



The impact of
TRANSPARENCY
on patient safety and liability

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rofessional liability and unsafe care resulting in adverse outcomes are uppermost among the problems we surgeons face today. We have attempted to mitigate liability through tort reform and bad outcomes by way of continuing medical education (CME) and peer review protected by confidentiality. Even so, both problems continue to plague us.

In terms of outcomes, it can be empirically stated that CME for improving patient safety has been productive. But benefits from CME are arguably maximized, and errors are still all too prevalent: Researchers identified adverse events in 2.9 percent to 3.7 percent of hospital charts, 27.4 percent to 32.6 percent of which were caused by medical errors.^{1,2}

In terms of liability, insurance premiums have continued upward as the severity of awards has relentlessly increased: Gradually increasing over the decades, more than 7.7 percent of plaintiff awards exceeded \$1,000,000 in 2004 with no ceiling in sight.³ State tort reforms have proven that liability insurance premiums can be mitigated: Premiums in states with tort reforms are 17.1 percent lower on average compared with states without reforms.⁴ In addition, states with reforms increased their physician supply 2.4 percent between 1985 and 2001, but this came at the expense of states without reforms, creating access-to-care problems as physicians migrated to the more liability-friendly states.⁵ This maldistribution of the physician workforce could be resolved by federal reforms that make all states equal, but federal reforms are not forthcoming. Unfortunately, there are no demonstrable signs in states with tort reforms that peer review is enhanced, error reporting is facilitated, defensive medical practices are deterred, injured patients are more globally compensated, claims run their course quicker, sued physicians are less aggrieved, jackpot justice is curbed, or claims without merit are decreased.

New approaches

Faced with these failures to additionally reduce bad outcomes and liability, new approaches are being pursued. Prompted by the Institute of Medicine (IOM) reports *To Err Is Human* and

Crossing the Quality Chasm, health policymakers and legislators from both sides of the stagnant tort reform issue have found a way to put their gridlocked differences aside by focusing on the common ground of patient safety.⁶⁻⁸ Among these policymakers, the American College of Surgeons is a major player. On behalf of surgeons and their patients, the College sponsors the Surgical Quality Alliance chaired by Frank Opelka, MD, FACS.⁹ This alliance has gained credibility among other policymaking groups and government agencies, enabling surgeons to have significant input. Moving forward with a new approach, patient safety and liability are now firmly linked.

Pursuing patient safety and liability as a single agenda is gaining momentum. The common thread for change is transparency: clear honest communication for the purpose of disclosure. Examples of national changes involving disclosure include the Surgical Care Improvement Project (SCIP), the Patient Safety and Quality Improvement Act of 2005, the Centers for Medicare & Medicaid Services Physician Quality Reporting Initiative, and pay for performance. At the state level, examples include laws in Pennsylvania, Utah, and Florida that require mandatory notification of patients when an error in care occurs.¹⁰ Many other plans at national and state levels are already in place or in the pipeline.

Changing surgeons' programming

Disclosure and transparency are contrary to that which surgeons have traditionally considered the best approach. We have always touted confidentiality as a critical protection for reporting errors and conducting peer review for safer care.^{11,12} Intuitively, surgeons are programmed by the punitive nature of our tort system, which creates a culture of blame, to resist even confidential disclosure much less transparent disclosure. Now, there is strong evidence that indicates transparent disclosure is better. Transparency for disclosure, including the disclosure of errors, may actually benefit safe care and quell liability. For those who equate confidentiality with secrecy, deception, and neglect, the opportunity for transparency provides relief.

In 1987, after losing two malpractice judgments totaling more than \$1.5 million, officials

at the Veterans Affairs (VA) Medical Center in Lexington, KY, initiated an innovative new risk management policy that included careful review of all adverse events, transparent disclosure of errors with an apology or expression of regret when preventable adverse events were identified, and an offer of reasonable awards according to the circumstances. The results from a report presenting data for 1990 through 1996 were astounding.¹³ Even though the frequency of losses increased as additional deserving, injured patients received awards, the severity of awards was profoundly curtailed. The average loss per award in the VA system as a whole was \$98,000, but the average loss per event at the Lexington VA was \$15,622. Even though the costs for defending claims in the VA system could not be exactly measured, expenses were clearly reduced with this new transparency-based style of risk management. Comparisons with other VA hospitals with varying workloads were difficult, but among 36 similar facilities in the VA system, the Lexington VA losses were among the lowest. Plaintiff attorneys were accepting of honest disclosure and were not generally inclined to seek awards for noneconomic damages, such as pain and suffering.

The University of Michigan Health System implemented a somewhat similar approach to risk management in 2002. Before implementation of the transparent disclosure/apology/early offer/patient safety improvement program for risk management in 2001, the system's annual litigation costs were \$3 million. By 2005, costs were reduced to \$1 million. The average time from introduction to closure of claims and lawsuits was reduced from 20.7 to 9.5 months, and the number of claims was reduced from 262 to 114 annually.^{14,15}

These risk management programs based on transparent disclosure have clearly reduced the costs of litigation and improved justice for injured patients. If we accept that transparent disclosure is better than secretive confidentiality, then more material for peer review may improve patient safety and outcomes as well, but this potential benefit is difficult to measure. Health care providers at the University of Michigan report that transparency has enhanced peer review, promoted the emergence of a team approach for

triage and investigation of adverse events, and created a shift from the traditional "find blame" focus to a new "get it right" focus.¹⁵ Time will tell if these changes will lead to safer care and better outcomes.

