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A DOSE OF REALITY FOR MEDICAL MALPRACTICE REFORM

JOANNA C. SCHWARTZ*

Every year, medical error kills and injures hundreds of thousands of people and costs billions of dollars in lost income, lost household production, disability, and healthcare expenses. In recent years, hospitals have implemented multiple systems to gather information about medical errors, understand the causes of these errors, and change policies and practices to improve patient safety. The effect of malpractice lawsuits on these patient safety efforts is hotly contested. Some believe that the fear of malpractice liability inhibits the kind of openness and transparency needed to identify and address the root causes of medical error. Others believe that malpractice litigation brings crucial information about medical error to the surface and creates financial, political, and institutional pressures to improve. Yet neither side in this debate offers much evidence to support its claims.

Drawing on a national survey of healthcare professionals and thirty-five in-depth interviews of those responsible for managing risk and improving patient safety in hospitals across the country, I find reason to believe that malpractice litigation is not significantly compromising the patient safety movement's call for transparency. In fact, the opposite appears to be occurring: The openness and transparency promoted by patient safety advocates appear to be influencing hospitals' responses to litigation risk. Hospitals, once afraid of disclosing and discussing error for fear of liability, increasingly encourage transparency with patients and medical staff. Moreover, lawsuits play a productive role in hospital patient safety efforts by revealing valuable information about weaknesses in hospital policies, practices, providers, and administration. These findings should inform open and pressing questions about medical malpractice reform and the best ways to continue improving patient safety.

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INTRODUCTION

Every year, tens of thousands of people die in hospitals from preventable medical errors.¹ Over a million more are injured.² And the

¹ See INST. OF MED., TO ERR IS HUMAN 26 (Linda T. Kohn et al. eds., 1999) [hereinafter TO ERR IS HUMAN] (estimating that between 44,000 and 98,000 people die each year from preventable medical error). Some have argued that the Institute of Medicine’s estimates are too high. See, e.g., Clement J. McDonald et al., *Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report*, 284 JAMA 93, 94 (2000) (criticizing the Institute of Medicine’s methodology); Frank A. Sloan & Lindsey M. Chepke, *The Law and Economics of Public Health*, 3 FOUND. & TRENDS MICROECONOMICS 331, 395 (2007)

costs of medical error are not only measured in lives: Preventable adverse events cost between \$17 billion and \$29 billion annually in lost income, lost household production, disability, and healthcare expenses.³

In 1999, the Institute of Medicine's report, *To Err Is Human*, focused public attention on the scope and devastation of medical error.⁴ The report also offered an antidote: Comprehensive collection and analysis of information about medical errors, the Institute of Medicine contended, is a critical first step toward improving patient safety.⁵ With such data, researchers, providers, and other stakeholders can better understand the system-level weaknesses that lead to error, craft interventions to reduce the incidence of error, and measure the effectiveness of those interventions.⁶

Heeding the Institute of Medicine's call, states, the federal government, and nongovernmental organizations have increasingly used a combination of regulatory and market-based approaches to improve data collection and analysis.⁷ Hospitals have also implemented multiple systems to gather information about patient errors, understand

(observing that “[t]he number of deaths per annum in hospitals due to medical errors may be ‘softer’ than the IOM’s message implies”). Other researchers have concluded that the Institute of Medicine’s estimates are too low. *See, e.g.*, OFFICE OF THE INSPECTOR GEN., U.S. DEP’T OF HEALTH AND HUMAN SERVS., ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES, at ii (2010) [hereinafter ADVERSE EVENTS IN HOSPITALS] (finding that medical errors contribute to the deaths of 180,000 hospitalized Medicare patients each year); Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries, and Social Policy*, 38 LOY. L.A. L. REV. 1217, 1222 (2005) (describing a 2004 study that found that medical error likely causes 195,000 deaths per year).

² *See* ADVERSE EVENTS IN HOSPITALS, *supra* note 1, at i (finding that medical errors injure 1.4 million hospitalized Medicare patients each year).

³ *See* TO ERR IS HUMAN, *supra* note 1, at 27 (describing estimates of costs of errors based on the 1999 study); Jill Van Den Bos et al., *The \$17.1 Billion Problem: The Annual Cost of Measurable Medical Errors*, 30 HEALTH AFF. 596, 597 (2011) (estimating that medical errors cost \$17.1 billion in 2008).

⁴ For descriptions of the effects of the Institute of Medicine’s report on public understandings of patient safety, *see infra* notes 34–42.

⁵ *See* TO ERR IS HUMAN, *supra* note 1, at 4 (“[A]dverse events resulting in serious injury or death should be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events occurring in the future. Errors that do not result in harm also represent an important opportunity to identify system improvements . . .”).

⁶ *See id.* at 5–15 (summarizing the Institute of Medicine’s recommendations).

⁷ *See* Michelle M. Mello et al., *Fostering Rational Regulation of Patient Safety*, 30 J. HEALTH POL. POL’Y & L. 375, 381 (2005) (describing the “pluralistic” nature of healthcare regulation, in which “top-down forms of regulation such as statutes and agency oversight are supplemented with private and quasi-private, bottom-up approaches including tort law and the market”).

the root causes of those errors, and change policies and practices to improve patient safety.⁸

“Conventional wisdom”⁹ has long been that malpractice lawsuits do little to help patient safety and, in fact, harm the cause.¹⁰ Lawsuits are considered a deeply flawed source of information because only a very small fraction of harmed patients bring suits, meritless cases are commonplace, and damages awarded may be unrelated to the extent of harm caused by providers.¹¹ But the “deeper problem”¹² according to some medical providers and patient safety advocates is that the adversarial “deny and defend” culture of malpractice litigation is fundamentally opposed to the culture of openness and transparency advocated by the Institute of Medicine.¹³ Key to promoting a culture of safety is “being honest with patients about iatrogenic injuries and sharing information about injuries with systems that facilitate analysis

⁸ See *infra* Part I for an overview of these developments.

⁹ I borrow this phrase from David Hyman, Charles Silver, and Tom Baker, who use it to characterize this same point of view. See David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 909 (2005) (describing as “conventional wisdom” the claim that “liability exposure impedes quality improvement by discouraging error reporting”); TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 97 (2005) (describing as “conventional wisdom” the notion that “lawsuits drive medical mistakes underground”). One can take issue with the accuracy of the phrase. Indeed, the most “conventional” view of the effects of lawsuits on organizational behavior generally would be the deterrence view that lawsuits’ financial and other effects incentivize efficient performance improvements. See generally GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* (1970); WILLIAM M. LANDES & RICHARD A. POSNER, *THE ECONOMIC STRUCTURE OF TORT LAW* (1987); STEVEN SHAVELL, *ECONOMIC ANALYSIS OF ACCIDENT LAW* (1987). And, in recent years, the “conventional wisdom” has become much more vigorously contested and, thus, less “conventional.” See *infra* Part II.B (describing increasing challenges to conventional wisdom). Nevertheless, I adopt the phrase because it reflects the long-dominant view about the effects of lawsuits on patient safety efforts and because it has been used by some of its most vigorous critics.

¹⁰ For data about the prevalence and costs of medical malpractice litigation, see *infra* notes 64–65 and accompanying text.

¹¹ See *infra* Part V.C (describing evidence of lawsuits’ weaknesses as an information source).

¹² See ATUL GAWANDE, *COMPLICATIONS: A SURGEON’S NOTES ON AN IMPERFECT SCIENCE* 57 (2002) (describing the negative effects of litigation on the openness and transparency needed to improve patient safety).

¹³ See Randall R. Bovbjerg et al., *Paths to Reducing Medical Injury: Professional Liability and Discipline v. Patient Safety—and the Need for a Third Way*, 29 J.L. MED. & ETHICS 369, 374 (2001) (describing the silencing effects of malpractice litigation on hospitals and providers).

and learning.”¹⁴ The threat of suit and liability, in contrast, is believed to discourage reporting, discussion, and assessment of error.¹⁵

Critics of this “conventional wisdom” reject the notion that malpractice lawsuits discourage transparency with patients and other providers, arguing instead that lawsuits play a productive role in patient safety.¹⁶ Lawsuits publicly reveal information about medical errors, these critics contend, and create financial and political pressures to improve. And malpractice litigation generates valuable information about error: Suits are “a data source for adverse events, and a continuing method of pinpointing medical failures and articulating new and necessary duties of care.”¹⁷

Advocates and critics of the “conventional wisdom” view the world in starkly different terms, and their disagreements raise fundamental questions about the relationship between patient safety and malpractice litigation. Does malpractice litigation bring medical errors to the surface, allowing them to be corrected? Or does the fear of litigation drive these errors underground? Are lawsuits fatally flawed sources of information—random and often meritless—offering little of value to patient safety efforts? Or do lawsuits “identify dangerous conditions and risky practices [and] provid[e] the opportunity to improve those conditions and practices”?¹⁸ Do we need malpractice reform so that providers will not fear suit and can speak more openly to other doctors and their patients? Or should we maintain incentives for plaintiffs to sue so that lawsuits can continue to uncover the information that providers are otherwise unwilling to disclose?

Despite the strong rhetoric used by both camps, neither side offers much evidence in support of its claims. To be sure, researchers have examined various effects of medical malpractice suits on the provision of medical care.¹⁹ But no empirical studies support the

¹⁴ Michelle M. Mello et al., “*Health Courts*” and Accountability for Patient Safety, 84 MILBANK Q. 459, 472 (2006) (describing the importance of disclosing and learning from injuries caused by medical treatment).

¹⁵ See *infra* Part II.A for a discussion of these criticisms of malpractice litigation.

¹⁶ See *infra* Part II.B for further description of these critiques of the conventional wisdom.

¹⁷ Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 67 (2011).

¹⁸ BAKER, *supra* note 9, at 99.

¹⁹ Studies have examined whether the threat of malpractice suits leads to defensive medicine. See, e.g., Tara F. Bishop et al., *Physicians’ Views on Defensive Medicine: A National Survey*, 170 ARCHIVES INTERNAL MED. 1081, 1081 (2010) (finding evidence of defensive medicine); Emily R. Carrier et al., *Physicians’ Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms*, 29 HEALTH AFF. 1585, 1585 (2010) (finding that defensive medicine is not directly tied to the threat of being sued); Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1606–07 (2002) (finding that defensive medicine does not occur as

contention that the threat of medical malpractice suits prevents open discussion with providers and patients.²⁰ There is also limited evidence to support the contrary view. As Tom Baker has noted, there are case studies but “no systematic research on the role of medical malpractice lawsuits in identifying dangerous conditions and dangerous doctors.”²¹ Given researchers’ attempts empirically to measure other effects of malpractice litigation and the significant role that the “conventional wisdom” plays in debates about medical malpractice reform, this gap in the literature is particularly confounding.

This Article aims to fill this gap by examining the function that medical malpractice litigation plays in hospital patient safety efforts across the country. I conducted a national survey of healthcare professionals and thirty-five in-depth interviews of those responsible for

much as is suggested in popular accounts). Studies have examined the effects of malpractice litigation on insurance costs. *See, e.g.,* J. ROBERT HUNTER ET AL., *AMS. FOR INS. REFORM, TRUE RISK: MEDICAL LIABILITY, MALPRACTICE INSURANCE AND HEALTH CARE* 14 (2009), available at <http://www.centerjd.org/air/TrueRiskF.pdf> (finding no connection between rising insurance rates and medical malpractice claims). And studies have examined whether state tort reform has an effect on physician supply. *See, e.g.,* David A. Matsa, *Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps*, 36 J. LEGAL STUD. S143, S146 (2007) (finding that “laws limiting damage awards for medical malpractice have no significant effect on physician supply for most Americans”); David A. Hyman et al., *Does Tort Reform Affect Physician Supply? Evidence from Texas 2* (Univ. of Ill. Program in Law, Behavior and Soc. Sci., Research Paper No. LE12-12, 2012), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2047433 (finding no evidence that tort reform led to increased physician supply). It would be impossible to catalog the voluminous studies of the effects of malpractice suits on the provision of medical care here; this amounts to an illustrative but vastly incomplete survey of available research.

²⁰ *See, e.g.,* BAKER, *supra* note 9, at 97 (reviewing available research about medical injuries and finding “no research testing the conventional wisdom that medical malpractice lawsuits drive medical mistakes underground”); David A. Hyman & Charles Silver, *Speak Not of Error*, 28 REG. 52, 55 (2005) (considering whether the threat of litigation inhibits ex post communications among providers and observing that empirical evidence “is not available”); Hyman & Silver, *supra* note 9, at 914 (“Although commentators routinely invoke the conventional wisdom, they never offer any rigorous evidence or empirical research supporting their position.”). This is not to suggest that doctors do not underreport; multiple studies have shown that they do. *See infra* note 103 and accompanying text (discussing these studies). But available research suggests that the threat of litigation plays little role in underreporting. *See infra* notes 104–07 and accompanying text (discussing this research).

²¹ BAKER, *supra* note 9, at 99. To be sure, available case studies offer illuminating, even if isolated, evidence about the role of lawsuits in patient safety. *See, e.g., id.* at 99–105 (offering several examples of situations in which malpractice lawsuits publicly revealed information about dangerous conditions); Margo Schlanger, *Operationalizing Deterrence: Claims Management (in Hospitals, a Large Retailer, and Jails and Prisons)*, 2 J. TORT L. 1 (2008) (studying claims management processes in hospitals—and other settings—and observing the ways in which efforts to reduce liability risk can lead to performance improvements); *infra* notes 249–53 and accompanying text (describing the American Society of Anesthesiologists’s closed claims study).

managing risk and improving patient safety.²² I focus on hospitals, as they are a primary locus of both incidents of medical malpractice and patient safety initiatives.²³ I focus on risk managers, as well as patient safety and quality personnel, because they are key players in hospitals' responses to malpractice litigation and the design and implementation of hospital patient safety initiatives.²⁴ My study includes personnel working in a wide variety of positions and hospitals that vary in size, location, profit status, and insurance status.²⁵

The interviewees and survey respondents told a largely consistent story that contradicts, in two significant ways, the conventional wisdom that malpractice lawsuits are incompatible with patient safety. First, my research reveals that malpractice liability does not necessarily inhibit the kind of openness and transparency needed to identify and address the root causes of medical error. Interviewees confirmed that hospitals historically took an adversarial and secretive approach to lawsuits and error. Yet interviewees also reported that, in recent years, the openness and transparency promoted by patient safety advocates has influenced hospitals' responses to litigation risk. When errors occur, hospitals are increasingly open with patients. And hospitals are more willing to discuss and reflect on errors with hospital staff. Study participants attribute this evolution to several factors, including risk managers' increasing focus on patient safety, the widespread promulgation of laws mandating disclosure and apology to patients, measurable risk reduction through disclosure and apology, and confidentiality protections for hospitals' internal discussions of error.

