

Solving for Communication Failures in Medical Malpractice Claims

Leveraging Structured Handoff Tools to Improve Patient Safety and Reduce the Financial Burden of Medical Malpractice Claims on Healthcare Systems

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Executive Summary

Poor communication in healthcare settings leads to serious consequences for clinicians and their patients. Research conducted over the past two decades demonstrates that communication failures are a leading driver of patient safety failures and malpractice claims. These incidents can result in patient injury and death, which in turn negatively impacts both providers involved in these incidents and the overall healthcare system.

While specific clinical and thematic areas in healthcare (such as surgery, diagnosis, obstetrics, and medication administration) face unique safety and malpractice risks, miscommunication is an issue that drives safety failures and malpractice claims across specialties, disciplines, and care settings. Viewed industry-wide, miscommunication is the number one root cause of sentinel events and malpractice claims across care areas, playing a key role in

30% to 70% of all events and claims.¹ Miscommunication is often the core issue that underlies surgical errors, medication errors, and diagnostic failures. Yet, while strategies have emerged to successfully address these communication failures, their uptake nationally has been quite limited. The failure to effectively address this critical vulnerability may be a key reason that the patient safety movement has had only a modest impact after two decades of effort.

Research conducted over the past two decades demonstrates that **communication failures are a leading driver of patient safety failures and malpractices claims.**

An intentional approach is critical in identifying which miscommunications lead to safety failures, and to understand how we can reduce these failures. As informed participants in the healthcare industry, we all are responsible for finding the root causes of sentinel

events and investing in solutions and resources that elevate the national standard of care. It's time to bridge the gap from research results to systemic safety using structured communication tools.

Acknowledging the Current State of Patient Safety and Medical Malpractice

PATIENT SAFETY TRENDS

When the Institute of Medicine (IOM; now the National Academy of Medicine) released its groundbreaking report, *To Err is Human: Building a Safer Health System*, in 1999, media coverage focused largely on the report's declaration that errors cause a high number of patient deaths and injuries in hospitals, which in turn generated significant public concern.² Beyond the noise of the media frenzy, healthcare leaders appropriately focused on the primary intent of the report: to address the overall quality of care by improving patient safety. Yet, while that initial IOM report, and others produced behind it, have garnered tremendous attention, progress in achieving important patient safety goals continues to evade the industry. Today, more than two decades since the initial report's publication, healthcare remains far behind other high-risk industries in standardizing safety measures, or in bringing about reductions in harm.³

There has been progress in reaching safety goals with the implementation of key initiatives, such as the use of infection control bundles to reduce catheter related bloodstream infections and other hospital acquired infections; the surgical safety checklist; computerized medication ordering; and obstetric team training, but these initiatives have largely been focused in higher-risk areas such as intensive care units, operating rooms, and labor and delivery units.^{4,5,6} While these care areas are critical, they are vertical silos; routine care delivery in inpatient and ambulatory settings has received far less attention. Furthermore, as patients move between each of these silos, few resources have been devoted to addressing the well-known vulnerabilities often surfacing in care transitions. Unfortunately, these

hidden dangers often go unnoticed, only to be brought to light after a patient has already been harmed.

Using a retrospective lens on sentinel events and malpractice cases, we are often able to pinpoint the origin of persistent patient safety harms that can guide us to solutions. Malpractice insurance companies and captives have been doing these types of analyses for years, as have progressive, data-savvy hospitals. But other groups are also looking closely at the data. To that point, a recent analysis performed by The Joint Commission identified communication breakdowns as the leading cause of sentinel events.⁷

Systemic change requires systemic efforts. While the efforts of patient safety champions within particular specialties or institutions are laudable, fundamental change will only occur when evidence-based standards are broadly implemented at a national level. The healthcare industry must act as one to create a standard for more consistent care delivery that sustainably improves patient safety.

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MEDICAL MALPRACTICE TRENDS

Adverse events that cause patient harm or death often result in the filing of a medical liability claim, primarily to compensate for damages incurred but sometimes fueled by the desire to just hold someone accountable. Medical liability has long-lasting effects on all parties

involved and contributes to associated cost burdens on the healthcare system.⁸ A number of recent trends indicate that medical malpractice claims are growing in frequency and severity. The following are a few examples.

