Final Progress Report
NPSF Joint Medical-Legal Conference at SMU
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Structured Abstract

Purpose: This conference was designed to bring together senior members of the medical and legal professions for an intense, collegial discussion to forge common goals in specific areas for the improvement of patient safety.

Scope: The subjects included (1) creating effective medical reporting systems; (2) creating a legal atmosphere conducive to open clinical communication devoid of the fear of extraneous litigation; (3) establishment as a national standard of full, immediate disclosure of injuries to patients (when such injuries involve medical mistakes); and (4) identification of needed model statutory changes.

Methods: To enable productive, responsive, Socratically moderated discussion, participants were limited to fewer than 20, and presentation of formal positions was banned in favor of inviting use of the extensive expertise of each member as an individual.

Results: An impressive level of agreement was produced regarding the major systemic, societal blockages to communication, disclosure of medical injuries, and establishment of reporting systems. Also produced were the beginnings of a coherent series of steps for long-term and short-term national solutions, inclusive of suggested immediate statutory changes. Although, as expected, there was insufficient time to draft such statutes, the distillation of advanced, cooperative thought created an unprecedented framework for understanding the conflicts and providing new pathways to national solutions; specifically, discovering that disclosure is already operationally effective in blocking punitive damage recoveries constituted a breakthrough.

Keywords: Disclosure, Reporting, Clinical Communication, Patient Safety, Medical-Legal.

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Purpose

The concept for this meeting arose from the recognition that two great American systems - legal and medical - are impeding the urgent national interest in improving patient safety wherein they collide over incidents of medical malpractice. In fact, the negative influences of each on the other are costing Americans dearly in many ways, and, in addition to the negative impact on the quest to improve the safety of American healthcare, even regarding individual rights of recovery for injuries, our jurisprudential structure is failing to deliver what it was constitutionally designed to provide.

The contemporary realization (as embodied in the pivotal 1999 IOM report, *To Err is Human*) that the incidence of serious and lethal medical errors has far surpassed epidemic proportions is now driving the corresponding nationwide emphasis on patient safety. This emphasis, in turn, has focused us on the reality that, as the medical and legal professions interact on the battlefield of tort law, the intense defensive reactions sparked on both sides vastly decrease our ability to improve patient safety levels through open communication.

Utilizing the theory that, when great institutions become hopelessly polarized and deadlocked on a major issue, their representative professional associations will be equally and myopically preoccupied with preaching their respective positions, this conference was constructed around the philosophy that little would be gained by hosting a conference featuring formal representatives of such associations. Instead, we used the operative philosophy that bringing experienced members of each profession together *as individual Americans* with the shared goal of looking for common ground and solutions to a major American problem would remove the posturing and enable a fresh examination of all facets of the subject.

The theory was validated by this conference, which brought forth a rich panoply of ideas, information, and formulation of common goals as well as potential solutions. In addition, we limited the size to fewer than 20 participants and thus gave ourselves the ability to maintain a free and open running dialogue with minimal intervention and direction by the moderator. What was achieved was an exemplary atmosphere of respectful and unimpeded collegiality among professionals normally perceived to be at war with each other. The first result of this conference, then, is a solid validation of the concept that this form and method should be freely recommended as a model for discussing even the most difficult problems. Regardless of institutional deadlock and ideological calcification, men and women of good will in this society can always find a way to sit down with each other and focus on what we have in common, and the goals we want to achieve together, rather than further institutionalize what divides us.

The conference was to consider a narrow scope of three areas:

1. **Communication** - How to enhance the informational exchange among professional clinicians across the spectrum of American healthcare so as to rapidly learn from errors and omissions as well as mistakes and disasters with the goal of never repeating them;

2. **Reporting Systems** - How to create and nurture and appropriately protect and use national reporting systems with a level of effectiveness similar to the NASA-run ASRS (Aviation Safety Reporting System);

3. **Disclosure** - How to change the practice and the expectation of the healthcare culture so that full and immediate disclosure of injuries caused by medical errors becomes the unquestioned standard in every case.

