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Louise Kertesz

# Admitting medical errors leads to reduced liability costs

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Doctors who make an error but then acknowledge the mistake and correct it are getting a positive prognosis in return: fewer patient claims filed against them and reduced liability costs, research shows.

Hospitals on the leading edge of this strategy are implementing the medical error best practice, which involves immediate reporting to designated staff of an error in care.

Supported by the institution, physicians apologize to the patient if an error has caused harm and, where appropriate, fair compensation is offered. Timely analysis of the error takes place, which leads to improved care, experts say.

The practice was developed as a new risk management function—patient safety officer or specialist—was established at some health care facilities (see [related story](#)).

The Washington-based National Quality Forum's safe practice guideline has advanced such disclosure by linking it to high-quality care. But the best practice is not driven primarily by the various state mandates requiring disclosure of medical errors, industry experts said.

“Public reporting is not the motivation behind this at all. We do it for two reasons: It's the right thing to do and it makes good business sense,” said Jeffrey Driver, chief risk officer of Stanford University Medical Center and executive vp of the Stanford University Medical Indemnity and Trust in Stanford, Calif. Stanford implemented its version of the model, called the Process for Early Assessment and Resolution of Loss, or PEARL, in 2007.

The best practice grew out of widespread recognition that attempting to keep medical errors secret “doesn't work for patients or providers” because it fuels costly litigation and fails to improve patient safety, said Dr. Alan Woodward, past

president of the Massachusetts Medical Society and chair of its committee on professional liability.

Pioneered at the Veterans Administration hospital in Lexington, Ky., the model is in place primarily at academic hospitals and relatively few others. Several malpractice insurers also support the effort and provide disclosure training for physicians.

The Agency for Healthcare Research and Quality, a Rockville, Md.-based unit of the U.S. Department of Health and Human Services, has awarded grants to projects testing various components of the practice.

□We're likely to see even broader expansions of these programs once the results about how generalizable they are become available,□ said Dr. Thomas Gallagher, associate professor of medicine at the University of Washington in Seattle.

The best risk management practice goes against the traditional □deny and defend□ approach, which is based on fear that the patient will sue if an error is disclosed. But hospitals that have adopted the model say it results in reduced claims against the hospital and fewer lawsuits.

At the University of Michigan Health System in Ann Arbor, Chief Risk Officer Richard Boothman said the hospital system implemented its program of full disclosure and compensation for medical errors 10 years ago.

Previously, the approach was, □Don't talk about it,□ which created □a cone of silence□ around an adverse event, he said.

□We were denying and defending everything without thought of whether it was a good idea, cutting off patient improvement, settling the lion's share of suits without going to trial. That ramped up defense costs,□ Mr. Boothman said. □It's the general model in the hospital industry.□

But with the new system in place, the hospital system found the approach resulted in □a decrease in new legal claims (including the number of new lawsuits per month), time to claim resolution and total liability costs□ in 2007 compared with 1995, according to a 2010 study published in the Annals of Internal Medicine.

□We found a 61% decrease in spending at the UMHS on legal defense costs, and this supports the possibility that patients may be less likely to file lawsuits when given prompt transparency and an offer of compensation,□ said Dr. Allen Kachalia, a co-author of the study, in a statement.

At Stanford, claim frequency also dropped, falling 36% after PEARL was implemented, and its medical trust is saving \$3.2 million a year, Stanford reported.

Experts point to the importance of quickly reporting an error that may result in a claim. An Aon Corp. study found that "the more time passes, the more severe a claim gets on average," said Erik Johnson, health care practice leader for Aon Risk Solutions' actuarial and analysis practice in Raleigh, N.C.

The Virginia Mason Medical Center in Seattle also, in 2002, adopted a patient safety alert system that requires all staff to immediately report any activity that has harmed or may harm a patient, and cease that activity until the problem is corrected.

"We get 450 patient safety alerts a month. We want at least 800," said Cathie Furman, senior vp of quality and compliance. "Most of those cause no harm," she said. But when there is harm to a patient, "we have trained all of our physicians to disclose the error and say, 'I'm sorry' and explain what's being done to prevent the problem from recurring. We apologize to the family and cover any extra expenses, including travel, she said.

The effort has paid off. Virginia Mason's hospital professional liability premium "has gone down about 56% since 2004. We've been able to negotiate double-digit decreases every year, because many insurance carriers want to get on our profile since we're pretty low-risk," Ms. Furman said.

At Beth Israel Deaconess Medical Center, the Boston facility and the Massachusetts Medical Society received a planning grant from the AHRQ to develop a roadmap "to take what's been done in closed systems and implement it in hospitals and health systems across the state," Dr. Woodward said.

Beth Israel, two other Massachusetts hospitals, the Massachusetts Hospital Assn. and the Massachusetts Medical Society, among other stakeholders, have applied for a demonstration grant to provide resources and information to other hospitals interested in implementing the approach, "and many are," said Dr. Woodward.

The University of Washington also received an AHRQ grant to test if the approach can work outside of a self-insured system. The test involves promoting collaboration across the state among different parties, including doctors and multiple insurers, Dr. Gallagher said.

"The partnerships are all in place and there is widespread agreement that this approach has merit. But creating those relationships and understanding how the process will work is complex. The question is, rather than pointing the finger, can we work together on analyzing the (adverse) event, communicate with the patient and provide compensation when appropriate," Dr. Gallagher said.