



JOURNAL OF HEALTH & LIFE SCIENCES LAW

VOLUME 2, NUMBER 2

JANUARY 2009

TABLE OF CONTENTS

Patient-Tailored Medicine, Part Two:
Personalized Medicine and the Legal Landscape
*American Health Lawyers Association's Advisory Council
on Racial and Ethnic Diversity*

Patient Access to Unapproved Therapies:
The Leading Edge of Medicine and Law
Leah Voigt Romano and Peter D. Jacobson

Enforcement Related to Off-Label Marketing and Use of Drugs
and Devices: Where Have We Been and Where Are We Going?
John N. Joseph, David Deaton, Houman Ehsan, and Mark A. Bonanno

Protecting Yourself from Your Assertions: Navigating Multiple
Regulatory Schemes and Disclosure
Alicia Griffin Mills and Ross D'Emanuele

NOTES AND COMMENTS

A Better Approach to Medical Malpractice Claims?
The University of Michigan Experience
*Richard C. Boothman, Amy C. Blackwell, Darrell A. Campbell, Jr.,
Elaine Commiskey, and Susan Anderson*

Physician Ownership and Use of In-Office Advanced Diagnostic
Imaging Equipment: Are IDTF Standards a Meaningful Response
to Overutilization, Quality, and Costs?
Markus P. Cicka

PRACTICE RESOURCE

Hospital-Physician Joint Ventures in a Changing Regulatory
Environment: Planning for an Unwind
Beth Connor Guest



AMERICAN
HEALTH LAWYERS
ASSOCIATION



NOTES & COMMENTS

A Better Approach to Medical Malpractice Claims? The University of Michigan Experience

Richard C. Boothman, Amy C. Blackwell, Darrell A. Campbell, Jr., Elaine Commiskey, and Susan Anderson

ABSTRACT: The root causes of medical malpractice claims are deeper and closer to home than most in the medical community care to admit. The University of Michigan Health System's experience suggests that a response by the medical community more directly aimed at what drives patients to call lawyers would more effectively reduce claims, without compromising meritorious defenses. More importantly, honest assessments of medical care give rise to clinical improvements that reduce patient injuries. Using a true case example, this article compares the traditional approach to claims with what is being done at the University of Michigan. The case example illustrates how an honest, principle-driven approach to claims is better for all those involved—the patient, the healthcare providers, the institution, future patients, and even the lawyers.

CITATION: Richard C. Boothman, Amy C. Blackwell, Darrell A. Campbell, Jr., Elaine Commiskey, and Susan Anderson, *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, J. HEALTH & LIFE SCI. L., January 2009, at 125. © 2009 American Health Lawyers Association, www.healthlawyers.org/bookstore. All rights reserved.

The authors' biographical statements appear on the following page.

RICHARD C. BOOTHMAN, J.D. is the Chief Risk Officer for the University of Michigan Health System. Before joining the University of Michigan in 2001, Mr. Boothman defended doctors and hospitals in malpractice lawsuits in Michigan and Ohio for more than two decades. He is a national speaker on transparency and the implementation of a principled, proactive approach to claims and risk management. Contact him via email at boothman@med.umich.edu.

AMY C. BLACKWELL, J.D., is the Claims Analyst for the Office of the Chief Risk Officer, University of Michigan Health System. Ms. Blackwell was a trial attorney specializing in medical malpractice litigation for seven years before joining the University of Michigan's Department of Risk Management in 2006. Contact her via email at acbla@med.umich.edu.

DARRELL A. CAMPBELL, JR., M.D. is the Henry King Ransom Professor of Surgery, Assistant Dean for Clinical Affairs, and Chief of Clinical Affairs for the University of Michigan Health System. Dr. Campbell is an accomplished transplant surgeon and, as Chief of Clinical Affairs, is responsible for the overall quality of care delivered at the University of Michigan Health System. He is a nationally respected advocate for patient safety, earning the 2007 Eisenberg Patient Safety and Quality award for individual achievement given by the Joint Commission and National Quality Forum. Contact him via email at darrellc@med.umich.edu.

ELAINE COMMISKEY, M.S., is the Project Manager, University of Michigan Health System Department of Risk Management. Ms. Commiskey specializes in the accumulation and organization of risk management data, an integral part of improving patient safety. Contact her via email at commiske@med.umich.edu.

SUSAN ANDERSON, M.B.A., M.S.N., C.P.H.R.M., is the Director, University of Michigan Health System Department of Risk Management. Ms. Anderson has been involved in many aspects of healthcare delivery for more than 20 years, focusing on the healthcare risk management industry for the last 10 years. Contact her via email at sander@med.umich.edu.

UNIV. OF MICHIGAN: A BETTER APPROACH TO CLAIMS?

Contents

Introduction	127
Current State of Affairs in Medical Malpractice	127
The Drivers of Medical Malpractice.....	133
A Program that Responds to the Drivers of Medical Malpractice.....	135
The University of Michigan’s Approach to Patient Injuries	137
Case Example: Patient JW	151
Conclusion.....	159

Introduction

Each of the past three decades has had its well-publicized medical malpractice crisis, leaving the various players increasingly polarized. Rounds of tort reforms in the 1980s and 1990s have met with only minimal success. No one seems pleased. The left insists the system is working well and concerns are manufactured or overblown. The right accuses the left of being in the pocket of trial lawyers and advocates abolishing medical malpractice litigation altogether. Calls for no fault systems continue, despite concerns that such systems would invite claims and bankrupt the system. The insurance industry raises premiums and blames the increases on litigation. The University of Michigan Health System’s experience suggests that the problem persists in large part because past efforts have not been aimed at the right targets—and that there is a better way.

Current State of Affairs in Medical Malpractice

Although disclosure, transparency, and improving patient safety are becoming hotter topics, “deny and defend” continues to describe doctors’ and hospitals’ prevailing response to patient injuries. Professor William Sage notes:

When health care goes awry and a patient sues, liability insurers representing individual physicians defend or settle most claims. Physician defendants are happiest if few claims arise, fewer claims are validated by verdict or settlement, and still fewer claims are publicized. Accordingly, the prudent insurer and its counsel urge secrecy, dispute fault, deflect responsibility, and make it as slow and expensive as possible for plaintiffs to continue the fight.

As a result, claims involving serious injury (the only category for which litigation is a realistic option) often take five or more years to resolve, with predictable consequences. Information about the cause of injuries is denied patients and families for prolonged periods, compensation is unavailable when it is most needed, and quality feedback to providers is attenuated to the point of uselessness. Delay also exacerbates volatility in premiums by increasing legal uncertainty and making malpractice insurers more dependent on investment income for profitability. The contrast between this fragmented, dilatory, adversarial environment and the Institute of Medicine's (IOM's) futurist vision of a safe, effective, patient-centered, timely, efficient, and equitable health care system based on institutional quality improvement could hardly be more stark.¹

This environment has developed in spite of patient expectations and physicians' sense of their ethical duties. Over the years, myriad fears have fueled physicians' and hospital administrators' reluctance to speak openly with patients about not only medical mistakes, but even complications that occurred in the absence of negligence. These fears include:

- a natural aversion to confronting angry people;
- concerns that disclosure might invite a claim that otherwise would not be asserted;
- anxiety that the discussion will compromise courtroom defenses later; and
- fear that the conversation may lead to loss of malpractice insurance or higher premiums.

1 William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 23 HEALTH AFFAIRS 11–12 (2004).

The “deny and defend” strategy was born of these fears and continues to thrive, fed by them. Given the medical community’s well-publicized loathing of litigation,² it is ironic that over the past 30 years, litigation remains the dominant response by hospitals, healthcare providers, and insurers to patients with complaints about their medical care. Deny and defend is an incredibly inefficient and costly (financially, emotionally, and otherwise) response to patient complaints. A recent study showed that overhead costs associated with malpractice litigation are “exorbitant” and demonstrated that “for every dollar spent on compensation, 54 cents went to administrative expenses (including those involving lawyers, experts, and courts).”³ Of particular interest to this discussion, 37% of the claims examined in the study did *not* involve errors; claims not involving errors accounted for between 13 and 16% of the system’s total monetary costs, a meaningful percentage.⁴

Healthcare practitioners most often lay blame for their fears squarely at the feet of the legal profession. Anyone who has practiced law in this arena will vouch for the accuracy of sentiments like these sprinkled liberally throughout the medical literature:

For over a century, American physicians have regarded malpractice suits as unjustified affronts to medical professionalism, and have directed their ire at plaintiffs’ lawyers... and the legal system in which they operate.⁵

Physicians revile malpractice claims as random events that visit unwarranted expense and emotional pain on competent, hardworking practitioners...⁶

A 2008 study confirmed the prevalence of these attitudes. The study examined how physicians communicate about medical errors and found that physicians were “concerned about the confidentiality and legal discoverability of the error information they report.”⁷ The authors went on to comment, “these concerns are understandable given the malpractice system’s focus on identifying provider fault and the limited availability of affordable malpractice insurance.”⁸ This fear and apprehension of malpractice litigation seems out of proportion to reality, however.