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Scope

The conference was divided into 3 days, beginning with a working, get-acquainted dinner on the first evening following arrival and check-in; a full working day on day two; and a half-day morning on day three, including summary and action planning for future use of the ideas generated. This form, too, was highly successful, in that the level of cooperative collegiality is served by having the opportunity for personal introduction and acquaintance of the participants, all of whom are highly educated and motivated professionals. The list of participants is memorialized elsewhere in these filings (see Appendix I); participants included several extremely effective and experienced trial lawyers typically representing plaintiffs in medical malpractice cases as well as a cross-section of physicians, academicians, governmental representatives, and other associated professional members of the healthcare community. The common goals were clearly defined, and the common interest of improving patient safety was clearly accepted by all. There was no expectation of writing a definitive new statute or series of rules or changes in a mere 3 days, but the process, it was hoped, would begin with this conference, and indeed it did.

Though one of the admonitions of this conference was that it was not designed to discuss or consider the highly volatile and largely hyperbolized subject of “tort reform,” the participants found it impossible to not consider certain aspects of the current dysfunctional system, why it is dysfunctional, what effect it has on patient safety, and what systems and principles need to be changed societally. One area of early unanimity is that the current various crises facing the United States healthcare system arise in surprising measure from a common problem, the out-of-control swings in the market for professional (malpractice) insurance. The role of the insurance industry does not end with the wildly volatile swings in premiums but involves and drives a wide variety of negative effects as well, including the inherent involvement of insurance lawyers and adjustors in making decisions on disclosure, settlements, reporting systems, standards of practice, and many other elements central to the questions revolving around the need to significantly improve patient safety systems. Indeed, the insurance industry mightily influences so many aspects of the problems discussed that the many facets of such influence were seldom out of our discussions. Inasmuch as the insurance industry has on one hand the ability to create negative influences, it also has a massive ability to make needed changes; as such, the industry should be recruited, however reluctantly, as a major partner in the many different alterations this conference discussed as needed changes.

Of the many insights arising from this conference, one very significant realization of mutual understanding involved the concept that disclosure is far more than just a good idea or a beneficial or moral methodology; it not only should be a right---it appears by common law to be, in fact, a right. Specifically, each patient has a right under the common law, whether or not it is couched as a fiduciary responsibility, to be fully, completely, promptly, and honestly informed when a medical error of any sort materially affects that patient. Though not statutorily defined on a national basis as yet, and though not incorporated as a standard article of the common law, there was considered to be sufficient precedent to maintain that the right has been established. That is a very important and very new concept.

Methods

All three of the primary areas were discussed, but the vast majority of the practical focus ended up centering on disclosure and reporting systems. Although communication was inadequately addressed as a standalone issue, the principles that will enhance open discussion among clinicians are essentially identical to those that govern the major changes needed to achieve disclosure and establish effective reporting systems. Therefore, all three basic goals of discussion were thoroughly examined in essence.

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Among the areas of reasonable unanimity were several subjects not easily placed in any of the three basic discussion categories. The first of these arises from the shared assumption that there are very few truly bad physicians, nurses, pharmacists, and other medical professionals in practice, and those "bad actors" who do exist share similar profiles:

1. The current system is egregiously ineffective in identifying and permanently removing such individuals from practice, especially in the case of physicians;

2. Such "bad actors" account for a very disproportional number of the medical malpractice claims filed annually across the nation;

3. Such "bad actors" tend to make repeat appearances as defendants in medical malpractice actions;

4. The faith of the American public in the reliability and trustworthiness of the healthcare system is inordinately compromised by such individuals.

The opinion that the medical profession in general must, for the first time in the history of American healthcare, vastly alter its methods so as to effectively identify and eliminate such "bad actors" is paramount to substantive improvement in patient safety. Clearly the present systems and methods involving licensing do not accomplish this goal, and the American public is becoming acutely aware of this generic failure. Although very small in number and percentage, these people wreak havoc on the practice of medicine and its reputation, and they significantly contribute to the number of annual patient injuries; this represents a major challenge that must be addressed concurrently with any restructuring of the system to improve communication, enable disclosure, and create reporting systems. By definition, the number of medical malpractice suits and the amount of money recovered in such suits will drop dramatically once this problem has been dealt with effectively.

A second area of unanimity involves the National Practitioner Database, set up to identify physicians who have been involved in litigation, regardless of the cause or efficacy of the action. The database is a very serious barrier to disclosure, reporting systems, and free communication, in that the near-myopic struggle of every physician involved in a medical malpractice action to avoid being listed on the database leads to skewed priorities, blocks settlements of fair compensation for injuries, affects the willingness to disclose, and exacerbates the reluctance to trust a reporting system. Though fear of monetary devastation resulting from an uncovered medical malpractice lawsuit recovery against an individual physician or nurse (or other practitioner) is a major driving force in the defensive decisions (including the decision to be dishonest) of such people, the intense determination to avoid listing on the database is equally destructive. It is the clear consensus of this conference - both the medical and legal participants - that Congress needs to dissolve the National Practitioner Database as fast as possible as an important step toward improving patient safety.

