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Impact of Malpractice Claims Outcome Analysis on Patient Safety

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Abstract

Background: Medical error data can be found in medical malpractice claim files, which is a valuable resource. A deeper comprehension of the allegations could therefore provide light on their root causes and aid in their prevention.

Aim of Study: The overarching objective of this study is to determine the underlying causes of events which is crucial to preventing their occurrence in the future and to develop a model to be used to improve patient safety and decrease medical errors.

Material and Methods: A retrospective review study will be conducted by reviewing files of closed malpractice claims which had been received and investigated by the medical liability committee in the years 2017 to 2022. The extracted data included: Claim/complaint statement, involved Healthcare staff/ specialty, cases' outcomes, and litigations' outcomes (medical liability committee decision report). Inclusion criteria: All closed malpractice claims cases (total population) which had been received and investigated by the medical liability committee in the years 2017 to 2022. Exclusion criteria: All open malpractice claims cases that were not yet investigated by the medical liability committee in the years 2017 to 2022. Collected data will be analyzed using IBM software SPSS statistics to calculate frequency and percentage of claims' categories.

Results: The study included 94 medical malpractice claims. Surgical error was the most frequent (38.6%), followed by diagnosis error (18.5%) and policy and procedure error (16.4%). The severity level of medical errors exhibits specific characteristics. Moderate severity level was the most frequent (55.32%), followed by major severity level (18.09%) and catastrophic severity level (17.02%). We found that there were more male defendants (84) than female defendants (47). Regarding the characteristics of the defendant, obstetrics and gynecology were the most frequent (19), followed by the nursing department (13) and general surgery department (12). Consultants were the most frequent (36.6%), followed by specialists (35.2%) and registered nurses (9%). Nonparametric correlations between the medical error category and healthcare provider sex showed a direct, very weak correlation coefficient (.084).

Conclusion: The study highlights the importance of patient education and equitable policies in preventing malpractice in healthcare. It emphasizes the need for healthcare professionals to prioritize patients' needs, follow the law, and treat them with compassion. A comprehensive professional liability insurance policy is crucial in today's litigious environment. The findings provide a framework for strategies to reduce medico-legal cases and raise public and healthcare worker knowledge of medical mistakes.

Recommendations: A 4-pillar model for preventing medical errors needs to be used which includes the following Pillar 1 of the healthcare safety strategy outlines the establishment of laws, regulations, policies, and standards to ensure safe patient treatment and protect medical personnel. A national patient safety agency should oversee safety measures and provide direction on resource distribution and action plan execution. A strategic plan with safety objectives should be established, and an organizational patient safety committee should adapt to national priorities. A patient safety culture survey should be conducted, and data-driven action plans should be implemented. An independent organization should be appointed to receive, analyze, synthesize, and publicly report healthcare safety information. Pillar 2 recommends enhancing resilience through robust human factors and ergonomics perspectives, implementing national initiatives for occupational safety and health, providing mental health and social support services, vaccinating healthcare professionals, maintaining personal protective equipment, and implementing safeguards against harassment, bullying, and discrimination. Proactive assessment of care settings for hazards and risks is recommended. Pillar 3 suggests establishing a consultative group for patient and family involvement, involving senior executives in an organization-wide patient engagement strategy. Patients should voice safety concerns, and an online portal should be provided for easy access to medical information. Pillar 4 outlines procedures for assessing and learning from near-misses and safety incidents, including event review procedures and anonymous reporting platforms.

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Key Words: Medical malpractice – Doctor- Patients Relationship – Communication – Complications – Preventive Measures – Retrospective Study – Healthcare – Negligence.

