

**IACT Program**  
**A Medical Disclosure and Transparency Program**

Doctors are human! Despite best efforts to provide the safest care possible, mistakes can and do occur. Modern health care involves such complexity that our ability to deliver flawless care becomes increasingly difficult. Our tort system is meant to compensate patients when harmful errors occur, but does the system really work? Are doctors and hospitals able to learn from mistakes? Do we truly meet the underlying needs of patients? And finally, is litigation the best method for resolving issues that arise in the health care context?

Currently, medical error is the eighth leading cause of death in this country – a ranking that does not include the number of errors resulting in permanent injuries that do not involve death.<sup>1</sup> Better systems and policies that account for human fallibility are essential in our efforts to improve patient safety, as the Institute of Medicine report states, 90% of errors could be prevented by improved “systems.”<sup>2</sup> Nationally, tremendous effort has been aimed at encouraging disclosure of errors and “near misses” so errors can be examined and appropriate system changes can be made.

However, a deeply entrenched culture of secrecy has made it difficult for doctors and hospitals to disclose errors. Ingrained in this culture is an expectation of perfection, even amongst physicians themselves, stemming from medical education and even from the AMA ethical guidelines dating back to the early 1900’s. Secrecy is reinforced by the fact that when errors are realized, doctors view as punitive those actions taken by insurers, accreditation bodies and medical boards that require reporting to outside sources such as the National Practitioner Databank. These responses and investigations are often triggered by patients wanting to understand what happened to them when unanticipated outcomes occur.

Doctors are targeted individually in our current tort system and are strongly impacted by lawsuits against them - emotionally, financially and professionally. Symptomatic reactions are exceedingly common among physicians that have been sued for malpractice, with 97% experiencing physical or emotional reactions.<sup>3</sup> Even though actual rates of error are high, doctors also overestimate the rate of malpractice claims brought in response to those errors.<sup>4</sup> They often feel that malpractice claims are

unjustified - and they may be correct.<sup>5</sup> One study showed 40% of 1400 claims retrospectively evaluated involved no underlying medical mistake.<sup>6</sup> As a result of these impressions, the tolerance for uncertainty about medical outcomes is pushed to very low levels. “Consequently, physicians may conclude that the only way to avoid a suit is to do everything possible to avoid an adverse outcome, no matter how unlikely the bad outcome is or how costly the intervention.”<sup>7</sup>

In reality, only 2-3% of patients injured by medical mistakes actually file lawsuits and far fewer ever receive compensation.<sup>8</sup> When they do, it is on average five years later. By that time, tremendous costs have accumulated - often well over \$100,000. Typically, patients receive approximately half the amount they are eventually compensated, with the remainder needed to cover costs and attorney fees.<sup>9</sup>

Medical malpractice defense attorneys have traditionally instructed doctors not to disclose information to their patients - utilizing the traditional ‘deny and defend’ stance. Though this advice may be aligned with the ‘win-lose’ adversarial litigation system where the only remedy is monetary compensation, this position does not address the underlying needs of doctors or patients.

Physicians involved in medical error need more emotional support and they may need assistance to most effectively communicate errors with patients and their families. “For many physicians, the most difficult challenge is forgiving themselves for the error.”<sup>10</sup> One study found that doctors who are aware of mistakes they have made in the past few months experience a sense of diminished quality of life and higher burnout, as well as, symptoms of depression, and decreased empathy with patients.<sup>11</sup> Thus, the making of an error results not only in personal distress for the doctor, but also negatively impacts subsequent patient care.

Patients, on the other hand, need engagement by physicians and often find themselves pursuing litigation simply to obtain information that has not been forthcoming. Research over the past decade has shown that the three things patients want most in the face of medical error are: 1) information about what happened to them; 2) a sincere apology; and 3) reassurances that measures will be taken to prevent recurrences.<sup>12</sup> Financial compensation is actually quite low on the list with patients generally seeking attorneys out of anger rather than greed. When unanticipated adverse outcomes occur, whether or not there has been

error, doctors tend to distance themselves due to feelings of guilt and fear of malpractice litigation.<sup>13</sup> This defensive response only serves to fuel speculation that something must have gone wrong or the information would not have been withheld.

Our current tort system, though aimed at compensating patients injured through medical negligence, is really at odds with improving patient safety. Recognizing this irony, the Joint Commission said, “[t]here is in fact a fundamental dissonance between the medical liability system and the patient safety movement. The latter depends on the transparency of information on which to base improvement; the former drives such information underground.”<sup>14</sup>

Why not resolve conflicts early, through a process that facilitates disclosure and brings parties together face-to-face to work together toward conflict resolution and restoring relationships before a lawsuit is ever filed?

### **A New Model: Collaborative Law in the Health Care Context**

In contrast to the current litigation system, our approach for a medical disclosure and transparency program provides a safe, supportive and highly effective process that addresses both the disclosure and patient safety goals set by both the NQF and the Joint Commission. At the same time, the transformative aspect of the process restores relationships enables communication and closure among patients, practitioners and health care organizations in the face of adverse outcomes while decreasing litigation costs to providers and insurers.

