2022 Council Resolution 37: Enhance Patient Safety and Physician Wellness

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **In Progress**

SUBMITTED BY: New York Chapter ACEP

Purpose:

Support the protection of the integrity of the quality improvement/patient safety/peer review process and its participants and work with chapters to identify and lobby against state laws that limit these important discussions.

Fiscal Impact:

Budgeted committee and staff resources for state advocacy initiatives.

Background:

WHEREAS, Medical error causes 250,000 excess deaths annually in the USA (per National Patient Safety Board); and

WHEREAS, Medical error causes “second victim syndrome,” which multiplies physician stress, impacts wellness, and factors into a disproportionately high physician suicide rate; and

WHEREAS, The medical profession’s shift from a culture of “shame and blame” to one of accepting human fallibility and building peer support (as noted in the American Medical Association (AMA)) peer support declaration) is hamstrung by several state laws (such as those in CA, NY, and FL) which limit or effectively prohibit the participation of physicians in Quality Assurance (QA) reviews and Morbidity and Mortality (M&M) discussions of cases in which they were involved; and

WHEREAS, Such state laws deny physicians a safe space in which to process their feelings and take part in debriefings that would enhance coping with traumatic events; and

WHEREAS, A culture of openness and free discussion of problematic cases, especially by those directly involved, will contribute to patient safety, physician support, and enhanced learning, and must include not only institutional peer review activities, but also individual wellness sessions; and

WHEREAS, A model of full disclosure and openness exists in the airline industry and has dramatically improved airline safety, while the toll from medical error remains unacceptably high; therefore be it

RESOLVED, That ACEP support the protection of all participants in discussions of cases of potential medical error, whether Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), or any patient safety forum, from legal discovery; and be it further

RESOLVED, That ACEP encourage and support state chapters in identifying pending or existing state laws limiting free discussion of cases of potential medical error in quality assurance/quality improvement, Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), and similar environments, and in lobbying against them.

This resolution calls for ACEP to support the protection of all participants in discussions of cases of potential

medical errors such as quality assurance (QA)/quality improvement (QI), M&M, RCA, and other patient safety forums from legal discovery. It also asks ACEP to work with state chapters to identify pending or existing state laws that will pierce the protections afforded to these patient safety discussions.

The conceptual framework of evaluating poor outcomes can be traced back to Florence Nightingale and the Crimean war. Dr. Ernest Amory Codman, a surgeon from Massachusetts General Hospital, is credited with creating a transparent process that examined patient outcomes that would later become M&M. The anesthesia study commission improved the process by discussing the cases in a confidential open forum. In 1952, the Centers for Disease Control and Prevention's *Morbidity and Mortality Weekly Report* was first published. In 1983, the Accreditation Council for Graduate Medical Education (ACGME) recognized the importance of these patient safety discussions in physician education and they became a requirement for all training programs.

The Health Care Quality Improvement Act (HCQIA) of 1986 was designed to protect peer review activities from discoverability and established the National Practitioner Data Bank, an information clearinghouse, to collect and release certain information related to the professional competence and conduct of physicians and other designated healthcare professionals.

The Institute for Medicine (IOM) published its landmark report "To Err Is Human: Building a Safer Health System in 2000. The magnitude of the problem of medical error became clear. The report estimated that between 44,000 and 98,000 deaths per year in U.S. hospitals were attributable to medical error. The report also framed medical errors as a systems issue rather than mistakes by individuals. Creating an environment where physicians and other healthcare workers can report and examine patient safety events is essential to improving systems and patient care. Greater reporting and analysis of patient safety events will yield increased data and better understanding of patient safety events. One barrier to these discussions has been the fear of increased liability risk for physicians.

ACEP's policy statement "Disclosure of Medical Errors" states:

"ACEP recognizes that substantial obstacles, including unrealistic expectations of physician infallibility, lack of training about disclosure of errors, and fear of increased malpractice exposure, may obstruct the free disclosure to patients of medical errors. To overcome these obstacles, ACEP recommends the following initiatives:

- Health care institutions should develop and implement policies and procedures for identifying and responding to medical errors, including continuous quality improvement (CQI) systems and procedures for disclosing significant errors to patients.
- Medical educators should develop and provide specific instruction to trainees at all levels on identifying and preventing medical errors and on communicating truthfully and sensitively with patients or their representatives about errors.
- States should enact legislation that makes apology statements by physicians related to disclosure of medical errors inadmissible in malpractice actions."

