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Introduction - Fact Patterns from Anonymous Closed Medical Liability Cases

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FACT PATTERNS FROM ANONYMOUS CLOSED MEDICAL LIABILITY CASES MADE AVAILABLE BY NEW YORK LAW SCHOOL'S (NYLS'S) PATIENT SAFETY PROJECT (PSP)

Each of the anonymous fact patterns obtained from closed medical liability cases are made available to healthcare providers, medical liability insurance companies and healthcare risk managers intended to be used as teaching tools to promote safer health care. It has been noted that "medical errors ... will not be found without diligent conversations with those who provide care."[1] Therefore, ideally each of these fact patterns can promote "conversations" about how under similar circumstances technical factors, organizational issues and human factors that lead to avoidable potential adverse patient outcomes can be anticipated.

It has been noted that:

> "one can think of a medical injury as being the result of a chain of events and factors leading to the injury ... the injury prevention model [therefore] looks for the weakest link in the chain of causation, recognizing that breaking any link in the chain may prevent the injury ...."[2]

By the use of "diligent conversations" about these fact patterns, not per se about legal culpability but rather about potential injury and error prevention it is intended that such discussions can become a part of safety processes that anticipate and reduce the incidence of avoidable patient injury.

The safety focus should, of course, be on the preventability of the patient's injury. Because each anonymous liability case is now closed, issues of legal culpability no longer remain. The intrinsic motivation of health care providers, shaped by their professional ethics, norms and expectations can and should be a motivating force energizing conversations to improve safety. Awareness that reducing the incidence of similar medical patient

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[1] R. McNutt, R. Abrams and D. Aron. Patient Safety Should Focus on Medical Errors; JAMA 2002, Vol. 287, No. 15, pp. 1997-2001.

[2] P. Layde, et al. Patient Safety Efforts Should Focus On Medical Injuries. JAMA 2002, Vol. 287, No. 15, pp. 1993-1997.

energizing the efforts of healthcare leaders and grassroot practitioners.

Therefore, it is suggested that there be a conversation about how breaking links in each chain of events might be applied to similar circumstances that practitioners can anticipate they will be confronted with. The conversations can include an analysis of technical factors, organizational causes, and human factors that can lead to patient injury.

Dr. Merkatz has been part of a patient safety initiative in which risk managers and liability insurance experts at four major institutions shared their safety knowledge.[3] The sharing of knowledge and safety initiatives included feedback that produced sustainable decreases in adverse outcomes.

Acceptance and use of any part of the data from the NYLS PSP creates no obligation on the part of any stakeholder. However, the NYLS Project would gratefully accept any feedback that might when shared with others on an anonymous basis have a positive potential to improve safety.

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[3] D. Goffman, M. Brennan, A.J. Friedman, H. Minkoff, I.R. Merkatz, Improved Obstetric Safety Through Programmatic Collaboration. Journal of Healthcare Risk Management, 2014. Vol. 33, No. 3, pp. 14-22.