Second, in contrast to conventional wisdom that malpractice lawsuits offer little information of value to patient safety efforts, the vast majority of my interviewees and survey participants report that litigation data have proven useful in their efforts to identify and address error. Lawsuits reveal allegations of medical negligence and other patient safety issues that fall through the cracks of hospitals' reporting systems, depositions and discovery materials expose previously

²² There were three phases of data collection: First, I conducted semi-structured interviews of twenty-five people working in fifteen hospitals across the country. Second, I sent a nineteen-question survey to the over 5000 members of a national organization of risk managers and received 413 responses. Third, I interviewed ten survey respondents, chosen to increase the diversity of hospitals represented in the interviews. For a detailed description of survey methodology, see *infra* Part III.

²³ See *infra* note 117 for a description of available data concerning the frequency of malpractice in hospitals and other settings.

²⁴ See *infra* notes 54–57 and accompanying text for descriptions of these types of personnel and *infra* note 118 and accompanying text for a description of the benefits and drawbacks of my focus on the perspectives of risk managers and patient safety and quality personnel.

²⁵ For details about the characteristics of survey respondents, see Appendix A, *infra*.

unknown details of adverse events, analyses of claim trends bring to light problematic procedures and departments, and closed claims files serve as rich teaching tools. Malpractice litigation data also have many flaws, yet hospital personnel and researchers report that they recognize and account for these flaws in their reviews.

My findings undermine conventional wisdom about the presumed incompatibility of malpractice litigation and patient safety as a descriptive matter. Malpractice litigation can—and does, in hospitals across the country—coexist with and constructively contribute to patient safety efforts. My findings also should inform consideration of the many interventions proposed to address the ill effects of malpractice litigation and improve patient safety. This Article does not contend that malpractice lawsuits can solve the problems plaguing our nation's healthcare system.²⁶ Nor does it reach conclusions about the optimal malpractice regime or the sensibility of current proposals for reform. Instead, this Article examines a key tenet of the debate and finds evidence that malpractice litigation is not incompatible with a culture of patient safety and, moreover, can play a productive role in efforts to reduce medical error.

This Article additionally contributes to a larger conversation about the role of lawsuits in organizational decisionmaking. In previous research, I examined the extent to which law enforcement agencies gather and analyze information from lawsuits that have been filed against them, and the value of lawsuit data to litigation-attentive departments.²⁷ This study asks similar questions of hospitals. There are notable similarities in the practices of police departments and hospitals: Both gather the same types of information from lawsuits and analyze litigation information in similar ways. Both also use lawsuit data to fill gaps in internal information systems' design and implementation. But while only a small fraction of police departments appear to integrate litigation information into their performance improvement efforts, over 95% of hospitals in this study use litigation information

²⁶ See, e.g., Hyman & Silver, *supra* note 9, at 909 (describing various possible causes for poor healthcare quality, including the decentralization of healthcare delivery, third-party insurance, deference to healthcare providers to address quality concerns, the culture of medical providers, and the difficulty of identifying errors when they occur).

²⁷ See Joanna C. Schwartz, *Myths and Mechanics of Deterrence: The Role of Lawsuits in Law Enforcement Decisionmaking*, 57 UCLA L. REV. 1023, 1028 (2010) (finding that few police departments gather and analyze lawsuits brought against them and their officers, and contrasting department practices with theories of deterrence); Joanna C. Schwartz, *What Police Learn from Lawsuits*, 33 CARDOZO L. REV. 841, 844–46 (2012) [hereinafter Schwartz, *What Police Learn*] (describing the ways in which litigation-attentive departments gather and analyze information from suits brought against them and their officers).

in their patient safety efforts.²⁸ The similarities and dissimilarities between hospital and police department practices merit further scrutiny and can prompt more generalizable observations about the process of organizational learning through lawsuit information—a practice I have called “introspection through litigation”²⁹—as well as the causes for its prevalence in some settings but not others. These questions will be addressed in future work.

The remainder of this Article proceeds as follows: The rise of the patient safety movement is documented in Part I, focusing on advances in hospital patient safety in the years following the Institute of Medicine’s 1999 report. Part II describes the so-called “conventional wisdom” that malpractice lawsuits impair patient safety efforts and critics’ challenges of that view. The study methodology is laid out in Part III. Part IV describes the first major finding of the study: The culture of hospital risk management is evolving. The openness and transparency promoted by patient safety advocates appear to be transforming the previously cloistered world of hospital risk management. The study’s second major finding is discussed in Part V: The overwhelming majority of hospitals in my study incorporate information from each stage of malpractice litigation in their patient safety efforts and consider lawsuits a valuable source of information about patient safety. Part VI considers the implications of my findings for current understandings of the relationship between malpractice lawsuits and patient safety, as well as for proposals for reform.

I

THE RISE OF PATIENT SAFETY

Until quite recently, there were few patient safety initiatives in medicine. The regulation of medical care was guided by what has been called the “perfectibility model”—the notion that “if physicians and nurses could be properly trained and motivated, then they would make no mistakes.”³⁰ When doctors or nurses erred, peer disapproval and malpractice suits were expected to “encourage proper performance.”³¹ Apart from these sanctions, there were few steps taken to improve patient safety.³² And there was, people thought, little else that needed to be done to protect patients: Medical error was believed

²⁸ See *infra* note 218 (describing evidence that less than 5% of survey respondents reported “never” or “rarely” using litigation data for patient safety and quality purposes).

²⁹ See Schwartz, *What Police Learn*, *supra* note 27, at 890.

³⁰ Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1856 (1994).

³¹ *Id.*

³² See *id.* at 1856 (“Investigation of accidents is often superficial, unless a malpractice action is likely; noninjurious error . . . is rarely examined at all. Incident reports are

to be rare, and malpractice suits were considered frivolous on the whole, the products of overzealous lawyers.³³

In 1999, the Institute of Medicine's report, *To Err Is Human*, helped transform popular understandings of medical error and called for dramatic changes to improve patient safety.³⁴ Extrapolating from previous studies, the Institute estimated that preventable medical errors in hospitals killed between 44,000 and 98,000 people every year—more than are killed by car crashes, breast cancer, or AIDS.³⁵ These staggering numbers convinced practitioners and the public that medical error existed and was a significant problem. As Lucian Leape, a co-author of the report, described: "Patient safety, a topic that had been little understood and even less discussed in care systems, became a frequent focus for journalists, healthcare leaders, and concerned citizens."³⁶

To Err Is Human also argued, drawing on the work of Charles Perrow and James Reason, that medical errors were caused not exclusively or primarily by individual actors—as had previously been assumed—but instead by systemwide weaknesses in policy, organization, equipment, and technology.³⁷ As a result, the Institute contended, discovering and fixing those systemic weaknesses would more effectively reduce error than would sanctions directed at individual providers.³⁸ This argument changed the understanding of the causes of medical error: "The concept that bad systems, not bad people, lead to

frequently perceived as punitive instruments. As a result, they are often not filed, and when they are, they almost invariably focus on the individual's misconduct.").

³³ See William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, in HEALTH LAW HANDBOOK 1, 2 (Alice G. Gosfield ed., 2003) ("According to conventional wisdom in the medical community, lawsuits [in the 1970s and 1980s] reflected patient opportunism and lawyer entrepreneurship. The prevalence of medical errors was considered low, and injured patients were thought to have adequate recourse.").

³⁴ See Eric J. Alper & Robert M. Wachter, *Medical Malpractice and Patient Safety: Tear Down That Wall!*, 86 ACAD. MED. 282, 282–83 (2011) (describing the transformative effects of the Institute of Medicine's report); *infra* notes 36, 39 and accompanying text (same). For those researching patient safety, however, the report's conclusions came as no surprise. See Sage, *supra* note 33, at 4 (observing that "researchers and advocates who had been studying patient safety" already knew the information in the IOM's report); see also Leape, *supra* note 30, at 1852 (advocating for the systems approach to medical error ultimately adopted by the IOM in *To Err Is Human*); *infra* note 337 (describing studies of medical error that predated the IOM's report and provided supporting evidence for the IOM's conclusions).

³⁵ TO ERR IS HUMAN, *supra* note 1, at 26.

³⁶ Lucian L. Leape & Donald M. Berwick, *Five Years After To Err Is Human: What Have We Learned?*, 293 JAMA 2384, 2384 (2005).

³⁷ See TO ERR IS HUMAN, *supra* note 1, at 55–56 (describing the "systems" view).

³⁸ See *id.* at 56 (describing ways to reduce error systemically).

the majority of errors and injuries . . . has become a mantra in health care.”³⁹

Finally, the report focused on the need to gather and analyze information about past medical errors and near misses with an eye toward understanding the root causes of harm. The Institute of Medicine recommended changes to federal and state law, and to the policies and practices in individual facilities, to increase reporting and analysis of medical error.⁴⁰ Although some of the report’s key remedial recommendations have yet to be implemented,⁴¹ healthcare organizations have embraced its fundamental premise: In order to understand the prevalence and causes of error and improve patient safety, it is critical to do a better job of collecting and analyzing information about errors and close calls.⁴²

To Err Is Human has significantly increased the extent to which hospitals gather and analyze information about their performance. To be sure, hospitals engaged in some self-reflection in earlier years. In morbidity and mortality conferences, medical staff—particularly surgeons, and especially in academic institutions—have long gathered to discuss unexpected outcomes with an eye toward avoiding similar situations in the future.⁴³ And hospitals have long had peer review, in which a committee of medical professionals evaluates the appropriateness of care by their colleagues.⁴⁴ But, in recent years, hospitals have made several additions to their patient safety infrastructures.

³⁹ Leape & Berwick, *supra* note 36, at 2385.

⁴⁰ The report offered several specific recommendations, including that a federal agency promulgate reporting standards about adverse events so that standardized information could be collected by healthcare organizations. To encourage voluntary reporting and analysis, the report recommended that Congress pass federal legislation to extend evidentiary protections to all data collected and analyzed for the purpose of patient safety and quality improvement. The report also recommended that every healthcare organization have a patient safety program focused on improving safety by increasing the reporting and analysis of error and enforcing established safety practices. For a detailed description of these recommendations, see *TO ERR IS HUMAN*, *supra* note 1, at 10–14.

⁴¹ See *infra* note 59 for a description of continuing struggles in implementing the Institute of Medicine’s recommendations.

⁴² The notion that increased reporting and assessment of error can improve safety is a perpetual theme in patient safety scholarship. See, e.g., David C. Classen et al., ‘Global Trigger Tool’ Shows that Adverse Events in Hospitals May Be Ten Times Greater than Previously Measured, 30 *HEALTH AFF.* 581, 587 (2011) (“Sound measurement helps establish priorities, generate ideas for improvement, and evaluate whether improvement efforts work.”); Lucian L. Leape, *Reporting of Adverse Events*, 347 *NEW ENG. J. MED.* 1633, 1638 (2002) (“If reporting is safe and provides reporters with useful information from expert analysis, it can measurably improve safety.”).

⁴³ For a description of morbidity and mortality conferences, see GAWANDE, *supra* note 12, at 57–70.

⁴⁴ See Frederick Levy et al., *The Patient Safety and Quality Improvement Act of 2005: Preventing Error and Promoting Safety*, 31 *J. LEGAL MED.* 397, 401 (2010) (observing that

For example, hospitals have developed more robust incident reporting systems, whereby nurses, doctors, and other staff can report errors when they occur.⁴⁵ Hospitals had incident reporting systems before 2000, but many incidents went unreported and the information that was gathered was used primarily to reduce liability risk—not to improve patient safety. As Robert Wachter has described, hospital incident reports traditionally “went to the hospital’s risk manager, whose main concern was often to limit his or her institution’s potential legal liability. There was little emphasis on systems improvement, and dissemination of incidents to others in the system (other managers, caregivers, educators) was unusual.”⁴⁶

Hospitals have also begun to collect data from other sources, including reports to risk management, patient complaints, and executive walk rounds (where executive staff walk through the facility and speak with medical staff).⁴⁷ Hospitals are now required, as a condition of accreditation by the Joint Commission,⁴⁸ to conduct an extensive investigation—called a root cause analysis—of all serious unexpected injuries and other “sentinel events” that occur and to create an action plan to prevent future similar incidents.⁴⁹ Hospitals are strongly encouraged to report the most serious sentinel events and root cause analyses directly to the Joint Commission.⁵⁰ And twenty-seven states

peer reviews occur periodically, for credentialing purposes, and can occur after an adverse event).

⁴⁵ Incident reporting systems are systems that capture information about errors through reports by those providing healthcare services to a patient when the error occurs. See ROBERT M. WACHTER, *UNDERSTANDING PATIENT SAFETY* 233–34 (2d ed. 2012) (describing incident reporting systems).

⁴⁶ *Id.* at 236 (citations omitted).

⁴⁷ See Osnat Levtzion-Korach et al., *Integrating Incident Data from Five Reporting Systems to Assess Patient Safety: Making Sense of the Elephant*, 36 *JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY* 402, 403–04 (2010) (describing each of these data sources); see also Allan Frankel et al., *Improving Patient Safety Across a Large Integrated Health Care Delivery System*, 15 *INT’L J. FOR QUALITY HEALTH CARE* i31, i33–34 (2003) (describing Executive WalkRounds, developed by the Institute of Healthcare Improvement).