2 William M. Sage, *Medical Malpractice Insurance and the Emperor’s Clothes*, 54 DEPAUL L. REV. 463, 464 (2005).

3 David M. Stewart et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024–33 (2006).

4 *Id.*

5 William M. Sage, *Medical Malpractice Insurance and the Emperor’s Clothes*, 54 DEPAUL L. REV. 463, 464 (2005).

6 David M. Studdert, Michelle M. Mello & Troyen A. Brennan, *Medical Malpractice*, 350 NEW ENG. J. MED. 283 (2004).

7 Jane Garbutt et al, *Lost Opportunities: How Physicians Communicate About Medical Errors*, 27 HEALTH AFFAIRS 246–55 (2008).

8 *Id.*

Based on this fear of claims and rising malpractice insurance premiums, some have forecasted gloom and doom for transparency between healthcare providers and patients. Intelligent transparency neither will impair the effective management of malpractice litigation nor increase healthcare costs. According to some, rising malpractice premiums and a reduction in the number of firms offering malpractice coverage characterize the third medical malpractice crisis in the United States in the past 40 years.⁹ The U.S. Government Accountability Office's (GAO's) studies about the impact of medical malpractice claims on insurance premiums and physician migration, however, have shown the perceived impact is not substantiated by the data.¹⁰ Many of the provider actions ascribed to rising malpractice premiums were not substantiated or did not affect access to healthcare on a widespread basis.¹¹ Natural disasters and stock market fluctuations affect insurance premiums far more than medical malpractice litigation does.¹² The GAO observed that from 1998 to 2001, malpractice insurers experienced decreases in investment income because of falling interest rates.¹³ Hospitals and doctors paid the price with higher premiums, even while the insurance industry recruited them to lobby for tort reform. With high investment returns in the early and mid-1990s, robust competition in the malpractice insurance industry resulted in lowered premiums. When the market declined, companies left the market, and the vacuum in competition led to increased premiums.¹⁴ According to the government, these dynamics, not malpractice litigation, account for rising insurance premiums.

The GAO's conclusions are consistent with those of Americans for Insurance Reform (AIR),¹⁵ an advocacy group that supports insurance reform. AIR has periodically examined trends in medical malpractice

9 Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFFAIRS, Jan. 21, 2004, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1/DC1>.

10 U.S. GEN. ACCOUNTING OFFICE, GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (2003), *available at* www.gao.gov/new.items/d03702.pdf; U.S. GEN. ACCOUNTING OFFICE, GAO-03-836, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE (2003), *available at* www.gao.gov/new.items/d03836.pdf.

11 MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE.

12 *Id.*

13 MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES.

14 *Id.*

15 AIR is a project of the Center for Justice and Democracy. It is a political group. Per its website, "[AIR] is a national coalition of public interest organizations that support effective insurance industry reforms to control skyrocketing insurance rates, reduced insurance coverage, arbitrary policy cancellations, mismanagement and other insurance industry abuses." AIR, www.insurance-reform.org/about/index.html (last visited Sept. 11, 2008).

insurance. In doing so, AIR systematically examines in constant dollars what insurers have taken in and what they have paid out.

AIR has consistently found that total payouts have been stable, tracking the rate of medical inflation, but premiums have not. Rather, premiums that doctors pay rise and fall in sync with the state of the economy, reflecting profitability of the insurance industry, including gains or losses experienced by the insurance industry's bond and stock market investments.¹⁶

The increases in insurance premiums that doctors experienced in the first half of this decade were not connected to actual payouts. "Rather, they reflected a well-known cyclical phenomenon called a 'hard' market."¹⁷ This further suggests claims do not drive premiums.

Simultaneous with repeated cries about the malpractice crisis,¹⁸ the medical community at large has slowly, grudgingly, started to acknowledge its own failings. In 1999, the Institute of Medicine published its seminal report on healthcare safety, *To Err is Human*.¹⁹ The report acknowledged what was for some a startling admission: as many as 98,000 deaths occurred each year because of medical errors.²⁰ Despite this recognition, patient safety experts agree that we have a long way to go to address patient safety.²¹ Most experts continue to view the fear of liability as the primary barrier to the development of effective and wide-sweeping patient safety initiatives in hospitals.²²

Transparency seems to be gaining currency as a concept, but individual physicians, hospitals, insurers, and defense lawyers still cling to "deny and defend" as a comfortable, safe response to claims, despite its drawbacks. In an effort to ease physicians' fears of the consequences of apologizing, 35 states have adopted "Apology Laws."²³ These statutes

16 AMS. FOR INS. REFORM, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2007* (2007), available at <http://insurance-reform.org/StableLosses2007.pdf>.

17 *Id.*

18 Whether there truly is a "medical malpractice crisis" should be the subject of a different article; however, it is worth mentioning that many reasonably intelligent people question the existence of any such crisis.

19 INST. OF MED., *To Err Is Human: Building a Safer Health System* (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson, eds., 1999).

20 *Id.*

21 Lucian L. Leape & Donald M. Berwick, *Five Years After "To Err Is Human": What Have We Learned?*, 293 JAMA 2384–90 (2005); Robert M. Wachter, *The End of the Beginning: Patient Safety Five Years After "To Err Is Human,"* HEALTH AFFAIRS W4-534 (2004), available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.534v1>; Drew E. Altman, Carolyn Clancy & Robert J. Blendon, *Improving Patient Safety: Five Years After the IOM Report*, 351 NEW ENG. J. MED. 2041–43 (2004); Patrick S. Romano, *Improving the Quality of Hospital Care in America*, 353 NEW ENG. J. MED. 302–04 (2005).

22 *Improving the Quality of Hospital Care in America*.

23 Am. Soc'y for Healthcare Risk Mgmt., Disclosure, www.ashrm.org/ashrm/resources/disclosurelaws.html (last visited Sept. 11, 2008).

variably make a physician's apology or statements of sympathy inadmissible to prove negligence in a civil lawsuit. These statutes range from broad and far-reaching to narrow. For example, the Colorado law makes healthcare providers' "statements, affirmations, gestures, or conduct expressing apology, fault, sympathy... or a general sense of benevolence which are made... to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim... inadmissible as evidence of an admission of liability or as evidence of an admission against interest."²⁴ In contrast, the Texas and Vermont statutes have narrowing attributes. In Texas, only expressions of sympathy and statements conveying a general sense of benevolence are inadmissible (i.e., "excited utterances" that also include statements concerning negligence or culpability *are* admissible to prove liability). Vermont's statute is limited to oral expressions of regret or apology.²⁵ Variations among these statutes may have important legal and evidentiary implications; however, if after thoughtful investigation and analysis, it is clear to the healthcare provider an error was made, there should be no risk to openly acknowledging the error, with or without statutory protection. This is true unless the healthcare provider believes he or she can privately acknowledge an error but publicly defend the care as appropriate. Ignoring for a moment ethical considerations in the inherent hypocrisy, the inability to do both realistically and effectively highlights the true cost of deny and defend: by defaulting to deny and defend, true quality improvement is inhibited and patient safety suffers.

In 2005, Senators Hillary Clinton and Barack Obama recognized the link between fears of litigation and the chilling effect deny and defend had on the more important problem of patient safety by offering the National Medical Error Disclosure and Compensation Act (MEDiC).²⁶ The proposed legislation attempted to meld a non-litigation approach to resolution of medical malpractice claims with essential data collection on errors, a mechanism for disseminating information about patient injuries widely, and incentives for improving patient safety. Though the act died in committee, the senators intend to reintroduce it or a similar proposal that may focus more attention on a fundamental truth of healthcare risk management: The very best risk management continues to be keeping patients safe from unreasonable medical mistakes.

With the recent focus on improving quality and patient safety, it appears that portions of the medical community are anxious to

24 COLO. REV. STAT. § 13-25-135.

25 TEX. CIV. PRAC. & REM. CODE ANN. § 18.061; Vermont S. 198 Sec. 1. 12 V.S.A. § 1912, available at www.leg.state.vt.us/DOCS/2006/BILLS/PASSED/S-198.DOC.

26 Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205-08 (2006).

embrace a new approach to malpractice claims, one aimed at the root cause of malpractice litigation: medical errors. It is time the entire medical community—and the legal and insurance communities—face their fears and follow suit.