Introduction

THE importance of patient safety was recognized in the 19th century, and as a result, decision-makers around the world have prioritized patient safety in the first place. Earlier the duties and responsibilities of the medical and dental professionals were regarded as noble and benevolent. However, with the surge in medical malpractice and negligence, this profession is now viewed with suspicion and contempt. The standard of patient treatment has deteriorated as a result of monetary gains, and patients are becoming more conscious of their rights **[1].**

Medical malpractice is a term used to describe a medical act committed by a primary care physician/specialist that diverges from the rules and regulations specified as treatment protocols and results in a patient's medical injury. As a result, there are iatrogenic conditions that can occur in any medical specialty. Malpractice is considered the second most significant concern to patient safety in healthcare sectors in terms of overall quality **[1].**

Malpractice represents the intersection of medicine and law and can be categorized into two forms: tort or personal injury law which requires proof that the defendant owed a duty of care to the plaintiff and that the defendant breached this duty by failing to adhere to the expected standard of care, and that the breach of duty caused an injury to the plaintiff and criminal law which is rare and requires egregious actions that violate a country's criminal code **[2].** Medical malpractice claims represent a valuable source of information on medical errors **[3].**

Strategies to lower the risk of medical malpractice claims against hospitalists include empathetic communication with patients, standardized handoffs or discharge summaries, direct and close communication with outpatient physicians, and timely referral and consultation **[4].**

A review of the literature of medical malpractice cases and its impact on patient safety was conducted. Several literature search engines were reviewed including google scholar using different key words including "Analysis" "Medical Errors", "Medical Malpractice", "Claims", "Patient safety", "Impact".

Medical malpractice cases showed opportunities to improve safe medical care; A preliminary literature review showed that past studies are primarily focused on analysis of medical malpractice cases. What was missing from the past studies is a comprehensive and structured approach on using medical malpractice cases as a valuable source to improve patient care and consequently patient safety.

Material and Methods

Literature review:

Since Hippocrates first used the adage "first, do no harm," the idea that patients could suffer injury while undergoing medical treatment has been widely accepted. The word "iatrogenesis," which is still used to describe patient injury brought on by the medical system, comes from the Greek meaning "originating from a physician **[5].**

Medical malpractice is a global public health issue involving the wrong choice or improper execution of a medical practitioner's recommended course of action during patient treatment or diagnosis. This compromises patient safety, posing a serious danger of illness, incapacity, damage, or death **[6].**

Several preventative steps are recommended to shield physicians against malpractice lawsuits. These include adopting new perspectives, expressing regret for medical mistakes, and abstaining from holding other healthcare professionals accountable for unfavourable results. Respecting clinical recommendations is essential to raising the standard of treatment and lowering patient variability. To comprehend the patient's experience and respond to inquiries on the duty of care, documentation is crucial. By fostering a good rapport with patients, empathy can reduce the likelihood that they will sue a doctor. Adherence to hospital policies is crucial in order to prevent difficulties and guarantee adherence to laws **[7].**

The following was recommended to keep yourself out of a negligence lawsuit: Place the patient's care first, Work within your area of expertise and ask for help when necessary, Continually review specialization and clinical practice guidelines, Converse with your patient and coworkers: Unfavourable Communication style raises the possibility of legal action, Clearly record everything, including patient refusals, Identify and control the patient's expectations, and make sure the consent procedure puts the patient first, Respond to concerns promptly, offering an apology where appropriate, Take care of yourself and your coworkers; Identify any medical or psychological problems and, if required, seek help **[8].**

Medical negligence can lead to psychological and physical side effects for employees, causing a vicious cycle if not addressed. Hospital administration should regularly investigate personnel handling cases, especially young, non-medical staff, to ensure safety and well-being **[9].**

Building a robust healthcare system that can certify, oversee, and assess the medical services offered is crucial. In order to maintain safe procedures, it is also crucial that doctors get ongoing training and on-the-job coaching. Additionally, it is crucial to

implement and uphold legislative prohibitions and regulatory controls, as well as to educate the public on consumer rights and acceptable therapeutic practices **[10]**.

Results

The study included 94 medical malpractice claims which had been received and investigated by the medical liability committee in the years 2017 to 2022.

Table (1): Shows the characteristics of medical error categories. Surgical error was the most frequent (38.6%), followed by diagnosis error (18.5%) and policy and procedure error (16.4%).

