

# Disclosure of Medical Errors: The Right Thing to Do, But What is the Cost?



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Does your organization disclose medical errors when they occur?  
Does the practice of disclosure increase or decrease your liability costs?



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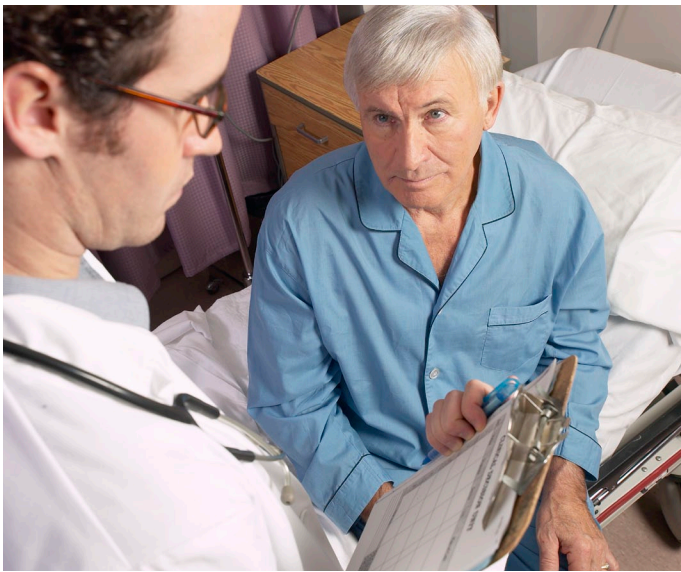
The reported evidence from several medical centers indicates that there are both patient safety and financial benefits with disclosing medical errors. However, a widely reported and controversial expert study offers significant cautions about the disclosure route.

This paper provides an overview of medical error disclosure, and analyzes the financial impact of disclosure on health care organizations.

## DISCLOSURE - HOW DID IT START?

In 1987, more than a decade before the pivotal 1999 Institute of Medicine report that launched a new era of patient safety efforts, the Veterans Affairs Medical Center in Lexington, Kentucky adopted an untested and untried response to medical errors: disclose, apologize and compensate.<sup>1,2</sup> This approach was contrary to the decades-old strategy of “deny and defend.” What were they thinking?

VAMC Lexington saw a need for a more proactive approach to medical errors after losing two malpractice claims totaling more than \$1.5 million. Hoping to better defend malpractice claims, the new policy promoted identifying and investigating apparent medical errors. An ethical conundrum arose when an



investigation identified a medical error of which the patient or family member was apparently unaware. The risk management committee of VAMC Lexington decided that in that case, the facility had an ethical duty to notify the patient or family of the error.<sup>3</sup>

## RESULTS

Twelve years later, the VAMC Lexington reported that the practice of disclosing medical errors continued to be followed because the administration and staff believe it is the right thing to do, *and* because it resulted in unanticipated financial benefits to the medical center.<sup>4</sup>

The VAMC Lexington reported that its disclosure practice “suggests but does not prove the financial superiority of a full disclosure policy.” How so? For the seven-year period studied (1990-1996), the Lexington facility had 88 malpractice claims, and paid out a total of \$1,330,790, an average of \$15,622 per claim.<sup>5</sup> The VAMC did not provide its own claims data for a pre-disclosure time period, but the report authors note that for the entire Veterans Affairs medical system, the average cost of liability payments between 1990 and 1997 was \$720,000 for court judgments, \$205,000 for cases settled at suit or by general counsel, and \$35,000 for local settlements.<sup>6</sup>

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The 1999 Lexington study also compared the malpractice claim history of that facility with that of all similar VAMCs located east of the Mississippi River during the same seven-year period. The conclusion: the VAMC Lexington’s liability payments were moderate and “comparable to those of similar facilities.”<sup>7</sup> The data reflects that of the 36 facilities, although only 5 other VA facilities had a higher number of claims (6th out of 36), the VAMC Lexington was 29th out of 36 in total dollars paid. (This included payments resulting from court judgments, claims settled during litigation, and claims settled by VA counsel.)<sup>8</sup>

Although all 36 VA facilities provided tertiary care and were closely affiliated with medical schools, the study estimated exposure to risk by comparing “complexity-adjusted facility workload” for each of the medical centers. VAMC Lexington ranked 23rd out of 36 on this measure.<sup>9</sup> Stating it another way: the Lexington facility ranked 23rd for risk exposure, but ranked 29th in dollars paid.

