NATIONAL HEALTH POLICY FORUM

FORUM SESSION

When There's Harm in the Hospital: Can Transparency Replace "Deny and Defend"?

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There are no guarantees in life, and health care is no exception. Even in situations where knowledge, skill, and good will are brought to bear, things can go wrong, and the cause may not be obvious.

Medical errors in the hospital can be especially difficult to recover from, physically and emotionally. Patients may experience anger, fear, loss, and pain, whereas providers may react with fear, guilt, discomfort, and defensiveness. How such a situation is addressed and resolved has personal, financial, and legal implications for all concerned. Resolution lies not just in the handling of a particular case, but in the context and culture that surrounds it. Some hospitals have attempted to shift their culture from one of denial and defense to one that uses transparency and communication to address errors. This Forum session looked at such efforts and some of the policy issues that may arise.

BACKGROUND

The traditional model for resolving disputes related to medical error has been the medical malpractice lawsuit, in which the patient or family seeks compensation for damage and the hospital seeks to defend its conduct. (This response has come to be known by the shorthand "deny and defend.") The patient must satisfy a two-part legal test: (i) did the provider violate the standard of care? and (ii) did this violation cause actual injury?[1] Negotiation related to such a case may be quite protracted. One patient advocate's experience has become something of a cautionary tale: she says it took "three years, seven months, and 28 days" for the hospital where her daughter died to discuss it with her.[2]

Over the years, visionary hospital leaders have tried to construct a different mechanism—and indeed a different attitude—for addressing disputes, which has come to be known as a communication-and-resolution program (CRP). A CRP seeks to tell patients and families what really happened, offer them appropriate compensation, and take action to prevent such a thing happening again. Leaders stress that, if it is to succeed, a CRP is not, should not, cannot be regarded as a risk management strategy or simply an alternative dispute resolution mechanism. In the words of Mr. Richard Boothman, who pioneered the CRP approach at the University of Michigan, CRP reflects an ethical obligation and a commitment to patient safety.

Ideally, a CRP will have multiple channels for identifying and investigating an adverse event, even if the event is not likely to lead to litigation. While critics suggest that such broad scope will raise costs, proponents say that it conveys to both patients and hospital staff a commitment to accountability and appropriate action. Such commitment may be especially demanding where potential rather than actual harm has been identified, for example when equipment has been contaminated or a clinician is found to be practicing in a way that violates standards of care. CRP leaders consider disclosure in such cases not only a moral obligation, but also the best way to shine light on systemic problems.

As far back as 1987, the Veterans Affairs (VA) Medical Center in Lexington, Kentucky, decided to adopt a more proactive policy for cases that could result in litigation. The new policy was intended to better prepare the hospital to defend malpractice claims by identifying and investigating apparent accidents and incidents of medical negligence. Patients and families were notified of investigation results. Leaders of the effort, Dr. Steve Kraman and Ms. Ginny Hamm, wrote in 1999 that the facility continued to follow the practice "because administration and staff believe it is the right thing to do and because it has resulted in unanticipated financial benefits to the medical center."[3] Dr. Kraman and Ms. Hamm did not seek to have their policy implemented department-wide, though the VA ultimately did adopt a policy on disclosure of adverse events to patients.[4]

The first health system to adopt a CRP was the University of Michigan, beginning in 2004. It explicitly provided for apology and the offer of compensation to patients where warranted. A before-after analysis published in 2010 found that the average rate of

National Health Policy Forum

2100 Pennsylvania Avenue, NW
Suite 305
Washington, DC 20037

T 202/994-6491
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones, MA
Director

Sally Coberly, PhD
Deputy Director

Forum Session Manager

Lisa Sprague, MBA
Principal Policy Analyst

monthly malpractice claims fell from 7.03 to 4.52 per 100,000 patient encounters, while the rate of lawsuits for the same number of encounters decreased from 2.13 to 0.75. The median time from claim reporting to resolution decreased from 1.36 to 0.95 years, while average costs related to total liability, patient compensation, and legal costs all declined. Program evaluation is ongoing.

Other organizations, including the University of Illinois at Chicago and Stanford University Medical Center, were also CRP pioneers. The Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) was convened in 2012 to implement a policy known as Communication, Apology, and Resolution (CARe).

As part of the Patient Safety and Medical Liability Initiative launched in 2009, the Agency for Healthcare Research and Quality (AHRQ) funded a number of demonstration and planning grants incorporating the key patient safety themes of preventing harm through best practices, improving communication with patients, and identifying alternative methods of dispute resolution. These in turn gave rise to grants to 14 hospitals to implement what was dubbed the Communication and Optimal Resolution (CANDOR) program. Those grant periods have ended; AHRQ is now working on a CANDOR toolkit that can be made publicly available.

STAKEHOLDERS

The decision to adopt and learn to work within a CRP requires commitment and cooperation at all levels of a medical system. Additionally—and critically—it requires buy-in from the patient and potentially that patient's attorney. Ordinarily, a patient may decide to bring a lawsuit for various reasons, including a reasonable expectation of compensation for harm done, anger, or revenge. A patient may decide to sue to acquire information that a hospital is refusing to disclose. In the presence of a full-disclosure CRP, reactions may be different and mixed. Should the patient trust the hospital to be honest, to negotiate in good faith, and to offer fair compensation? Plaintiffs' attorneys not surprisingly point out that counsel should be involved to ensure the patient understands what has happened, what is being offered, and how to proceed wisely. Risk managers may concur, fearing that agreements reached in the absence of counsel are more likely subject to later challenge. Patients (and family members) who have become spokespersons on

the basis of their experience with medical error agree that access to information is important, and so is trying to ensure that the error does not happen again.