⁴⁸ The Joint Commission (formerly called the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and prior to that the Joint Commission on Accreditation of Hospitals (JCAH)), founded in 1951, provides voluntary accreditation to approximately 7800 healthcare organizations and programs. See James S. Roberts, Jack G. Coale & Robert R. Redman, *A History of the Joint Commission on Accreditation of Hospitals*, 258 *JAMA* 936, 938, 940 (1987) (describing the history of the Joint Commission).

⁴⁹ Sentinel events are defined as “any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.” *Facts About the Sentinel Event Policy*, *JOINT COMM’N* 1 (Sept. 2009), <http://www.jointcommission.org/assets/1/18/Sentinel%20Event%20Policy.pdf>. The Joint Commission began requiring hospitals to conduct root cause analyses in 1996. Mello et al., *supra* note 7, at 382.

⁵⁰ See *Facts About the Sentinel Event Policy*, *supra* note 49, at 1 (noting that “[e]ach accredited healthcare organization is encouraged, but not required, to report to The Joint

require hospitals to report adverse events to state agencies when they occur.⁵¹

Hospitals have also adopted patient safety innovations that are focused less directly on the collection and analysis of information. Some safety measures, including requirements that surgeons verify the patient's identity and the correct site of surgery, are mandated by the Joint Commission.⁵² Other innovations, such as the use of checklists by doctors and nurses before performing medical procedures, are the brainchildren of medical providers.⁵³

Hospitals have also hired personnel to take on these new patient safety and healthcare quality responsibilities. Since the 1970s, hospitals have employed risk managers who are responsible for purchasing and managing the hospital's insurance and for managing and defending legal claims.⁵⁴ The Institute of Medicine's 1999 report identified the need to approach error from a different perspective—to focus on system-level problems, encourage the collection of data, and proactively identify solutions.⁵⁵ Hospitals began hiring patient safety personnel charged with implementing these system-level, proactive changes.⁵⁶ Some hospitals have also hired separate “quality”

Commission any sentinel event” that “result[s] in an unanticipated death or other major permanent loss of function, not related to the natural course of the patient's illness or underlying condition” or results in one of several other serious conditions, including suicide, rape, wrong site surgery, and retention of a foreign body in an individual after a procedure).

⁵¹ See Robert M. Wachter, *Patient Safety at Ten: Unmistakable Progress, Troubling Gaps*, 29 HEALTH AFF. 165, 167 (2010) (describing state law requirements).

⁵² See, e.g., Leape & Berwick, *supra* note 36, at 2386 (attributing to the publication of *To Err Is Human* the promulgation of eleven safety practices required by the Joint Commission beginning in 2003, “including improving patient identification, communication, and surgical-site verification”).

⁵³ For a description of hospital checklists, see ATUL GAWANDE, *THE CHECKLIST MANIFESTO: HOW TO GET THINGS RIGHT* 37–38 (2010); PETER PRONOVOST & ERIC VOHR, *SAFE PATIENTS, SMART HOSPITALS* 24–30 (2010). For other examples of hospitals' innovations, see David A. Hyman & Charles Silver, *Healthcare Quality, Patient Safety, and the Culture of Medicine: “Denial Ain't Just a River in Egypt,”* 46 NEW ENG. L. REV. 417, 432–35 (2012), which describes the rigorous application of effective surgical and post-operative recovery techniques developed by Dr. Earle Shouldice, the founder of a Canadian hospital, and the obstetrical patient safety program developed at New York-Presbyterian Hospital/Weill Cornell Medical Center.

⁵⁴ See Judith Napier & Barbara J. Youngberg, *Risk Management and Patient Safety: The Synergy and the Tension*, in *PRINCIPLES OF RISK MANAGEMENT AND PATIENT SAFETY* 3, 3–4 (Barbara J. Youngberg ed., 2011) (describing the responsibilities of risk managers prior to the rise of the patient safety movement).

⁵⁵ See *id.* at 8 (describing the difference between traditional risk management and patient safety as the difference between “fixing problems and driving change toward creating a safer environment”).

⁵⁶ There are no estimates of the total number of patient safety officers and other personnel, although they appear to be a growing breed. See Charles R. Denham, *The New Patient Safety Officer: A Lifeline for Patients, a Life Jacket for CEOs*, 3 J. PATIENT SAFETY

personnel charged with gathering and reporting the data mandated by state law and accreditation standards.⁵⁷

There has been “unmistakable progress”⁵⁸ in hospital patient safety over the past fourteen years, but scholars, practitioners, and patient safety advocates agree that there is much left to do.⁵⁹ Although hospitals now have more rigorous policies to collect and analyze information about errors, doctors and nurses continue to underreport errors when they occur.⁶⁰ Further, despite comprehensive accreditation requirements, state and federal regulations, and hospital initiatives to improve patient safety, estimates of the prevalence of medical error have only increased.⁶¹

43, 44 (2007) (noting that more than 90% of hospitals surveyed had assigned formal accountability for patient safety to institutional leaders). For a description of the responsibilities of patient safety officers, see, for example, Frankel et al., *supra* note 47, at i32 (2003), which examines the development of a safety culture in one hospital and paraphrases the job description of the patient safety officer position they created as needing “to change the culture of [their] hospitals . . . and to revise the hospitals’ methods of analyzing adverse events so that they measure and delineate process problems, pinpoint longstanding unsafe traditions, and delineate actions to address them.”

⁵⁷ See, e.g., Maureen O. Larkin, *Nebulous, but Necessary*, HEALTHLEADERS MEDIA (June 25, 2008), http://www.healthleadersmedia.com/content/214138/topic/WS_HLM2_QUA/Nebulous-But-Necessary.html (describing the role of hospital quality officers as typically including “[i]nfection control, clinical outcomes, and compliance with The Joint Commission’s standards”).

⁵⁸ Wachter, *supra* note 51, at 165.

⁵⁹ See, e.g., STUART WRIGHT, DEP’T OF HEALTH AND HUMAN SERVS., MEMORANDUM REPORT: ADVERSE EVENTS IN HOSPITALS: PUBLIC DISCLOSURE OF INFORMATION ABOUT EVENTS 3 (2010) (noting that the Institute of Medicine’s recommendation for a national adverse event reporting system has not been implemented; instead, “separate Federal, State, and nongovernmental entities . . . receive and disclose adverse event information”); Wachter, *supra* note 51, at 166 (giving current patient safety efforts an overall grade of “B-,” up from “C+” in 2004, based on an assessment of numerous factors, including regulation, reporting systems, malpractice and accountability, and training, among others); Carolyn M. Clancy, *Patient Safety: One Decade After To Err Is Human*, AHRQ (Sept./Oct. 2009), available at <http://www.psqh.com/septemberoctober-2009/234-september-october-2009-ahrq.html> (attributing limited advancements to the “fragmented, paper-based health care system” and the failure to change the culture of medicine).

⁶⁰ See *infra* note 103 and accompanying text (describing the frequency of underreporting).

⁶¹ *To Err Is Human* estimated between 44,000 and 98,000 deaths per year from preventable human error, but a report published in 2010 by the Health and Human Services Office of the Inspector General found that medical errors contribute to the death of 180,000 hospitalized Medicare patients each year. See *supra* note 1. Note, also, that the Health and Human Services report measures deaths only of hospitalized Medicare patients, while the figures in *To Err Is Human* are measuring the deaths of all hospitalized patients. *Id.*; see also, e.g., Classen et al., *supra* note 42, at 586 (2011) (finding “far more adverse events in hospitalized patients than have been found in prior studies,” including results of the Harvard Medical Practice Study, which are cited in *To Err Is Human*, *supra* note 1, at 30–31). In *To Err Is Human*, the Institute of Medicine estimated that medical error is the eighth leading cause of death. *TO ERR IS HUMAN*, *supra* note 1, at 31. More recent estimates suggest that medical error is one of the top three causes of death. See *How*

II

THE CONTESTED COMPATIBILITY OF MALPRACTICE
LITIGATION AND PATIENT SAFETY

Malpractice lawsuits are a “bottom-up”⁶² approach to improving patient safety; suits brought by injured patients are expected to have a deterrent effect, reducing the likelihood of future similar harms.⁶³ Given that most doctors will be sued at least once while in practice⁶⁴ and the almost \$10 billion estimated to be spent in payments and administrative expenses associated with medical malpractice lawsuits each year,⁶⁵ one might imagine that the deterrent effects of medical malpractice lawsuits would be quite strong. Indeed, some believe that the deterrent effect of medical malpractice suits is too strong, leading to overdeterrence in the form of “defensive medicine.”⁶⁶ Others

Safe is Your Hospital? Our New Ratings Find that Some Are Riskier than Others, CONSUMER REPORTS MAGAZINE (Aug. 2012), <http://www.consumerreports.org/cro/magazine/2012/08/how-safe-is-your-hospital/index.htm> (quoting Peter Pronovost, Senior Vice President for Patient Safety and Quality at Johns Hopkins Medicine, as estimating medical error to be one of the top three causes of death in the United States). *But see* Sloan & Chepke, *supra* note 1, at 395 (observing that “[t]he number of deaths per annum in hospitals due to medical errors may be ‘softer’ than the IOM’s message implies”).

⁶² Mello et al., *supra* note 7, at 386.

⁶³ *See id.* at 386–87 (“In the absence of strong government oversight of health care, tort law has served as the primary form of patient safety regulation.”).

⁶⁴ A recent study projected that 75% of physicians in “low-risk” specialties and 99% of physicians in “high-risk” specialties would face a malpractice claim by age sixty-five; 19% of doctors in low-risk specialties and 71% of doctors in high-risk specialties were projected to make an indemnity payment on a lawsuit by age sixty-five. Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 *NEW ENG. J. MED.* 629, 633–34 (2011). There is, however, evidence that the number of malpractice claims being filed is declining. *See, e.g.*, TAYLOR LINCOLN, PUB. CITIZEN, *MEDICAL MALPRACTICE PAYMENTS SUNK TO RECORD LOW IN 2011*, at 4 (2012) (finding reduced number of medical malpractice claims and payouts in 2011); Cynthia G. Lee & Robert C. LaFountain, *Medical Malpractice Litigation in State Courts*, CASELOAD HIGHLIGHTS (Nat’l Center for State Courts, Williamsburg, Va.), Apr. 2011, at 1–2 (finding declining numbers of medical malpractice claims and that malpractice claims are far less common than other types of claims including motor vehicle tort lawsuits); *see also* Mark A. Rothstein, *Currents in Contemporary Bioethics: Health Care Reform and Medical Malpractice Claims*, 38 *J.L. MED. & ETHICS* 871, 872–73 (2010) (finding that national healthcare coverage will not likely increase the number of medical malpractice claims).

⁶⁵ *See* Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 *HEALTH AFF.* 1569, 1570 (2010) (finding “good” quality evidence to support a finding of \$5.72 billion spent yearly in indemnity payments and “moderate” evidence of \$4.13 billion spent yearly in administrative expenses, including defendants’ legal expenses and other overhead expenses); *cf.* BAIRD WEBEL ET AL., CONGRESSIONAL RESEARCH SERV., *MEDICAL MALPRACTICE: BACKGROUND AND LEGISLATION IN THE 112TH CONGRESS* 4 (2011) (noting that “medical malpractice insurance adds relatively little to the direct cost of health care relative to total health care spending”).

⁶⁶ “Defensive medicine” refers to medical practices—tests, procedures, and the like—taken to prevent future lawsuits, instead of for the benefit of patients. For studies describing the prevalence and costs of defensive medicine, *see* Mello et al., *supra* note 65,

doubt the efficacy of malpractice lawsuits' deterrent signal given the infrequency with which claims are brought, disparities between the merits of cases and their outcomes, and the prevalence of malpractice insurance, which dampens the effects of awards.⁶⁷

The publication of *To Err Is Human* and the increasing prominence of patient safety efforts have inspired further debate among politicians, scholars, and patient safety advocates about the relationship between malpractice litigation and patient safety. The Institute of Medicine's report called for increased openness and transparency about error as a way of better understanding its systemic causes.⁶⁸ Medical malpractice litigation was criticized—in *To Err Is Human* itself and by practitioners, scholars, and patient safety advocates—as incompatible with the openness and transparency needed to improve patient safety.⁶⁹ Yet a growing number of scholars have criticized the “conventional wisdom” for being empirically unsupported and for overlooking ways in which malpractice litigation can encourage patient safety advancements.⁷⁰ This Part describes both the contention that malpractice litigation is incompatible with patient safety efforts and the vigorous criticisms of this view.⁷¹

A. *The Conventional Wisdom*

One view—what I and others call the “conventional wisdom” given its longstanding adoption by patient safety advocates, scholars, and practitioners⁷²—is that malpractice litigation is counterproductive

at 1574, which estimates the costs of defensive medicine to total over \$45 billion per year, and *supra* note 19. This Article does not examine the existence, extent, or costs of “defensive medicine” practiced in response to the threat of medical malpractice litigation.

⁶⁷ See Mello & Brennan, *supra* note 19 (providing an overview of criticisms of the deterrence view); Mello et al., *supra* note 7, at 387–89 (same). See also Part V.C for a description of the ways in which hospital practices account for these limitations of malpractice litigation data.

⁶⁸ See *supra* note 40 and accompanying text.

⁶⁹ See *infra* notes 72–84 and accompanying text.

⁷⁰ See *infra* notes 103–07 and accompanying text (describing arguments about the lack of empirical support for the “conventional wisdom”); see also *infra* notes 108–15 and accompanying text (describing arguments about the ways in which malpractice litigation promotes patient safety).