As stated, disclosure accounted for a majority of the focus of the discussions. A rough definition (by no means a consensus-derived definition) as used by the participants would be that disclosure is the act of informing a patient and/or family of the fact of an injury resulting from a mistake or error of whatever nature; expressing regret and/or apologizing and providing supportive sympathy; and declaring the intent to either compensate or otherwise help ameliorate the medical condition created as well as declaring intent to faithfully discover all aspects of the causation chain and then alter the system with the stated purpose of never allowing a similar injury to occur to anyone else.

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The case **for** disclosure consists of the following major elements:

1. The clear medical ethical mandate as enunciated by The Joint Commission is clear and unambiguous. Practitioners do not have an ethical choice of whether or not to disclose.

2. There is strong and persistent anecdotal evidence that disclosure is the best, safest, and most economical course for any hospital, healthcare organization, or individual practitioner to follow. In economic terms alone, it is estimated that a minimum of 62% of medical malpractice cases would never have been filed had disclosure (to include apology) occurred. Correspondingly, the devastating monetary awards that often result from a jury discovering that a physician or hospital has been lying and attempting to cover up an error leading to an injury should lead all such individuals and institutions to adopt a policy of strict, unquestioned disclosure on economic grounds alone.

3. There appears to be in common law a right or the presumption of a right vested in every patient to expect disclosure as an integral part of the standard of care. There was discussion of whether this had been sufficiently established and a feeling that it has not. There was also the feeling expressed that the patient safety crisis is far too serious and immediate to wait for case law to slowly establish this. One participant made the point that, though he never liked to favor legislation to make people do what they ought to be doing anyway, disclosure was probably an exception, and, in regard to the reliance on case law and a common law right to establish a universal disclosure policy nationwide, the time required is obviously unreasonable, being measured in decades.

Furthermore, it was stated that the reason that we have so little formal data supporting the economic value of disclosure is the fact that, although more and more practitioners and institutions are adopting disclosure as their norm and being faithful to it, they are very reluctant to report what they're doing or to otherwise publicize it. Thus, we have no experiential data despite the fact that there is a growing body of experience out there validating the economic, business case for disclosure.

According to one participant:

> "If there is a policy of disclosure, there will be a significant reduction in cost for the insurers and the providers they insure. Every patient who has been apologized to and fully informed about the details of a medical error that had adverse impact on him or her takes less money in settlement or award than in the absence of such disclosure."

The general feeling was that this is an axiom, but the challenge is to find the statistics to fully prove what we already perceive to be true about this.

Disclosure was also defined as a process of defusing the situation of a medical error resulting in injury by muting the intense emotions that result from (1) not knowing the truth of what really happened and why; (2) having no indication that the institution or the practitioner is affected by it and humanly sorry it occurred; and (3) having no indication that the system will be changed to make sure no one else is so affected.

There was much substantive discussion about the acknowledged power of disclosure to defuse the intense feelings of survivors of medical injuries arising from error and help direct those feelings toward useful, restorative, and non-litigious efforts. This fact does not imply a recommendation to use disclosure as a means of blunting or defusing the legitimate interests of an injured patient to be made as whole by monetary means as soon as possible.

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However, when addressing an injury (in the absence of some future form of non-litigation compensation system), disclosure can promote a more rapid and efficient means of providing just compensation to the injured by defusing the need to automatically litigate just in order to force answers and remedial action.

The barriers to establishing disclosure as the national standard for healthcare were discussed as follows:

1. Though physicians in particular know that they have an ethical obligation to disclose, that obligation is typically ignored and is considered trumped by their obligation to their family and community to refrain from engaging in what is too often considered professionally self-destructive conduct.

2. Hospital lawyers (otherwise known as in-house counsel or general counsels) typically advise their clients to remain silent and not disclose, because this is the safest course of action from a legal exposure point of view and because such lawyers do not want to be guilty of malpractice in giving the right moral advice that is, in fact, the wrong legal advice. This begs the question of how to change the tendency of lawyers to advise silence to one in which the lawyer's ethical obligations - as well as his perception of the best course of action for the client - require advising immediate disclosure.

