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Two words that can avoid malpractice claims: I'm sorry

A new initiative in Massachusetts attempts to reduce the financial burden of malpractice claims

Hospitals and physicians spend millions of dollars in legal fees, along with years of litigation and court hearings, on medical malpractice suits. What if you could wipe that all way with a simple, sincere apology?

As idealistic as it may seem, an initiative led by the Massachusetts Medical Society (MMS), along with Massachusetts patient advocacy groups and statewide provider organizations, is attempting to change the way hospitals approach medical errors in the hopes of drastically reducing the time and money spent on medical malpractice litigation.

The program, entitled Roadmap to Reform, is anchored by a process called Disclosure, Apology, and Offer (DA&O). During this process, healthcare practitioners and institutions disclose unanticipated adverse outcomes to patients and families, and (where appropriate) apologize and offer fair financial compensation. Institutions will rely on a root cause analysis to determine who was at fault and to identify procedures or processes that can be fixed to prevent future errors.

"This avoids the need for the patient to file a lawsuit to get compensation or pursue a legal claim to get compensation," says **Alan Woodward, MD,** chair of the MMS' Committee on Professional Liability in Waltham, Mass., and a past MMS president.

> **Traditionally what we have done is denied mistakes and buried mistakes and didn't talk about them and didn't learn from them."**
>
> *—Alan Woodward, MD*

The question is, can the DA&O process work? Although the details are still unclear, the indication so far is that with buy-in from physicians and patients, the program may not only reduce medical malpractice claims, but also promote a more open and honest medical environment.

Past success stories

This initiative has been in the works since 2010 when MMS and Beth Israel Deaconess Medical Center received a grant from the Agency for Healthcare Research and Quality (AHRQ) to create an alternative medical liability model in Massachusetts. Seven hospitals will adopt the initiative this year to evaluate its effectiveness, but there is already some indication that it can be successful.

The University of Michigan Health System has had this system in place since 2001. The health system has seen a dramatic reduction in malpractice claims and cost per claim, as well as a hastened claims resolution process. Perhaps more importantly, it has created a more honest healthcare environment—its medical error reporting increased from 3,900 reports in 2002

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to 18,000 in 2009. According to AHRQ, other notable statistics include:

- **Fewer malpractice claims.** The backlog of open claims dropped from 262 in 2001 to 83 in 2009. Yearly filings decreased from 121 in 2001 to 61 in 2006 and remained steady through 2009.
- **Faster resolutions.** The average time to resolve a claim decreased from 20 months in 2001 to eight months in 2007.
- **Lowered costs.** Between 2001 and 2007, costs per claim decreased 50% and the level of insurance reserves decreased by two-thirds.
- **Increased happiness.** A survey showed 98% of physicians fully approved of the new approach, while a survey of 26 lawyers in southeastern Michigan indicated that 100% of respondents rated the University of Michigan Health System as "the best" or "among the best," 81% said they had changed their approach to the health system, and 57% said they hadn't pursued malpractice cases that they would have pursued prior to the program.

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"It's had a really positive impact on the environment there and the trust in the system, and they're trying to reduce the fear on the part of providers so they will practice evidence-based medicine rather than defensive medicine," Woodward says.

The difference with the Massachusetts initiative is that it is building a road map for a group of hospital systems rather than just one hospital system. This requires collaboration with captive insurers in closed systems as well as physicians with commercial insurers.

The University of Michigan's success has led other states to try a similar approach, says **Michelle Mello, PhD, JD,** professor of law and public health at the Department of Health Policy and Management at the Harvard School of Public Health in Boston. However, these states, which include New York, Washington, Illinois, and Texas, have run into a variety of environmental liability factors, including what tort reforms are in place and how physicians perceive the liability environment.

"Generally there has been a great deal of commitment on the part of the institutions towards trying to make this work," Mello says. "In many cases it's proving to be somewhat more challenging due to a variety of factors than what the folks at Michigan encountered when they went about it at one institution."

