devote to the function and the ability to take actions to implement solutions. A good champion is a communication channel between the department staff, the facility risk manager and the steering committee.

Risk champions in action

One large healthcare system embraced the risk champion program by defining and ratifying their charter. Once strategy and logistics were defined in concept, the program was implemented in a pilot study with identified risk managers who, in turn, created a network of risk champions. The risk managers met with the group of champions for initial training, and maintained the program to create a system-wide culture of risk awareness. For this healthcare system, that meant the unit/department risk champions recognized unsafe or risky practices and took steps with the facility risk manager to reduce the risk/potential loss.

An example of risk awareness in the new program involved the dispensing of medications via the Pyxis system. A risk champion observed that two similar medication bottles were stored in sections right next to each other by brand names, potentially leading to a mix-up and medication error. The risk champion worked with pharmacy staff to rearrange bottles by their generic names. Thus, the similar looking bottles were no longer kept next to each other, reducing the possibility of medication errors.

Other areas of potential risk and loss, as defined by the Centers for Medicare & Medicaid Services, sparked initiatives for this healthcare system. Some of these included prevention of pressure ulcers, nosocomial infections, medication errors and falls.

The success for the program was assessed using a survey tool, the number of event reports generated monthly, and a decrease in the number of complaints or claims generated monthly. A pre- and post-risk champion initiative questionnaire measured the change in the general staff's awareness of risk and how they could be a part of minimizing loss. By proactively addressing risk issues and taking loss prevention measures before an event occurred, the facility hoped to increase quality of care through the participation of engaged risk champions.

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Upcoming events

Connect with Sedgwick's professional liability and healthcare risk management team at these upcoming conferences:

- **Crittenden Medical Insurance Conference**
  April 2-4 | Miami, FL
- **Becker's Hospital Review 8th Annual Meeting**
  April 17-20 | Chicago, IL
  – *visit the Sedgwick booth*
- **Risk & Insurance Management Society (RIMS)**
  April 23-26 | Philadelphia, PA
  – *visit Sedgwick at booth #2127*
- **Northern New England Society for Healthcare Risk Management (NNESHRM) Regional Healthcare Conference**
  April 30 - May 3 | Mystic, CT
  – *visit the Sedgwick booth*
- **Southern California Association for Healthcare Risk Management (SCAHRM) Annual Educational Conference**
  May 3-5 | Rancho Mirage, CA
  – *visit the Sedgwick booth*
- **Society for Health Care Risk Management of NJ (SHCRM-NJ) Annual Spring Meeting**
  May 5 | Princeton, NJ
  – *visit the Sedgwick booth*
- **National Patient Safety Foundation (NPSF) Annual Patient Safety Congress**
  May 17-19 | Orlando, FL
  – *visit the Sedgwick booth*
- **Association for Healthcare Risk Management of New York (AHRMNY) Annual Meeting**
  June 9 | New York, NY

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