3. Physicians and nurses have a near-universal perception, right or wrong, that disclosure makes them a personal target, not only for any opposing counsel in a lawsuit but for the medical licensing authorities, their employer/hospital/HMO, etc., and even their peers. Regardless of the ethical breach and the typical lying that is required to remain "silent," silence is clearly perceived as the safest course of action - for the individual as well as the institution.

An important component of this is that doctors often worry that a judgment against them personally will exceed the limits of their malpractice policy, thus exposing everything they own to confiscatory verdicts. Though the reality shows that this fear clearly is grossly overstated, it is nevertheless true that the perception drives the decisional actions of practitioners to hide and deny and not disclose based on their substantial fear of such factors. In addition, the fear of being sued includes the fear of being reviled as a bad person or a bad doctor and dealing with yet another episode of self-critique and insecurity in addition to what most practitioners feel on the commission of an error, however small. Reputational concerns are a substantial motivator not to disclose, especially wherein a practitioner believes that the error can successfully be covered up by silence.

4. Most participants did not feel that the following is a major problem, but there was discussion of the fact that most malpractice insurance contracts contain provisions that could in theory be used to deny coverage for a covered practitioner who disclosed without insurance company approval.

5. Most physicians in particular do not disclosure simply because they do not believe that they did anything wrong to begin with. Disclosure is perceived as admitting not just a human mistake but a professional incapacity and shortcoming that would be deeply embarrassing to a person taught to expect an impossible level of perfection of himself (or herself). In addition, most physicians do not believe that silence (not disclosing) is wrong. Such practitioners feel that the disclosure requirement is limited and pliable, even though that perception is in diametric opposition to the clearly enunciated ethical imperative.

6. As a system, the process of disclosure fails to guide physicians as an ethical requirement, because there is no supporting infrastructure to counter the human fears of needing to avoid exposure to extraneous personal harm.

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7. As a group nationwide, doctors, nurses, and other practitioners do not believe that disclosure is the safest course of action. This belief is increasingly seen to be erroneous, but the cultural mythology is a strong bond requiring massive and multifaceted efforts to overcome.

8. Lack of Enterprise Liability is a significant bar to disclosure, because each practitioner tends to circle his own wagons in defense, having watched too many colleagues singled out in past litigation in which the individual, and not the system that supported his error, becomes the blameworthy component. If one member of a medical team refuses to disclose, for instance, the result can be no disclosure, or censure for the one who breaks ranks. There is a destructive intramural battle in many cases over who gets the blame, and such battles effectively destroy any ability of the team or the system to learn from the mistake and incorporate the lessons to prevent a recurrence. Errors are messages from the underlying system, but assignment of blame to an individual fails to utilize such messages.

One of the most effective and powerful realizations came on the third day of the conference with the relating of a recent medical malpractice case and the principle it embodied, as well as the use that could be made of such examples. In brief, following knee replacement surgery, a nurse put the right pain medication in the wrong path (epidural[1] anesthetic placed in an IV), resulting in seizure and coronary arrest and resuscitation, leaving a formerly healthy 75-year old woman brain damaged, incontinent, and in need of nursing home care for the remainder of her life. The CEO of the hospital within 24 hours went to the family, fully disclosed and discussed the error and the situation, promised to find out all the causal elements and change his system to prevent recurrence, and promised aid and compensation as appropriate. The family hired an attorney who duly filed suit and was amazed to have the hospital system's general counsel call and ask for a meeting to agree on the damages to be paid. As a result, no expert witnesses were hired at high expense (two life planners were the sole outside expenditure), only a few months of work was required, and all issues were settled. The key point is that, because the hospital did all the things that we would define as full and honest and immediate disclosure, the ability of the trial lawyer to get, or even ask for, punitive damages was essentially neutralized.

In the words of the attorney:

> "Now, what happened in this mediation is exactly what I think would happen to every single healthcare provider that operates like this. I'm sitting there in both mediations telling my clients, 'your compensatory damages are big and we are going to fully recover them...life care plan, pain and suffering, all that Texas law says you should get. But, folks, it's my humble opinion that punitive damages, which is what changes a solid compensatory verdict into what the defense bar and medical community would call a runaway verdict, is not there.' I listen to the mediator, and every time he says, now this is an egregious error...it's a big error...but think about what these people did [after the fact]. Do you really think you're going to be able to hit them for punitive damages on these facts? And the honest answer is no. So what happened? Not one deposition was taken, we hired no experts except for the life planners, and litigation which would have taken 2 or 3 years took a few months...we signed a confidentiality agreement on nondisclosing identities.

