Patients First, Privilege Second

by: Brett Schreiber, CASD President

The genesis of this month's column comes from several pending cases our office is currently litigating. It's an all too common scenario where a negligent medical provider admits fault in a peer review proceeding and then subsequently denies it – under oath – in a lawsuit. Thanks to *Cal. Evidence Code* §1157 we can never fully prove by a preponderance of evidence that this double speak occurs since the peer review process is immune from discovery. Without getting into the granular details of the pending litigation we have very strong evidence to suggest that the immunity granted to peer review is often nothing more than a mechanism to smother the truth-seeking function of the civil justice system.

Let's look at it another way: imagine if lawyers committed malpractice at the same alarming rate as medical professionals, resulting in a similar number of dire outcomes (see, for instance, "Medical Errors – the third leading cause of death in the US", *British Medical Journal*, published May 3, 2016). Those lawyers, upon realizing that their negligence catastrophically injured and/or killed their clients, then got together amongst a group of like-minded professionals to determine what went wrong and how to cover it up. Later, when that same lawyer was sued for his or her negligence – after acknowledging his mistakes in front of the group - invoked a complete immunity to discovery of the committee's fact finding and testified to a polar opposite conclusion in litigation? Can you imagine the public outcry if this sham were to be exposed? Tragically, throughout California and much of this country, that is exactly what happens in the peer review setting.

But it doesn't have to. Thankfully, there are institutions like the University of Michigan (and most recently Stanford University), that are proving that truthfulness, full disclosure, peer review, and the civil justice system are *not* mutually exclusive to one another. The "Michigan Model," as it is known, takes a new approach when it comes to patient safety, medical mishaps, and medical malpractice litigation. For starters, they have an institutional policy of "saying sorry," or apologizing and having an open discussion, when clini-

Continued on page 4

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cal care does not go as planned. While apologies are just part of the approach, the Michigan Model emphasizes that communication, full disclosure, and learning from mistakes are all vitally important as well. The University says it best when it summarizes its approach as follows: *"[i]n short, we're trying to "do the right thing" for our patients, our medical staff, and the public interest. We believe that court should be the last resort, not the first, when a medical mishap, complication or near-miss occurs."*

It's a sad testament to the state of affairs within the medical-industrial-insurance complex when the preceding statement – so logical and sensible – feels like a breath of fresh air. But again, it shouldn't have to be. In the years since instituting this approach the University of Michigan has steadily reduced the number of malpractice claims pending against it and its physicians, slashed its malpractice expenses, dramatically dropped the amount paid to plaintiffs as a result of judgments or settlements, and cut the time it takes to handle a claim. (See *"Hospitals Can Break Through the 'Wall of Silence' with New Toolkit"*, ***Michigan Health Lab***, May 23, 2016)

As part of this new model – slowly being implemented in more progressive hospitals nationwide - when a patient complains, or a staff person realizes that a mishap or near miss has occurred, several things happen: first, there is open and direct communication with the patient and/or his representative in the aftermath of the situation. In fact, one of the first things done is to arrange a face-to-face meeting with the patient (and to the extent one is retained, their lawyer) to discuss the case and answer questions about the review. When was the last time any of you has sent a Notice of Intent to Sue letter to a defendant medical provider and ever received a request for a sit down with the medical staff involved in the patient's care? Presumably never. If anything, you get a boilerplate responsive letter from the insurance company and/or risk manager asking for your client to sign an overbroad medical release so the potential defendant can obtain the records already in their possession. In my experience, even when I reach out to discuss the case with the responsive carrier/risk manager, I'm given the same tired trope of "our investigation is continuing," "we need more time to review the claim," etc. Never once have we received an apology or been offered an opportunity to sit down, discuss our questions, and get answers about what went wrong. It appears that part of that decision-making is based upon the shortsighted belief that the only place to admit mistakes is in the peer-review setting; a place where, often times, the truth goes to die.

Continued on page 27

Now, I'm not suggesting that all filed medical malpractice claims are viable cases. Many – I dare say most – are likely not. But I can tell you as someone who gets called on these cases on a weekly basis many of these patients simply want answers and would likely be satisfied with full and candid explanations. Allowing the aggrieved to feel heard– rather than ignored and treated unfairly– is likely to result in many complai nts being answered and many suits being dropped. (*4 Tips to Implement a Transparent Medical Error Disclosure Policy* ***Becker's Hospital Review***, July 2013.)

In fact, after nearly a decade of implementing these reforms and not simply using the peer review process as a cloak of secrecy, the Michigan Model is bearing fruit that irrefutably shows a better way:

- A decade ago the University averaged more than 260 pending pre-suit claims and lawsuits. Today, it's less than 100.
- Legal costs in defending suits are down more than 50 percent.
- Severity of claims is rising far less rapidly than the national average. While nationally, the severity of the malpractice claims rises 10 percent annually, at University of Michigan its annual rise has been approximately 2.5%.
- Duration of claims has gone from taking more than 20 months on average to less than 10, and despite large increases in their clinical practice, the University's malpractice premiums have remained level over the past decade (which is completely opposite of national trends).

Is the medical malpractice system at institutions like University of Michigan perfect? Of course not. Far from it. But does the implementation of such systems over the past decade prove that acknowledging errors and focusing on transparency and accountability not only improves patients' outcomes but also helps the hospital's bottom line? Absolutely.

We must ask ourselves what social good is served if our medical system continues with review processes that only encourage truthfulness and accountability if shrouded in secrecy and kept from the public eye? *Cal. Evidence Code* §1157 is part of the problem, not the solution. It needs to be amended as part of a head-to-toe reevaluation of claims handling for all preventable medical errors. **TBN**

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