The Drivers of Medical Malpractice

Studies that have examined patients' reasons for seeking legal help following unanticipated medical outcomes suggest that caregivers' reluctance to disclose actually may drive patients to lawyers' offices. A common societal misconception is that plaintiffs who sue are primarily opportunists trying to squeeze every dime they can from the system (e.g., the McDonald's coffee case). Although compensation is clearly *one* factor in the decision to sue, "patients and relatives are hoping for more than compensation when they embark on a legal action."²⁷ Consider the act of retaining a lawyer, not exactly a common experience for the vast majority of patients who sue. Implicit in that phone call is the underlying perception that the patient needs an advocate. Common themes supporting that sense repeat in published studies. One study found that patients feel the need to hire an advocate when they have not received adequate answers to questions about their outcomes, when they sense the absence of accountability for what happened to them, and when they worry the same mistake could be made in another patient's care.²⁸ In the same study, when asked what could have been done to avert a lawsuit, 37% of respondents said an explanation and an apology would have made the difference.²⁹ Gerald Hickson, M.D., found that 24% of the patients he surveyed filed suit when they found that "the physician had failed to be completely honest with them about what happened, allowed them to believe things that were not true, or intentionally misled them."³⁰

The need to understand what happened, a strong desire to protect the safety of others, and the overall comfort that comes from knowing that their caregivers are accountable: If these represent the driving factors of medical malpractice claims, it should come as no surprise that tort reforms have not impacted the malpractice scene directly. Fueled by the common belief that lawyers and the legal system were the causes for their malpractice problem, most "reforms" promoted by the medical community were aimed at those targets, seeking to make

27 Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609–13 (1994).

28 *Id.*

29 *Id.*

30 Gerald B. Hickson, Ellen W. Clayton, Penny B. Githens & Frank A. Sloan, *Factors That Prompted Families to File Medical Malpractice Claims Following Prenatal Injuries*, 267 JAMA 1359, 1361 (1992).

claims more difficult to bring and less lucrative. State tort reforms included damage caps, limiting of joint and several liability, statutory caps on attorney fees, and limits on collateral source rules. Each of these measures is aimed at limiting the amount of recovery. We are not suggesting that reforms were unwarranted, but that most do not get to the heart of why patients decide to call a lawyer: These reforms do nothing to ensure an explanation to an injured patient, ensure the safety of others, or ensure negligent healthcare systems and caregivers are accountable. In other words, they do nothing to address the primary reasons patients sue. Despite tort reforms passed in waves across the country in the midst of crises in the late 1970s, then the late 1980s, and again in the early-to-mid 1990s, litigation persists as the primary solution for patients injured in the course of receiving medical care.

The tort system has its weaknesses, which often are exploited by opportunistic attorneys. That exploitation complicates the discussion. Over the years, deficiencies in the basic design of our litigation process have obscured the true causes of poor patient care by:

- Taking issues complex enough that we allow/invite/require experts to weigh in so prominently that most claims become a “battle of the experts.”
- Fueling the process with liberal doses of financial incentives for attorneys and experts alike.
- Presenting the claims to a jury purposely de-selected for any understanding of the medical issues being litigated.
- Expecting that jury to decide who is telling the truth and who is lying.
- Encouraging lawyers and the press to advertise the occasional runaway verdict widely.

Physicians understandably focus on the inherent unfairness, even absurdity, of it all and eagerly overlook their own involvement in the underlying reasons their patient turned to the court system.

The root causes for medical malpractice claims are deeper and closer to home than most in the medical community care to admit. The University of Michigan Health System’s experience suggests that a response by the medical community more directly aimed at what drives a patient to call a lawyer would better address the root cause of the problem.

A Program that Responds to the Drivers of Medical Malpractice

Envision a program that directly responds to the identified drivers of medical malpractice:

Before an error occurs

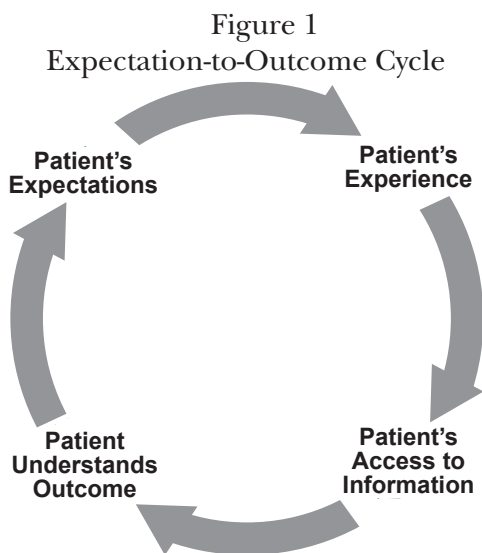
- Create realistic expectations about the proposed treatment or surgery in both patient and caregiver via thoughtful, thorough communication. Informed consent is an opportunity to set reasonable expectations, not just a legal hurdle to be crossed. Likewise, patients' responsibilities are acknowledged and documented.
- Create a resource for caregivers with tools to identify patient injuries before they become claims. The resource has proven expertise in assisting patients and families in the event of a problem and in satisfying the identified factors that would otherwise motivate patients to look to lawyers. (At the University of Michigan Health System, this resource is the Department of Risk Management.)
- Create institutional appreciation for the value of early detection of unexpected outcomes, familiarity with and confidence in the resource identified in the preceding bullet, and the expectation house-wide that the resource will be engaged for help in those situations.

After an unanticipated outcome occurs

- Patients/families are approached, acknowledged, and engaged in the acute phase.
- Patient care needs are prioritized.
- Patients/families receive answers (to the extent they are known).
- Expectations for follow-up are established, the patient and family understand the situation is being addressed, and the patient and family are doing their parts.
- Patients and families receive acknowledgement of, and an apology for, true mistakes. They receive a thorough explanation regardless.
- The patient's experience is studied for improvements that later are shared with the patient and family.
- Future clinical care is monitored via metrics established and measured to evaluate efficacy and durability of improvements.

An approach to potential patient claims with these features better responds to the known factors that prompt a patient to seek an advocate and ultimately look to litigation for satisfaction. This is the rough architecture of the system evolving at the University of Michigan.

In this approach, addressing the root causes of litigation begins before an injury occurs. The informed consent process is an underappreciated opportunity to establish rapport with the patient and create realistic expectations. It is the beginning of the cycle, as illustrated in Figure 1.



If the patient's experience reasonably mirrors expectations, if the patient's need for information is met readily, if the patient is assisted in processing the information, and if the patient believes that the system has responded to his or her experience with improvements, the likelihood that the patient will feel the need for an advocate or seek satisfaction through the legal system diminishes significantly.

The nature and content of the dialogue is different depending upon whether there was indeed an error, or merely a bad outcome. Medical commentators have debated alternative terms to describe a compensable injury, like "preventable errors" and "avoidable errors," with split-hair definitions. Troyen Brennan, M.D., a prolific commentator and researcher in this arena, strongly criticized the Institute of Medicine's *To Err is Human* report because of its reliance on the term "preventable" to describe adverse events arising from medical care.³¹ The University of Michigan employs the more time-honored and

31 Troyen A. Brennan, *The Institute of Medicine Report on Medical Errors—Could It Do Harm?*, 342 *NEW ENG. J. MED.* 1123–25 (2000).

(we believe) common-sense term used in most jurisdictions: a medical error occurs when a patient is injured as a result of medical care that was *unreasonable* under the circumstances.

With few exceptions (usually characterized by imposition of strict liability), in our society we are expected to act reasonably, not perfectly, under the circumstances. Medicine is an imperfect science, and medical care is, in most cases, inherently dangerous. Caregivers deal with dangerous diseases and situations every day. They are required to apply their knowledge and exercise their judgment, but as one of our surgeons often comments, “Clairvoyance is not the standard of care.”³² Caregiver decisions, in hindsight, may turn out to be wrong, and an error indeed may have been “preventable” or “avoidable”; however, acting prospectively, one could still say the caregiver behaved *reasonably*. Any system designed to respond to patient claims must be capable of investigating and distinguishing between medical errors and complications that can and do arise in the absence of negligence. To do this, thorough expert investigation and objective internal, and often external, expert reviews are required.

The University of Michigan's Approach to Patient Injuries

The University of Michigan Health System (UMHS) provided an excellent platform for approaching patient injuries and claims in a way aimed at the reasons people turn to lawyers. The UMHS always had been considered an ethical institution that strove to do the right thing, even in response to claims. Its medical staff generally is regarded as among those of the highest quality. Its physicians are both employees of the university and faculty members of its medical school. UMHS has been self-insured since the mid-1980s, which allowed for consistency and alignment of ethical and financial motivation between the hospital, care providers, and insurer. Alignment of these components remains an important advantage.

Michigan laws encourage proactive responses to patient injuries and claims. UMHS benefits from a compulsory six-month pre-suit notice period. In Michigan, before filing a medical malpractice suit, a plaintiff must provide the prospective defendants written specifics of the intended claims.³³ Generally, the plaintiff may not file suit for 182 days after serving the notice. This notice is intended to be a

32 Richard E. Burney, MD, Professor of Surgery, Chief, Division of Colorectal Surgery.

33 MICH. COMP. LAWS § 600.2912b.

highly substantive document and, by statute, must contain the following information:

1. The factual basis for the claim.
2. The applicable standard of practice or care alleged (e.g., whether the applicable standard of care is that of a board certified general surgeon, board certified internist, registered nurse, etc.).
3. The manner in which the applicable standard of care was breached.
4. The alleged action that should have been taken to achieve compliance with the alleged standard of care.
5. The manner in which it is alleged the breach of the standard of care was the proximate cause of the injury claimed in the notice.
6. The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.³⁴

The pre-suit notice offers prospective defendants time to investigate the claim and the opportunity to engage the patient or family. This period also offers patients time to reconsider their decision to sue. In reality, however, few institutions and healthcare providers in Michigan have used the notice period for these purposes.