In a 2001 publication Dr. Kraman stated, “We average about 14 cases a year where we make payments. That’s high for a VA hospital. But the average payment per case is only \$15,000. The average in the VA system is closer to \$100,000.”<sup>10</sup>

The 1999 report concluded, “...an honest and forthright risk management policy that puts the patient’s interests first may be relatively inexpensive because it allows avoidance of lawsuit preparation, litigation, court judgments, and settlements at trial. Although goodwill and the maintenance of the caregiver role are less tangible benefits, they are also important advantages of such a policy.”<sup>11</sup>

## CULTURE CHANGE

Following the IOM and VAMC Lexington 1999 reports, a new vocabulary emerged in healthcare: transparency, disclosure, and apology. In 2001, the Joint Commission rolled out a disclosure requirement, and the University of Michigan Health System (UMHS) implemented a disclosure program.<sup>12</sup> In 2005 the SorryWorks! Coalition formed, an organization of doctors, lawyers, insurers and patient advocates dedicated to promoting full disclosure and apologies for medical errors.<sup>13</sup> A significant culture shift was occurring.

## SIMILAR RESULTS

In 2005, Children's Hospitals and Clinics in Minneapolis reported a nearly 50% drop in malpractice lawsuits since it began a medical error disclosure program.<sup>14</sup>

In 2006, UMHS Chief Risk Officer Richard Boothman testified before the U.S. Senate Committee on Health, Education, Labor and Pensions that despite an increase in clinical activity from August 2001 to August 2005, the number of open claims dropped steadily from 262 to below one hundred during this time.<sup>15</sup> (A subsequent paper indicated open claims totaled 114 in 2005, dropping to 83 by August 2007.<sup>16</sup>) Claim processing times and average litigation costs dropped more than half, and total medical malpractice reserves dropped by more than two thirds.<sup>17</sup>

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## CONTROVERSY

Then in 2007, David M. Studdert et al, published a study asserting that disclosure of medical errors might be the right thing to do, but in the long run this approach will increase the cost of healthcare liability claims. Contrary to the data provided by VAMC Lexington, the UMHS and others, the Studdert study found, “...the chance that disclosure would decrease either the frequency or cost of malpractice litigation to be remote. On the contrary, an increase in litigation volume and costs was highly likely.”<sup>18</sup>

### THE STUDY:

- ❖ Using previous research and publicly available data, the authors estimated:
  - The number of severe medical injuries in the US annually
  - The numbers of severe medical injuries due to negligence and not due to negligence
  - The numbers of patients who experienced a severe medical injury (whether due to negligence or not) who sue and who do not sue.
- ❖ The authors assumed that disclosure of a medical error would change the numbers of patients who sue and who do not sue. To determine the impact of disclosure, the authors presented 78 medico-legal “experts” with four hypothetical scenarios involving patients who sustained a serious medical injury. The hypotheticals varied i) whether the injury was due to negligence, and ii) the patient’s plans to sue both before and after full disclosure of how and why the injury occurred. The experts were then asked to predict the percentage of patients who would react to disclosure consistent with each of the four scenarios, including
  - Their best guess
  - Lowest reasonable number
  - Highest reasonable number.
- ❖ Using data from the 65 experts who responded to the survey, the authors then used a Monte Carlo simulation to generate probability distributions of the outcomes.<sup>19</sup>

## STUDDERT ET AL RESULTS

The experts predicted that among patients who experienced a severe injury as a result of medical negligence, disclosure would deter 32 percent from suing, and prompt claims by 31 percent of patients. Among patients whose injuries were not due to medical negligence, the experts predicted disclosure would deter 57 percent of claims, and prompt claims 17 percent of the time.<sup>20</sup>

## STUDDERT ET AL CONCLUDE:

- ❖ The vast majority of patients injured by medical error never sue, resulting in a huge number of potential claims. The authors assert that 80% of serious injuries due to medical negligence never trigger litigation.<sup>21</sup> (In another study Studdert co-authored, it is reported that only two to three percent of patients injured by negligence file malpractice claims.<sup>22</sup>)
- ❖ The reason some injured patients do not sue is that they are unaware they have been injured by medical error<sup>23</sup>
- ❖ Disclosure of medical error will therefore prompt claims. Even a small increase in the number of claims prompted by disclosure will overwhelm the relatively small number of claims that may be deterred by disclosure<sup>24</sup>.