Medical error categories	Frequency	Percent	Cumulative Percent
Surgical Error	73	38.6	38.6
Diagnosis error	35	18.5	57.1
Medication Error	16	8.5	65.6
Policy/Procedure Error	31	16.4	82.0
Documentation Error	18	9.5	91.5
Equipment error	3	1.6	93.1
Staffing error	12	6.3	99.5
Physiotherapy related error	1	.5	100.0

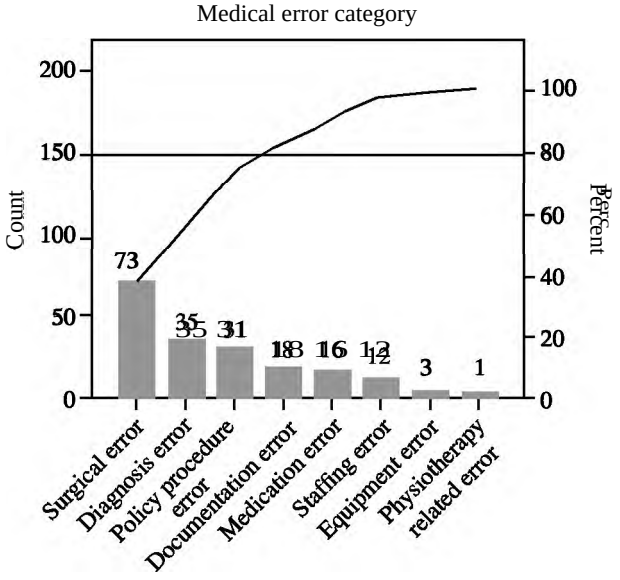

Fig. (1): Pareto chart shows the characteristics of medical error categories. Surgical error was the most frequent (73), followed by diagnosis error (35) and policy and procedure error (31).

Regarding the frequency of surgical error categories. Improper performance of surgery/procedure was the most frequent (28), followed by Surgical/ Procedural complications (9), Failure to deal with complications resulting from surgery/procedure (9) and delay in surgery/procedure (8).

Regarding the frequency of diagnosis error categories. Missed diagnosis was the most frequent (15), followed by delay in diagnosis (11), Error in diagnosis (4) and Failure to employ indicated tests/ examination (4).

Regarding thefrequency of policy/procedure error. Noncompliance with patient and family education policywas the most frequent (8), followed by noncompliance with consultation policy (4).

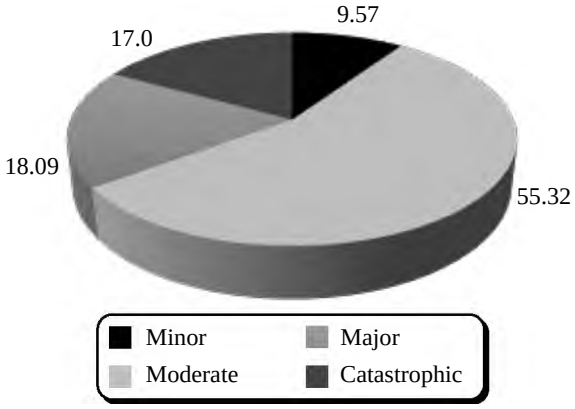

Fig. (2): Pie chart Shows the characteristics of medical error severity level. Moderate severity level was the most frequent (55.32%), followed by major severity level (18.09%) and catastrophic severity level (17.02%).

Table (2): Shows the characteristics of the defendant healthcare provider, male was found to be more frequent defendants (84) than female (47).

Characteristics of the defendant healthcare providers sex	Frequency	Percent	Cumulative Percent
1 Male	84	64.12	64.12
2 Female	47	35.88	100.0

Regarding the characteristics of the defendant (Specialty-Dept). Obstetrics and gynaecology was the most frequent (19), followed by nursing department (13) and general surgery department (12).

Regarding the characteristics of defendants (Qualification-Position-Entity), Consultant was the most frequent (36.6%), followed by specialist (35.2%) and registered nurse (9%).

Medical Error Category and Healthcare Provider Sex, there is direct very weak correlation coefficient (.084).