⁷¹ This Part offers strong versions of the “conventional wisdom” and its critiques to illustrate the debate in its starkest terms. There are more qualified statements of these positions and commentators who agree with aspects of both views. See, e.g., Robert M. Wachter & Peter J. Pronovost, *Balancing “No Blame” and Accountability in Patient Safety*, 361 *NEW ENG. J. MED.* 1401, 1402 (2009) (advocating for a balance between patient advocates' recommended “no blame” approach to errors and the need for accountability in which, “once a reasonable safety rule is implemented and vetted . . . failure to adhere leaves the world of ‘no blame’ and enters the domain of accountability”).

⁷² See *supra* note 9 and accompanying text (describing reasons for using “conventional wisdom” to describe this point of view).

to the patient safety innovations set in motion by the Institute of Medicine's report. In *To Err Is Human*, the Institute of Medicine wrote that patient safety is "hindered through the liability system and the threat of malpractice" because the threat of liability and the discoverability of data "discourage[s] the surfacing of errors and communication about how to correct them."⁷³ Five years after *To Err Is Human*, authors of the report attributed continuing patient safety challenges to the "fear of malpractice liability," which "may create an unwillingness to discuss or even admit to errors."⁷⁴ Scholars, politicians, and patient safety advocates have echoed these concerns, leveling three related critiques.

First, the blaming culture surrounding malpractice litigation is considered incompatible with the openness promoted by patient safety advocates. Scholars describe malpractice litigation and patient safety as belonging to two separate, incongruous worlds:

Because patient safety and professionalism see the world differently, especially with regard to sanctions, it is hard to implement them fully together. To work, patient safety approaches must create an organizational culture of openness to discovery and discussion of problems within clinical settings, but it is doubtful that this culture can coexist with the negative and blaming culture of professional discipline and liability.⁷⁵

Researchers at the Harvard School of Public Health similarly describe the sanctions-focused world of malpractice litigation as "antithetical to the non-punitive, systems-oriented, cooperative strategies promoted by leaders of the patient-safety movement."⁷⁶ And Randall Bovbjerg and Brian Raymond write that malpractice litigation "undercuts the evolution of an effective safety culture in health care institutions."⁷⁷

Second, many believe that the malpractice system prevents doctors from reporting error—both to patients and to hospital administrators—because they fear the information will be used against them in court.⁷⁸ Atul Gawande writes that, given the threat of malpractice

⁷³ TO ERR IS HUMAN, *supra* note 1, at 22, 43.

⁷⁴ Leape & Berwick, *supra* note 36, at 2387.

⁷⁵ Bovbjerg et al., *supra* note 13, at 374.

⁷⁶ David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 287 (2004).

⁷⁷ Randall R. Bovbjerg & Brian Raymond, *Patient Safety, Just Compensation, and Medical Liability Reform*, ISSUE BRIEF (Kaiser Permanente Institute for Health Policy, Oakland, Cal.), Summer 2003, at 1, available at http://xnet.kp.org/ihp/publications/docs/safety_brief.pdf.

⁷⁸ See Hyman & Silver, *supra* note 9, at 909–13 (offering multiple examples of this point of view).

liability, it is “almost impossible for a physician to talk to a patient honestly about mistakes.”⁷⁹ Medical providers are also believed not to report adverse events to hospital administrators because the information may be used against them. Bryan Liang writes that “physicians with tort liability concerns may be hesitant to report adverse events and medical errors for fear that plaintiffs’ attorneys will have access to this information, thus exposing physicians to liability.”⁸⁰ Randall Bovbjerg contends that “individually oriented discipline and liability greatly inhibit providers’ cooperation with systems managers, particularly the reporting of information about errors and injuries.”⁸¹

Third, malpractice lawsuits are believed to stifle the kind of open discussions necessary to learn from errors when they occur. Hospital risk managers are at least partially blamed for the silence surrounding medical errors: “Classical risk management” is said to teach physicians “never to admit responsibility or openly discuss errors or injuries” with patients or their colleagues, thus “creat[ing] a wall of silence surrounding poor outcomes.”⁸² For each of these reasons, the malpractice litigation system is believed to “compromis[e] efforts to ascertain root causes of medical errors”⁸³ and “discourag[e] patient safety’s emphasis on learning, feedback, and improvement.”⁸⁴

Conventional wisdom about the negative effects of malpractice litigation on patient safety efforts has been used to advance policy reforms. Some advocate creating “health courts,” administrative bodies that would process malpractice claims outside the tort system.⁸⁵ Specially trained judges would make compensation decisions based on an assessment of whether the error was avoidable (a lower standard than negligence) and would follow guidelines about how much compensation is appropriate for economic and noneconomic harms.⁸⁶ Supporters argue that health courts would be faster, more reliable, and would increase the number of patients who receive some

⁷⁹ GAWANDE, *supra* note 12, at 57.

⁸⁰ Bryan A. Liang, *Error in Medicine: Legal Impediments to U.S. Reform*, 24 J. HEALTH POL. POL’Y & L. 27, 39 (1999).

⁸¹ Bovbjerg et al., *supra* note 13, at 374; *see also* Stephen D. Sugarman, *Doing Away with Tort Law*, 73 CAL. L. REV. 555, 583 (1985) (“Besides resource waste through ‘defensive medicine,’ insureds conceal their bad conduct after the fact. Plaintiffs’ lawyers tell many stories of conspiracies of silence, of shredding or hiding of crucial documents, and of dissembling in depositions. . . . Tort law can also discourage safety improvements in the face of pending liability.”).

⁸² Mello et al., *supra* note 14, at 472.

⁸³ William M. Sage, *Unfinished Business: How Litigation Relates to Health Care Regulation*, 28 J. HEALTH POL. POL’Y & L. 387, 407 (2003).

⁸⁴ Bovbjerg & Raymond, *supra* note 77, at 1.

⁸⁵ Mello et al., *supra* note 14, at 460.

⁸⁶ *Id.* at 460–61.

recovery.⁸⁷ In addition, supporters contend that such systems would increase transparency and, as a result, patient safety.⁸⁸ “Unlike the negligence-based system, which breeds physician silence because of fear of guilt and blame, [health courts’] avoidance-based model would encourage communication to optimize future patient care.”⁸⁹ Supporters of health courts from the Harvard School of Public Health acknowledge that “[s]ome barriers to reporting and disclosure would remain in a health court system,” but contend that “the environment for transparency would likely be markedly improved.”⁹⁰

Others advocate for caps on damages and other requirements designed to increase the burdens on plaintiffs filing malpractice claims.⁹¹ Supporters of damages caps argue that limiting damages will increase physician supply and decrease the costs of malpractice insurance.⁹² Advocates of medical malpractice tort reform also argue that limiting litigation would improve patient safety by reducing the fear of suit and thus prompting more disclosure.⁹³

Scholars and practitioners additionally seek to prevent doctors’ apologies and disclosures to patients from being used as evidence in malpractice suits on the ground that these evidentiary protections will encourage transparency. Thirty-four states already statutorily prohibit apologies from being used as admissions of guilt, and six protect doctors’ disclosures of adverse events to patients.⁹⁴ But most states with apology laws protect only expressions of sympathy, not discussions of

⁸⁷ *Id.* at 468, 470.

⁸⁸ *See id.* at 471–74 (explaining that a culture of increased disclosure will increase patient autonomy and dedication to the patient’s best interests).

⁸⁹ Christopher M. Burkley, *Medical Malpractice: Can We Rescue a Decaying System?*, 86 MAYO CLINIC PROC. 326, 330 (2011).

⁹⁰ Mello et al., *supra* note 14, at 473.

⁹¹ Thirty-three states have damages caps. *See Matsa, supra* note 19, at S147 (describing different types of damages caps). The tort reform measures adopted by Texas in 2003 illustrate some additional requirements, including “higher evidentiary standards for cases involving emergency room care, a requirement that plaintiffs file an expert report within 120 days of suit with regard to each defendant’s negligence (by a practicing physician, if the defendant is a physician), and a ten year statute of repose.” Hyman et al., *supra* note 19, at 6 n.18.

⁹² For studies examining whether damages caps result in these benefits, see *supra* note 19.

⁹³ *See, e.g.,* Ronald M. Stewart et al., *Malpractice Risk and Cost Are Significantly Reduced After Tort Reform*, 212 J. AM. C. SURGEONS 463, 466 (2011) (advocating for “tort reform” on the ground that it “removes perceived barriers to those who are committed to performance improvement”).

⁹⁴ *See* Anna C. Mastroianni et al., *The Flaws in State ‘Apology’ and ‘Disclosure’ Laws Dilute Their Intended Impact on Malpractice Suits*, 29 HEALTH AFF. 1611, 1612–14 (2010) (describing study of apology and disclosure protections nationwide).

the underlying causes of error or fault.⁹⁵ Scholars advocate for broader evidentiary protections, believing that “many injurers withhold apologies because they have long been used as evidence of liability.”⁹⁶

Scholars and practitioners additionally seek greater protections of communications about medical error among medical staff. The contents of morbidity and mortality conferences⁹⁷ and root cause analyses⁹⁸ have historically been protected from discovery in legal proceedings. Though all states also protect peer review from disclosure in discovery, the strength of states’ peer review protections vary from state to state.⁹⁹ Scholars advocate for broader evidentiary protections on the ground that physicians in states without “comprehensive” peer review protections “are reluctant to participate in systems-based safety programs for fear of having the information they share with other providers used as evidence against them in civil suits.”¹⁰⁰

⁹⁵ *Id.* at 1612–13 (“The vast majority of the apology laws—found in twenty-five states and the District of Columbia—are sympathy-only laws, which protect only the expression of sympathy made after an unanticipated outcome . . . [P]rotection provided by sympathy-only laws does not inherently extend to statements of explanation or fault.”).

⁹⁶ Jeffrey S. Helmreich, *Does ‘Sorry’ Incriminate? Evidence, Harm and the Protection of Apology*, 21 CORNELL J.L. & PUB. POL’Y 567, 567 (2011); see also Maria Pearlmuter, Note, *Physician Apologies and General Admissions of Fault: Amending the Federal Rules of Evidence*, 72 OHIO ST. L.J. 687, 687 (2011) (arguing for amendment of the Federal Rules of Evidence to prevent admission of apologies in federal court because the current lack of protection “results in an understandable reluctance to disclose and apologize when an error is made”); Michael B. Runnels, *Apologies All Around: Advocating Federal Protection for the Full Apology in Civil Cases*, 46 SAN DIEGO L. REV. 137, 157 (2009) (arguing for federal evidentiary protection of apologies because state law evidentiary protections are not “guaranteed deference in federal courts in cases involving federal causes of action”); cf. Mastroianni et al., *supra* note 94, at 1611 (observing that “[a] key barrier to more-open communication between health care providers and patients is the concern that such conversations might precipitate lawsuits” but acknowledging that “it is unclear” whether protections of apologies “will achieve their goals” of encouraging disclosure).

⁹⁷ See GAWANDE, *supra* note 12, at 57 (describing evidentiary protections of information disclosed during morbidity and mortality conferences).

⁹⁸ See Ansley Boyd Barton, *Recent Remedies for Health Care Ills*, 21 GA. ST. U. L. REV. 831, 844–45 (2005) (describing protections of root cause analyses).

⁹⁹ Levy et al., *supra* note 44, at 402. For example, some states protect peer review in hospitals but not in non-hospital entities like outpatient facilities and clinics. See *id.* at 402–03 (describing variations in protections offered by various states’ peer review statutes). There are also variations in who can claim the privilege. See Patricia A. Sullivan & Jon M. Anderson, *The Health Care Debate: If Lack of Tort Reform Is Part of the Problem, Federalized Protection for Peer Review Needs to Be Part of the Solution*, 15 ROGER WILLIAMS U. L. REV. 41, 57 (2010) (describing variations in state peer review statutes as to who can claim the privilege).

¹⁰⁰ Levy et al., *supra* note 44, at 414; see also Sullivan & Anderson, *supra* note 99, at 42–43 (2010) (arguing for a federal peer review protection to encourage discussion of error).

B. Criticism of the Conventional Wisdom

Until recently, as David Hyman and Charles Silver have observed, the “conventional wisdom enjoy[ed] widespread, if not unanimous, support.”¹⁰¹ Yet a growing number of scholars have questioned the notion that medical malpractice litigation is counterproductive to patient safety. Defenders of malpractice litigation offer three main challenges to the conventional wisdom.

First, scholars point to the lack of evidence supporting the claim that the threat of malpractice litigation discourages openness and transparency. Hyman and Silver note, for example, that no study has shown that the threat of malpractice litigation prevents internal discussions amongst healthcare providers.¹⁰² Others challenge the contention that the threat of malpractice litigation prevents doctors from reporting error: Although doctors are widely recognized to underreport error,¹⁰³ there is no evidence that the threat of being sued is the cause. Doctors underreport even when they specialize in an area of medicine not often subject to suit.¹⁰⁴ Doctors underreport even in jurisdictions with no-fault compensation systems.¹⁰⁵ Doctors underreport even when their jurisdiction keeps incident reports confidential.¹⁰⁶ These findings suggest, as Stephen Landsman observes, that “the medical world’s silence about its mistakes may be the product of

¹⁰¹ Hyman & Silver, *supra* note 9, at 913.

¹⁰² See *id.* at 926 (“[T]he effect of increased liability on ex post communication to other providers is unclear . . . [W]e know of no evidence that providers discuss mistakes among themselves ex post less freely today than they did a century or more ago.”).

¹⁰³ See, e.g., Classen et al., *supra* note 42, at 583–86 (2011) (finding, in a study of three large hospitals recognized for their patient safety initiatives, that voluntary reporting systems failed to catch 90% of adverse events); James A. Taylor et al., *Use of Incident Reports by Physicians and Nurses to Document Medical Errors in Pediatric Patients*, 114 *PEDIATRICS* 729, 729 (2004) (finding, in a survey of nurses and physicians at a large children’s hospital, that 34.8% of respondents reported fewer than 20% of their perceived medical errors in the past year, and 32.6% reported fewer than 40% of perceived errors committed by colleagues).

