A Roadmap for Transforming Medical Liability and Improving Patient Safety in Massachusetts

(Funded by AHRQ Planning Grant #R21 HS19537-01)

Executive Summary
April 2012

Synopsis

In a joint initiative with the Massachusetts Medical Society (MMS), Beth Israel Deaconess Medical Center (BIDMC) received a planning grant from the Agency for Health Care Research and Quality to transform the medical liability system in Massachusetts by examining the potential for disclosure, apology and offer (DA&O) programs. The BIDMC/MMS initiative had four aims: 1) to identify the barriers to implementation of a DA&O model in Massachusetts, 2) to develop strategies for overcoming these barriers, 3) to design an in-state roadmap for DA&O program implementation, and 4) to assess applicability of the roadmap to other states. This document summarizes that Roadmap and the central messages from the study:

- Strong support for the DA&O approach—above any other model—among respondents
- Consistent view that such a model is the "right thing to do" ethically, with cost savings as an additional benefit
- Many proposed strategies can be pursued relatively quickly and easily
- The DA&O approach benefits patient safety by encouraging open discussion of error, leading to improved reporting and deeper understanding of safety risks.

Methodology

Structured interviews were conducted with 27 key stakeholders holding leadership positions in organizations central to implementation of the DA&O approach: the Massachusetts legislature and administration, hospital systems (including academic health centers and community hospitals), practicing physicians, liability insurers, health insurers, medical professional associations, patient advocacy organizations, malpractice attorneys, patient safety experts, major physician practice groups, and a major business association.

The barriers and strategies collectively identified during the interviews were then shared with the project's interviewees for individual feedback. The project team integrated stakeholder feedback into the Roadmap prior to presentation at a symposium entitled *Roadmap for Transforming Medical Liability and Improving Patient Safety in Massachusetts* held at MMS in March 2011. The roadmap was then further refined based on additional feedback from the approximately 150 symposium participants, primarily physicians but also representatives of each of the other stakeholder groups.

Barriers and strategies

The interviews revealed several barriers and potential solutions to implementation of a DA&O model. Below are the 12 most commonly cited barriers, each followed by proposed strategies for overcoming it.

1. Fairness and accountability: education of the public and media; legal representation for patients/families; standardized root cause analysis processes; transparent compensation formulas; and mechanisms for sharing "lessons learned" to improve patient safety.
2. Physician discomfort with disclosure: physician education and training including peer mentors; establishment of a "just culture"; support from hospital/health enterprise leadership.
3. Concern about increased liability: data dissemination from sites having implemented the model.
4. Physician name-based reporting: education; process change allowing institution-based reporting for adverse outcomes deemed to be system failures; and clear reporting requirements.

5. Charitable immunity law: system liability through a voluntary waiver-by-settlement approach.
6. Difficulty coordinating insurers: Convening a forum for insurers to cooperatively resolve codefendant issues.
7. Opposition by liability insurers: data collection to better quantify the financial bottom line; education; and early involvement of liability insurers in cases where error is suspected.
8. Concern that model may not be replicable in certain settings: creation of a centralized resource center; standardized policies; education and training; and statewide risk-pooling.
9. Attorneys' interest in maintaining the status quo: education of attorneys regarding cost effectiveness and role of legal representation in the model; sharing of experience by attorneys who have participated in DA&O models.
10. Difficulty of getting supporting legislation passed: education of legislators; identification of key supporters among the legislators as well as other key stakeholders such as state court judges.
11. Forces of inertia: creation of resources to support leaders; identification of champions in each constituency; capitalizing on opinion leaders and patient representatives; dissemination of data on the shortcomings of the current system; collaborative influence of key stakeholders.
12. Insufficient evidence that the DA&O approach works: collection and dissemination of data from institutions that have implemented the model, including pilot programs in varied settings.

Discussion and recommendations

As a result of this study, several key findings emerged. First, and perhaps most striking, was the degree to which the stakeholders in aggregate felt that the DA&O model holds great potential for Massachusetts – more than any other alternative. Second, ethical considerations trumped cost-saving implications as most appealing aspects of adopting the model. In fact, the most commonly cited factor supporting the model across constituencies is that it was morally and ethically the "right thing to do." Third, respondents consistently viewed the DA&O model – above all else—as a patient safety priority. Fourth, a majority of identified barriers and solutions have more universal implications – potentially applicable to other states considering a DA&O model. Finally, while some of the proposed strategies are likely to require significant time and resources to implement, (such as altering legislation or regulatory standards), the majority are "actionable items" that could be pursued relatively quickly and easily.

Immediate strategies allowing for rapid progress:

- Launch broad-based education efforts for the public (including patients and media), physicians, hospital/health care organization leadership, attorneys and insurers.
- Establish champions in each stakeholder group.
- Develop DA&O model implementation guidelines.
- Organize collaborative working groups to tackle barriers.

Longer term strategies:

- Promote enabling legislation.
- Collect and disseminate data on DA&O models in various settings.

Conclusion

The central message from the interviews was clear: strong support for the DA&O approach—above any other strategy for liability reform. The proposed strategies, many of which are quite feasible, can enable a fundamental transformation from the current flawed approach to patient safety and medical liability, and put Massachusetts and other states firmly on the road to creating a fair, efficient, reliable, just and accountable system that more effectively supports patient safety.