Medical Error Category and Defendants (Specialty-Dept), there is inverse very weak correlation coefficient (-.029).

Medical Error Category and Defendants (Qualification-Position-Entity) there is inverse very weak correlation coefficient (-.100).

Table (3): Shows nonparametric correlations between Medical Error Category and Healthcare Provider Sex, Defendants (Specialty-Dept), Defendants (Qualification-Position-Entity).

	Medical Error Category	Healthcare Provider Sex	Defendants (Specialty-Dept)	Defendants (Qualification-Position-Entity)
Spearman's rho:				
Medical Error Category:				
Correlation Coefficient	1.000	.084	-.029	-.100
Sig. (2-tailed)	.	.343	.733	.233
N	189	131	145	145
Healthcare Provider Sex:				
Correlation Coefficient:	.084	1.000	-.073	.192*
Sig. (2-tailed)	.343	.	.410	.028
N	131	131	131	131
Defendants (Specialty-Dept):				
Correlation Coefficient	-.029	-.073	1.000	.072
Sig. (2-tailed)	.733	.410	.	.388
N	145	131	145	145
Defendants (Qualification-Position-Entity):				
Correlation Coefficient	-.100	.192*	.072	1.000
Sig. (2-tailed)	.233	.028	.388	.
N	145	131	145	145

*. Correlation is significant at the 0.05 level (2-tailed).

Discussion

It is expected of healthcare professionals to provide their patients high-quality treatment and to advocate for it. But practitioners are human and may make errors. Errors may vary in severity from negligible to catastrophic for a patient's health and welfare. Errors may result in suffering, harm, or even death. Risks must be recognized and evaluated, as well as the processes for managing them. Health care professionals with a poor or terrible malpractice liability record may put patients' safety at risk **[1].**

Regarding the characteristics of defendant Specialty/Department in this study, Obstetrics and gynaecology was the most frequent (10.1%), followed by nursing department (6.9%) and general surgery department (6.3%). the primary clinical disciplines involved in the malpractice instances found were paediatrics, surgery, and obstetrics and gynaecology **[2].**

Internal medicine, surgery, orthopaedics, and obstetrics and gynaecology were the specialties most frequently involved in litigation **[3].**

General surgery, emergency medicine, orthopaedics and traumatology, and obstetrics and gynaecology were the disciplines most engaged. The inclusion of emergency medicine on this list can be attributed to the underutilization of primary health care services in our nation and the abuse of these services **[11].**

The most likely profession to be mentioned in a malpractice lawsuit is surgery. A surgeon facing legal action may anticipate experiencing uncertainty, nervousness, and insomnia **[12].**

According to this study, there were more medical malpractice lawsuits made against male physicians (64.2%) than against female physicians (35.88%). Male physicians are more likely to practice in specialties that are subject to lawsuits, such as surgery, obstetrics, and gynaecology, therefore this might be explained by the disparities in specialty distribution between male and female physicians. There is also significant difference in liability risk based on gender. During their careers, 24 percent of female physicians have faced lawsuits, whereas 36.8 percent of their male colleagues have experienced the same. Women are less likely to be sued for a variety of reasons. They often work in less hazardous specialty and see patients for shorter periods of time, which lowers the short-term danger **[6].**

In this study consultant was the most frequent (36.6%), followed by specialist (35.2%) and registered nurse (9%). This may be explained by the fact that consultants and specialists are more likely to be sued for malpractice since they deal with more difficult patients and significant procedures.

In this study the characteristics of medical error categories. Surgical error was the most frequent (38.6%), followed by diagnosis error (18.5%) and policy and procedure error (16.4%). Medical mal-

practice cases were most frequently caused by diagnostic mistakes *[11]*. Errors can arise from misdiagnosis, delayed diagnosis, or inaccurate diagnosis. This frequently has to do with not developing a thorough differential diagnosis, not pursuing a differential diagnosis, not ordering the necessary diagnostic tests, not dealing with an aberrant test result, and not considering all the facts at hand. Premature hospital release and neglect to consult lead to further unfavourable outcomes *[13]*. Diagnostic mistakes were more likely than other types of errors to cause significant patient injury or death *[14]*.