Although the pre-suit notice requirement makes proactivity easier, in practice UMHS claims management is not dependent upon it. Providers in states without a compulsory notice provision also may use transparency proactively in claims management. Early in the UMHS effort to institute a systematic claims management program, the health system invested in an online incident reporting system. The Department of Risk Management undertook the ambitious dual tasks of educating the staff in the system's use and publicizing the importance of early notification of patient injuries toward maintenance of a comprehensive databank to evaluate trends and patterns. The staff increasingly utilizes the system; the number of reports grew from 3,891 in 2002 to 13,989 in 2006, and the growth continues. More *potential* claims are captured through the system than before its implementation—on more than one occasion, calls have been placed from the operating room.

Outreach efforts to the plaintiff's bar in Southeast Michigan also have stimulated early notification. It is not unusual for a lawyer to send an email or make a phone call to UMHS about a potential claim well before the lawyer has investigated it or decided to take the case. In gen-

34 *Id.*

eral, UMHS investigates claims (a patient injury coupled by a request for compensation) and potential claims in essentially the same way. This has been accomplished through efforts independent of the pre-suit notice requirement.

Thus, the University of Michigan built upon its institutional and legal advantages and instituted a program to achieve a systematic and principled response to unanticipated patient outcomes and, at the same time, route patient complaints to groups dedicated to clinical quality improvement or peer review. At the outset, three broad—and we believe, inarguable—principles were identified, around which the risk management/claims management response would take place:

1. Compensate quickly and fairly when unreasonable medical care causes injury.
2. Defend medically reasonable care vigorously.
3. Reduce patient injuries (and therefore claims) by learning from patients' experiences.

These principles mold the institutional response to patient injuries, fostering consistency and predictability for patients, medical staff, lawyers, and courts.

The key challenge is distinguishing between reasonable and unreasonable care. This determination is pivotal—it provides direction for the institutional response—and it is critical to get it right. UMHS developed the expertise to accomplish the detailed investigation and expert assessments necessary to know the difference between reasonable and unreasonable care. The risk management department was revamped to serve this goal. Experienced nurses were employed, as they were expected to understand the medical issues, the language used, and the reality of delivering care, thereby increasing the likelihood that events would be correctly sorted as error or not. Based on the reasoning that it would be easier to teach claims handling to caregivers than to acquaint claims handlers with complex medical issues, UMHS remade the department.

Using experienced caregivers to review claims also serves the third principle outlined above: learning from patients' experiences to reduce patient injuries. Every risk management consultant at UMHS is assigned specific clinical services. It is the consultant's task to understand how care is delivered, counsel the department chair or division chief, and continually look for ways to improve patient safety and decrease the risks of injury and mistake. Careful and in-depth investigation of patients' complaints provides the risk management consultants with a window on broader issues of patient safety and enables them to advise the clinical services more effectively.

Budgets for risk management departments are driven largely by wages. Experienced caregivers are expensive, but their salary range is wider than that of the typical insurance claims professional. The UMHS risk management budget expanded considerably, but the return on investment was clear. Spending more to pay less makes sense, especially if it ultimately leads to safer patients, lower future claims, and reduced costs.

To provide a check and balance against UMHS Risk Management's conclusions about the reasonableness of care, a committee was constructed to review each case and pass on the information gathered. Conclusions reached by a committee comprised of caregivers would be more credible to the caregivers whose care was at issue than conclusions reached by claims people, or ultimately, juries empanelled in courtrooms. As caregivers, the committee members would better understand the circumstances in which the care was rendered, would better understand the challenges of rendering that care, and would in most ways be better situated to reach a fair opinion about "the reasonableness of the care rendered under the circumstances" than non-caregivers. At UMHS, members span nearly 20 specialties, which helps keep specialties in check by preventing any member from improperly exonerating or unduly criticizing his or her direct colleague. Often, the most challenging criticism or glowing praise comes from those members outside the specialty under review. Reviews by outside experts help protect against any inclination to "protect one's own." Most importantly, the idea that UMHS faculty and staff would be served best by early, honest reviews rather than grudging admissions of error following years of litigation was made part of the claims management culture in a conscious way. Striking while the issues were fresh, the committee ideally also would provide the pivot around which UMHS would identify and act upon continual quality, peer review, and educational opportunities.

To achieve this, a committee already in place and originally intended as a resource for trial lawyers representing UMHS was reconfigured. Its membership was expanded from 6 to 32 to include representation of several commonly helpful medical specialties, nursing, and hospital administration. The committee's primary charge is to assist in the claims process by answering two questions: (1) Was the care at issue reasonable under the circumstances? and (2) Did the care adversely impact the patient's outcome? Secondarily, the committee considers every case for potential peer review, quality improvement, and educational opportunities. The discussions, actions, and activities associated with this committee are viewed as "protected" from discovery. In Michigan, as in most other states, statutes protect against disclosure of both discussions taken in anticipation of litigation and information

generated in the course of quality improvement and peer review activities. In essence, these statutes state that records, data, and knowledge collected for or by individuals or committees assigned a hospital or health facility review function are confidential and not available for court subpoena.³⁵ In addition, to monitor regulatory considerations and potential legal concerns, a lawyer from the UMHS legal office is present for every committee meeting. The lawyer often fields questions or offers opinions on issues as they arise. The lawyer's presence and involvement allows for the protection of those issues upon which he or she consults.

Some have argued that the committee's activities are conducted "in anticipation of litigation" as opposed to promoting quality improvement/peer review. This is an important distinction, because the work-product privilege afforded to activities in anticipation of litigation is a qualified privilege. In Michigan, documents prepared in anticipation of litigation could be discoverable if the party seeking discovery shows "a substantial need of the material in the preparation of the case" and "is unable without undue hardship to obtain the substantial equivalent of the materials by other means."³⁶ Only the mental impressions, conclusions, opinions, or legal theories of an attorney would remain protected.³⁷ Consequently, the committee's work is subject to layers of various protections, should they be needed. Although the protections are comforting, they should not be tested often; in accordance with UMHS principles, where the committee has concluded that mistakes altered a patient's outcome, UMHS likely will be trying to settle the claim.

Pre-suit, the interest of patients and UMHS are aligned: Both sides seek honest answers to questions raised by the patient's adverse outcome. Facing the prospect of litigation, neither side wants to make a mistake. Hospitals and healthcare providers do not want to defend a claim for years only to decide later that the claim warranted settlement. Doing so is financially expensive and unnecessarily harmful to both patient and caregiver. From a practical perspective, neither the patient nor his or her lawyer wants to engage in expensive, time-consuming, and emotionally draining litigation, only to lose the case. Discovery devices in Michigan and in most states (i.e., depositions, interrogatories, requests for admissions, requests for medical exams, etc.) eventually lead to full disclosure, so why not simply fast-forward the process to share conclusions early and less expensively? If one side's conclusions are wrong, better to know before litigating. To date, nearly every plaintiff's lawyer has agreed with this approach and readily participated.

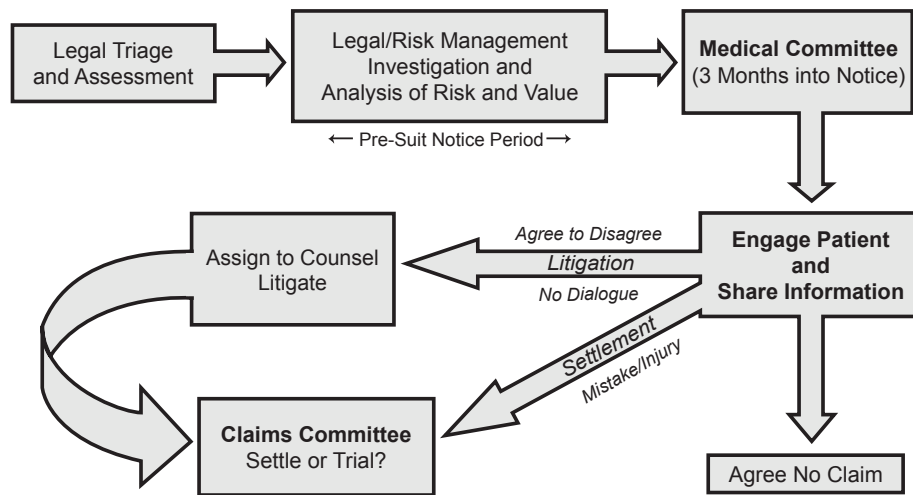
35 MICH. COMP. LAWS §§ 333.20175, .21515, .531, .533.