How it works

The DA&O system is fairly simple. If a medical error occurs, that error is disclosed to the patient after a root cause analysis is conducted by the hospital. This analysis shows where the mistake was made—for example, whether it was an error made by a physician or other practitioner, or something attributable to hospital

procedures or policies. The hospital then assesses the patient's medical needs going forward. If there is an economic impact or long-term disability, the hospital or physician makes a fair offer to compensate the patient for the injury.

Michigan enacted legislation that allows a six-month interval, known as a pre-litigation resolution period, in which the two parties can attempt to resolve the issue through an apology and compensation. This does not preclude the patient from taking legal action, but it has shown to help cover damages without the need for litigation. In Massachusetts the average time to go through the court system to get an award or judgment is five and a half years, Woodward says.

"It's premiums that drive practitioners to practice defensive medicine," he says. "It's the fear of being involved in the court system for five and a half years where even if you were exonerated you lose because you lost five and a half years of sleepless nights and lost income for all the time you have to contribute to this."

Providing legal protections

MMS has filed legislation with the aim of providing apology protections; it has passed the House and the Senate and should be signed into law in the next couple of months. The legislation prohibits a physician's apology from being used against the physician in court if the patient decides to sue.

The majority of states have apology protections in place, but the strength of this protection varies from state to state. For example, most states protect the apology, but not the explanation to the patient, Mello says.

"That's really what is at the heart of these types of approaches, is trying to explain to patients what happened," she says. "A lot of physicians would say, 'Well, it doesn't do me very much good to say I'm sorry if my explanation of how my staff committed an egregious error is admissible in trial.' "

The Massachusetts program is at least attempting to change this attitude and provide some armor for physicians who have been told for years, "When something goes wrong, don't say anything to anyone except your lawyer."

"We're trying to overcome all of the years of fear that have been engendered by that kind of approach, and give physicians confidence that they can have an open and honest discussion without the fear of retribution about being open and honest," Woodward says.

Another issue that is at the forefront of these DA&O programs is how to handle reports to the NPDB. Under the NPDB statute, healthcare facilities are required to report malpractice settlements with physicians. The University of Michigan Health System has openly taken the approach of substituting the hospital as the defendant, especially if an error occurred as a result of hospital procedures.

"Their reason is that generally these are system problems and they don't think it's right that physicians need to accept that report in his or her name only," Mello says. "But there is some question as to whether that meets the spirit of the reporting requirement or not, and it remains to be seen how other institutions will handle that."

Changing the approach to patient care

More than simply reducing litigation costs and financial strain for healthcare systems, the MMS initiative is trying to change the way physicians and healthcare systems approach patient care, which has historically been shrouded in secrecy.

"Traditionally what we have done is denied mistakes and buried mistakes and didn't talk about them and didn't learn from them," Woodward says. "Everyone just clammed up when something went wrong, and they didn't talk to the patient and they didn't talk to the family and they didn't talk to each other and they didn't make things better. So it was a dysfunctional process."

MMS is also trying to get hospitals to be more accountable for their own actions and processes. In Massachusetts there is a $20,000 charitable immunity cap for nonprofit

entities, so physicians—with a $2 million insurance policy—often had the deeper pockets. Now the state is moving toward accountable care organizations that are willing to recognize system errors and take responsibility.

For example, if a physician puts the decimal in the wrong place and orders 10 times the required dose of chemotherapy drugs, it can be argued that it was the physician's fault for placing the wrong order, but that it's also the responsibility of the hospital to have some kind of fail-safe in the computer system to prevent such an error from occurring.

"The most important thing is it's the right thing to do for patients medically, as well as morally and ethically," Woodward says. "It's the right thing to do for providers and it's the right thing to do for healthcare systems if we want to improve patient safety and stop driving defensive medicine costs, which are in the range of 10%–20% of healthcare dollars."

Physician disclosure is not necessarily a new idea, since it's required by The Joint Commission and supported by various professional organizations, but liability issues have impeded full disclosure.