“The vast majority of patients injured by medical error never sue, resulting in a huge number of potential claims.”



“Not only is there an ethical benefit to disclosure and transparency, but it also makes financial sense.”

## THE RESPONSE

An academic brawl ensued. Kraman and Hamm (authors of the VAMC Lexington study) rebuked the Studdert team for a flawed study that was both “irresponsible and bad science.”<sup>25</sup> Representatives from the National Open Disclosure Program in Brisbane, Australia, and the Australian Commission on Safety and Quality in Health Care joined in, also finding the study flawed and unsustainable. The Australians noted that it is simply not proven that patients’ ignorance about their injuries is an important factor in explaining why they do not seek legal redress; but it is known that patients instigate litigation because of perceived suspicion of cover-up of errors.<sup>26</sup>

Studdert and colleagues stood by their study, reiterating that their survey of “experts” predicted disclosure would eliminate lawsuits from 25 percent of patients injured due to negligence, but would prompt 25 percent of those who have not sued to do so following disclosure of medical error.<sup>27</sup>

## WHAT NEXT?

In January of 2009, Boothman and colleagues published a detailed analysis of the UMHS approach to medical malpractice claims. Again citing decreased open claims, claim processing times, and litigation costs since practicing medical error disclosure, the 2009 article concluded that contrary to Studdert et al’s 2007 study, “Not only is there an ethical benefit to disclosure and transparency, but it also makes financial sense.”<sup>28</sup>

Eighteen months later (August 2010), Allen Kachalia and colleagues (including Richard Boothman) published a study specifically focused on comparing UMHS liability claims and costs before and after implementation of its disclosure-with-offer program. Their study reviewed 1131 claims reported to UMHS risk management from July 1995 to September 2007.<sup>29</sup>

Among their findings:

### Fewer Lawsuits

- ❖ **38.7** Lawsuits per year before and **17.0** per year after disclosure program implementation<sup>30</sup>
- ❖ Monthly rate of new claims decreased from **7.03** per 100,000 patient encounters before initial program implementation to **4.52** after full implementation<sup>31</sup>

### Faster Resolution

- ❖ Median time to claim resolution was **1.36** years before initial implementation, and **0.95** year after initial program implementation<sup>32</sup>

### Lower Costs

- ❖ Average cost per lawsuit decreased from **\$405,921** before to **\$228,308** after initial program implementation<sup>33</sup>
- ❖ Mean legal expenses for UMHS **decreased** by about 61%, **but** part of these savings were offset by the increase in the UMHS risk management budget needed to more proactively address claims internally.<sup>34</sup>

“The reason for disclosure of medical errors is **not** cost savings, but the larger goal of patient safety.”

## CONCLUSION

Advocates of disclosure, including Mr. Boothman, are adamant that the reason for disclosure of medical errors is *not* cost savings, but the larger goal of patient safety. In a November 20, 2010 posting on the National Patient Safety Foundation Listserv, Mr. Boothman reiterated that honesty (disclosure) is the foundation of three principles embraced by UMHS:

- ❖ Where inappropriate medical care caused patient injury, the provider owes the patient quick and fair compensation
- ❖ Where caregivers acted reasonably or where there was no patient injury, caregivers will receive a thoughtful and vigorous defense
- ❖ Providers need to learn from patients' experiences to improve patient care.<sup>36</sup>

Mr. Boothman concludes that financial gain should not be the reason to safeguard patients, but that an honest approach to patient injuries does lead to financial savings.<sup>37</sup>

Whether additional research will eventually confirm or repudiate Studdert and colleague's theoretical model remains to be seen. We do know disclosure of medical errors has been increasingly accepted and expected by caregivers, patients, and others with an interest in patient safety, and that almost all agree disclosure is the right thing to do. Fortunately, the early data indicates disclosure will not increase liability costs, and may decrease costs. Stay tuned.



“The early data indicates disclosure will not increase liability costs, and may decrease costs. Stay tuned.”