36 MICH. COMP. LAWS Rule 2.302(B)(3)(a).

37 *Id.*

Every patient, and, if the patient is represented, his or her lawyer, is invited to an open and honest dialogue about the issues raised in the course of his or her medical care. Open, honest, and robust discussions occur between patients and their doctors and between doctors and the lawyers poised to sue them. Expert opinions are exchanged and agreements are reached—agreements to drop the claim, agreements to settle (sometimes with an apology), and occasionally, agreements to disagree. Patients develop a thorough understanding of what happened before misconceptions and bogus information drive them to the courthouse. Constructive engagement allows the parties to understand what they face with litigation. Both sides can move forward with “informed consent.” In this dynamic, litigation is relegated to the role it was meant to play: a last resort for resolving intransigent disputes.

Figure 2
University of Michigan Claims Management Model



The UMHS approach, illustrated in Figure 2, offers benefits not achievable through litigation. By interrupting the march to the courthouse, the animosity intrinsic to suing someone is lessened and often avoided, which allows for discussions not impassioned by name-calling, threats of professional ruin, reinforced victimhood, exaggerated claims, and dismissive defenses. If it appears that compensation is owed, the discussion shifts from the typical approach, in which both sides take equally unreasonable financial positions and work towards a middle ground, evidence-based discussions about what is truly owed because of the medical error. With this approach, it is not uncommon for a settlement amount to be very close to the original offer and for both sides to agree on the substantive basis for the settlement.

Perhaps most importantly, commitment to the three principles enumerated above opens the door to immediate and decisive quality improvement measures and peer review opportunities. It seems virtually impossible to publicly deny responsibility for medical error and simultaneously privately admit that mistakes were made and care should have been better. The deny and defend approach is mutually exclusive to the honest introspection necessary to true identification of errors, and to the will to correct them. Brennan noted, "Any effort to prevent injury due to medical care is complicated by the dead weight of a litigation system that induces secrecy and silence."³⁸ The first step to recovery must be to admit there is a problem.³⁹ Ethical medical care requires that caregivers not wait for litigation to run its course before confronting the need for clinical improvement and carrying out changes. At UMHS, patient complaints, even those seemingly without substance, are routed through a process that asks in every single instance: Should we reasonably have done better?

The results

Some have predicted that open and honest disclosure would result in increased malpractice litigation.⁴⁰ Reacting to earlier research that suggested as little as two percent of medical errors ever receive a lawyer's attention, Studdert et al. reasoned that opening the door to medical errors would tap the previously untapped reservoir of claims.⁴¹ The University of Michigan Health System has not seen those floodgates swing open. Despite predictions, the number of new claims has fallen:

1999: 136	2003: 81
2000: 122	2004: 91
2001: 121	2005: 85
2002: 88	2006: 61

The claims reported above are not adjusted for increases in clinical activity over the same period. Arguably, they also are inflated by a reporting system that captures unanticipated outcomes faster, often recognizing potential claims far ahead of any request for compensation.

38 Troyen A. Brennan, *The Institute of Medicine Report on Medical Errors—Could It Do Harm?*, 342 *NEW ENG. J. MED.* 1123–25 (2000).

39 *Alcoholics Anonymous*, 1939.

40 David M. Studdert et al., *Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy*, 26 *HEALTH AFFAIRS* 215–26 (2007).

41 *Id.*

UMHS also is moving claims through its system much faster, as evidenced by the progression of open claims at the end of August 2001 as a benchmark:

- In August, 2001, UMHS had 262 total open claims;
- in 2002, 220;
- in 2003, 193;
- in 2004, 155;
- in 2005, 114;
- in 2006, 106;
- in 2007, 83.

Over that same time span (August 2001 through August 2007), the average claims processing time dropped from 20.3 months to about 8 months. Total insurance reserves dropped by more than two-thirds. Average litigation costs have been more than halved.

Transparency alone does not account for these numbers. Tort filings, including medical malpractice filings, across the country are experiencing a general downward trend,⁴² and there are other, ongoing efforts to address medical care problems. The Institute for Healthcare Improvement's (IHI) nationwide 100,000 Lives Campaign, begun in 2004, and its 5 Million Lives Campaign, launched in 2006, have made laudable strides toward improving patient safety.⁴³ The Joint Commission issued a Sentinel Event Policy in 1996 that required accredited institutions to investigate adverse events, identify the root cause, identify and implement measures to prevent the event from happening again, and monitor the progress of those measures.⁴⁴ The Joint Commission also announced new patient safety standards in 2001, one of which requires accredited hospitals to tell patients of their outcomes, good or bad.⁴⁵ In 2002, the Joint Commission first announced National Patient Safety Goals that accredited organizations must implement and maintain.⁴⁶ Hopefully, these measures have had their impact. In addition, an effort to improve patient safety with a stick instead of a carrot,

42 NAT'L CTR. FOR STATE COURTS, EXAMINING THE WORK OF STATE COURTS, 2005: A NATIONAL PERSPECTIVE FROM THE COURT STATISTICS PROJECT 27 (2006), available at <http://207.242.75.69/cgi-bin/showfile.exe?CISOROOT=/ctadmin&CISOPTR=412>.

43 The 100,000 Lives Campaign was launched in 2004 as a nationwide initiative to reduce preventable deaths in U.S. hospitals. Fueled by the success of the 100,000 Lives Campaign, the 5 Million Lives Campaign began in 2006 and is geared toward preventing 5 million non-fatal medical injuries over a 2-year period. An overview of both campaigns is available at www.ihl.org/IHI/Programs/Campaign/Campaign.htm?TabId=1.

44 JOINT COMM'N & HEALTHCARE SAFETY AND QUALITY, SETTING THE STANDARD, available at www.jointcommission.org/NR/rdonlyres/6C33FEDB-BB50-4CEE-950B-A6246DA4911E/0/setting_the_standard.pdf [hereinafter *Setting the Standard*].

45 *Id.*

46 *Id.*

Medicare and Medicaid have announced there are some events for which they will simply not pay (e.g., wrong-site surgery, pressure ulcers, foreign body left in after surgery). Private insurers like Blue Cross/Blue Shield are following suit. UMHS patients hopefully are safer and better informed than ever as the root causes of medical malpractice claims are addressed through the claims process. Although singular factors giving rise to decreased claims cannot be identified precisely, clearly, transparency at UMHS has not been the catastrophe predicted—and it has yielded unquestionable benefits that enable UMHS and its staff to deliver safer and better care.

Several clinical improvements made at UMHS trace their origins to the claims process. UMHS has invested money liberated from the insurance program in ways designed to improve patient safety:

- Initiation of the online incident reporting system
- Expansion of the risk management budget
- Establishment of a patient safety contingency fund that allows the chief of staff to pay for needed clinical improvements without traversing a ponderous institutional capital process
- Formation and deployment of rapid response teams
- Development of a large hospitalist service
- Utilization of patient safety coordinators who, with the chief of staff, visit hospital floors weekly to ask caregivers directly for patient safety suggestions, correct problems, and make those suggestions a reality
- Changes in clinical staffing and supervisory designs
- Research into risk factors for pulmonary embolus, and practical development of tools to identify patients at risk on admission
- Purchase of walkie-talkie-type communication devices to streamline communications between treatment teams in focused areas
- Provision of pulse oximetry for adult and pediatric inpatients
- Purchase of portable “vein sensors” to reduce complications in line placements

This list is only a small sample of improvements triggered by the hard link established between the claims process and the institutional quality improvement efforts.

Surveys suggest that the UMHS approach may have achieved the unthinkable: It appears to satisfy doctors *and* trial lawyers. Surveys conducted in early 2006 of UMHS medical faculty and the plaintiff's bar

in Southeastern Michigan yielded approval from both groups. Four hundred nineteen UMHS faculty physicians responded to the survey:

- 87% said the threat of litigation adversely impacted the satisfaction they derived from practicing medicine.
- 98% perceived a difference in the University of Michigan's approach to malpractice claims after 2001.
- 98% fully approved of the approach.
- 55% said that the approach was a "significant factor" in their decision to stay at the University of Michigan.
- The only consistent criticism was that they wanted more attention from Risk Management to assist in reducing the threat of malpractice.

At the same time, 26 members of the plaintiff's bar in Southeastern Michigan specializing in medical malpractice responded to our survey:

- 100% rated the University of Michigan "the best" and "among the best" health systems for transparency.
- 90% recognized a change in the UMHS approach since 2001.
- 81% said that they had changed their approach to UMHS in response.
- 81% said their costs were lower.
- 71% admitted that when they settled cases with UMHS, the settlement amount was less than anticipated.
- 86% agreed that transparency allowed them to make better decisions about the claims they chose to pursue.
- 57% admitted they declined to pursue cases after 2001 that they believe they would have pursued before the claims system changes.