¹⁰⁴ See Stephen Landsman, *Reflections on Juryphobia and Medical Malpractice Reform*, 57 *DEPAUL L. REV.* 221, 233 (2008) (“[D]octors specializing in certain areas of medical practice, like obstetrics, are far more likely to be sued than those in other specialties. In none of the less litigious specialties, however, is reporting more robust.”).

¹⁰⁵ See George J. Annas, *The Patient’s Right to Safety—Improving the Quality of Care Through Litigation Against Hospitals*, 354 *NEW ENG. J. MED.* 2063, 2065 (2006) (citing a study finding that doctors in New Zealand, a country with no-fault malpractice insurance, underreport almost as much as U.S. doctors); Jane Garbutt et al., *Lost Opportunities: How Physicians Communicate About Medical Errors*, 27 *HEALTH AFF.* 246, 252 n.14 (2008) (citing studies showing that doctors underreport even in no-fault jurisdictions).

¹⁰⁶ See Barry R. Furrow, *Medical Mistakes: Tiptoeing Toward Safety*, 3 *HOUS. J. HEALTH L. & POL’Y* 181, 203 (2003) (reporting that a 2003 fifty-state survey showed “little difference between systems that provided confidentiality and those that did not” and that “[u]nderreporting occurred in both systems at about the same levels”). For a description of hospital incident reports, see *supra* notes 45–46 and accompanying text.

forces and views within medicine, rather than a response to intrusions of the legal system.”¹⁰⁷

Second, scholars challenging the conventional wisdom contend that malpractice lawsuits can encourage patient safety advancements. The costs of malpractice claims can create financial incentives for hospitals and providers to improve their behavior.¹⁰⁸ High-profile cases can publicly reveal problem conditions, practices, and practitioners, “energizing government agencies to discipline doctors or order hospitals to take corrective action.”¹⁰⁹ Cases can also educate prospective patients: “The resolution of malpractice claims provides public information that consumers can use when choosing a provider,” and study data offers “some evidence that they do use this information—physician volume drops following the disposition of a large claim.”¹¹⁰ Rising costs of malpractice lawsuits can incentivize insurers to demand improved patient safety by their insureds.¹¹¹ And hospital risk managers, hired to reduce the costs of malpractice litigation, can assist in patient safety efforts.¹¹²

¹⁰⁷ Landsman, *supra* note 104, at 223; *see also* William M. Sage et al., *Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice*, 59 VAND. L. REV. 1263 (2006) (describing multiple non-litigation reasons for doctors not to report errors).

¹⁰⁸ *See, e.g.*, David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1131 (2006) (“Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients.”); Jennifer Arlen, *Contracting over Liability: Medical Malpractice and the Cost of Choice*, 158 U. PA. L. REV. 957, 959–60 (2010) (“Well-designed malpractice liability can optimally deter error by giving medical providers direct financial incentives to make cost-effective investments in patient safety. . . . In its current form, however, medical malpractice liability is not as effective as it could be.”); Furrow, *supra* note 17, at 58 (“[P]roperly calibrated litigation and increased costs will push providers to reduce adverse events in order to reduce liability.”).

¹⁰⁹ BAKER, *supra* note 9, at 99. In his book, Baker describes several high-profile cases in which “there was an unsafe condition that health-care professionals knew about but did not correct.” *Id.* He finds that, “[i]n each case, it took a serious injury and a malpractice lawsuit to bring the unsafe condition (and the previous failure to act) to light.” *Id.*

¹¹⁰ Darren Grant & Melayne Morgan McInnes, *Malpractice Experience and the Incidence of Cesarean Delivery: A Physician-Level Longitudinal Analysis*, 41 INQUIRY 170, 185 (2004).

¹¹¹ *See* BAKER, *supra* note 9, at 107 (“[M]edical malpractice lawsuits have put liability insurance companies into the medical injury-prevention business, especially for their hospital and institutional customers.”); *see also* Furrow, *supra* note 17, at 57 (“Insurers should also be motivated to demand patient safety measures to reduce their own exposure.”).

¹¹² *See* BAKER, *supra* note 9, at 107 (“Risk managers and risk management departments keep track of patient complaints, manage malpractice claims, provide feedback to senior administrators on unsafe practices revealed by the complaints and claims, and serve as a clearinghouse for patient-safety information.”); Furrow, *supra* note 17, at 65 (“Avoidance of litigation has led to the growth of offices of risk and quality management, Patient Safety Compliance Officers, and has promoted a new emphasis on problem-solving behavior in complex health care settings like hospitals.”); Schlanger, *supra* note 21, at 35 (“The result

Third, scholars argue that lawsuits generate information useful to patient safety efforts. Almost all scholars describing the productive effects of malpractice suits mention the American Society of Anesthesiology's study of closed medical malpractice claims files, widely recognized to have reduced significantly the risk of anesthesia error.¹¹³ Tom Baker and Timothy Lytton have written about the Harvard hospitals' risk management consulting group, which "uses medical malpractice claims experience to improve patient safety in hospitals."¹¹⁴ And, in her study of a hospital's claims management processes, Margo Schlanger found that claims files and incident reports, created to reduce litigation risk, were also used "to assess safety and quality of care problems . . . [and] design useful interventions."¹¹⁵

III STUDY METHODOLOGY

Although the effects of malpractice litigation on patient safety efforts are hotly contested, limited empirical evidence has been gathered to support either side of the debate.¹¹⁶ To better understand the relationship between malpractice litigation and patient safety, I conducted thirty-five in-depth interviews and a nationwide survey of those responsible for risk management, claims management, and quality improvement in hospitals around the country. I focused on hospitals, as they are a primary locus of both incidents of medical malpractice and patient safety initiatives.¹¹⁷ And I focused on risk

of risk managers' growing professional orientation towards patient safety is an increasing likelihood that they will find time to concern themselves with harm prevention, instead and in addition to claims management . . .").

¹¹³ For scholarship describing the positive effects of the American Society of Anesthesiology's study of closed malpractice claims on patient safety, see, for example, Annas, *supra* note 105, at 2065; Tom Baker & Timothy D. Lytton, *Allowing Patients to Waive the Right to Sue for Medical Malpractice: A Response to Thaler and Sunstein*, 104 Nw. U. L. REV. 233, 242 (2010); Hyman & Silver, *supra* note 9, at 919; Schlanger, *supra* note 21, at 32.

¹¹⁴ Baker & Lytton, *supra* note 113, at 242.

¹¹⁵ Schlanger, *supra* note 21, at 31.

¹¹⁶ See *supra* notes 19–21 and accompanying text (describing limited existing empirical analysis of the claims described *supra* in Part II).

¹¹⁷ See Bovbjerg et al., *supra* note 13, at 371 (explaining, in 2001, that "[s]afety research and initiatives have only just begun and have to date mainly addressed hospital care" and that "[h]ospitals constitute the most organized medical sites; they also treat the sickest patients, provide the most complex services, and their care gives rise to most cases addressed by professional discipline and liability"); Lee Harris, *Tort Reform as Carrot-and-Stick*, 46 HARV. J. ON LEGIS. 163, 183 (2009) ("[T]he vast majority of reported medical malpractice events occur at hospitals."). Hospitals are not, of course, the only locus of malpractice: There are almost thirty times more outpatient visits than hospital discharges

managers and patient safety and quality personnel, as they are key players in hospitals' responses to malpractice litigation and the design and implementation of patient safety initiatives.¹¹⁸

There were three phases of data collection. Phase One was partially exploratory and involved semi-structured interviews with twenty-five people who work to reduce risk and improve patient safety in hospitals.¹¹⁹ In each semi-structured interview, I asked a consistent series of questions but offered the interviewee the opportunity to describe their practices in their own terms and offer examples to illustrate their observations.¹²⁰ I identified interviewees through a snowball recruitment technique¹²¹ and seeded the snowball with

each year, and a recent study found that almost half of malpractice claims concerned outpatient treatment. See Tara F. Bishop et al., *Paid Malpractice Claims for Adverse Events in Inpatient and Outpatient Settings*, 305 JAMA 2427, 2428 (2011). Notably, ambulatory care settings do not typically have risk management programs (unless the outpatient facility is part of a larger healthcare system), increasing the difficulty of systematically addressing patient safety weaknesses. See Gianna Zuccotti & Luke Sato, *Malpractice Risk in Ambulatory Settings: An Increasing and Underrecognized Problem*, 305 JAMA 2464, 2464 (2011) (describing the lack of risk management programs outside hospital settings and "increasing risk of malpractice in the ambulatory area"). The role of malpractice suits in patient safety efforts in outpatient settings is not the focus of this Article, but it merits further review.

¹¹⁸ My approach is consistent with long-standing efforts by Lauren Edelman and others to understand organizational responses to regulations and law by examining the changing roles and perspectives of key administrative personnel. See, e.g., Lauren B. Edelman et al., *Legal Ambiguity and the Politics of Compliance: Affirmative Action Officers' Dilemma*, 13 LAW & POL'Y 173 (1991) (examining the role of affirmative action officers in effectuating equal employment opportunity and affirmative action mandates). The focus on administrators means that my results do not reflect the opinions of direct providers except as described by those administrators. There are, however, other studies that examine providers' practices and views. See, e.g., *infra* notes 282–91 and accompanying text (describing healthcare providers' reporting rates and their perspectives on error and reporting).

¹¹⁹ Phase One interviews were conducted between August 2009 and January 2012, with the bulk of interviews conducted between March and December 2011.

¹²⁰ Questions during these interviews concerned: interviewees' job descriptions and responsibilities; the organizational relationship of personnel responsible for risk, claims, quality, and patient safety; the extent and manner that malpractice data are incorporated into hospital quality and safety efforts at each stage of litigation; interviewees' opinions about the reasons for variations in hospital practices; interviewees' views about the effects of malpractice litigation on patient safety efforts; the effects of evidentiary protections for apologies and confidentiality protections of peer review on patient safety; and the values and limitations of litigation data as a source of information relevant to patient safety and quality. Given the semi-structured nature of the interviews, additional questions and topics were addressed in some of the discussions.

¹²¹ For descriptions of snowball sampling, see, for example, Leo A. Goodman, *Snowball Sampling*, 32 ANNALS MATHEMATICAL STAT. 148, 148 (1961), which defines the "snowball sampling procedure" as one in which a sample of people are interviewed, each person is asked to identify a certain number of people—his "best friends," "individuals with whom he most frequently associates," or "individuals whose opinions he most frequently seeks"—after which each of those individuals is interviewed and asked to identify the same sort of people, and so on. For differences in uses of snowball sampling, see Mark S.

several contacts from the hospital at my home institution, the Ronald Reagan–UCLA Medical Center. These twenty-five interviewees work at or are affiliated with fifteen hospitals and healthcare systems across the country.¹²²

The results of these twenty-five interviews informed Phase Two of data collection: a quantitative assessment of the role of malpractice lawsuits in patient safety and quality improvement efforts. I designed a nineteen-question survey based on the information gathered during the first phase of interviews.¹²³ A national professional association of over 5000 risk managers, quality personnel, lawyers, and other interested parties agreed to send the survey to its members.¹²⁴ I received 413 survey responses,¹²⁵ a response rate of approximately 8%.¹²⁶

Handcock & Krista J. Gile, *Comment: On the Concept of Snowball Sampling*, 41 SOC. METHODOLOGY 367 (2011). Many qualitative studies employ a snowball technique to identify interviewees. See, e.g., Tom Baker & Sean J. Griffith, *How the Merit Matter: Directors' and Officers' Insurance and Securities Settlements*, 157 U. PA. L. REV. 755, 783 (2009) (“We began our interviews with people about whom we learned in our prior research, then worked outward to references from those interviewees.”); see also Kenneth A. Bamberger & Dierdre K. Mulligan, *Privacy on the Books and on the Ground*, 63 STAN. L. REV. 247, 247 (2011) (examining “how corporations actually manage privacy and what motivates them” through interviews of corporate chief privacy officers); Angela Littwin, *Beyond Usury: A Study of Credit Card Use and Preference Among Low-Income Consumers*, 86 TEX. L. REV. 451, 454 (2008) (interviewing fifty low-income women to understand the “risks and rewards of consumer credit for low-income families”).

¹²² I spoke to multiple people employed by five of the fifteen hospitals. Two interviewees from Phase One are not affiliated with a hospital: One works at a national advocacy organization and one is a scholar of law and public health.

¹²³ The survey was designed on Qualtrics’s online survey software. Among other questions, respondents were asked to estimate: how often notices of claim and lawsuits are used in patient safety and quality improvement efforts; how often lawsuits, discovery, and closed claims reveal new and useful information relevant to patient safety and quality concerns; the utility of various litigation and non-litigation sources of information in identifying and addressing safety and quality concerns; and whether their hospital has a policy of apologizing to patients. Survey respondents also had an opportunity to provide additional comments about the role of lawsuits in their facilities’ safety and quality efforts. For the complete survey, see Appendix C, *infra*.

¹²⁴ To limit entries to one per respondent while retaining anonymity, 5251 unique URLs were generated (one for each association member) and sent to the association. The association matched the URLs to its email list and sent out four recruitment emails over a period of three weeks from April 24 to May 8, 2012.

¹²⁵ Four hundred nineteen people responded to the survey, but six were removed from the survey results because they practice outside the United States and the focus of this research is on the effects of U.S. malpractice law on patient safety efforts. For an overview of the demographics of survey respondents, see Appendix A, *infra*.

¹²⁶ There is reason to believe that a non-trivial portion of the 5251 members of the association were not eligible for the survey (i.e., they were scholars, lawyers, or otherwise unaffiliated with hospital facilities) so the overall response rate may be somewhat higher. Note, also, that not all respondents answered all nineteen questions, so the response rate varies across questions.