[1] **Def.** - Epidural anesthetic - an anesthetic that is injected into the "epidural space" in the middle and lower back, just outside the spinal space, to numb the lower extremities.

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> I don't know how much they saved, but if they'd acted in any way to cover it up, I would have wanted multiple punitive damages, and under these facts I would have gotten it."

The reason this is a powerful point is that, amidst the discussions of the previous days on how to convince practitioners and hospitals alike that disclosure is the best, safest, and most economical course of action, the discussions revolved of necessity around various methods of statutorily mandating or otherwise creating powerful incentives to disclose. Among those ideas were potential tradeoffs; specifically, the concept was discussed that, perhaps in compensation for full and immediate disclosure, a hospital or practitioner would be protected from punitive damages except in extreme cases of wanton or clearly reckless behavior. What this story does is establish the fact that the ability of disclosure to bar punitive damages, though not guaranteed in all instances, is essentially already a fact. The challenge, in other words, is to communicate this reality though this and other similar case experiences to the medical community, neutralizing arguments against disclosure by the reality that it is the best and most compelling way to prevent so-called runaway verdicts. As one of the participants put it, "Disclosure takes the sting out of the case and defuses the anger. Whatever happens would have been worse without it."

The question progressed to the following: How do we change the system so that in-house counsel would never advise anything but full and immediate disclosure, and physicians and nurses would never think of <u>not</u> running quickly to fully disclose?

In long-term thinking, the potential involvement of the American Law Institute was suggested, providing a substantial, if slow, method of legitimizing disclosure as a national standard of care requirement by finding a way to universally codify it. While considered by most to be an excellent suggestion, such a course does not solve the problem quickly. It was re-emphasized that changing the culture will first require changing the perception of physicians and nurses regarding the personal exposure arising from disclosure. That led to discussion of the various ways in which practitioners could be enticed to disclose, and sanctioned or punished for doing the opposite.

As one stated:

> "One of the truths here is that on one side of disclosure - those who lie and don't disclose - we need to increase the sanctions to a near-Draconian level. On the other side, we need to make all aspects of disclosure so attractive and compelling that even the in-house counsel will advise you disclose every time and quickly."

There was discussion of a suggestion to convene a meeting among the prime representatives of the respective professions, the American Bar Association and the American Medical Association, asking them to take a stand together specifically on this issue of disclosure. Bringing some of the major insurers in to do the same thing would have an even more profound effect, because it would impact the marketplace and invite unanimous agreement among insurers for the purpose of avoiding competitive reputational advantage. Involving some of the larger hospital organizations is another method. The underlying theme was that the quickest way of instituting this concept is having major organizations champion the reality that it is the safest and the only ethical choice, which helps disseminate such case histories; specific research is solicited to provide a formal validation of this reality that, whatever else happens, disclosure is the most economical course.

Associated with this approach is the reality that some legal changes over time will be needed on either a state or a federal level to absolutely protect those who disclose from certain forms of retaliation or retribution.

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Enterprise liability is the most profoundly effective method of doing this, but attention should be paid to the punitive reactions inherent in licensing boards nationwide, especially nursing boards, which are perceived as having no hesitation to take a disclosure and use it as the basis for a disciplinary action. This area is probably ripe for some form of commerce clause federal legislation, in that it is clearly in the public interest to have universal disclosure without hesitation due to fear and because the ability to extract lessons and information leading to systemic repair depend on such disclosures. It is, in other words, in the national interest to treat this matter uniformly.

One eloquent summation of this subject was as follows:

> "You can postulate a right of a patient to receive prompt notice of medical injury resulting from an error. You can argue whether the right is already in existence, in what states, on some sort of implied or potential or common law basis. But there is a way to begin to build support for the notion that there is a right and should be a right and that it should be considered either through a state law or federal as a stand-alone law. And, if you have such a law, a uniform law saying the patient's right to be fully informed may not be abridged, then the insurance companies are going to have to walk a far different line than before and must advise disclosure."