Transporting the Michigan approach

Admittedly, UMHS has institutional and legal advantages that help make this approach work so well. That is not to say that individual doctors, hospitals with independent medical staffs, or even insurance companies cannot apply the same principles.

Other hospitals and health systems have reported success with similar approaches. One commentator reported that the 28 hospitals in the Kaiser Permanente network, The Children's Hospital & Clinic of Minnesota, and Johns Hopkins have experienced success with a trans-

parent approach.⁴⁷ Catholic Healthcare West is a system of 41 hospitals and medical centers in California, Arizona, and Nevada that reportedly has been applying a similar approach since 1999. Owing to the success of the program, Catholic Healthcare West has apparently managed to convince the insurance carrier of its independent doctors to buy into the approach as well.⁴⁸ Physicians Reimbursement Fund, Inc., a risk retention group located in California, implemented a full-disclosure approach in 2002 and, by 2005, reported a 40% reduction in claims payments and claims.⁴⁹

The COPIC example

An interesting example worthy of discussion is the program employed at COPIC Insurance Company (COPIC), a large Colorado medical malpractice insurance carrier. In 2000, COPIC instituted the 3Rs Program. The program purports to combine disclosure with early offers of compensation by applying the following principles:

1. Recognize unanticipated events;
2. Respond soon after the event occurs; and
3. Resolve any related issues.⁵⁰

COPIC's 3Rs Program is a no-fault system designed to keep medical injuries from entering the "traditional," "ineffective," and "inefficient" legal system.⁵¹ COPIC encourages its insured physicians to disclose all unanticipated outcomes to patients. For events that meet strict criteria, patients can receive monetary awards up to \$30,000 and reimbursement for out-of-pocket expenses.⁵² There are significant exclusions and limitations to COPIC's program. Cases involving patient deaths, attorney involvement, written demand, complaints to the Board of Medical Examiners, and cases in which a complaint has been filed all are excluded.⁵³ Even with the program's limitations, by 2005, malpractice claims against COPIC physicians reportedly dropped by 50% and settlement costs dropped 23%.⁵⁴ As of June 2007, there were

47 Michael J. Moody, *Could It Really Be This Easy? A Bold New Risk Management Approach—Doctors Tell the Truth and Apologize*, <http://www.roughnotes.com/rnmagazine/2005/november05/11p124.htm>. Last accessed Oct. 8, 2008 [hereinafter Moody].

48 *Id.*

49 *Id.*

50 Richert Quinn, *COPIC's 3Rs Program Recognize, Respond to and Resolve Patient Injury*, PowerPoint presentation, available at www.sorryworks.net/files/3rsaosreq.ppt.

51 *Id.*

52 *Id.*

53 COPIC Ins. Co., *A Success Story*, 1 COPIC'S 3RS PROGRAM NEWSL. (Mar. 2004), available at www.callcopic.com/resources/custom/PDF/3rs-newsletter/vol-1-issue-1-mar-2004.pdf [hereinafter COPIC].

54 Moody.

4,600 R-qualifying incidents, resulting in 953 patient reimbursements, for a total of \$5,044,069 paid (average of \$5,293 per incident).⁵⁵

Because no effort in the 3Rs Program is devoted to determining whether the unanticipated outcome was due to negligence, there seems to be no opportunity to improve patient safety. Nonetheless, Thomas Gallagher, MD, commented on COPIC's "success":

To date, the program has handled over 3,000 events in the 3Rs program. Two-thirds of these events have been closed with no payment to the patient. Of those events where payment was made, the average payment was only \$5,000. No 3Rs event has proceeded to a formal jury trial. For this selected group of events, COPIC's approach of open disclosure and early offers of compensation appears to be a way to resolve these events less adversarially and more effectively than could be accomplished through the traditional torts system.⁵⁶

With its limitations and small scale, which most risk managers might characterize as "service recovery," COPIC's program is modest compared to the scope of the medical error landscape, but it represents a good start within an insurance industry slow to embrace an approach other than "deny and defend."

Individual physicians

For many individual physicians, the UMHS approach is probably not so novel. Many physicians have spent their careers, without fanfare, talking candidly with patients, setting reasonable expectations before an error occurs, and acknowledging the error afterward. This comes naturally to some physicians. Others need to be coached, or at least reassured that it is not as risky as they have been conditioned to fear.

Fears that impede individual physicians from open disclosure are the fear of losing malpractice insurance coverage, the fear of the patient finding out that the physician made a mistake, the fear of compromising a future malpractice case, and the fear of financial ruin. Some of these fears can be assuaged with a little knowledge, courage, a change in culture, and planning. There is evidence of a culture shift: The majority of states have passed apology laws, partly in an effort to make transparency and apology more palatable to independent physicians and hospitals.

⁵⁵ COPIC.

⁵⁶ THOMAS H. GALLAGHER, COMM'N OF INQUIRY ON HORMONE RECEPTOR TESTING, DISCLOSING UNANTICIPATED OUTCOMES TO PATIENTS: INTERNATIONAL TRENDS AND NORMS 7 (2007), available at www.cihr.nl.ca/pdf/Gallagher.pdf.

The misconception among physicians that they will lose insurance coverage if they have an honest conversation with a patient after an error occurs likely shares parentage with the deny and defend approach. The insurance industry seeks to control that which represents its only risk: claims outcomes. The industry, however, has no intrinsic investment in the quality of care, preservation of the physician-patient relationship, or patient safety improvements. If the company does a good job underwriting, concerns such as these typically are beyond its interest. Physicians, conversely, swear to uphold the Hippocratic Oath to do no harm to their patients and promise to engage patients actively in their own care. More recently, Patients Bills of Rights⁵⁷ (statements of rights to which patients are entitled as recipients of medical care, including the right to information geared toward greater autonomy over their medical care) and the Joint Commission mandate open, honest discussions with patients about their treatment and outcomes.⁵⁸ Physicians must not abrogate their roles and duties in the physician-patient relationship to an insurance company. Insurance policy language prohibiting or penalizing honest discussions about a patient's healthcare outcomes with the patient or family probably is unethical and surely is unenforceable. A physician's duty to his or her patient does not end when something goes wrong.

Individual physicians without a resource like the Risk Management Department at the University of Michigan could consider establishing a relationship with an independent lawyer before a crisis occurs, effectively creating his or her own risk management support. Physicians generally are too close to the problem to best judge how to handle patient communication after an unanticipated outcome. Rather than abrogate the physician-patient relationship to a medical malpractice claims person, the physician can arrange for counsel when needed. The physician should view his or her attorney as part of the professional support team, not unlike an accountant or corporate attorney. Establishing a relationship before a crisis arises, with a clear understanding of the ethical and cultural balance the physician seeks to achieve, makes good sense, and it would instill confidence that the planned disclosure would not improperly impact the physician's position should the complication lead to litigation.

57 In general, Patients Bills of Rights have been adopted by health plans and associations. See Consumer Patient Rights and Responsibilities, Advisory Commission on Consumer Protection and Quality in the Health Care Industry, available at www.hcqualitycommission.gov/cborr/exsumm.html, and American Hospital Association, available at www.aha.org/aha/issues/Communicating-With-Patients/pt-care-partnership.html.

58 *Setting the Standard*.

The private practice staff model

The UMHS response to patient injury also is relevant in private practice staff models, though clearly transparency is challenged by the diversity of perspectives, the multiplicity of interests (including those of the commercial malpractice insurers), and the very real potential that some medical staff members will find value in brinksmanship. It seems possible to adopt a transparency-based claims process only with a consensus concerning the ethics of disclosure at the medical staff level. The hospital and its staff must share values. Both must accept that a culture of honesty and transparency is not only the right thing to do, but also the smart thing to do. Independent medical staff members must be comfortable working closely with the hospital risk management department when a medical malpractice claim is received. Likewise, the hospital should cooperate with the physician's attorney and support the staff physician to the extent he or she seeks openness with his or her patients.

Physicians not employed by large, financially secure institutions may fear financial ruin if they engage in open discussions with their patients when an error occurs. Physicians should not be penny wise and pound foolish with respect to their malpractice insurance limits. Solid insurance coverage, if affordable, is the best security most independent physicians can obtain. States should consider developing umbrella coverage for their healthcare workers—by spreading the cost of coverage broadly, available excess coverage could go a long way toward encouraging transparency and safety.

Hospitals with independent staff physicians should do their best to reassure physicians and encourage them to embrace a culture of honesty and transparency. Successful transparency requires hospital leaders to reach healthcare providers on an ethical level, as well as a practical level. If a joint understanding is not possible because of differing insurance company ethics or inconsistent direction, we believe a hospital should move forward with its vision and trust that the independent physicians will soon see that an open and honest environment makes sense. Even with its considerable advantages, it took time before most UMHS physicians accepted the culture shift. It is still a work in progress. No one denies the challenge. If deny and defend has not effectively addressed the problem to date, more of it will not necessarily help.