Phase Three of data collection was an additional round of semi-structured interviews with survey respondents. At the conclusion of the survey, respondents could include their email address if they were interested in participating in a follow-up interview. I emailed respondents who worked in facilities that were underrepresented in the first round of interviews.¹²⁷ Of the twenty-four survey respondents I emailed, ten responded.¹²⁸

I employed this combination of empirical methods to unearth distinct, but related, types of information. The survey was aimed at capturing data about hospital practices across respondents: what data hospitals collect for patient safety purposes, how litigation data is used in patient safety improvement efforts, how often lawsuits revealed new and useful information regarding safety issues, and so on. The semi-structured interviews were aimed at gathering richer stories about the details of hospital practices, the shifts in the roles of risk managers and patient safety personnel over time, the reasons for these shifts, perspectives about the role of lawsuits in patient safety, and other details that could not be captured through the survey.¹²⁹

The methodologies I have employed necessarily limit the conclusiveness of my findings. Neither sample is random: There are likely some risk managers who are not members of the association I surveyed, and my data do not capture their views. Moreover, although the survey URL was emailed to all members of the association, survey respondents were self-selected in that they chose to fill out the survey.¹³⁰ Interviewees were either recommended by others in their field or agreed in their response to the survey to submit to an additional interview. And because both methodologies rely on respondents to provide accurate responses, there are limited ways to learn if

¹²⁷ The vast majority of subjects of the first round of interviews were from mid-sized and large nonprofits and large government hospitals. Accordingly, I followed up with survey respondents from small non-profits, for-profits, and government facilities, and medium and large for-profit facilities so that the interviews could be more representative of hospitals nationwide. For information about the representativeness of my data set, see Appendix B, *infra*.

¹²⁸ The same protocol described *supra* note 120 and accompanying text was followed with respect to this second round of semi-structured interviews. Less time was typically spent on each interview of survey respondents, as they had provided significant information already through the survey instrument.

¹²⁹ See Baker & Griffith, *supra* note 121, at 759 n.15 (“Qualitative research employs field interviews and other sociological techniques to develop thick descriptions of a problem area.”); see also *supra* note 121 (offering examples of this type of qualitative research).

¹³⁰ Given the topic of the survey, it is possible that those association members who chose not to respond are more likely to agree with the so-called “conventional wisdom.” I have, however, no evidence to support this hypothesis nor do I have evidence more generally about which members declined to fill out the survey.

and when respondents offered self-serving, incomplete, or otherwise inaccurate answers to the questions posed. Interviewees were, however, assured confidentiality to minimize self-serving statements and to encourage them to speak frankly about their practices and beliefs.¹³¹

Despite these arguably inevitable limitations, the data are broadly representative in several respects. The data set includes a diverse group of study participants and hospitals. Interviewees include: hospital risk, claims, quality, and safety directors and senior staff; risk managers for two captive insurers;¹³² and those in the highest levels of hospital management, including a chief medical officer, a medical director for quality and safety, a chair of anesthesiology, and the chief executive officer of a hospital. The hospitals in the survey and interview pool vary in size, profit status, whether they are self-insured, and whether they insure medical providers for claims of malpractice.¹³³ The hospitals are geographically diverse: Hospitals in my study are from forty-four states and the District of Columbia¹³⁴ and are located in rural, suburban, and urban settings. The hospitals also vary in reputation: Four of the hospitals in the data set are among

¹³¹ Pursuant to a research protocol approved by the Institutional Review Board of UCLA, interviewees were assured confidentiality. Interviewees were asked whether the interview could be recorded, and most agreed. Those interviews that were recorded were later transcribed; contemporaneous notes were taken during the interviews that were not recorded. Identifying information was removed from the interview transcripts and notes and provided to the *New York University Law Review* editors. To maintain interviewees' confidentiality while still making available useful information about the size and profit status of represented hospitals, each interviewee has been assigned a moniker with two letters and one number: The first letter refers to the size of the facility (small (1–99 beds), medium (100–399 beds), large (over 400 beds)), while the second letter refers to the profit status of the facility (for-profit, nonprofit, government), and the number distinguishes between multiple interviewees from similar facilities. So, for example, interviewees who work at small for-profit facilities are dubbed S.F.1, S.F.2, etc. Survey respondents whose narrative responses to the final question of the survey instrument are quoted in this Article have been assigned numbers (i.e., Survey Response #1, Survey Response #2, etc.) to maintain their confidentiality.

¹³² A captive insurer is an insurance company created to provide insurance for a parent company. See Eleanor D. Kinney, *The Potential of Captive Medical Liability Insurance Carrier and Damages Caps for Real Malpractice Reform*, 46 *NEW ENG. L. REV.* 489, 495–98 (2012) (describing the form and history of captive insurers).

¹³³ See Appendix B, *infra*, for an overview of many of these characteristics of survey respondents and a comparison of these demographics with hospitals nationwide.

¹³⁴ The six states from which there are no survey responses are among the least populated in the country: Delaware (45th), Nebraska (38th), North Dakota (48th), Rhode Island (43rd), South Dakota (46th), and Wyoming (50th). See U.S. DEP'T OF COMMERCE, U.S. CENSUS BUREAU, APPORTIONMENT POPULATION AND NUMBER OF REPRESENTATIVES BY STATE: 2010 CENSUS, [http://www.census.gov/population/apportionment/files/Apportionment%20Population%202010.pdf](http://www.census.gov/population/apportionment/files/Appportionment%20Population%202010.pdf) (last visited Aug. 7, 2013).

U.S. News and World Report's designated "Honor Roll."¹³⁵ Others appear nowhere on U.S. News's lists.

Those surveyed and interviewed also work for a sizeable portion of the hospitals nationwide: between 6.5% and 7.2%, depending on how one counts.¹³⁶ And because the dataset overrepresents the largest hospitals,¹³⁷ my findings reflect practices relevant to an even larger percentage of the nation's hospital beds, hospital patient safety initiatives, and hospital-based incidents of malpractice and litigation.

IV

HOSPITALS' EVOLVING RESPONSE TO RISK

This Part describes the bases for my first major finding: Despite the secrecy historically surrounding malpractice litigation, participants in my study report an evolution in hospitals' responses to liability risk in recent years. The openness and transparency promoted by patient safety advocates appear increasingly to have been adopted by hospital personnel in their responses to lawsuits and risk.

In 1999, when the Institute of Medicine issued its report, there was good reason to believe that the threat of malpractice litigation might impair patient safety advancements. Hospitals hired risk managers beginning in the 1970s to reduce the costs of malpractice litigation through insurance and claims processing.¹³⁸ A key component of effective risk management was considered to be "controlling the spread of information" about errors.¹³⁹ As Lucian Leape has described, risk managers have for decades "claimed that admitting responsibility and apologizing will increase the likelihood of the patient filing a malpractice suit and be used against the doctor in court

¹³⁵ See Kimberly Leonard, *Best Hospitals 2013–14: Overview and Honor Roll*, U.S. NEWS & WORLD REP. (July 16, 2013), <http://health.usnews.com/health-news/best-hospitals/articles/2013/07/16/best-hospitals-2013-14-overview-and-honor-roll> (identifying eighteen hospitals "near the top" in at least six of sixteen specialties); see also *Photos: A Tour of the Best Hospitals 2012–13*, U.S. NEWS & WORLD REP. (July 16, 2012), <http://health.usnews.com/health-news/best-hospitals/slideshows/photos-a-tour-of-the-best-hospitals-2012-2013> (identifying seventeen hospitals that score "at or near the top" in at least six of sixteen specialties). Four hospitals in this study appear in both the 2013–14 and 2012–13 lists.

¹³⁶ The American Hospital Association (AHA), an organization that annually surveys hospitals nationwide, reports that there are 5754 U.S. hospitals registered with the AHA and 6334 hospitals total. AHA Summary of Hospitals (May 1, 2012) (on file with the *New York University Law Review*). For data about hospital demographics and a description of what it means to be a "registered hospital," see *Fast Facts on US Hospitals*, AM. HOSP. ASS'N (Jan. 3, 2013), <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml>.

¹³⁷ Hospitals with over 400 beds represent 41% of survey respondents but just 9% of registered hospitals and 8% of all hospitals nationwide. For more information about the representativeness of the data set, see Appendix B, *infra*.

¹³⁸ Napier & Youngberg, *supra* note 54, at 3–4.

¹³⁹ Alper & Wachter, *supra* note 34, at 283.

if they do sue.”¹⁴⁰ As a result, lawsuits and potential claims were shrouded in secrecy. “The initial response to a claim was to ‘hunker down,’ sequester the information, prepare to aggressively defend and/or contain the loss, admit to nothing, and leave it for the attorneys to resolve.”¹⁴¹ Malpractice litigation data were “among the most closely guarded within the medical center, with access limited to a select few administrators and clinical leaders.”¹⁴²

Despite the secrecy historically surrounding malpractice litigation, participants in my study report an evolution in hospitals’ responses to liability risk in recent years. Three notable shifts contradict conventional wisdom about the negative effects of malpractice litigation on patient safety: 1) Risk managers increasingly see themselves as responsible for improving patient safety; 2) hospitals are becoming more transparent with patients when errors occur; and 3) hospitals increasingly encourage discussion of errors by hospital staff as a means of improving performance. This Part describes each of these developments, drawing on interviewees’ descriptions, survey responses, and other available data about hospital practices. This Part also describes several factors that appear to have contributed to hospitals’ increasing openness and transparency with patients and hospital staff.

It is worth emphasizing at the outset that not all hospitals’ views on risk have evolved in the manner I am about to describe. A small number of survey respondents—less than 5%—reported never or rarely using litigation data in patient safety and quality improvement efforts.¹⁴³ And a handful of interviewees reported that there is a connection between lawsuits and patient safety, but the connection could be strengthened.¹⁴⁴ Still, the overwhelming sense from study participants is that the openness and transparency of the patient safety

¹⁴⁰ Lucian L. Leape, *Full Disclosure and Apology—An Idea Whose Time Has Come*, 32 *PHYSICIAN EXECUTIVE* 16, 17 (2006).

¹⁴¹ Napier & Youngberg, *supra* note 54, at 4.

¹⁴² Alper & Wachter, *supra* note 34, at 282.

¹⁴³ A few survey respondents expressed the view that there should not be a connection between malpractice litigation and patient safety because lawsuits offer few useful lessons. *See infra* notes 344–45. Others wished there were a closer connection between litigation data and patient safety in their facilities. *See, e.g.*, Survey Response #1 (May 1, 2012) (on file with the *New York University Law Review*) (“In my opinion, lawsuits do not, and should, play a larger role in our safety [sic] and quality efforts.”); Survey Response #2 (Apr. 26, 2012) (“Wished we used [litigation] information more in patient safety improvement activities.”) (on file with the *New York University Law Review*).

¹⁴⁴ *See, e.g.*, Telephone Interview with L.G.8 (Jan. 12, 2012) (“[W]hen something comes at us from a litigation lens, it’s treated in a much more delicate, cloistered way”); Telephone Interview with M.N.1 (Mar. 7, 2011) (“[T]here is a wealth of information from lawsuits, which could be used to improve quality of care. . . . [But] it’s very rare [that the information is used]”); Telephone Interview with M.N.3 (Dec. 7, 2011) (“[T]he link

movement are prying open the previously cloistered world of hospital risk management.

A. *Increasing Focus on Patient Safety*

Although risk managers historically focused on reducing risk through claims management, they have increasingly come to see themselves as responsible for improving patient safety. Margo Schlanger observed this evolution in her case study of a hospital's claims management practices, writing that hospital risk managers, "brought into hospitals' organizational structures in order to minimize the cost and maximize the effectiveness of claims processing," have "[o]ver the past twenty years . . . shifted their focus in significant part, though far from entirely, to ex ante patient safety and harm prevention."¹⁴⁵ Schlanger attributes this shift in part to the efforts of the American Society for Healthcare Risk Management (ASHRM), which has, since its founding in 1980, "pushed for the expansion and acknowledgement of its members' contribution to patient safety, not just to hospitals' bottom line."¹⁴⁶ Schlanger describes the evolution of risk management's core functions from claims management to patient safety as a "professional project still in progress" but one that is "evidently high on the agenda of the kinds of risk managers who run professional societies, put on conferences, and write academic and quasi-academic articles."¹⁴⁷

Consistent with Schlanger's observations, risk managers interviewed for this study—including risk managers who do not appear to play a leadership role in the field—repeatedly described patient safety as a key component of their jobs.¹⁴⁸ One risk manager explained that her work was previously "more of a claims management process. An after-the-fact retrospective. Now it is extremely proactive and preventative. That would be the biggest change in the last really eight to ten years."¹⁴⁹ Another risk manager similarly recalled that, over the

between litigation and insurance and prevention of patient safety could be a lot tighter than it is today.").

¹⁴⁵ Schlanger, *supra* note 21, at 35.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 37.

¹⁴⁸ See, e.g., Telephone Interview with L.N.2 (Nov. 29, 2011) (stating that she does not see safety and risk as separate things); Telephone Interview with L.N.7 and L.N.8 (Dec. 9, 2011) (describing the increasing use of proactive measures by risk management); Telephone Interview with M.N.3, *supra* note 144 ("[Q]uality is everywhere [T]o the extent that we are doing high reliability work in risk, that's quality. And we do a lot of safety prevention work.").