It was brought up that insurance companies will not uniformly want to support such legislation, because they enjoy the economic advantages of the inherent gatekeeping function of the current tort system in weeding out claims not sufficiently high to support the enormous cost of litigation. That gatekeeping function essentially denies redress the vast majority of injured patients, and the estimate is that as much as 75% of injured patients are locked out of any recovery even for minor amounts (lost time on the job and medical expenses). In addition, disclosure will make potential plaintiffs of those who might not otherwise have even known their injury was caused by a mistake; if a potential plaintiff is ignorant of the tort, he won't seek a lawyer or sue. Though both these reasons are outrageous and clearly contrary to the public interest, to the extent that they exist, they can be effectively overcome by changing the national standard to one of disclosure by federal statute.

One of the senior lawyers present added:

> "If you could show a hospital board the dramatic effect of having either an administrator or a doctor on the stand in a long trial, where no one doubts that the negligent conduct caused the injury, when they're asked the question, have you apologized? That is damning when they can't answer yes; you can hear a pin drop. Usually what happens is this: at the beginning of the trial, the defendant has denied responsibility, but by the end everyone knows from the evidence that's not true, and it's obvious they knew it from the first. That inability is devastating to the defendant."

Results

Although we did not formally emerge with specific recommendations or statutes, there was a degree of unanimity in the idea that a statute should be considered on the federal level, as a stand-alone law that affirms not the responsibility of disclosure but the **right** of every patient as a part of his expectation of receiving an adequate standard of care to receive disclosure in the unfortunate event of an injury caused in whole or in part by error or mistake.

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Hand in glove with any such statute should be one also under federal pre-emption that says, in effect: **"No apology or expression of sympathy or regret by a medical practitioner following a patient injury arising in whole or in part from a medical error shall be considered an admission in any court of any jurisdiction in the United States."**

The discussion, of necessity, focused on the various ways in which the tort system impedes communication, reporting systems, and disclosure. From that discussion came some very profound realizations:

Our system of truth finding and tort addressing of injuries to make people whole was designed by the US Constitution, but, when it comes to medical mistake injuries, the system does not work:

1. It intimidates practitioners to silence, zeroing out the potential exchange of vital clinical information about mistakes as well as practice problems supporting such mistakes. (The fact that the threat is overstated by practitioners is immaterial, because the perception is so strong as to be the operative problem.)

2. The vast majority of those injured possess claims too small to justify a contingency lawsuit, and such individuals are least likely to be able to afford to bankroll their own case. In addition, many insurance carriers as well as doctors will fight to the death even small cases to avoid (a) the database and (b) any admission of imperfection whatsoever.

3. It presupposes the need for blame and the presence of negligence in negative societal terms that are de facto massive assaults on the professionalism of practitioners, even though the majority of such cases involve human errors, not discretionary professional errors for which blame appropriately ensues.

4. Instead of spurring correction of systemic problems, it fosters blind defense and sometimes even the need not to change in order to maintain the facade of perfection.

5. It consumes vast resources, wasting time and money and sometimes requiring the expenditure of millions in order to extract a truth that - for societal purposes and public safety - needed to come out within days of the incident.

6. It is a debilitating experience for all involved, and, far from being a minor consideration, it significantly alters in the negative the lives and sometimes the lifestyles of those who are forced to turn to it (the tort system) for addressing occurrences that in and of themselves may have been personally devastating.

There is a key point in the philosophical aims of both systems being so different. One of the greatest problems is the inability of the tort system and the current mentality of the medical system to accommodate the critical differences of (on one hand) the setting of legal responsibility/negligence/blame/liability as a method for deciding who pays for a mistake under the very narrow intent to make a victim whole with money; on the other hand is the concept that injuries arising from medical mistakes are system errors require full investigation and correction of *all* contributing elements, and these comprise vital messages form the underlying system, separate and apart from any consideration of payment of damages.

Clearly, the legal system is designed to find and deal with only <u>fault</u>, though a desired system of open clinical communication and systemic analysis is one in which the object is to discover <u>causation</u>. Fault is a moral and legal concept. Causation is a modern concept key to improving the performance of human systems. Aviation safety provides a powerful parallel, in that only thorough the adoption of the concept that no aviation accident was ever caused by a single failure were the true complex chains of various accidents understood.

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Each link in a causal chain may help forge a path to a very different accident sometime later, so addressing just one link - such as the failure of an individual - leaves many more systemic problems ticking away like bombs ready to cause another disaster. Therefore, finding fault in the personal and singular sense of pinpointing **who** was wrong in an accident or incident wholly ignores the fact that there is never one cause to a medical misadventure, and any human failure was supported by a host of systemic failures, every one of which must be addressed and corrected. Thus, the tort system, inasmuch as it seeks only to assign blame and thus find fault, is essentially useless as a tool for repairing a flawed system.