Case Example: Patient JW

The following case example illustrates how the deny and defend approach to medical errors exacerbates a claim, stokes the costs, and inflates potential exposure. Some might disagree with the assumptions made in the following case discussion, but the analysis should pass muster with anyone experienced in malpractice claims.

Facts

JW was a 36-year-old school teacher with a master's degree earning \$68,000, plus benefits. She was married and the mother of two boys, ages six and eight. She had no previous health issues, was a compliant patient, and had a good work history.

In August 2003, JW presented to her primary care physician for her annual physical, at which time a breast exam revealed "no masses, skin changes, nipple discharge." In November 2003, she noticed a lump in her right breast while showering and returned to her primary care physician's office, where she was seen by a physician covering for her usual doctor. After examining JW, the physician concluded the lesion was not worrisome. He instructed JW to perform monthly self-exams, watch for changing or asymmetric lesions, and begin mammograms at age 40. As he put it later, "I guess I put the onus on the patient to monitor for changes."

JW returned for a physical with her primary care physician on August 24, 2004. She reported "no problems whatsoever." On breast exam, there were no masses, skin changes, or nipple discharge. No mention was made of the lump she had a year before.

JW returned in July 2005 for evaluation of a tender, right-sided breast lump. On exam, her primary care physician palpated a nodule. She was scheduled for a mammogram, possible ultrasound, and fine-needle aspiration, which confirmed invasive ductal carcinoma that had metastasized. Surgical and medical oncologists made recommendations for mastectomy and chemotherapy.

JW underwent four months of chemotherapy before a lumpectomy was attempted. Unfortunately, surgical margins and two out of 35 lymph nodes were positive. A surgical oncologist recommended and performed a complete mastectomy. In February 2006, she underwent post-mastectomy radiation.

During that same month, UMHS received a claim letter from JW's attorney, describing the claim and asserting a lien. The claim alleged failure to diagnose breast cancer in August 2003, November 2003, and August 2004. According to the claim, the delay diminished her

opportunity for cure; increased her likelihood of recurrence; and caused unnecessary disfigurement, unnecessary surgery, unnecessary chemo and radiation, lost life expectancy, lost wages, disability, loss of future earnings, present and future pain, suffering, disability, anxiety, depression, loss of consortium, unnecessary medical bills for care, and psychotherapy.

In June 2006, JW's primary care physician described her as disabled due to chronic fatigue syndrome, depressed, suffering chronic shoulder pain, and plagued by anxiety over the fear of recurrence. She requested a formal disability finding to support a demand for benefits.

Assessment and analysis of the care

The assessment of the care was not entirely black and white. The UMHS Department of Risk Management conducted interviews, reviewed and summarized charts, and obtained a number of expert reviews (internal and external). The doctors involved vigorously asserted that their care had been reasonable, though the patient's treating physician expressed discomfort with the covering physician's decision not to order mammography when the patient presented with a mass in November 2003. The investigation pointed to the following conclusions:

- The standard of care was met for the patient's physical in August 2003.
- The standard of care for the November 2003 visit required referral for mammogram or, at the least, short-term follow-up to see if the lump changed in size.
- The August 2004 physical was perplexing: If she had cancer in November 2003, why would she report "no complaints whatsoever," and why was her breast exam negative?

All reviewers agreed the covering doctor's care in November 2003 was below expectations for UMHS faculty. Three reviewers said that the decision not to follow up on JW's concerns with mammography and referral to a surgeon was a violation of the standard of care. Two other reviewers hesitantly offered to testify that because short-term follow-up would have been an acceptable clinical decision in November 2003, and because a short-term follow-up likely would have been negative based on the absence of recorded findings later, they could argue that the August 2004 exam satisfied the need for short-term follow-up. They reasoned that JW was partly responsible for not following the mass she felt in November and returning for care when it changed. The reviewers could defend the case, while admitting privately they would have handled it differently and expected more of their colleagues under the same or similar circumstances.

The options for responding to the claim were either deny and defend or admit the deficiencies and address the harm. Arguably, deny and defend offered an outside chance of winning the case. Statistically, doctors and hospitals win far more often than they lose at trial,⁵⁹ though this likely reflects sophisticated case selection. Defending would appeal to the physicians involved and their natural desire to feel they did nothing wrong. The plaintiffs' bar is often close knit; publicizing the fact that a claim against UMHS will be met with draining, expensive, and time-consuming tactics could have a deterrent effect. Discovery could strengthen the defendants' case. Note that the potential advantages of the deny and defend approach mostly stem from the vagaries and weaknesses of litigation as a means of resolving this dispute. Despite caregivers' criticisms of the litigation process, clearly the defense in a medical error case calculates those cracks in the system that work to its advantage.

On the other hand, the deny and defend approach presents significant potential disadvantages that defendants must weigh. Amicable discussion is preempted—any potential that reasoned analysis will resolve this dispute is, at a minimum, put on hold. As litigation proceeds, both sides incur legal costs, raising the entry price to any settlement discussions absent one side or the other scoring a knockout in discovery. Litigation exposes medical and clinic staff members to the anxiety of a lawsuit, discovery, and trial. Experts are very expensive, most charging in the neighborhood of \$300–\$500 per hour to review records and testimony. At the outset of this case, the experts willing to defend the care were lukewarm, diminishing the likelihood of a knockout in discovery or an outright victory at trial. The risk of adverse publicity is ever present. Productivity is lost. Most importantly, the likelihood that JW's care would be critically examined for quality improvement purposes during the litigation was non-existent. deny and defend impedes clinical improvement and peer review.

Litigating JW's case

With two experts willing to support JW's care, many institutions, healthcare providers, or insurance companies would litigate the case. Examining the likely course, however, strongly suggested that litigation would come at a very high cost and likely would result in a much greater financial loss.

From the defendant physicians' perspective: The physicians would be told that experts could defend their care (albeit not entirely comfortably). Given the inherent uncertainty of cancer progression, defense

59 Thomas H. Cohen, J.D., Ph.D., Bureau of Justice Statistics, *Medical Malpractice Trials and Verdicts in Large Counties, 2001*, April 2004, NCJ 203098.

experts could be found to undermine the proximate cause and damages components of JW's claim. Because denial is such a strong part of human nature, the defendant physicians would be inclined to see themselves as victims of an unfair system, reassuring them that they acted reasonably under the circumstances—at least two others were willing to say so under oath—ultimately assuming the role of Studdert et al.'s victim, upon whom “unwarranted expense and emotional pain” has been visited randomly and unfairly.⁶⁰ They lose sleep, office time, and money as they spend increasing time with lawyers. The conflict will adversely affect personal and professional relationships. It would not be surprising if the physicians emerge from the experience having learned nothing other than to loathe the legal system and the lawyers who profited from their misfortune.

From JW's perspective: In the end, she would pay an even greater cost. Although the prospect of litigation holds for her the concomitant chance of a financial windfall, that chance would come at significant expense. Her lawyer would have no problem finding physicians to testify that the standard of care was violated. Motivated in an adversarial system to present the strongest (most valuable) case for JW, her lawyer would seek causation experts to paint the most dire picture: She was likely to experience a recurrence any day, she was indeed disabled by the progression of her disease and the treatment required as a result of the delay, and her life expectancy was reduced to month-to-month. JW's worst fears would be reinforced during years of litigation. Her lawyer would retain an economist to value her disability and lost life expectancy, together with cost-of-living adjustments, inflation factors, and a host of other economic predictions and projections in the millions. The exposure to the defendants would be as inflated, with economic assumptions calculated to maximize loss. The cost to settle would increase with every dollar the plaintiff's lawyer spends on experts. The defendants would view these costs as unjustified, and the perceived gap in the value of the case would grow.