Doctors can play an active role in dispute resolution rather than simply waiting passively to find out whether or not a lawsuit will be filed. In fact, doctors, health care organizations, and patients all have the power to initiate the process internally. However, participation is voluntary; the process cannot be mandated, and litigation remains an option.

Our program, called the IACT Program, provides for an informal pathway for disclosure for straight-forward situations or may involve the more formal pathway including a Collaborative Conference. In either case, disclosures occur as soon as practical after an adverse outcome. The patient is apprised of known facts with further disclosures when more information becomes available. Also, expressions of regret or apology may be made as appropriate. Providers are assisted with disclosures. Post

disclosure support is offered to help providers with the emotional impact caused by mistakes, and even by mere allegations of mistakes.

The more formalized pathway requires the signing a Participation Agreement containing a confidentiality clause. Each party is represented by a Collaborative Law attorney specifically trained in dispute resolution techniques aimed at addressing underlying issues - thereby eliminating the adversarial maneuvering to maximize financial recovery that occurs with litigation. Non-contingency based fees are essential in order to eliminate the mandate for financial outcomes. Neutral experts are obtained only as agreed upon in advance by the parties and may include medical, financial and other experts, as needed.

Additionally, IACT is one of a few disclosure programs that truly possess the potential to impact organizational culture. The removal of the punitive focus internally allows and encourages greater reporting - shifting the paradigm to a culture of safety and shared responsibility for patient outcomes. Information collected through the intensive screening of errors and near-misses is filtered into a data system which allows for comprehensive statistical analysis and trending to enhance health care quality.

Currently, few hospitals and doctors are regularly disclosing information in a proactive collaborative manner but are instead acting in a reactive defensive one. There are fewer than a dozen formalized proactive disclosure programs in the country and not all encompass an improved patient safety component with enhanced reporting and feedback of information for system improvements. Even though these programs are limited to the disclosure component and do not encompass the transformative aspect of the IACT Program that the Collaborative Law process provides, these programs have nonetheless, experienced dramatic decreases in litigation, most by greater than 50%. Providers involved in the disclosure process report they are very often surprised by the forgiving nature of patients and families even in the face of permanent and severe injuries.

## **Conclusion**

The breakthrough potential is enormous with the IACT Program for medical disclosures. Resolving conflict in a supportive process that

promotes the healing and well-being of those involved, without increasing legal costs, simply makes good sense. Leaders with vision are needed to make the shift and integrate this process within medical organizations for the benefit of the multiple stakeholders - including patients, doctors, hospitals and society, in general. The IACT Program gives closure and compensation to a greater percentage of patients harmed by medical errors and will also allow for increased learning opportunities from which to improve quality and reduce waste.

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<sup>1</sup>Kohn LT, Corrigan JM, Donaldson M., eds *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 2000.

<sup>2</sup>Kohn LT, Corrigan JM, Donaldson M., eds *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 2000.

<sup>3</sup>Charles SC, Pyskotty, CE and Nelson A. Physician on Trial-Self-Reported Reactions to Malpractice Trials. *West J Med*. 1988 Mar: 358-360.

<sup>4</sup>U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H--6O2 (Washington, DC: U.S. Government Printing Office, July 1994).

<sup>5</sup>U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H--6O2 (Washington, DC: U.S. Government Printing Office, July 1994).

<sup>6</sup>Studdert DM, Mello MM, Gawande AA, et al., Claims, errors, and compensation payments in medical malpractice litigation. *N Engl J Med*. 2006;354(19):2024-33.

<sup>7</sup>U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H--6O2 (Washington, DC: U.S. Government Printing Office, July 1994).

<sup>8</sup>Studdert DM, Mello MM, Brennan TA. Medical malpractice. *N Engl J Med*. 2004;350(3):283-92.

<sup>9</sup>Boothman, R.C., Blackwell, A.C., et al. A better approach to medical malpractice claims? The university of Michigan experience. *Journal of Health & Life Sciences Law*. 2009;2(2):125-159.

<sup>10</sup>Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patient's and Physicians' Attitudes Regarding the Disclosure of Medical Errors. *JAMA*. 2003;289(8):1001-1007.

<sup>11</sup>West CP, Huschka MM, Novotny PJ, et al., Association of Perceived Medical Errors With Resident Distress and Empathy: A Prospective Longitudinal Study. *JAMA*. 2006;296(9):1071-1078.

<sup>12</sup>Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA*. 2003;289:1001-1007.

<sup>13</sup>Mazor KM, EdD, Simon SR, Gurwitz JH, Communicating with Patients about Medical Errors. *Archives Internal Med*. 2004;164:1690-1697.

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<sup>14</sup>The Joint Commission. Healthcare at a Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury. 2005.