In the present study we found the characteristics of medical error severity level. Moderate severity level was the most frequent (55.32%), followed by major severity level (18.09%) and catastrophic severity level (17.02%). The analysis of medical malpractice claims revealed that the most common medical error severity level was medium (52%), followed by high severity (34%), and low severity (13%) *[15]*.

In present study correlations between medical error category and healthcare provider sex was direct very weak correlation coefficient. Correlation between complication and provider sex was weak correlation *[11]*.

Conclusion:

The study highlights the importance of patient education and equitable policies in preventing malpractice in healthcare. It emphasizes the need for healthcare professionals to prioritize patients' needs, follow the law, and treat them with compassion. A comprehensive professional liability insurance policy is crucial in today's litigious environment. The findings provide a framework for strategies to reduce medico-legal cases and raise public and healthcare worker knowledge of medical mistakes.

Recommendation:

We advise using the following 4-pillar model to establish a comprehensive strategy for preventing medical errors:

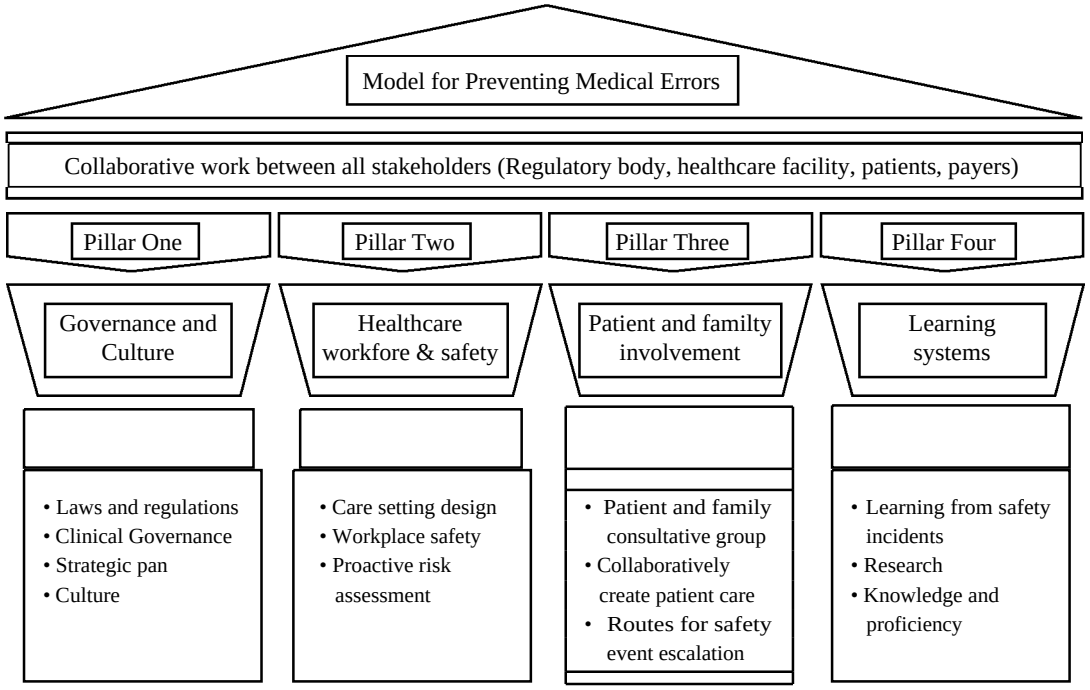

Fig. (3): Model for preventing medical errors.

For Pillar1, The regulatory body should establish laws, regulations, policies, and standards to ensure safe treatment for patients and protect medical personnel from punishment. A national patient safety agency should oversee patient safety measures and provide direction on resource distribution and action plan execution. A regulation should reward healthcare providers for meeting quality indicators or efficacy parameters. A strategic plan with safety objectives should be established, and an organizational patient safety committee should be established to adapt to national priorities. A strong clinical governance framework should be established to involve front-line medical staff in patient safety policies and initiatives. The regulatory body and healthcare organizations should promote openness and justice through policies and a reporting mechanism. A patient safety culture survey should be conducted, and data-driven action plans should be implemented. An independent organization should be appointed to receive, analyze, synthesize, and publicly report healthcare safety information. Clear boundaries between medical errors and negligence should be established, and open, respectful, rights-based organizational cultures should be created.

