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Disclosure, Apology and Offer: A New Approach to Medical Liability

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Although juries find in favor of physicians in the vast majority of malpractice cases that make it to court, the often years-long battle in our current litigation system leaves physicians far from unscathed.

Massachusetts is poised to make changes that will better promote healing for all parties involved — and prevent recurrence of mistakes — by adopting a policy of Disclosure, Apology and Offer (DA&O) when patients suffer avoidable medical harms.

There are a number of reasons proponents see DA&O as good for physicians as it is for patients.

“This is a fundamental transformation of liability systems from one that is reactive and very adversarial and creates a culture of secrecy and a blame-and-deny mentality,” says Alan Woodward, M.D., past president of the MMS and chair of its Committee on Professional Liability.

“What we’re transforming to is exactly the opposite. It’s a very proactive system where physicians can advocate for patients who are injured rather than being told they can’t even talk to them,” said Dr. Woodward.

The effort was launched this April by an alliance of health organizations, including the Massachusetts Medical Society, with the Commonwealth’s Roadmap to Reform, which was the result of a 2010 planning grant from the Agency for Healthcare Research and Quality made to the MMS and Beth Israel Deaconess Medical Center (BIDMC) as part of President Obama’s Patient Safety and Medical Liability Initiative.

Using the grant, seven Massachusetts hospitals, including Beth Israel Deaconess Medical Center in Boston, Beth Israel Deaconess Hospital-Needham, Beth Israel Deaconess Hospital-Milton, Baystate Medical Center in Springfield, Baystate Franklin Medical Center in Greenfield, Baystate Mary Lane Hospital in Ware, and Massachusetts General Hospital, will pilot test a DA&O approach modeled after the system used by the University of Michigan.

How DA&O Works

Under this model, when unanticipated adverse outcomes occur, patients and their families are provided full disclosure of what happened, what it means for the patient medically, and what will be done to prevent the error from reoccurring.

Physicians and health care organizations are given the opportunity to apologize without fear of their words being later used against them in court. Organizations work with their liability insurers to give patients a fair and timely offer of financial compensation.

By giving patients the opportunity to receive transparent information and prompt financial recourse, the hope is that the court system would be used only as a last resort.

The ability to address adverse outcomes quickly is another major advantage of DA&O, Dr. Woodward added, considering that patients who bring medical malpractice lawsuits in Massachusetts wait an average of five-and-a-half years until receiving an award.

Perhaps the most promising aspect of DA&O, however, is that the system promotes improved patient safety,

said Evan Benjamin, M.D., senior vice president and chief quality officer for Baystate Health and associate professor of medicine at Tufts University School of Medicine.

Although health care organizations have long performed root-cause analyses to determine the reasons medical mistakes occur, a prevailing culture of secrecy has undermined their ability to use that information optimally.

“The current malpractice system, which encourages people to hide errors and encourages people to sue, really has the exact opposite effect of what we’re trying to achieve in the patient safety movement,” said Dr. Benjamin.

“We’re trying to improve the transparency of events when there is an error so we can learn from it. DA&O offers an approach that is respecting the patient in allowing them to have redress for failure, but also complements the patient safety movement as we’re trying to continue to learn,” he said.

Education and Support

Despite all of its potential benefits, implementing DA&O involves a learning curve, noted Dr. Benjamin, who has been using a policy of disclosure and apology throughout Baystate Health for the past four years. “It’s been a long journey for us in terms of investing in patient safety,” he said, “but we’ve seen improvements in our relations with patients and the support we’ve been able to offer patients.”

Organizations must first foster a cultural change in which physicians understand the value of transparency

and become comfortable discussing matters they've traditionally been urged to hold close to the chest, Dr. Benjamin said. Once physicians adapt to the new mentality, they need training and support to learn how to conduct such difficult conversations with patients and their families.

To help facilitate change, Baystate gave its physicians access to a team of coaches available to work through how to start the conversation once an incident occurred — a resource Dr. Woodward said was essential.

“We know that beyond just providing education, you need support at the moment of the incident,” Dr. Woodward said. “You need to have peer mentors who can help, maybe the chief medical officer at the institution or others who can work with the physician in explaining this type of situation when communication is often very difficult.”

Addressing Misconceptions

Dr. Woodward said he intends to speak to medical organizations across the state about the new approach to adverse events and how to implement it.

One key point of this message, according to Kenneth Sands, M.D., senior vice president for health care quality at BIDMC, is the importance of collaboration with the physicians involved. “It’s not something we have any intention of forcing on individuals,” he said.

Also important to clarify, said Dr. Sands, is that DA&O does not constitute no-fault insurance in which patients who are injured would be indemnified regardless of fault. Rather, compensation would

generally only be offered when a root-cause analysis clearly demonstrates that the health provider or system is at fault for a preventable event, such as a wrong-site surgery or other unforeseen consequence.

Dr. Benjamin concurred that the question of which incidents fit the protocol is tricky.

“We don’t really have all the answers, because every case is different and the communication is different in every case, but that’s a common question that comes up,” he said. “The way we’ve approached this is really dealing with the truly obvious cases where there was an unexpected adverse event that we also believe was preventable.”

And while DA&O does have some barriers to overcome, the allegation that it could manipulate patients or put them in a position to assess offers without fully understanding their rights is unfounded, Dr. Woodward said, noting that patients are told to obtain independent counsel while going through the DA&O process.

“The last thing you want is to have made an offer to a patient and have them accept it and then feel as though they were pushed into it or didn’t have good counsel,” he says. “All of this is trying to provide an option to patients that is much better, much more efficient, much more equitable, and is not in any way an attempt to ‘chintz’ the patient.”

The University of Michigan model, in fact, promotes compensating patients generously, he added. Cost savings come from not having to hire lawyers and experts to spend years fighting out cases that could be resolved in months.

Overcoming Barriers

The MMS and BIDMC have created the *Roadmap for Removing Barriers to DA&O in Massachusetts*, which cites a number of potential impediments to the program’s success. While many of these, such as physician discomfort with disclosure, can be managed through educational efforts, more substantive changes will be needed to ensure physician name-based reporting of safety events and insurer settlements doesn’t unfairly penalize physicians.

Part of the payment reform legislation released in May proposes changes to reporting requirements that would prevent giving individual physicians a black mark when their insurers make payments for systems-based errors. For example, if a patient were harmed from a blood transfusion because the blood was mismatched in the lab, as long as it was an appropriate transfusion, that mistake would not be reported against the individual doctor, Woodward explains.

While it remains to be seen which proposals will ultimately become law, the pilot program, along with a state-wide push toward DA&O, will place Massachusetts squarely at the forefront of liability reform.

“This is precedent-setting nationally,” Dr. Woodward said, “We sat down with these parties, and we are going to put patients first and patient safety first and provide a legal framework that encourages everyone to do the right thing in improving patient safety instead of thwarting patient safety, which is what the current system does.” **VS**