Whereas, The current predominant professional malpractice defense is “deny and defend”; and

Whereas, The “deny and defend” process hinders open communication between patients and providers, resulting in the lack of transparency in hospitals of personnel and system errors. This results in an impediment of any improvement in the quality of care in our healthcare delivery system; and

Whereas, The “deny and defend” process is increasing costs to physicians in time, preparation, and malpractice premiums; and

Whereas, Physicians involved in a medical malpractice suit frequently suffer major depression, adjustment disorders, and increased morbidity with physical health; and

Whereas, A Medscape survey found 36 percent of female physicians and 26 percent of male physicians said it was “one of the worst experiences in my life”, while 20 percent of all physicians said “it was disruptive and humiliating”; and

Whereas, The current malpractice environment encourages the practice of defensive medicine that results in an increase of total health care costs that does not contribute and can potentially hurt patients’ health outcome; and

Whereas, The concept of alternative programs to medical malpractice suits will never completely end the principle of the “right by trial by jury” when there is a grievance. Alternative programs need to be studied and assessed as to their effectiveness in decreasing the negative consequences for patients, physicians, total health care cost, and quality of care using “deny and defend”; and

Whereas, One such alternative is the Communication and Resolution program (CRP) which is typically composed of six general components:

1. Hospital policy requires full disclosure when an unexpected bad outcome occurs; and

2. Staff report unexpected adverse outcomes they observe to Risk Management and Quality Improvement Departments; staff also encourage patients to report to Risk Management any unexpected bad outcome the patient experienced; and

3. Risk Management reports all cases that are notified to them to the Quality Improvement Department for evaluation of errors and possible correction of system errors or personnel errors; and
4. The patient and family, with an attorney if desired, meet with Risk Management representatives and describe their concerns/experience. The hospital investigates and reports back to the patient/family. The hospital and physician makes a full disclosure of their analysis; and

5. If a medical injury occurred due to medical error by the physician, he/she will give full disclosure to the patient with an attorney if desired. If the hospital committed the medical injury, Risk Management representatives will provide the full disclosure when a hospital error occurred. Full disclosure includes an explanation, an apology, and an exploration of ways to prevent the injury from occurring in future to others. The hospital asks how the patient would like to resolve the case and pay appropriate compensation if requested; and

6. If no medical error resulting in an injury occurred, no compensation is offered. The patient may proceed to litigation if desired. The hospital vigorously defends any claim filed when there is no evidence of medical error; and

Whereas, Studies of CRP show decrease defense costs, settlement costs, number of claims filed, and time interval to resolve a claim; and

Whereas, Several studies have demonstrated that CRP is more successful in a closed system (physicians are employed and insured by hospital), than open settings (physicians are not employed nor insured by hospital). However, one study demonstrated success in a hospital with a majority of physicians were not employed by the hospital and no physician was insured by this hospital; and

Whereas, Another study showed a reduction in diagnostic testing and imaging after implementation of CRP. These findings suggest defensive medicine practice is decreased using CRP as opposed to deny and defend; and

Whereas, Though patients still have the right to litigate, when CRP was initiated in one hospital study, in 43 percent of cases, the patient’s needs were met with an explanation and apology while the remaining 57 percent received financial compensation in addition to an explanation and apology. No health care bills were submitted to patient or their insurance company if a medical error resulted in injury to the patient; and

Whereas, One study demonstrated a concordance rate between compensation and medical error of 99.6 percent; and

Whereas, This system would encourage hospitals to implement patient safety initiatives. The resultant improvement in quality of care would result in less adverse outcomes due to medical error. This could result in physicians experiencing a decreased incidence in reports to the National Practitioner Data Bank (NPDB), the state’s medical board, and the physician’s hospital review board; and

Whereas, More study and vetting is needed to assess if CRP has a place in lowering liability outcomes, decrease the practice of defensive medicine, improve quality of care, and decrease the stress to the patient and physicians when an adverse outcome occurs; therefore be it

RESOLVED, That our American Medical Association urgently research the Communication and Resolution Program as a viable option to settle disputes, prior to litigation. (Directive to Take Action)
RELEVANT AMA POLICY

Our AMA: (1) reaffirms its support for investigating promising Alternative Dispute Resolution (ADR) mechanisms, in the context of demonstration projects designed to evaluate whether they resolve medical liability claims fairly and in a more timely and cost-effective manner. (2) The AMA strongly recommends that if cost containment goals are to be achieved, ADR proposals designed to provide greater access to legal process must incorporate effective mechanisms to: (a) identify non-meritorious claims and dispose of them; (b) decrease the proportion of cases being litigated; (c) increase the portion of any settlement payment received by the patient; and (d) identify appropriate guidelines for the payment of damages; and (3) continues to monitor and disseminate information to state and component medical societies about state and federal initiatives that address the issue of protections from liability risks for physicians who provide volunteer activities and care of the indigent, as well as the effectiveness of those initiatives. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.
Citation: BOT Rep. M, I-92; BOT Rep. I-93-53; Modified: Sub. Res. 205 and Reaffirmation A-00; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed in lieu of first resolve of Res. 214, I-15

Enterprise Liability H-435.968
The AMA: (1) affirms its position that effective medical liability reform based on California’s MICRA model is integral to health system reform, and must be included in any comprehensive health system reform proposal that hopes to be effective in containing costs, providing access to health care services and promoting the quality and safety of health care services; (2) opposes any proposal that would mandate or impose enterprise liability concepts. Federal funding to evaluate the comparative advantages and disadvantages of enterprise liability may be best spent studying the operation, effect on liability costs and patient safety/injury prevention results of liability channeling systems that already exist and function as close analogs to the enterprise liability model (BOT Rep. I-93-53); and (3) supports strong patient safety initiatives and the investigation of alternative dispute resolution models, appropriate uses of practice parameters in medical liability litigation and other reform ideas that have the potential to decrease defensive medicine costs and more fairly and cost-effectively compensate persons injured in the course of receiving health care services.