¹⁴⁹ Interview with L.G.1 (Apr. 23, 2010). Note that this interview occurred in April 2010, so she is referring to changes from 2000 or 2002 to 2010.

past decade, risk managers have increasingly come to understand their role to be about “prevention, detection, [and] correction.”¹⁵⁰

B. Increasing Transparency with Patients

Interviewees acknowledged fearing transparency with patients in prior years. As the risk manager for a small for-profit hospital reported: “[W]hen I first got here . . . nobody would talk about the lawsuits . . . [A]s soon as they said the word ‘lawyer’ everybody panicked and ran . . . screaming into the night.”¹⁵¹ Another risk manager remembered that when risk managers first entered hospitals in the 1970s, they “had a message, and the message was ‘Don’t talk . . . because it will be used against you.’ And it went on . . . for years and years.”¹⁵² Even at the University of Michigan Health System (UMHS)—one of the most innovative in the country when it comes to integrating lawsuits and patient safety¹⁵³—“deny and defend” was the norm.¹⁵⁴ Until 2001 or 2002, UMHS discouraged open discussion of error: “Whenever something bad happened our legal team would say ‘Shut up Don’t talk to anybody.’”¹⁵⁵

The risk managers I interviewed reported increasing transparency with patients in recent years. As one risk manager described it: “If a practitioner called us [in 2000 saying] that something ha[d] gone wrong, the advice was ‘Don’t talk to anyone . . . just stay away from the patients,’ and that is exactly the opposite now. The trend now is disclosure and transparency.”¹⁵⁶ Another interviewee, who has served as a risk manager for over thirty years, noted a similar transformation: “More and more risk management programs are transparent . . . in what we do. . . . [I]f we have got errors we are transparent about it and we disclose.”¹⁵⁷

Interviewees observed that fear of malpractice liability may discourage doctors from disclosing errors to patients. But risk managers

¹⁵⁰ Telephone Interview with M.N.3, *supra* note 144.

¹⁵¹ Telephone Interview with S.F.1 (May 29, 2012).

¹⁵² Telephone Interview with M.N.3, *supra* note 144.

¹⁵³ See *infra* note 171 and accompanying text (describing innovations from the University of Michigan being adopted by other hospitals across the country); see also, e.g., Telephone Interview with L.G.8, *supra* note 144 (describing the University of Michigan Health Service as a leader in changes since the Institute of Medicine’s report); Telephone Interview with L.N.7 and L.N.8, *supra* note 148 (describing review of the University of Michigan model when setting up their program); Telephone Interview with M.N.6 (Nov. 21, 2011) (describing Michigan’s approach as getting a lot of attention).

¹⁵⁴ Telephone Interview with L.N.4 (Apr. 1, 2011).

¹⁵⁵ *Id.*

¹⁵⁶ Telephone Interview with L.G.2 (Apr. 5, 2011).

¹⁵⁷ Telephone Interview with M.F.4 (June 13, 2012).

saw it as their job to encourage transparency regardless of doctors' countervailing interests.

[T]here is always going to be a certain group of people who aren't comfortable because they're always afraid that they're going to get in trouble or . . . it's going to hurt them financially . . . and that's when risk management has to come in sometimes and has to help them through that and go, you have got to do this because it's the right thing to do.¹⁵⁸

Risk managers supported disclosing errors to patients even though disclosure might lead to suit. As one risk manager explained: "[W]e try to be as transparent as possible around our mistakes and the ones that we should have prevented. We tell people we should have prevented it, and if they want to take that and go down the street to . . . their medical malpractice attorney, they do."¹⁵⁹ Indeed, some risk managers said they preferred that they, rather than plaintiffs' attorneys, disclosed errors to patients. One risk manager explained: "[T]hey can hear it from me the way I would like to deliver the message, or they can get it from their attorney, who delivers it however he or she feels fit to divulge it. And I'd rather they hear from me . . ."¹⁶⁰

What explains the increasing transparency with patients? My interviews suggest two possible influences: first, law and accreditation requirements mandating disclosure, and second, the cost-effectiveness of apology and disclosure. Scholars and patient safety advocates have offered a third possible explanation: Protection of apologies from disclosure in litigation may encourage transparency with patients.

1. *Mandates*

One explanation for the move towards transparency with patients is that hospitals are increasingly required to disclose and apologize for medical errors when they occur. In 2001, the Joint Commission began requiring disclosure of adverse outcomes to patients and their families.¹⁶¹ States have also increasingly begun requiring disclosure of adverse events.¹⁶² And non-profit organizations, scholars, and patient safety advocates have encouraged apologizing to patients when errors

¹⁵⁸ Telephone Interview with S.N.2 (May 29, 2012).

¹⁵⁹ Telephone Interview with L.N.2, *supra* note 148.

¹⁶⁰ Interview with L.G.1, *supra* note 149; *see also* Telephone Interview with M.N.3, *supra* note 144 ("[Y]ou never want a situation where the first person to tell the family the truth is the plaintiff's lawyer. You know? It used to happen. It can just never happen again.").

¹⁶¹ *See* Doug Wojcieszak et al., *The Sorry Works! Coalition: Making the Case for Full Disclosure*, 32 JOINT COMM'N J. ON QUALITY & PATIENT SAFETY 344, 344 (2006) (describing the accreditation requirement).

¹⁶² *See* Mastroianni et al., *supra* note 94 (surveying states' disclosure and apology laws).

occur.¹⁶³ Hospitals in my sample appear to have heard the call: 81% of those responding to my survey report that their hospital has a policy of apologizing to patients when they conclude that they fell below the standard of care.¹⁶⁴

2. *Cost Effectiveness*

A second explanation for the shift toward transparency with patients is that hospitals have found disclosure and apology reduces the costs and frequency of litigation. Scholars at the Harvard School of Public Health have hypothesized that apology and disclosure programs will increase malpractice claims and payouts.¹⁶⁵ Disclosure is expected to inform previously unaware patients about medical errors, prompting them to sue. As a result, these scholars fear “the number and cost of prompted claims would negate—and possibly even trounce—any deterrent effect of disclosure on litigation.”¹⁶⁶

Yet hospitals that have implemented disclosure and apology policies report a decline in the frequency and costs of lawsuits. The Veterans Affairs Medical Center in Lexington, Kentucky, pioneered this practice. In 1987, the Center began apologizing and offering compensation when its medical staff committed errors,¹⁶⁷ and, over the

¹⁶³ See Wojcieszak et al., *supra* note 161, at 355 (describing the Sorry Works! Coalition, an organization that promotes full disclosure and apology for medical errors).

¹⁶⁴ A total of 293 survey participants responded to this question: 238 (81%) reported that their facility does have a policy of apologizing to patients upon concluding that care was unreasonable, and 55 (19%) reported that their hospital has no such policy. See Survey Dataset (on file with the *New York University Law Review*). A 2003 survey reached similar results, finding that 80% of risk managers reported disclosure policies in effect or in development at their hospitals. See Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFF. 73, 78–79 (2003). Neither survey examines the extent to which these policies are followed by staff and medical providers. Given that providers do not always follow hospital reporting policies, as is described *infra* notes 282–83 and accompanying text, providers may not always apologize, even when their hospital has a policy to do so.

¹⁶⁵ See David M. Studdert et al., *Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy*, 26 HEALTH AFF. 215, 216 (2007) (describing concerns that apology and disclosure will increase litigation). For scholarship contending, in contrast, that apologies can reduce litigation and promote settlement, among other benefits, see, for example, Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1065 (1999); Daniel W. Shuman, *The Role of Apology in Tort Law*, 83 JUDICATURE 180, 184 (2000). For empirical studies suggesting that apology can facilitate settlement, see, for example, Russell Korobkin & Chris Guthrie, *Psychological Barriers to Litigation Settlement: An Experimental Approach*, 93 MICH. L. REV. 107, 148–49 (1994); Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460 (2003).

¹⁶⁶ Studdert et al., *supra* note 165, at 216.

¹⁶⁷ See Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1448–54 (2000) (describing the VA Medical Center’s disclosure-and-offer policy); Steve S. Kraman & Ginny Hamm, *Risk Management:*

next decade, it dramatically reduced its claims payments.¹⁶⁸ More recently, much attention has been paid to UMHS's approach. UMHS has adopted a practice of openly discussing medical errors and offering to compensate patients when they occur. This approach has reduced the incidence of litigation significantly—from 136 claims filed in 1999 to just 61 claims filed in 2006.¹⁶⁹ Patients are bringing fewer claims, claims are being processed more quickly, and the average payout per case has dropped by almost half.¹⁷⁰ Other hospitals are adopting UMHS's "disclosure-and-offer" approach.¹⁷¹

Those I interviewed share the belief that patients are less likely to sue if the hospital is transparent about errors when they occur.¹⁷² As one risk manager succinctly put it: "It's hard to throw a stone without hitting a risk manager who will validate" the assertion that disclosure and apology are good for business.¹⁷³

My research additionally suggests that apology policies may reduce the frequency with which hospitals pay settlements in meritless

Extreme Honesty May Be the Best Policy, 131 ANNALS INTERNAL MED. 963, 964 (1999) (same).

¹⁶⁸ See Kraman & Hamm, *supra* note 167, at 965 (studying the effects of the VA Medical Center's disclose-and-offer approach and finding that the Lexington facility was in the lowest quartile of thirty-five comparable VA hospitals); see also Cohen, *supra* note 167, at 1453 (analyzing the data compiled by Kraman and Hamm and finding that the VA Medical Center was also in the "bottom sixth in terms of average liability payment per claim").

¹⁶⁹ See Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 127, 143 (2009) (analyzing the number of malpractice claims in UMHS over several years).

¹⁷⁰ See Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS INTERNAL MED. 213, 215–16 (2010) (finding that the percentage of claims compensated dropped from 50.5% to 42.8% after the policy; the average rate of claims filed each month decreased from 7.03 per 100,000 patient encounters to 4.52 per 100,000 encounters after the policy; the median time to claim resolution dropped from 1.36 years to 0.85 years after the policy; and that liability costs dropped from an average cost per lawsuit of \$405,921 to \$228,308 after the policy).

¹⁷¹ See Allen Kachalia & Michelle M. Mello, *New Directions in Medical Liability Reform*, 364 NEW ENG. J. MED. 1564, 1569 (2011) (describing four federally-funded demonstration projects "testing expansions of the disclosure-and-offer approach championed by the University of Michigan Health System"); Kevin Sack, *Doctors Start to Say 'I'm Sorry' Long Before 'See You in Court.'* N.Y. TIMES, May 18, 2008, at 1 (describing reduced cases at the University of Illinois Medical Center since it began disclosing and apologizing for errors in 2006).

¹⁷² See, e.g., Telephone Interview with L.N.5 (Nov. 9, 2012) ("I think though if a patient is treated as a person who we respect, and we tell them honestly what has happened and what we are going to do about it, you will have less anger and less risk of being sued."); Telephone Interview with M.G.1 (May 29, 2012) (explaining, in her experience, when patients are informed of errors "they're less likely to go forward in a lawsuit . . . because of the transparency and because they were informed about the unexpected event"); Telephone Interview with S.G.1 (June 18, 2012) (hypothesizing that her facility has had no claims in over five years because of its transparency with patients).

¹⁷³ Telephone Interview with M.N.3, *supra* note 144.

claims.¹⁷⁴ Survey respondents were asked how frequently they believed meritless claims against their hospital were resolved through each of three means: monetary compensation, a non-monetary benefit, or no compensatory or other benefit. Hospitals with no apology policy reported that a greater percentage of their meritless claims are resolved with monetary compensation than did hospitals with apology policies. Conversely, hospitals with apology policies reported that a greater percentage of meritless claims are resolved through some non-monetary benefit than did hospitals without apology policies. Although further study is needed, these preliminary results suggest that having an apology policy might reduce the frequency with which money is paid to resolve meritless claims.¹⁷⁵

3. Evidentiary Protections

A third possible explanation for the rise in transparency is the fact that states are increasingly preventing plaintiffs from using disclosures and apologies as admissions in malpractice litigation. More than two-thirds of states statutorily prohibit apologies from being used as admissions of guilt, and nine protect disclosures of adverse events to patients.¹⁷⁶ The effect of evidentiary protections on apologies is disputed. Some argue that evidentiary protections make it more likely

¹⁷⁴ “Meritless claims” include claims where a patient suffered an adverse event or an injury but could not satisfy the legal requirements of a medical malpractice claim. A recent study of over 1400 medical malpractice claims files found no error in approximately one-third of the cases, but “only a small fraction . . . lacked documented injuries.” David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 *NEW ENG. J. MED.* 2024, 2029 (2006). For scholarship describing the difficulties of proving a malpractice claim, see Eugene Chung et al., *Malpractice Suits and Physician Apologies in Cancer Care*, 7 *J. ONCOLOGY PRAC.* 389, 390 (2011) (“One of the difficulties in winning a medical malpractice case is proving causation, that is, proving that the physician’s negligence rather than chance resulted in an injury.”).

¹⁷⁵ A total of 293 people responded to questions about how meritless claims were resolved against their hospitals and the apology policies at their hospitals. T-tests were run on the estimated percentage of meritless claims reportedly resolved monetarily, non-monetarily, and with no compensation. The independent variable was whether the hospital had a policy of apology. There were significant differences between apology groups at the $\alpha = .05$ for the percentages of monetary compensation, $t(66) = -2.58$, $p < .05$ and non-monetary compensation, $t(101.8) = 2.33$, $p < .05$. No significant difference was found between groups that either did or did not have a policy of apology regarding no compensation. Where Levene’s Test for Equality of Variances was significant, the result for a test not assuming equal variances was used. Because there may be dependence between the independent variables, a multivariate analysis of variance was also run to test for omnibus effects. Pillai’s Trace, Wilks’s Lambda, Hotelling’s Trace, and Roy’s Largest Root were all significant at $p = .002$. Further analysis of variance tests of individual variables revealed the same results reported above as t-tests.

¹⁷⁶ See *supra* notes 94–95 and accompanying text (summarizing the relevant evidentiary rules).

that doctors will apologize and disclose error.¹⁷⁷ But a recent study contends that evidentiary protections are not necessary, pointing to Minnesota as an example of a state where, despite a lack of evidentiary protections for apologies, malpractice rates are relatively low and hospital policies to disclose error are widespread.¹⁷⁸

My study does not examine whether evidentiary protections make doctors more likely to apologize. But my findings do suggest that evidentiary protections are not the cause of hospitals' increasing use of disclosure and apology. The vast majority of hospitals in my survey require medical providers to apologize to injured patients, and hospitals in states with evidentiary protections for apologies were not statistically more likely to have such policies.¹⁷⁹

Consistent with my survey data, interviewees reported that the presence or absence of evidentiary protections does not affect their inclination to apologize. One interviewee in a state without evidentiary protections acknowledged that the lack of protection might make it more difficult for doctors to apologize.¹⁸⁰ Nevertheless, this risk manager encourages medical staff to be transparent with patients because "people need to feel very comfortable talking about errors, they need to be supported when errors occur, and we cannot be afraid of 'Oh my gosh, if we sit down with this family, what's going to happen?'"¹⁸¹

¹⁷⁷ See Mastroianni et al., *supra* note 94, at 1611 ("A key barrier to more-open communication between health care providers and patients is the concern that such conversations might precipitate lawsuits, especially when an adverse health outcome may have been preventable.").