Increased Claims About one in three physicians has had a medical liability claim filed against them.⁸ More claims have also been linked to social media—a key factor in the prevalence of batch claims as social platforms make it easier to find others with a similar experience.⁹

More Megaverdicts Medical professional liability (MPL) organizations are experiencing a steady rise in claims severity and outsized medical malpractice verdicts, or “megaverdicts.”¹⁰ High-severity injury cases that involve human factors like communication failures become much harder to defend and drive up payout amounts.

Increased Payouts The number of awards of more than \$1 million has gradually increased over time.¹⁰ One analysis found that the average cost of a medical malpractice claim rose by 50% since 2009. Additionally, payouts of more than \$5 million increased sharply since 2015, and verdict severity rose by 50% between 2016 and 2019 to an average of \$23 million.¹¹

Rising Premium Rates Medical malpractice insurance premiums continue to rise across the nation. In 2019, more than 25% of MPL insurance premium rates increased; the first time the industry experienced an increase since 2006.¹¹ In the past three years, the proportion of premiums that increased year over year reached highs not seen since the 2000s.¹²

Industry Shifts The medical malpractice insurance market has been impacted by industry changes—including the growing presence of private equity, consolidation of physician groups, and hospital employment of physicians—that are shrinking the premium base.¹¹

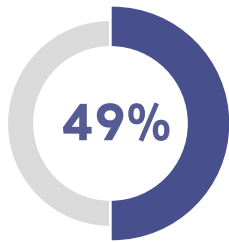
It’s critical for healthcare organizations to innovate and implement effective solutions to slow or reverse these trends. Healthcare organizations, including MPL insurers, are more likely to maintain long-term success if they invest in tools that help avoid risk and reduce cost.¹¹ While the landmark 1999 IOM report sought to serve as a catalyst for change, the current state of patient safety and medical malpractice makes it clear that there is still a long way to go.

Understanding the Impact of Communication Failures on Malpractice Claims

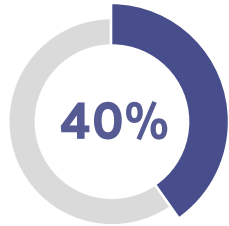
Historically, the field of healthcare risk management has been more reactive than proactive. Over the past two decades, however, many MPL insurers have sought to go beyond a reactive model, addressing patient safety risks before they manifest as claims. In order for MPL insurers, hospitals, clinicians, and payers to succeed in driving rates of safety incidents and claims downward, it’s important for all participants to have access to the same information.

Until recently, the impact of miscommunication on the epidemic of medical errors was poorly understood, particularly in malpractice claims datasets, as communication failures are often hidden beneath the surface. Because malpractice claims are primarily

analyzed in clinical silos, analyses of surgical and medical claims can overlook a common theme across all areas: communication errors. Recent analyses continue to show that miscommunication and handoff communication failures are a leading driver of claims across care areas, at all levels of severity. To many, this is not new intelligence. But now, there appears to be greater consensus that tackling communication lapses is the “next frontier” in the patient safety journey.



Communication failures were identified in 49% of malpractice claims.



A failed handoff was involved in 40% of communication failures.

To gain a deeper understanding of the role of miscommunication in malpractice claims, a retrospective review of malpractice claims over a 10-year period from 2001 to 2011 sought to determine the proportion of claims involving communication failure and describe their nature. The findings, published in the Journal of Patient Safety in 2021, revealed that communication failures were identified in 49% of malpractice claims.¹

Furthermore, the research showed that claims with communication failures were significantly less likely to be dropped, denied, or dismissed (54%) than claims without such failures (67%). In the claims reviewed, 53% involved provider–patient miscommunication and 47% involved provider–provider miscommunication.

The study found that the information types most frequently miscommunicated were contingency plans, diagnosis, and illness severity. Finally, the research highlighted the importance of effective communication during transitions of care: 40% of communication failures involved a failed handoff.

Since communication failures are a significant contributing cause of malpractice claims, they represent a substantial financial burden on the healthcare system. The Journal of Patient Safety study shows that communication-related malpractice claims are extremely expensive as they are difficult to defend and usually end quickly in a large settlement. Following are some of the financial impacts of communication failures on malpractice-related events.¹

The mean total costs for cases involving communication failures were significantly higher than for cases without communication failures (\$237,600 vs. \$154,100, P = 0.005).

The average settlement or court payout for a case involving a communication failure (i.e., one that was not dropped, denied, or dismissed) was \$643,100.

The cumulative total amount paid for all cases involving communication errors among the 500 cases studied was \$58 million vs. \$39.1 million for cases that did not involve communication errors.