Unless we can pinpoint how to realign these issues of fault versus causation in American healthcare and understand the profoundly different chemical makeup of each versus the other, there will be no ability to successfully alter the overall system in order to unlock (1) disclosure, (2) free and open and protected flow of clinical information, and (3) a structure of reporting systems. If our goal as a society is to extract as much clinical information from errors and mistakes as possible so as to prevent having to re-learn lessons over and over again at the expense of thousands of injured patients, then the process of discovering what went wrong must have a different primary aim than assigning blame and financial responsibility. The tort system is wholly unable to provide this service as a primary function, because assignment of blame is the bedrock element of the exercise, even when the only blame belongs to the system. This is one reason that, at minimum, enterprise liability must be in place in any tort system touching on medical mistakes or errors, not to protect individual practitioners but to keep the focus where it belongs, on the system.

There was also discussion of the fact that the concept of just compensation for injuries caused by medical mistake hovers on the periphery of all these subjects; because the current system is abysmal at providing compensation for small claims affecting the average American, some form of just compensation in a mediation-based system designed to rapidly extract useful clinical information about causation and apply it is needed. This does not and should not in any way preclude the tort system operating on major or egregious cases. Whatever form such a system should take - voluntary submission to mediation or mandatory mediation/binding arbitration with the ability to remove to the tort system, the operative point is that the current deadlock between the two, as demonstrated, does not serve the best interests of anyone, including the litigators who must spend enormous sums to extract the truth from those who do not want to reveal it, despite the inherent rights of a patient for that very commodity.

In addition, because a nearly universal desire of injured patients is to prevent the error from affecting anyone else, cases that do eventually end up in a potential award of punitive damages might be altered under a statutorily mandated form of equity jurisdiction as follows: Punitive awards (not compensatory) could be in whole or in part predicated on repair of the system. In other words, a jury could add a certain sum to a punitive award and give the defendant the choice to either pay the amount in full or fix his system and prove to the continuing jurisdiction of the court that the repair is sincere and permanent and effective, so repair then causes that portion of the punitive award to be waved. Giving a jury as the finder of facts the ability to mandate change thusly would partially address the complaint that monetary awards flowing from insurance carriers and other deep pockets seldom change systems.

The discussions on reporting systems involved tangential reference to all the points regarding disclosure in that one of the key elements of a reporting system that works has to be the faith of the practitioners/reporters that there will be no retribution or personally adverse use of the information provided. As one member said, “Nurses today consider both subjects (disclosure and reporting) tantamount to a joke because, if they admit a mistake, they get hit upside the head, not stroked or complimented.”

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The reality that our healthcare system is still by and large imbued and infused with a dedication to finding someone to blame and sanction (shame and blame) for any failure, and correspondingly the dangerously wrong expectation hammered into every doctor and nurse that they can and must be perfect and never make a mistake, means that the cultural change necessary to accommodate the prime directive of a reporting system will take time to achieve. That so-called prime directive is that the "human reporter" appreciates the fact that no human can be perfect, and the best method of fighting the potentially disastrous effects of human mistake is by constructing a system that understands and expects errors and builds enough buffers to safely absorb them. That recognition alone mandates sharing of clinical information about human failures and sets the stage for acceptance of methods to accomplish that goal. A national reporting system similar to the NASA ASRS system would be vastly more complex and widespread in its demands for funds and personnel, and enabling legislation would be greater than the aviation version - though the need to be absolutely certain that confidentiality of the de-identified reports can never be breached is equally paramount - but the effects over time will be to truly create a safety community in which errors are seen as important messages to be harvested and studied, not evidence for a hanging.

The insights of the conference on the subject of establishing reporting systems then included these basics:

1. The system's reporters have to have a 100% guarantee of protection by federal law and a congressional intent to defend the anonymity against all testing by any court. One breach, and the system collapses from widespread lack of confidence.

2. MedWatch is a good but limited beginning example in US healthcare somewhat modeled on the ASRS system.

3. The information provided must be dynamically used in real time, not just data banked.

4. A system providing for direct contact with the reporter prior to de-identification would be more effective, especially given the complexity of medicine.