"What's appealing about these programs is that they support physicians in doing the right thing around disclosure by creating a process to deal with the fallout, if any, in terms of liability, and by creating a way to meet the family's needs without requiring them to sue," Mello says. ■

Meeting the burden of proof for peer review protection

More instances of courts allowing documents to be discovered means hospitals' peer review information stays within the peer review committee

A rash of cases in 2012 have piqued the interest of healthcare systems and legal experts on the matter of peer review protections. These cases serve as a timely reminder that medical staff services departments should take some time to review their procedures and ensure they are meeting the requirements for those protections.

In May, *American Medical News* published an article entitled "Challenges to peer review confidentiality rising" and cited multiple cases in the last year where courts have allowed documents to be discovered. In Maine, a judge ordered a hospital to release internal peer review files created during the evaluation of a patient's treatment; in New York, the Supreme Court allowed the discovery of statements from a vascular surgeon during a peer review hearing; and in Massachusetts, a court forced a hospital to release residency program documents during a lawsuit that involved a former surgical resident.

The article indicates that there seems to be a shift among state courts toward allowing discovery of peer review documents. On the other hand, the real issue may be that hospitals aren't doing enough to lawfully grant those protections, says **Michael Callahan, Esq.,** partner at Katten Muchin Rosenman, LLP, in Chicago.

"The problem, in terms of whether the courts are going to be willing to extend the protections, depends on a number of factors," he says. "One is, has the hospital really jumped through the necessary hoops to establish that the info they are seeking to protect is in fact protected under state statute and applicable case law?"

Keep it inside the peer review committee

Federal and state statutes provide protection to peer review documents and processes in order to promote an open, honest discussion in the healthcare environment, but some fear that as more courts rule against such protections, doctors will feel less inclined to share information about their peers.

The most important thing to remember when it comes to protecting peer review information, either under the

federal Patient Safety and Quality Improvement Act of 2005 through patient safety organizations (PSO) or your state peer review statute, is to keep documents and processes under the purview of peer review.

"If you're generating information outside of the hospital defined quality and peer review process, but then you take that information and run it through the peer review process, it's not going to be protected," Callahan says.

For example, an Illinois case involved an incident report that was generated through the risk management department and then used in the peer review process, which produced a peer review report. The hospital tried to argue that the risk management incident report was protected from discovery because it was used in the peer review process. "The peer review report is protected and the committee's minutes are protected, but not the original incident report," Callahan says.

As a general rule, courts take the position that everything is discoverable unless a facility can prove that the information in question is protected. Hospitals often fall into the trap of assuming reports or documents are protected without checking to see if they've taken the appropriate measures to ensure that they have complied with the applicable state or federal law as well as any interpretive case law.

Introducing quality metrics

Quality data is increasingly included in malpractice and negligence claims. Healthcare facilities are tracking far more quality data than they were 10 years ago, and it's also more available to plaintiffs' attorneys.

For example, many hospitals have started delivering feedback reports to physicians as part of their quality improvement efforts, which include data on medications used, consultations, and outcomes, as well as comparisons to their peers and national averages. These reports are extremely valuable to hospitals and physicians for improving performance and quality. However, if the reports are not initiated through the peer review committee or the process defined under the law, they can be subpoenaed at any time and used in a malpractice or corporate negligence case, Callahan says. As such, he recommends moving quality outcome reports to the protected peer review or quality management process to protect the data.

"I think people lose sight of how they are managing the information and if they are doing it in a way to maximize these confidentiality protections," he says.

More healthcare facilities are also utilizing PSOs to protect information from legal discovery. But, again, hospitals need to ensure they are jumping through the right hoops.

"You have to be able to establish that it was done as part of the provider's patient safety evaluation system for the purpose of calling and reporting to a PSO and that it is related to a patient safety activity," says Callahan.

In the case of a PSO, the facility needs to collect the information and then document that it was reported to the PSO and not used for an alternative purpose.

CMS pay-for-performance regulations also play a role in determining what quality data is protected, says **Teresa P. Sappington, MBA/HCM/PM, BSHA, CAPPM, CPHQ, CPMSM, CPCS,** a consultant in Augusta, Ga., who specializes in medical staff affairs and healthcare regulatory compliance. Some information that was once considered peer review, such as statistical outcomes, is now being released to the public, according to Sappington. "A hospital needs to understand what is reportable, what is pay-for-performance, and what is not," she says.