COMMUNICATION ERRORS INVOLVED IN HANDOFF CARE

	Yes			No			P-value*	P-value (mean)
	N	Cumulative Total Costs \$, Millions	Total Costs Per case Mean (SD) \$, Thousands	N	Cumulative Total Costs \$, Millions	Total Costs Per case Mean (SD) \$, Thousand		
All Cases	97	33.85	348.9 (774.6)	140	22.48	160.6 (430.6)	0.004	0.002
Dropped/Denied/Dismissed	46	1.05	22.8 (31.9)	81	1.92	23.7 (58.5)	0.58	0.08
Settled/Court	51	32.80	643.1 (982.4)	59	20.56	348.5 (613.5)	0.01	0.01

Implementing Structured Communication for Systemic and Sustained Improvement

To advance patient safety and improve communication, it's critical to remove unnecessary variability, provide structure, and create consistency. There's a significant opportunity for healthcare institutions to create safer care environments with less process inconsistency.⁷ Healthcare organizations should adopt an approach to safety similar to that taken in high-risk, high-reliability industries like commercial aviation, nuclear safety, and automobile production, which have strict safety standards and little variation.¹³

Removing variability in how care teams communicate should be a primary focus for all stakeholders. Of course, communication is a broad topic that spans every vertical market in healthcare. So where to start? As recent research shows, handoffs are a particularly vulnerable time for communication failures that can lead to serious or fatal medical errors. As an industry, we should focus on introducing structured communication to critical transitions in care – from one care unit to another, from hospital to home, from ambulatory care facility to hospital, and so on.

Standardizing communication has become particularly urgent as the healthcare workforce has become more volatile since the onset of the COVID pandemic. Record numbers of clinicians – most notably physicians and nurses – are leaving the workforce and moving from one institution to another. This trend is expected to continue over the next few years. With nursing in particular, introducing structured processes is paramount. Traveling nurses know firsthand that care delivery processes differ across institutions, and that many of these processes directly involve the handoff of critical information related to patient care. While these variations cause an increased risk of patient harm, most institutions still have their own processes, or lack thereof, for handoff communication. If there are undefined ways of communicating within a health system, a visiting provider will not be familiar with the process, opening up myriad possibilities for critical information to be lost, thereby posing a serious risk to patients.

Leveraging Handoff Tools to Minimize Medical Malpractice Expenditures

The title of the 1999 IOM report was exactly right – “To Err is Human.” Errors happen. They will continue to happen. Whether they emanate from lack of skill or experience, or from overwork, momentary distraction, or just plain fatigue, the potential is always there. Therefore, it's important to arm clinicians with tools to help them avoid medical errors that could be detrimental to their careers, their patients, and the healthcare system as a whole, and to mitigate errors

wherever possible before they cause harm. The Journal of Patient Safety study suggests that interventions to improve transmission of critical patient information have the potential to substantially reduce malpractice expenditures. The research demonstrates how handoff tools can avert risk and its associated costs: of the 40% of cases with communication failures that included a handoff of care, 77% were likely preventable with a handoff tool.¹



49%

of medical malpractice cases include miscommunication



77%

of these cases are preventable with a handoff tool



27%

of all malpractice claim expenses could be reduced with structured communications like I-PASS

Handoff tools reduce care variability and have been shown to result in lower medical error rates and improved patient safety. Additionally, the presence of a structured handoff method allows clinicians to hand off information with a more complete, safeguarded approach and provides care teams with peace of mind after a busy shift. The best-studied tool to improve the reliability of care handoffs is I-PASS, a bundle of interventions built around the mnemonic I-PASS (Illness Severity; Patient Summary; Action List: Situational Awareness and Contingency Planning; and Synthesis by Receiver). In a series of studies (pilot studies funded

by CRICO; subsequent studies funded through federal grants), implementation of I-PASS was shown to improve the quality of handoffs and reduce the rates of harms due to handoff failures by roughly 30-50%.^{14,15,16}

Since 2016, the I-PASS Patient Safety Institute has been working to scale the I-PASS methodology for use across health systems. The I-PASS implementation team works directly with healthcare facilities to implement handoff training across the continuum while improving care team communication and culture in the process.

