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A Report on the Medical Care Availability and Reduction of Error Act

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A Report on the Medical Care Availability and Reduction of Error Act

On May 20, 2002, Governor Mark Schweiker signed Act 13, the MCARE Law (Medical Care Availability and Reduction of Error Act). This was a significant moment in Pennsylvania history since attempts at medical liability reform have essentially failed over the past twenty-five years. The Act has three significant portions, the first of which addresses liability reform. The second portion deals with liability insurance reform, including the CAT Fund (Medical Professional Liability Catastrophic Loss Fund). Chapter 3 of the Act addresses the complicated issue of patient safety.

The Act was the result of intense negotiations between the Pennsylvania Medical Society, the Hospital Alliance of Pennsylvania, the Pennsylvania Trial Lawyer's Association, the insurance industry and, of course, the Legislature. The fact that any law was actually signed is a credit to the medical and hospital communities who finally realized that talking about liability issues was not enough, but that active participation in the political process was necessary. What galvanized action and what was at stake, and remains at stake, is the availability of quality care for patients in Pennsylvania. It was this issue that finally prompted the passage of this historic Act.

Like all compromises, none of the groups at the table walked away fully satisfied that they had achieved all of their aims. Indeed further legislation was signed into law as Act 57 on June 19, 2002. On October 11, 2002, a bill to stop venue "shopping" also was signed. These new laws improved some of the medical liability issues not addressed in Act 13.

The major provisions of Chapter 3 establish a Patient Safety Trust Fund, which initially is set at five million dollars for the 2002-03 budget year. It also creates a Patient Safety Authority. Currently Chapter 51 of the state's licensure regulations (adopted June 1998) requires mandatory reporting of serious events to the Department of Health. When Act 13 is fully operational, it will supercede Chapter 51, and there will be mandatory reporting of serious events to the Patient Safety Authority as well as to the Department of Health. Infrastructure failures (power outages, strikes, etc.) will continue to be reported to the Department of Health. Of great significance is that for the first time it will be mandatory to report incidents ("near misses") to the Patient Safety Authority. It requires medical facilities to develop and implement a Patient Safety Plan, designate a Patient Safety Officer, and establish a Patient Safety Committee.

Chapter 3 further requires health care workers to report serious events to their Patient Safety Committee and provides "whistle blower" protection against retaliation to those reporting. Of importance is that the information is protected in both the Patient Safety Committee and the Patient Safety Authority by strong confidentiality provisions. Reports may also be sent anonymously to the Patient Safety Authority if there is a concern that the medical facilities' Patient Safety Committee is not responding appropriately. Failure by a health care worker to report a serious event must be referred to the appropriate professional licensing board. The Act also requires mandatory written disclosure of serious events to the patient.

The eleven members of the Patient Safety Authority are regulated by the Act – the House selects two, and the Senate selects two. The six appointed by the Governor consist of a physician, a nurse, a pharmacist, a health care worker employed by a hospital, and two residents of the State, only one of whom is a health care worker. The chairman of the Authority is the Physician General of the State – Robert S. Muscalus, D.O. The responsibilities of the Patient Safety Authority are very clearly delineated in the Act. They are to manage the Patient Safety Trust fund, contract with an appropriate entity to collect and analyze data regarding reports of serious events and incidents, issue recommendations on how to reduce serious events and incidents, receive and investigate anonymous reports, and report annually to the General Assembly. It is very clear that the organization wants to be a learning organization and plans to work to develop the trust of the medical facilities of the state that report to it. These medical facilities include acute care hospitals, birthing centers and surgery centers.

The Patient Safety portion of Act 13 presents a unique opportunity for the medical facilities in the state to learn from their serious events and incidents. It has the potential to carry out the mandate of the Institute of Medicine's Report of November 1999, *To Err is Human*, and to learn from serious events and incidents that compromise safe patient care. At the same time, there is great concern expressed by the health care community about sharing this critical data in a state and a city known for its unfriendly medical liability climate. This is understandable, but it is the law of the state, and if handled well, can be a positive undertaking for health care in our Commonwealth.

About the Author

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