Transparency for disclosure is after the fact—that is, after an error occurs. Beyond disclosure, the ACS Closed Claims Study (a review of 460 closed claims against general surgeons from nationwide data sources)¹⁶ has shown transparency for illumination, mutual understanding, and trust between surgeons, their patients, and other health care providers to be critically important for preventing bad outcomes and litigation before the fact—that is, before an error occurs.

The importance of communication

The extreme importance of communication in general, and transparent communication in particular, was not appreciated by the Fellows of the ACS who formulated the standardized data-collection form for the ACS Closed Claims Study. This awareness came after the data were collected: Complications and litigation were largely caused by the failure to communicate in 101 (22%) of the 460 claims. This profound impact of communication failures on patient safety and liability prompted a review of the dictated narratives for each of those 101 claims for additional insight. The results from the narratives for communication in general have been previously reported.¹⁷

Focus was then turned again to the narratives seeking information specific to the particular aspect of communication involving transparency. From among the 101 claims involving communication failures, 10 claims were excluded because of insufficient information and 10 claims were excluded because no specific transparency failures were identified. The remaining 81 (18%) of the 460 claims were filed largely if not entirely because of failure on the part of the defendant-surgeon to communicate transparently. The adverse consequences of these failures included medical errors, escalation of the consequences of otherwise nonpreventable adverse events, and anger or mistrust even when the standard of care was met.

Among these 81 claims, 40 involved the failure

to communicate with the patient and/or family and 49 involved communication failures between the defendant-surgeon and other health care providers. Eight claims involved failures with health care providers and patients and/or families.

Two claims involved the deliberate failure to transparently disclose information about an error with the patient and/or patient's family. For example, a patient experienced significant albeit self-limiting musculoskeletal injury while being transferred from the operating table to the stretcher. A claim was filed because a health care provider other than the dishonest surgeon revealed the event to the patient belatedly and only incidentally. Paradoxically, the failure to disclose caused the lawsuit that transparency might well have prevented. The remaining 79 claims involved the failure to illuminate, establish mutual understanding, or prevent mistrust.

Meeting the standard of care

When transparency was lacking between the defendant-surgeon and the patient and/or family, the standard of care was met in 25 cases, not met in 14, and impossible to judge in one. When the standard of care was met, claims were filed largely because of anger and mistrust stemming from the surgeons' failure to spend enough time preoperatively to transparently explain the surgical risks associated with the procedure, the disease, or the comorbidities. For example, a patient required an amputation after a failed bypass graft and subsequently filed a claim. It was apparent from statements in the patient's deposition that the surgeon's lack of transparency during the consent process resulted in the failure to provide the patient with a clear understanding regarding the frequency of graft failures related to disease factors beyond the surgeon's control and in spite of skillfully performed surgery.

Postoperatively, when the standard of care was met, litigation was often the result of a failure to make clear to the patient or family that their complaints were of concern and that an organized approach was being implemented to seek the cause of a symptom, sign, complication, or other adverse event. Failure to explain the details of why an unpreventable adverse event or complication occurred left patients lacking


trust and suspecting errors, which led to claims without merit.

When transparency was lacking with other health care providers, the standard of care was met in only seven cases and not met in 42. Unlike the failure to establish clarity through transparency with patients, failures with other health care providers usually lead to errors. For example, during the removal of a portacath using conscious sedation, the surgeon failed to communicate a clear, transparent, mutual understanding with the anesthetist regarding the use of electrocautery. This communication failure led to totally preventable facial burns when oxygen ignited beneath tented drapes. In another example, a surgeon failed to confirm the site of a cutaneous malignancy for wide excision from among several sites shaved by the referring dermatologist and proceeded to excise the wrong site. In addition, transparency during hand-offs was frequently found lacking. These findings are consistent with other recent work on communication failures during surgical care.^{18,19}

These are only a few examples from among many claims in this closed claims study that involved litigation against skillful surgeons whose surgical knowledge and technical skill were undermined by the lack of transparency. Certainly, there are skills to be learned to assist us in communicating transparently. Even so, transparency through communication is largely a matter of diligence, vigilance, tenacity, and time spent. Surgeons are not held to a standard of perfection in technical matters, but preventable adverse events resulting from the failure to establish clarity and mutual understanding are almost always inexcusable.

In the absence of transparent care, litigation proceeded in the milieu of a tort system that has run amok of its purposes of fairly compensating injured patients and protecting health care providers from claims without merit. When defendant-surgeons met the standard of care but failed to communicate transparently, uninjured patients receive an unwarranted award nonetheless, in 42 percent of cases. When defendant-surgeons fail to meet the standard of care, 23 percent of injured, deserving patients who sued received no award. The tort system is truly a system of jackpot justice.

Conclusion

In conclusion, data show that transparency for disclosure after an error has occurred can minimize the consequences of litigation. Disclosure may also improve patient safety through enhanced peer review, but this effect has not yet been studied. Data also show that errors can be prevented, escalation of nonpreventable adverse events can be minimized, and lawsuits without merit resulting from anger and mistrust can be avoided by transparent communication with patients and all members of the health care team. Finally, the tort system has run amok of its purposes and is a system of random awards and jackpot justice. Although tort reform has been shown to modestly prevent escalation of liability premiums in selected states, it has failed in every other way. Health care policymakers and legislators are increasingly addressing the problem of liability by linking risk management to patient safety. 

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