For Pillar 2, The healthcare workforce and safety recommendations include enhancing resilience through robust human factors and ergonomics perspectives, implementing national initiatives for occupational safety and health, providing mental health and social support services, vaccinating healthcare professionals, maintaining personal protective equipment, and implementing safeguards against harassment, bullying, and discrimination. Additionally, proactive assessment of care settings for hazards and risks to patient and healthcare worker safety is recommended.

For Pillar 3, The healthcare facility should establish a consultative group for patient and family involvement, involving senior executives in an organization-wide patient engagement strategy. The group should use checklists, shared decision-making tools, and "What matters to you?" inquiries to educate physicians about patient inclusion in treatment. Patients should voice safety concerns, and an online portal should be provided for easy access to medical information and visit notes. A fast response team should be established to escalate treatment concerns, and the organization should regularly examine safety issues and take appropriate action.

For Pillar 4, Healthcare facilities should establish procedures for assessing and learning from near-misses and safety incidents, including event review procedures and anonymous reporting platforms. Regular communication keeps employees informed about workplace safety risks and initiatives. The organization should actively share data and best practices, incorporating this knowledge into ongoing learning courses for healthcare professionals. Research should align with national standards, clinical practice guidelines, and protocols based on incidents and performance indicators. The regulatory body should develop a patient safety curriculum for all jobs, include it in continuing professional development, and incorporate it into interprofessional learning programs. Regular assessments and action plans for leaders, physicians, and staff are part of the organization's human resources strategy.

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تأثير تحليل نتائج دعاوى الإهمال الطبى على سلامة المرضى

الخلفية: يمكن العثور على بيانات الأخطاء الطبية فى ملفات المطالبات بالإهمال الطبى، وهو مورد قيم. وبالتالى فإن الفهم العميق للادعاءات يمكن أن يسلط الضوء على أسبابها الجذرية ويساعد فى منعها.

الأهداف: الهدف الشامل لهذه الدراسة هو تحديد الأسباب الكامنة وراء الأحداث التى تعد أمرًا بالغ الأهمية لمنع حدوثها فى المستقبل وتطوير نموذج يمكن استخدامه لتحسين سلامة المرضى وتقليل الأخطاء الطبية.

الطرق: سيتم إجراء دراسة مراجعة بأثر رجعى من خلال مراجعة ملفات المطالبات بالإهمال الطبى المغلقة التي تلقتها لجنة المسؤولية الطبية وحققت فيها في الأعوام من ٢٠١٧ إلى ٢٠٢٢. وتضمنت البيانات المستخرجة: بيان المطالبة/الشكوى، وموظفى الرعاية الصحية/التخصص المعنيين، ونتائج القضايا، ونتائج التقاضى (تقرير قرار لجنة المسؤولية الطبية). معايير الإدراج: جميع قضايا المطالبات بالإهمال الطبى المغلقة التي تلقتها وحققت فيها لجنة المسؤولية الطبية في الأعوام من ٢٠١٧ إلى ٢٠٢٢. معايير الاستبعاد: جميع قضايا المطالبات بالإهمال الطبي المفتوحة التى لم تحقق فيها لجنة المسؤولية الطبية بعد في الأعوام من ٢٠١٧ إلى ٢٠٢٢. سيتم تحليل البيانات المجمعة باستخدام إحصاءات برنامج IBM SPSS لحساب التردد ونسبة فئات المطالبات.