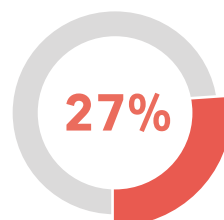
CASE STUDY: CARILION GILES COMMUNITY HOSPITAL

In the wake of training fatigue, there is often initial resistance to implement new tools or training at healthcare systems for fear of adding more to their clinical team's plates. Such was the case at one of the hospitals utilizing I-PASS for handoffs. In October 2021, Carilion Giles Community Hospital (CGCH) was experiencing the effects of poor handoff communication, averaging three communication-related adverse events per month, resulting in extended patient stays, increased adverse events, and increased patient complaints. Despite knowing they needed a solution, the CGCH frontline staff and their leaders were originally hesitant to embrace the I-PASS handoff bundle. But they quickly realized that the benefits of I-PASS far exceeded any upfront challenges. "There's such a fine balance between adding a meaningful tool for staff and not creating unnecessary work in the process," explained Jennifer Bailey, MHA, BSN, RN, Director of Quality and Patient Safety at CGCH. "But we were confident that implementing I-PASS would ultimately make life easier for the frontline nurses while ensuring that we maintain our patient safety and quality measures."

I-PASS helps create a shared mental model for clinicians, ensuring that the appropriate information will be shared and received. The nursing staff at CGCH appreciates that I-PASS provides a unified communication structure across the team.

"I-PASS helps ensure that we're all communicating the same information," explained Casey Asbury, RN. Ultimately, the ED and Med-Surg Nurses at CGCH reduced communication failure-related safety events by 68% since adopting the I-PASS handoff methodology.¹⁷

In addition to its benefits for patient safety and clinician experience, implementing I-PASS can help hospitals and health systems reduce costs. Research suggests that the financial ramifications of implementing handoff solutions could be profound: 27% of all malpractice claim expenses could potentially be averted with structured communications like I-PASS.¹ Malpractice claims cost the U.S. billions of dollars annually. If adopted widely and implemented well, I-PASS could avert a major proportion of these costs. For an MPL carrier trying to reduce the frequency of claims and prevent malpractice claim payouts – particularly megaverdicts, in which miscommunications play a disproportionately large role – I-PASS is an extremely powerful tool.



27% of all malpractice claim expenses could potentially be averted with structured communications like I-PASS.

Conclusions

Adverse events resulting from communication breakdowns among clinicians are common. Those that result in claims are often indefensible in court and end up costing the healthcare system enormous sums of money each year. As healthcare costs increase and margins tighten, health systems simply cannot afford miscommunication. Healthcare leaders in risk management, medical liability insurance, and clinical care must implement solutions that will help reduce malpractice claims on a large scale.

Because communication variability has historically been under-recognized as the cause of costly malpractice claims, most of the healthcare industry has yet to make a serious investment or commitment to standardizing communication. Targeting handoff communication is one of the most efficient ways to bend the claims curve, decrease the frequency of claims, and minimize rising claims payouts.

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IOM's To Err is Human set lofty short-term goals in the late 1990s. However, recent research emphasizes how little overall progress has been made. To achieve a truly safe environment for patients, it is essential that we effectively tackle overlooked root causes of harm. Miscommunication is the number one root cause of sentinel events and malpractice claims in the United States and has, to date, received far too little attention. I-PASS is a program for structured communication that creates a path forward to address the core problem of communication errors, and ultimately, to reduce sentinel events and malpractice claims.

AVOIDABLE MALPRACTICE CLAIM COSTS

Annual Malpractice Costs	\$10.0M
% of Malpractice Claims associated with a communication error	49%
% of communication errors that include a handoff error	40%
% of claims reduced through the use of tools such as I-PASS	77%
% of claims potentially avoidable	15%
Relative cost of a handoff related claims to all malpractice claims	179%
% of malpractice costs potential avoidable using a tool such as I-PASS	27%
Annual value of malpractice claims potentially avoided	2.7M



About I-PASS

The I-PASS Patient Safety Institute is a clinical leader in patient safety, enabling a standard of care for patient handoffs and closed-loop communication. Founded by clinicians in 2016, the I-PASS Institute leverages expert mentorship paired with technology and digital tools to scale the I-PASS methodology. The I-PASS Institute's solution, the I-PASS Bundle, consists of three core technical components: I-PASS Training, I-PASS Assessment and Improvement, and I-PASS eVIEW. When all three platforms are used in unison and with the guidance of an expert coach, institutions are able to reduce patient harm caused by miscommunication. The I-PASS Bundle is currently implemented at more than 100 institutions in areas ranging from pediatrics and residency programs to nursing and transitions of care with families.