Separate the credentialing file

One of the biggest mistakes hospitals make is including peer review information in the credentials file, Sappington says. "Peer review protection just goes back to ensuring your credentials files is just that—just the credentials," she says. "Everything else should be in a separate file and protected."

The credentials file, which is discoverable during malpractice claims, should include required information such as board certification, education, and verification of continuing education. Behavioral and quality issues, and anything related to OPPE and FPPE, should be categorized in a peer review file to protect it from discovery. If the court issues a summons for the credentialing file and the file includes peer review information, the hospital has unnecessarily opened that information up to the plaintiff.

Sappington also recommends having a written policy stating that ongoing reviews will be conducted through the peer review committee. "You need to use reasonable consideration as to what is peer review and what is general credentialing information when building files, and then separate that information," she says.

Memorize the statutes

Lastly, those involved with the legal aspects of peer review (i.e., legal counsel, administrators, committee chairs) need to have a comprehensive understanding of HCQIA as well as any applicable state statutes. Further, everyone should stay up to date on state peer review cases to gauge how the court system perceives peer review protections. "Those that are responsible need to have memorized these statutes and also need to know what the case law says," notes Callahan. "You can't just look at the statute without the case law or vice versa. Cases change and interpretations change and you have to adjust."

Facilities should also assess their policies and bylaws to ensure they align with state statutes, and adjust language accordingly as judgments arise. Policies and bylaws are the first line of defense for hospitals involved in a negligent credentialing claim.

"If I'm a plaintiff's attorney, I'm going to compare each legal requirement to your processes, bylaws, and standards, all of which are discoverable," Callahan says. "To the extent you did not meet all of the requirements, it allows me to argue the information I am seeking is therefore discoverable." ■

Editor's note: For tips on how to protect your organization from legal claims if using a Patient Safety Organization, visit www.credentialingresourcecenter.com.

Questions? Comments? Ideas?

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U.S. District Court in Virginia rules hospital fall prevention policies, training materials, and policy documents are discoverable

The U.S. District Court for the Western District of Virginia granted a plaintiff's motion to compel discovery of a hospital's fall prevention policies, training materials, and incident reports after a patient fell while his bed sensor was turned off and suffered injuries that caused his death later that same day.

In January 2010, Paul K. Fleming was admitted to Russell County Medical Center with progressive pneumonia. Fleming was deemed to be a fall risk and was given a bed sensor. In the early morning hours of January 17, the bed sensor was turned off and Fleming fell on the way to the bathroom, hitting his head and causing a fatal subdural hematoma.

Fleming's estate brought a negligence action against the hospital and filed a motion to produce the hospital's fall prevention policies; the hospital's in-service training manuals and documents; hospital policy documents regarding use of bed alarms; and any documents or reports related to Fleming's incident.

The hospital argued that the fall prevention policies, bed alarm policies, and incident reports were protected by Virginia's "quality assurance privilege," which precludes from discovery any proceedings, minutes, records, or reports of a hospital's quality assurance, quality of care, or peer review committees.

The court recognized a split among Virginia circuit courts on whether a hospital's policies and procedures are protected under the quality assurance privilege, but ultimately held that the privilege was not applicable in the instant case. The court examined Virginia legislative history and determined that the privilege was intended to promote open and frank discussions *during* a hospital's peer review process by protecting certain documents from discovery. In rejecting the hospital's argument for application of the privilege, the court found that discovery of the fall prevention policies, bed alarm policies, and incident reports would not threaten open discussion and debate within the hospital's review committees and was therefore permissible.

The hospital also objected to discovery of the incident reports relating to Fleming's fall, arguing that they were protected under the attorney-client privilege and the work product doctrine. The court disagreed, finding that the hospital provided no evidence that the incident reports contained communications between the hospital and its counsel, nor were they prepared by the hospital's counsel in preparation for litigation.