Several other ACEP policy statements address reporting and analysis of errors, near miss, or adverse events:

"Pediatric Readiness in the Emergency Department"
"encourage establishing a culture of safety that encourages reporting of near miss or other adverse events that can be analyzed to provide feedback into the system in a continuous quality improvement mode."

"Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided"
"Quality improvement efforts focus on peer protection and blame free disclosure to improve future processes, which would be hindered by the specter of criminal liability for routine patient care events."

"A Culture of Safety in EMS Systems"
"EMS systems should implement and support the Just Culture approach to facilitate honest and prompt reporting of risk and error and to support analysis of near miss and adverse events in an environment of professionalism and accountability for systems and individuals."

The Patient Safety and Quality Improvement Act (PSQIA) of 2005 passed in response to the IOM report and these concerns. It was designed to facilitate the confidential review and reporting of adverse patient events. The PSQIA created a federal peer review privilege and thereby affording substantial protections from the discovery of information related to adverse events when provided to a patient safety organization (PSO). In addition, the collection of patient safety information in relation to reporting to a PSO is also protected.

There is variability in state-based peer review protections for patient safety work. All 50 states and the District of Columbia have laws granting confidentiality and privilege protections for peer review activities. In almost all states there are exemptions from legal protections if the information is relevant to complaints involving criminal activity or discipline against a physician. The District of Columbia and 17 other states have additional gaps in protection.1In the 2017 case *Charles v. Southern Baptist,* the Supreme Court of Florida ruled that patient safety documents were not protected from discovery. Other states (including Florida in many cases) protect patient safety documents within the Patient Safety Organization (PSO) models.

The degree to which protections are lacking for emergency medicine physicians participating in patient safety actives is unknown. Further investigation is needed to identify priority states and opportunities for policy improvement in the short- and long-term at the national, state and chapter levels.

Stragegic Plan Reference:

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Develop and implement an ongoing, two-way system to identify and address the issues that hinder wellness and career satisfaction for emergency physicians and allow for members to be heard in more meaningful and effective ways.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- Expand and strengthen the role, approach, and impact of state-level advocacy.

Prior Council Action:

Amended Resolution 21(00) Peer Review and the Mandatory Federal Reporting of Errors adopted. called for the College to support initiatives in several areas of peer review including that information discovered during the peer review process be kept confidential and not discoverable in any legal action.

Prior Board Action:

June 2022, approved the policy statement "Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided."

April 2021, approved the revised policy statement "A Culture of Safety in EMS Systems;" originally approved March 2014.

June 2018, approved the revised policy statement "Pediatric Readiness in the Emergency Department" with the current title; revised and approved April 2009; originally approved December 2000 titled "Guidelines for the Care of Children in the Emergency Department.

April 2017, approved the revised policy statement "Disclosure of Medical Errors;" revised and approved April 2010; originally approved September 2003.

Amended Resolution 21(00) Peer Review and the Mandatory Federal Reporting of Errors adopted.

Council Action:

Reference Committee B recommended that Resolution 37(22) be adopted.

The Council adopted Resolution 37(22) on September 30, 2022.

Testimony:

Testimony was unanimously in support of the resolution. There was no asynchronous testimony in support or opposition to the resolution, but there was one comment recommending referral to the Board of Directors with

potential assignment to the State Legislative/Regulatory Affairs Committee and the possibility of a survey of issues state by state. During live testimony, one member highlighted the importance of protecting physicians and promoting patient safety. The Reference Committee recommends that the resolution be adopted because there is a need to protect physicians who participate in quality assurance/quality improvement, Morbidity & Mortality Conferences (M&M), and Root Cause Analysis (RCA) efforts.

Board Action:

The Board adopted Resolution 37(22) on October 3, 2022.

References:

1. Lindor RA, Campbell RL, Reddy S, Hyde RJ. State Variability in Peer Review Protections Heightens Liability Risks. Mayo Clin Proc Innov Qual Outcomes. 2021 Feb 6;5(2):476-479. doi: 10.1016/j.mayocpiqo.2020.10.011. PMID: 33997643; PMCID: PMC8105528.

Implementation Action:

Assigned first resolved to the Medical-Legal Committee to develop a policy statement. Assigned second resolved to Advocacy & Practice Affairs staff for federal and state advocacy initiatives and assist chapters with identifying pending or existing state laws.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP
Melissa Wysong Costello, MD, FACEP
Susan E Sedory, MA, CAE