In most jurisdictions, the case likely would snowball towards trial for some time before anyone stopped to take a sober look at the risk of an aberrant verdict. Litigation encourages each side to adopt an extreme position before they pause to evaluate the vulnerabilities of that position just prior to trial. The risks to the defendant of trying the case are high. The physician faces the probability of an unfavorable verdict. His reputation is on the line, possibly with follow-up disciplinary action. The pretrial emotional costs multiply in the roller coaster of trial. Few physicians who experience trial want to do it again—ever. The legal

60 David M. Studdert, Michelle M. Mello & Troyen A. Brennan, *Medical Malpractice*, 350 NEW ENG. J. MED. 283 (2004).

process is an “extremely stressful” experience for physicians and causes negative psychological, physical, and behavioral practice changes.⁶¹

Claims professionals across the country tend to use the same simplistic formula to guide their judgment about settlement and the financial range they consider. Typically, they ask, “If we try this case ten times, how many times do we win?” They calculate the worst-case scenario, mindful of the illogical windfalls possible in a jury trial. The typical formula looks something like this:

$$\text{Exposure} + \text{Costs} \times \text{Percent Chance of Losing} = \text{Settlement Range}$$

Applying the equation simplistically to this case, omitting advanced economic factors like inflation, the exposure clearly is significant. JW was young and planned to work an additional 29 years, at \$68,000 per year, yielding \$1,972,000 present value. Add to that 34% in lost benefits. Future care costs, pain/suffering and loss of society, albeit somewhat speculative, add considerable value to the case. The costs associated with trying the case were estimated to be \$100,000 to \$150,000. The chance of losing obviously is an opinion that will vary by claims professional and trial lawyer. A wild card here is the compelling picture JW might strike: a young school teacher, wife, and mother with a family worthy of a Rockwell painting, on death’s door, robbed of her family life, her professional life, life overall. Given the weak liability defense, the significant delay in diagnosis, and the compelling presentation of the plaintiff and her family, the chance of losing was pegged at 85%, assuming that in the lengthy interim between filing and trial, JW would not metastasize, an occurrence that would surely ramp up the sympathy factor, increase economic damages, diminish a proximate cause defense, and further reduce any chance of winning. The exposure calculation looks something like this:

Lost wages/benefits	\$2,350,000–\$2,750,000
Future care costs	\$250,000–\$400,000
Non-economic losses (capped in Michigan)	\$400,000
Costs to try	\$100,000–\$150,000
<hr/> Semi-total	<hr/> \$3,100,000–\$3,700,000

Assuming an 85% chance of losing at trial, the insurance professional might peg the settlement range before trial as \$2,635,000–\$3,145,000. Of course, the formula does not account for lost productivity, the cost of the infrastructure to manage trial counsel, the cost of trial, or the

61 Louise Nash, Christopher Tennant & Marilyn Walton, *The Psychological Impact of Complaints and Negligence Suits on Doctors*, 12 AUSTRALASIAN PSYCHIATRY 278–81 (2004).

risk of adverse publicity for denying to the end. Nor does it take into account the biggest cost to the institution and the healthcare provider: The lost opportunity to learn from the mistake and improve clinical care for future patients.

What actually happened—application of transparency

Applying UMHS claims management principles to JW's case yielded a very different result. Immediately after the notice of the claim was received in February 2006, records were obtained and summarized. In March, the chief risk officer and risk management consultant interviewed the target physician and other treating physicians. In April, the chief risk officer and risk management consultant obtained reviews from the chief of general medicine and three other faculty members. Additional discussions with involved faculty ensued.

The case was presented to the medical review committee in May 2006. Based upon the information presented, the committee concluded the standard of care was not met and that as a result, the patient had an increased chance of recurrence and more extensive surgery, but no change in her care with chemotherapy or radiation. The risk management education plan was set during the committee meeting. Immediately after the committee meeting, an invitation to meet was extended to the patient's attorney.

The plaintiff's lawyer agreed to meet on August 1, 2006. The plaintiff's demand at the time was \$2,000,000. The patient's concerns were explored during the meeting. The chance that she would not live long enough to see her sons to college was pressing. A subsequent meeting was scheduled with the treating physicians and the patient (and her attorney). The lien was investigated and a thorough economic evaluation was requested.

JW completed chemotherapy and radiation in September. The treating physicians were interviewed again regarding her disability and complaints of chronic fatigue. Efforts focused on what was owed due to the delay in diagnosis. The plaintiff's lawyer's economic assessment was critically reviewed by an economist expert retained by UMHS and a contra-assessment was prepared, pointing out unreasonable assumptions and inflated calculations. UMHS engaged a financial planner to calculate the cost of college funds for both boys; the financial planner prepared proposals for the college funds by the end of September. The chief risk officer sent a letter to the plaintiff's attorney critically evaluating the plaintiff's settlement demand and economic evaluation.

By the end of October 2006, UMHS received a new demand of \$1,200,000 in response to the written critique. The case was presented to the claims management committee (the committee that discusses settlement authority). The committee granted \$400,000 in settlement authority as requested, representing what it would take to respond to JW's concerns about financing her sons' college educations.

In December 2006, the physicians treating the patient for cancer, the patient, her husband, their attorney, and risk management representatives all met. This meeting was the opportunity for the patient and her husband to tell their story, and the opportunity for the physicians to share their thoughts and apologize, if appropriate. Having everyone at the table is far more efficient and satisfying to all than having these discussions *ex parte*. Most UMHS risk management consultants are trained mediators, which has helped prepare them to deal with the dynamics of such a meeting. At the outset of the meeting with JW, an apology with a commitment to settle the case was openly extended.

UMHS discovered a critical piece of information at the meeting. JW was asked why she reported "no complaints whatsoever" at the August 2004 visit and why she had not mentioned the lump from the previous year. The documentation suggested that the lump for which she sought care had disappeared, leading one expert to speculate that the finding that prompted her to see the physician was not the cancer that developed later. She explained she felt she had been given a clean bill of health with respect to the lump from the prior year, and she was reassured that it was not a problem. She did not report it on subsequent exams because a doctor already had told her it was not an abnormality. Hearing this explanation before litigation was immensely beneficial. The experts, when later provided with this information, responded that their support was further strained.

The meeting with JW also included a discussion of her risk of recurrence, understandably very important to her and her husband. That discussion spanned more than an hour. She had completely, albeit understandably, exaggerated her risk of recurrence before this meeting. She was reassured by her medical and surgical oncologists with evidence-based opinions markedly more optimistic than the experts her lawyer had secured. She openly discussed her reluctance to return to work. She was encouraged to resume her life. UMHS extended an offer to videotape her story for education purposes, which clearly piqued her interest.

Shortly after this meeting, UMHS extended a proposal to settle with a reasoned offer at the cost of \$400,000. After several counter-demands, the case ultimately settled for \$400,000 (incorporating annuities for college funds), and a promise to videotape the patient for medical education purposes.

Aftermath

In January and February 2007, the case was presented to Internal Medicine Grand Rounds, General Medicine faculty meeting, Family Medicine, and Ob/Gyn faculty meetings. It also was used in an Ob/Gyn resident workshop. In March 2007, the patient and her lawyer were videotaped. Her videotaped story has been shared with several groups of doctors.

The total cost of the principled approach was \$402,900. The patient returned to teaching. Her outlook on life is decidedly more optimistic. She no longer complains of chronic fatigue or depression. She is enjoying her life and her family. All UMHS primary care physicians have been educated from her case and her video. She remains a UMHS patient.

In her video, JW said:

After that night (of the meeting), I left there like I was on a mountaintop. I felt like I had finally been heard, they listened... If that had been the end of the legal pursuit, that would have been fine with me. I was perfectly satisfied after that night. What that apology meant to me was that they had listened finally and I had been heard. I can't even describe how euphoric I felt when I left that meeting....⁶²

UMHS also videotaped JW's lawyer. His experience mirrors what we have seen repeatedly: By applying a principled approach based on evidence and substance, not hyperbole, we effectively forced him into a different role. He observed:

Instead of adversarial, it was conversational. It was instead of trying to figure out what claims and defenses needed to be, I found myself trying to figure out some higher calling, what's the right thing to do here? What's the best thing to do here?... (My role) changed from advocate to warrior to counselor is the best way that I can describe it. (W)e are attorneys *and* counselors and the counselor part got emphasized, in fact became the dominant, ascendant part just as soon as it became clear the University Hospital was gonna take a different approach to this case.⁶³

⁶² Evolution Media, UMHS, Medical Litigation Series, JW Interview, September 2007.

⁶³ *Id.*

Conclusion

In a 2007 study, Studdert et al. hypothesized that with transparency, “the number and cost of prompted claims would negate—and possibly even trounce—any deterrent effect of disclosure on litigation.”⁶⁴ To date, the UMHS experience has shown otherwise. Not only is there an ethical benefit to disclosure and transparency, but it also makes financial sense. At a minimum, there is a practical alternative to deny and defend.

64 David M. Studdert et al., *Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy*, 26 HEALTH AFFAIRS 215–26 (2007).

Journal of Health and Life Sciences Law Order Form

Title	Quantity	ISBN	Price
<i>Journal of Health and Life Sciences Law (1 year subscription)</i>		9781422445853/ 9781422445860	\$149.00/\$199.00
Subtotal			

Subtotal

Total Amount Charged to Credit Cards \$_____ (LEAVE BLANK)

*applicable tax and shipping & handling charges will be added to your bill and charged to your credit card.

Name _____ Member ID# _____

Company _____

Shipping Address _____

Phone _____

Email _____

Please indicate payment method (check one):

American Express

VISA

MasterCard

Card # _____ Exp. Date ___/___/___

Signature _____

Billing Address (if different than shipping):

FAX THIS ORDER FORM TO:

Aditi Vaish
Custom Legal Publishing
LEXIS/NEXIS
(434) 972-7531

OR MAIL TO:

Aditi Vaish
Custom Legal Publishing
LEXIS/NEXIS
701 E. Water Street
Charlottesville, VA
22902

ORDER NOW!

Visit www.healthlawyers.org/bookstore

Or call 1-800-533-1637