Hospitals, while trying to conserve funds paid out in claims, also want to preserve their public reputations and their integrity. It is in their interest to see that patients receive fair compensation where harm has occurred and to address system malfunctions that led to the harm. Still, a CRP can seem a frightening departure from a norm where medical professionals do not admit to mistakes, or badly designed processes, or fractured communications that can lead to harm.

Physicians, and in some cases other practitioners, have another concern with respect to malpractice claims: what will be reported to the National Practitioner Data Bank (NPDB)? The NPDB is an electronic record of all payments made on behalf of a physician in connection with medical liability settlements or judgments, as well as adverse actions relating to a physician's license, clinical privileges, or professional society memberships. Federal law requires liability insurers to report to the NPDB any malpractice payments made on behalf of a health care practitioner. The NPDB, in turn, is required to make reported information available to hospitals, state licensure boards, specialty certification boards, and other health care entities that may enter into an employment or affiliation arrangement with the practitioner in question.[5] Though some states, notably Oregon and Massachusetts, have legislation that seeks to remove a mandate on reporting with respect to cases that do not proceed to litigation, the federal Department of Health and Human Services has not relaxed its rules.

As noted above, the deny and defend response has been standard operating procedure in most hospitals and systems. Clinicians involved in an adverse event may be cautioned about speaking to anyone about it—not just to the patient but to colleagues and even family. Such restrictions can exacerbate the feelings of guilt, isolation, and self-doubt that may arise when harm has occurred. CRP proponents stress that "caring for the caregiver" is a critical element of a successful program. As Sue Scott and colleagues have written, health professionals become second victims of a harmful event, feeling as though they have failed the patient and second-guessing their own clinical skills, knowledge, and career choice.[6]

Malpractice insurers hold a range of views about CRPs; some have been active supporters, some have reservations. As Dr. Michelle Mello and colleagues observed in a 2014 *JAMA* article, "Offering compensation is appealing to insurers when a patient has been seriously harmed and is openly contemplating litigation but less so when a lawsuit does not seem to be in the offing—for example, when a patient seems satisfied with an explanation and apology for the error. Insurers are accustomed to making compensation decisions based on not only whether the standard of care was violated but also the likelihood that the patient will find legal representation and prevail in a lawsuit."[7]

POLICY AND LAW

Legislative and regulatory activity relating to malpractice insurance occurs at the state level. For example, more than half of states set caps on damages—usually the noneconomic (referred to as "pain and suffering") portion—awarded in malpractice cases. Such a cap may have bearing on a plaintiff's willingness to accept a settlement versus proceed with litigation. More than three-quarters of states have enacted apology laws designed to protect a clinician's "I'm sorry" statement from being admissible as evidence of wrongdoing in a malpractice trial.

Federal law prevails with the NPDB and other hospital and physician reporting requirements. Payment policy with respect to Medicare and Medicaid can influence hospital practice, as has happened with Medicare's withholding of payment for "never events," such as wrong-site surgery. Beyond government agencies, the rules and approvals of national-level organizations such as The Joint Commission and the National Quality Forum can play a role in disclosure and settlement decisions.

GOING FORWARD

Public sentiment and the policies reflecting it are moving in the direction of greater transparency and accountability as well as a more central role for patients and families in medical care generally. However, the complexity of the hospital environment and the confluence of institutional, professional, and personal considerations involved mean that change is unlikely to be swift or smooth, however honorable the goal. CRP proponents aspire to

a culture of learning that leads to a culture of safety. Learning is the mode now, as CRP initiatives carry out what may be viewed as foundational research for the whole health system.

SPEAKERS

Richard Boothman, JD, executive director of clinical safety and chief risk officer with the University of Michigan Health System (UMHS), described the genesis of the communication-and-resolution program (CRP) concept and how it has been implemented by UMHS. **Susan Scott, RN, PhD**, manager of patient safety and risk management at the University of Missouri Health Care System, spoke to the importance of offering support to the caregiver when an adverse event occurs. **David Mayer, MD**, vice president of quality and safety with MedStar Health in the Washington, DC, area talked about the Agency for Healthcare Quality and Research's CANDOR project and MedStar's part in it, what it takes to implement such a program, and how success should be evaluated. **Jeffrey Catalano, JD**, a partner with Todd & Weld in Boston, presented the perspective of the plaintiffs' bar and describe a broad-based CRP coalition in Massachusetts. **Helen Haskell, MA**, president of Consumers Advancing Patient Safety and Mothers Against Medical Error, brought the discussion back to the patient and family's needs and desires in the wake of an adverse event, as well as suggest ways policymakers might support them.

KEY QUESTIONS

- What moves a hospital or medical system to adopt a communication-and-resolution (CRP) program? What are the chief barriers? What are the risks associated with CRP adoption?
- How important are structural elements, such as whether physicians are employed and insured by a hospital?
- What effect have CRPs had on the reporting of adverse events? The speed of their resolution? Their cost?
- What efforts have been made to change medical education to incorporate a CRP orientation with respect to transparency, talking with patients about adverse events, and the need to care for the caregiver?

- Are there efforts to educate legal and judicial personnel as well?
- What is the role of medical malpractice carriers in a CRP?
- Are there efforts to modify insurance contracts based on the existence of a CRP? What about reporting requirements?

ENDNOTES

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