Finally, the hospital objected to production of the in-service training manuals and bed alarm policies, arguing the request to disclose was overly broad, burdensome, and irrelevant. The court noted that previous court opinions shielded a company's internal policies, procedures, and protocols from discovery because those internal documents required the company to satisfy a higher standard of care than required by law. The court ruled that the hospital's protocols for fall prevention and bed alarms were relevant in determining if the hospital acted with the appropriate level of skill and diligence concerning its fall assessments and protocols. The court noted that it was making a determination only to whether the documents were discoverable, not whether they were admissible at trial.

Source: Fleming v. Mountain States Health Alliance, *No. 1:11cv00050 (W.D. Va. May 25, 2012).* ■

Pennsylvania Superior Court denies HCQIA immunity related to physician's termination of employment

The Pennsylvania Superior Court granted in part, reversed in part, and remanded in part a trial court's decision to grant summary judgment to two hospitals and two staff physicians claiming immunity under the Health Care Quality Improvement Act (HCQIA).

In June 1995, Terrance Babb, MD, was hired by the Geisinger Clinic as a staff physician for its OB/GYN clinic. Babb's relationship with two Geisinger staff physicians, Robin Oliver, MD, and Michael Chmielewski, MD, deteriorated over time, with Babb making professional complaints about Oliver and Chmielewski and vice versa. Geisinger eventually terminated Babb's employment.

A fair hearing committee found evidence that Babb provided irregular patient care, was unable to work with staff cooperatively, was consistently delinquent in his recordkeeping, and failed to maintain his medical charts. Geisinger's clinical practice committee accepted the fair hearing committee's recommendation, affirming Babb's termination and reporting him to the NPDB. Babb also had clinical privileges at Centre Community Hospital (CCH). After his termination by Geisinger, CCH withdrew his privileges.

Babb initiated the state action in the Court of Common Pleas of Centre County by filing a writ of summons against Geisinger, Oliver, and Chmielewski alleging discrimination, antitrust violations, breach of contract, and interference with contract. Babb later reapplied for privileges at CCH and filed a similar federal complaint in the U.S. District Court for the Middle District of Pennsylvania against Geisinger, Oliver, Chmielewski, and CCH.

Meanwhile, during the reapplication process, CCH received a copy of Babb's NPDB report filed by Geisinger. CCH requested underlying information from Geisinger, but Babb refused to sign a blanket release.

Babb's federal claims were terminated after the District Court granted the defendants' motion for summary judgment. He subsequently amended his state complaint to add CCH as a defendant. The defendants in the state action filed a motion for summary judgment, which was granted by the trial court.

Babb appealed the trial court's decision to the Superior Court, raising six different issues.

The Superior Court reviewed the standards for granting summary judgment and the immunity provisions of HCQIA and noted that for Geisinger to claim HCQIA immunity, it was not enough to show that the clinic believed that patient care issues were implicated; rather, Geisinger needed to show that its belief, and efforts made to adduce the facts supporting its belief, were reasonable.

Babb introduced the testimony of two expert witnesses who concluded that, based on Babb's medical records, there was no objectively reasonable basis for Geisinger to question his patient care. The Superior Court ruled that the reports from Babb's experts raised a material issue of fact as to whether Babb could show that either Geisinger's peer review process or its belief that its actions were in furtherance of patient care was unreasonable. The Superior Court reversed the trial court's decision to grant HCQIA immunity to Geisinger.

The Superior Court affirmed the trial court's decision to grant HCQIA immunity to Oliver, Chmielewski, and CCH, finding that Babb failed to establish sufficient evidence that Oliver and Chmielewski knowingly provided false information to Geisinger's fair hearing committee or that the CCH peer review procedures were objectively unreasonable.

The Superior Court remanded for further consideration the issues related to the status of Babb's employment and his causes of action for activities unrelated to Geisinger's peer review process.

Source: Babb v. Centre Community Hospital, *2012 PA Super 125 (Pa. Super. Jun. 14, 2011).* ■

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