النتائج: شملت الدراسة ٩٤ مطالبة بالإهمال الطبى. كان الخطأ الجراحى هو الأكثر شيوعًا (٣٨,٦٪)، يليه خطأ التشخيص (١٨,٥٪) وخطأ السياسة والإجراءات (١٦,٤٪). يُظهر مستوى شدة الأخطاء الطبية خصائص محددة. كان مستوى الشدة المتوسطة هو الأكثر شيوعًا (٥٥,٣٢٪)، يليه مستوى الشدة الكبرى (١٨,٠٩٪) ومستوى الشدة الكارثية (١٧,٠٢٪). وجدنا أن عدد المدعى عليهم الذكور (٨٤) أكبر من عدد المدعى عليهم الإناث (٤٧). فيما يتعلق بخصائص المدعى عليه، كانت أمراض النساء والتوليد هى الأكثر شيوعًا (١٩)، تليها قسم التمريض (١٣) وقسم الجراحة العامة (١٢). وكان الاستشاريون هم الأكثر شيوعًا (٣٦,٦٪)، يليهم المتخصصون (٣٥,٢٪) والممرضات المسجلات (٩٪). أظهرت الارتباطات غير المعيارية بين فئة الخطأ الطبى وجنس مقدم الرعاية الصحية معامل ارتباط مباشر ضعيف جدًا (٠,٠٨٤).

الخلاصة: تسلط الدراسة الضوء على أهمية تثقيف المرضى والسياسات العادلة فى منع الإهمال الطبى فى الرعاية الصحية. وتؤكد على الحاجة إلى أن يعطى المهنيون الصحيون الأولوية لاحتياجات المرضى، واتباع القانون، ومعاملتهم بعطف. تعد سياسة التأمين الشاملة للمسؤولية المهنية أمرًا بالغ الأهمية فى بيئة التقاضى اليوم. توفر النتائج إطارًا للاستراتيجيات الرامية إلى تقليل القضايا الطبية القانونية وزيادة معرفة الجمهور والعاملين فى مجال الرعاية الصحية بالأخطاء الطبية.

التوصيات: يجب استخدام نموذج من أربعة ركائز لمنع الأخطاء الطبية، والذي يتضمن الركيزة الأولى من استراتيجية سلامة الرعاية الصحية التي تحدد وضع القوانين واللوائح والسياسات والمعايير لضمان علاج المرضى بشكل آمن وحماية العاملين في المجال الطبي. يجب أن تشرف وكالة وطنية لسلامة المرضى على تدابير السلامة وتوفر التوجيه بشأن توزيع الموارد وتنفيذ خطة العمل. يجب وضع خطة استراتيجية بأهداف السلامة، ويجب أن تتكيف لجنة سلامة المرضى التنظيمية مع الأولويات الوطنية. يجب إجراء مسح لثقافة سلامة المرضى، ويجب تنفيذ خطط عمل قائمة على البيانات. يجب تعيين منظمة مستقلة لتلقى وتحليل وتلخيص والإبلاغ علنًا عن معلومات سلامة الرعاية الصحية. توصى الركيزة الثانية بتعزيز المرونة من خلال العوامل البشرية القوية ومنظورات بيئة العمل، وتنفيذ المبادرات الوطنية للسلامة والصحة المهنية، وتوفير خدمات الصحة العقلية والدعم الاجتماعى، وتطعيم المهنيين فى مجال الرعاية الصحية، والحفاظ على معدات الحماية الشخصية، وتنفيذ الضمانات ضد التنمر والتمييز. يوصى بالتقييم الاستباقى لأماكن الرعاية بحثًا عن المخاطر. يقترح الركيزة الثالثة إنشاء مجموعة استشارية لإشراك المرضى وعائلاتهم، وإشراك كبار المسؤولين التنفيذيين في استراتيجية إشراك المرضى على مستوى المنظمة. ويجب على المرضى التعبير عن مخاوفهم بشأن السلامة، ويجب توفير بوابة إلكترونية لسهولة الوصول إلى المعلومات الطبية. وتحدد الركيزة الرابعة الإجراءات اللازمة لتقييم الحوادث التى كادت تقع وحوادث السلامة والتعلم منها، بما فى ذلك إجراءات مراجعة الأحداث ومنصات الإبلاغ المجهولة.