- <sup>1</sup> Institute of Medicine, "To Err is Human: Building a Safer Health Care System" (Linda T. Kohn et al eds., National Academies Press 1999).
- <sup>2</sup> S. S. Kraman and G. Hamm, "Risk Management: Extreme Honesty May Be the Best Policy," *Annals of Internal Medicine* v. 131, no. 12 (1999) 963-967.
- <sup>3</sup> *Id.* at 964.
- <sup>4</sup> *Id.*
- <sup>5</sup> *Id.* at 963.
- <sup>6</sup> S.S. Kraman and G. Hamm, "Risk Management" at 964.
- <sup>7</sup> S.S. Kraman and G. Hamm, "Risk Management" at 966.
- <sup>8</sup> *Id.* at 965.
- <sup>9</sup> *Id.*
- <sup>10</sup> M. Crane, "What to Say If You Made a Mistake," *Medical Economics* 2001; 16:26.
- <sup>11</sup> *Id.* at 966.
- <sup>12</sup> Joint Commission on Accreditation of Healthcare Organizations, "Comprehensive Accreditation Manual for Hospitals: Standard RI.2.90" (Chicago: Joint Commission, 2001).
- <sup>13</sup> D. Wojcieszak, J. Banja and C. Houk, "The Sorry Works! Coalition: Making the Case for Full Disclosure," *Joint Commission Journal on Quality and Patient Safety* v. 32, no. 6 (June 2006), p.344-350.
- <sup>14</sup> F. Gebhart, "Federal Bill Would Promote Apology After Medical Errors," *Drug Topics Health-System Edition* (Nov. 21, 2005).
- <sup>15</sup> R. Boothman, "Medical Justice: Making the System Work Better for Patients and Doctors," (June 22, 2006) (Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions).
- <sup>16</sup> R. Boothman, A. Blackwell, D. Campbell, Jr., E. Commiskey, and S. Anderson, "A Better Approach to Medical Malpractice Claims? The University of Michigan Experience," *Journal of Health & Life Sciences Law* v. 2, no. 2 (January 2009) p. 125-159, 144.
- <sup>17</sup> *Id.* at 144.
- <sup>18</sup> D. Studdert, M. Mello, A. Gawande, T. Brennan and Y. C. Wang, "Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy," *Health Affairs* v. 26, no. 1 (January/February 2007) p. 215-226, 222.
- <sup>19</sup> *Id.* at 216-219.
- <sup>20</sup> *Id.* at 219.
- <sup>21</sup> *Id.* at 222.
- <sup>22</sup> M. Mello, D. Studdert, E. Thomas, C. Yoon and T. Brennan, "Who Pays for Medical Errors? An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for Patient Safety Improvement," *Journal of Empirical Legal Studies* v. 4, no. 4 (December 2007) p. 835-860, 838, 853.
- <sup>23</sup> D. Studdert et al, "Disclosure of Medical Injury to Patients" at 216.
- <sup>24</sup> *Id.* at 222.
- <sup>25</sup> S.S. Kraman and G. Hamm, Letter to the Editor, *Health Affairs* v. 26 no. 3 (May/June 2007) p. 903
- <sup>26</sup> J. Wakefield, C. Jorm, C. Ryan, Letter to the Editor, *Health Affairs* v. 26 no. 3 (May/June 2007) p. 903-904.
- <sup>27</sup> D. Studdert, M. Mello, A. Gawande, T. Brennan, Response to Letters to the Editor, *Health Affairs* v. 26 no. 3 (May/June 2007) p. 904-905.
- <sup>28</sup> R. Boothman et al, "A Better Approach to Medical Malpractice Claims?" at 159.
- <sup>29</sup> A. Kachalia, S. Kaufman, R. Boothman, S. Anderson, K. Welch, S. Saint and M. Rogers, "Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program," *Annals of Internal Medicine* v. 153, no. 4 (August 17, 2010) p. 213-221, 214, 215.
- <sup>30</sup> *Id.* at 215.
- <sup>31</sup> *Id.*
- <sup>32</sup> *Id.* at 217.
- <sup>33</sup> *Id.*
- <sup>34</sup> *Id.* at 220.
- <sup>35</sup> *Id.*
- <sup>36</sup> R. Boothman, Message on National Patient Safety Foundation Listserv (Nov. 20, 2010), <http://listserv.npsf.org/archives/patientsafety-1.html>.
- <sup>37</sup> *Id.*



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