5. Reporters must have an incentive to report beyond just goodwill. Suggestions of a nationwide insurance discount for reports or some similar incentive to match the ASRS "get out of jail free" exemption against FAA certificate action will be necessary.

6. The reporter must be given substantive feedback on how his or her input is being used or responded to. This requires a different type of de-identification system than ASRS, which does not provide individual feedback after the report is de-identified.

Future use of conference results: Several points were in essence agreed to. The first is that the vast majority of (if not all) the participants are willing and eager to meet again and continue working on building these rather unprecedented bridges between the professions in order to further elucidate the rather surprising (to some) number of areas in which both professions share the same interests and goals. Second, there is a mutual dedication arising from this meeting to both long-term and short-term solutions, including the drafting and promulgating of standalone legislation on a national (or state-by-state) basis to rapidly change specifically targeted areas from their current dysfunctional state (disclosure being the prime example) and long-term solutions, such as involving ALI and other major associations.

Discussion was had in frank terms about future funding possibilities and grant applications, and the intent of the organizers to produce two major papers - one for a leading medical journal, one for a leading law review - was described.

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Though the work product resulting from the conference will take time (given the lack of a formal staff), the product - and the method - of this conference was considered by all participants to be highly useful. One of the most oft-repeated concerns expressed by participants in the post-meeting reviews (see Appendix II) was an uncertainty over “where we go from here,” and, though no immediate answer can be fabricated without further work, discussion, circulation of executive summaries, and future meetings, the ability of a small, focused group such as this to achieve a substantive series of breakthroughs in understanding and focus of previously deadlocked, calcified issues is hopeful.

In summary, **the goal of this conference to engage in substantive dialogue toward common goals where two great professions have been unable to cooperate was well and truly achieved**. The resulting clarity in the statement of the issues, problems, and goals shared as concerned Americans is in and of itself significant and, to a certain degree, unprecedented.

List of Publications and Products

There are no publications and/or products to date, although two major papers, one for legal and one for medical, are pending.

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Appendix I – List of Participants
NPSF Joint Medical-Legal Conference at SMU

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Appendix II – Evaluation Results*
NPSF Joint Medical-Legal Conference at SMU

* *Not all participants submitted an evaluation form*	High		Average		Low
1. Overall, how would you rate the conference?	5	4	3	2	1

Comments:
The introduction of the dialogue was very useful particularly, I believe, to realize the trial lawyers really though all errors were hidden, doctors only tried to protect themselves, etc.

2. From your perspective, how effective was the conference in meeting its objectives?	5 ×××	4 ××	3 ×	2	1
3. Did the conference meet your expectations?	5	4	3	2	1

Comments:
I really didn't know what to expect as an outcome and I believe the dialogue was extremely informative and useful. I wish we could actually spread the dialogue to larger numbers of both physicians and lawyers.

4. Do you believe the subject matter was presented and discussed objectively and with fair balance?	5 ×××	4 ×	3	2	1

5. What did you like best about the conference?

- *Cooperative, respectful participation from all perspectives – unique combination of participants.*
- *The opportunity to gain the perspective of those who represent other sides of the patient safety issue (i.e., confidentiality v. the right to information).*
- *The blending of the professions of law and medicine in an effort to make changes that should be positive for people.*
- *Choice of participants*
- *The dialogue with colleagues from medicine and other side of tort reform issue*
- *The opportunity to hear the "other side" from people who were experienced, intelligent, and not extremist in their views. It was great to have some ideas about the cause of malpractice suites validated by those who pursue them.*
- *The ability to meet with and discuss with all members of the medical legal debate on issues of the perceptions of stakeholders.*

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6. What did you like least about the conference?

- *Unclear what ultimate goal of conference would be.*
- *There was nothing to dislike about the conference. It would be a shame, however, if this was just a one-time meeting. Patient safety and quality improvement are evolving. NPSF/AHRQ has the opportunity to convene regular meetings for stakeholders from different interests across the spectrum as this issue evolves. Funding for such meeting should continue, long-term conference objectives should be set, and progress reports should be submitted to NPSF and AHRQ for dissemination.*
- *I have some concern that the goals of some of the participants might be unrealistic.*
- *N/A*
- *I didn't come away with a clear idea of where to go with this, other than for someone to write it up. We didn't come up with a new grand strategy that will lead to resolution of the problem.*
- *There was little in the way of outcomes or deliverables that could be broadly disseminated to promote policy; a proceedings or future event based on the activities would have been welcomed.*

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