¹⁷⁸ See Lucinda E. Jesson & Peter B. Knapp, *My Lawyer Told Me to Say I'm Sorry: Lawyers, Doctors, and Medical Apologies*, 35 WM. MITCHELL L. REV. 1410, 1435-37 (2009).

¹⁷⁹ A total of 206 respondents both answered the question "Does your facility have a policy of apologizing to patients upon concluding that care was unreasonable?" and provided information about their facilities' location. Of the 171 hospitals in states with evidentiary protections of apologies, 84% had a policy of apologizing. Of the thirty-five hospitals in states without evidentiary protections of apologies, 80% had a policy of apologizing. A chi-squared test on policy of apologizing by presence of state evidentiary protections was not significant, $\chi^2(1) = .083$, $p = .773$. This result indicates that the two variables are independent of each other in this sample. Note, however, that this analysis does not distinguish between hospital policies in states that protect only expressions of sympathy and states that additionally protect discussions of the underlying causes of error or fault. For a discussion of variations in state apology protections, see Mastroianni et al., *supra* note 94, at 1614-15.

¹⁸⁰ See Telephone Interview with L.N.7 and L.N.8, *supra* note 148 ("So if a physician says, 'I'm really sorry I cut off your right leg,' that can be admitted at a trial and can [be] damning for her. I think not having that protection does impede a physician's comfort and having very transparent, very full continuous conversations with patients . . .").

¹⁸¹ *Id.*

A risk manager in a state considered to have weak evidentiary protections for apologies¹⁸² reported that she was unconcerned that apologizing would harm a malpractice case in subsequent litigation. “[M]y personal philosophy,” she explained, “is if they want to throw it in my face in a mediation or in court, that I made an apology to them, I think they’ll only look worse. To me it looks a whole lot worse to have never acknowledged and never have made an apology”¹⁸³

Risk managers in states with stronger evidentiary protections asserted that they would disclose error and apologize regardless of whether the statements were protected. UMHS’s leaders advocate for full disclosure regardless of evidentiary protections because the information will come out in discovery. As risk management and patient safety leadership at UMHS have described:

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.¹⁸⁴

Similarly, another risk manager stated: “[T]he way I look at it, you might as well get going on it and be honest and see what happens because they’re going to find out anyway.”¹⁸⁵

Hospitals, historically fearful of disclosing information about error, have become more transparent with patients in recent years. Whether motivated by legal and accreditation requirements mandating disclosure or a belief that disclosure reduces litigation risk, interviewees were consistent and near unanimous in their ultimate goal: to be more open with patients when errors occur.

C. *Increasing Transparency Within the Hospital*

Hospitals are also increasingly sharing information about lawsuits and other adverse events with risk managers, patient safety and quality personnel, and medical providers as a way of improving patient safety. This, too, is an evolution from prior years. The risk manager for a mid-sized for-profit hospital observed that, five years ago, her hospital was “a very closed environment, a very hush-hush

¹⁸² See Darra James Coleman, *The Power of the Apology: Resolving Medical Malpractice Claims in South Carolina*, RESOLVED, <http://adrepub.charlestonlaw.edu/wp-content/uploads/2012/06/Coleman-final-edit.pdf> (last visited Aug. 7, 2013) (describing limited evidentiary protections for apologies in South Carolina).

¹⁸³ Telephone Interview with M.F.2 (June 12, 2012).

¹⁸⁴ Boothman et al., *supra* note 169, at 141.

¹⁸⁵ Telephone Interview with S.N.2, *supra* note 158.

environment. Litigation was never discussed.”¹⁸⁶ But, she said, in the past few years, “there’s much more propensity to discussing what went wrong in an adverse event, regardless of the litigation status, because you truly want to prevent it from happening again.”¹⁸⁷

Key to increased transparency within the hospital is the increasing integration of quality and risk management personnel, information, and function. When quality and safety personnel were first hired to gather and analyze information about error, they did not work closely with risk managers.¹⁸⁸ They had different bosses: Risk management personnel reported to the general counsel, and quality and safety improvement personnel reported to the chief medical officer.¹⁸⁹ They had different backgrounds: Risk was led by lawyers, and quality and safety was led by nurses and physicians.¹⁹⁰ And they had different, even conflicting, approaches: In contrast to risk managers, who were inclined to protect information, patient safety personnel were focused on creating a culture of openness and learning.¹⁹¹

My data suggest that risk, patient safety, and quality have become more connected in recent years.¹⁹² Of the twenty-five hospitals represented in my interviews, twelve have a single person or department responsible for both risk management and patient safety.¹⁹³ In the

¹⁸⁶ Telephone Interview with M.F.2, *supra* note 183.

¹⁸⁷ *Id.*

¹⁸⁸ See Studdert et al., *supra* note 76, at 287 (reporting, in a 2004 publication, that “[r]isk management activities typically are divorced from quality-improvement activities”).

¹⁸⁹ See Telephone Interview with M.N.6, *supra* note 153 (describing different reporting structures for risk management and quality or safety).

¹⁹⁰ See Telephone Interview with L.N.3 (Jan. 3, 2012) (describing quality and safety as historically distinct from risk, with quality and safety led by nurses and physicians and risk led by lawyers); Telephone Interview with M.N.3, *supra* note 144 (identifying the fact that risk managers have historically been lawyers as a reason that hospital staff have feared them).

¹⁹¹ See *supra* note 56 (discussing the responsibilities of patient safety personnel).

¹⁹² See, e.g., Telephone Interview with M.N.4 (Mar. 7, 2011) (observing that risk management was previously separate from patients’ safety, but that they are now more connected).

¹⁹³ In small facilities, there may be just one employee responsible for both roles. See, e.g., Telephone Interview with S.F.1, *supra* note 151 (stating she is the only person responsible for risk management, claims, and patient safety in her department, reporting to the vice president of clinical quality); Telephone Interview with S.F.2 (May 29, 2012) (stating she is responsible for quality, risk management, and patient safety); Telephone Interview with S.G.1, *supra* note 172 (same); Telephone Interview with S.N.1 (May 21, 2012) (stating she is responsible for risk management and patient safety, although a separate employee is responsible for peer review and accreditation). In some larger hospitals, risk and patient safety personnel report to a single person who has both responsibilities. See, e.g., Telephone Interview with L.G.7 (Nov. 16, 2011); Telephone Interview with L.G.8, *supra* note 144; Telephone Interview with L.N.1 (Oct. 30, 2009); Telephone Interview with L.N.4, *supra* note 154; Telephone Interview with M.F.1 (June 12, 2012); Telephone Interview with M.F.2, *supra* note 183; Telephone Interview with M.G.1, *supra* note 172; Telephone

other thirteen hospitals, risk management and patient safety have remained separate, but most interviewees reported a close working relationship.¹⁹⁴

Several interviewees described a regular meeting with risk, quality, and safety personnel to discuss lawsuits, potential claims, and other troublesome events.¹⁹⁵ Interviewees described open communication between risk and patient safety during these meetings. For instance, patient safety and quality may tell risk management about issues that risk management needs to investigate. One risk manager described the situation thus:

We're constantly talking back and forth about cases—[quality improvement personnel may say] “Have you seen this?” Something that maybe doesn't come to my office because it's not prelitigated or nobody gave me a heads up, but as the case managers who always work for performance improvement, as they do their rounds

Interview with M.N.4, *supra* note 192. The survey was not designed to test how frequently hospitals merge risk management with quality improvement and patient safety functions. Instead, it asked respondents to choose one field in which they work: “risk management,” “quality improvement,” “claims management,” “patient safety,” or “other.” Nevertheless, forty-three people (10% of those who responded to the question) chose “other” and explained that they perform both risk management and quality improvement and/or patient safety. One assumes that even more respondents would have identified themselves as responsible for risk and quality and/or safety were they given this option in the survey.

¹⁹⁴ See, e.g., Telephone Interview with L.G.2, *supra* note 156 (describing a “kind of a synergy” between quality improvement and risk in that risk management will tell quality if a legal claim raises a potential issue with a physician and quality will tell risk if they see a problem or trend that could lead to lawsuits); Telephone Interview with L.N.5, *supra* note 172 (describing weekly meetings with claims and risk personnel); Telephone Interview with L.N.7 and L.N.8, *supra* note 148 (noting that risk works “pretty collaboratively and pretty closely with quality”); Telephone Interview with M.F.3 (June 5, 2012) (describing “a lot of overlap” and communication between risk and quality); Telephone Interview with M.F.4, *supra* note 157 (describing “constant interaction” between the risk manager and quality director); Telephone Interview with M.N.2 (Mar. 7, 2011) (explaining that risk management tells quality improvement of information that arises during their investigations). There are, however, variations in the level of integration between risk, safety, and quality. See, e.g., Telephone Interview with M.N.3, *supra* note 144 (reporting that risk management and quality and safety work together, but they have “run into issues where” risk offers advice to quality and safety personnel and they respond, “hey, you're not the boss of me; stay in your office”); Telephone Interview with M.N.6, *supra* note 153 (reporting that risk and patient safety are in silos and the chief executive officer for the hospital serves as a bridge between them); see also *supra* note 144 (quoting interviewees who believe that risk management and patient safety could be more closely connected).

¹⁹⁵ See, e.g., Interview with L.G.1, *supra* note 149 (“[E]ach week we have a patient quality and safety meeting, and our performance improvement director sits on that committee as do I, our chief medical officer, our chief nursing officer, and . . . we talk about what we have seen happen across the house the previous week . . .”); Telephone Interview with L.N.5, *supra* note 172 (describing a weekly meeting with risk and claim staff to discuss what happened in the prior week); Telephone Interview with L.N.7 and L.N.8, *supra* note 148 (describing a monthly meeting with claims, risk, patient safety, and the CEO of the hospital where they discuss what happened, why it happened, and what the next steps are).

they see stuff and they report up through their chain and because we meet every week, we share this information. “Gosh, my case managers were out on the floor last week and . . . here’s what they’re seeing. Have you heard anything like this?” “No, but gee, let’s figure out how we’re going to address it.” So . . . there’s that constant conversation going back and forth.¹⁹⁶

This risk manager also reported identifying issues that quality and patient safety should address. She explained:

I will make referrals to [quality] if I see patterns of things going on so that they might, perhaps, put together a Performance Improvement Team that will go out and look at this issue [T]hey cast the big wide net and pull in all the players and distill all the findings in order to change practice for safer patient care.¹⁹⁷

Risk managers and patient safety staff may also work in collaboration on root cause analyses, peer reviews, and other projects.¹⁹⁸ And, as is detailed in Part V, the vast majority of interview and survey participants report reviewing information from every stage of litigation for patient safety and quality lessons.

Interviewees suggest two reasons for increased transparency within the hospital and coordination of risk, safety, and quality: Assessment of past errors is considered key to improving safety, and evidentiary protections of internal deliberations encourage transparency.

1. *Enhancing Safety*

Interviewees believe that examining past errors is necessary to improve patient safety and reduce risk in the future.¹⁹⁹ The risk manager for a small nonprofit hospital described using past errors to educate others within the hospital system: “We try not to silo things, we try to make sure that we don’t keep things hidden because, you know, that doesn’t do anyone any good. We need to be open and transparent where we have issues.”²⁰⁰ As another risk manager explained: “It’s

¹⁹⁶ Interview with L.G.1, *supra* note 149.

¹⁹⁷ *Id.*

¹⁹⁸ See, e.g., Telephone Interview with L.G.2, *supra* note 156 (describing performance improvement committees, staffed with risk and quality, that “look[] at all the quality initiatives” for the facility); Telephone Interview with M.F.4, *supra* note 157 (describing collaboration between risk and quality in root cause analyses); Telephone Interview with M.N.2, *supra* note 194 (reporting that quality and risk work as a team on all root cause analyses); Telephone Interview with S.N.1, *supra* note 193 (reporting that quality and risk both attend peer reviews).

¹⁹⁹ See *supra* Part IV.A for descriptions of risk management’s increasing focus on patient safety; see also *infra* Part V.B for illustrations of the value of lawsuit data to patient safety and risk reduction efforts.

²⁰⁰ Telephone Interview with S.N.2, *supra* note 158.

just my personal philosophy that if we don't discuss [errors] . . . we won't make any changes, we won't make any true changes."²⁰¹ A third risk manager expressed more concern about the effects of transparency "because there is always a concern that if we are going to be honest and forthcoming, that we are going to open ourselves up for more litigation."²⁰² Nevertheless, she concluded: "I don't know how we can not move forward and talk about these things and be honest and open about them. Because without that then we're just going to continue to repeat the same mistakes over and over, so I don't know what choice we have."²⁰³

2. *Evidentiary Protections*

State rules protecting the discoverability of hospital information also appear to encourage freer discussion of error. In *To Err Is Human*, the Institute of Medicine feared that "[t]he discoverability of data under legal proceedings encourages silence about errors committed or observed" and recommended confidentiality protections for such data to encourage increased error reporting and analysis.²⁰⁴ Confidentiality and privilege provisions are now commonplace. Every state protects information generated in peer reviews of adverse events,²⁰⁵ most states protect morbidity and mortality conferences²⁰⁶ and root cause analyses,²⁰⁷ and at least twenty-one states protect error reports from discoverability in lawsuits.²⁰⁸ Recent federal legislation further protects information about errors discussed among medical staff: The Patient Safety and Quality Improvement Act of 2005 allows hospitals to be designated as patient safety organizations (PSOs), collect patient safety data from multiple hospitals, and use that data to identify problematic trends and craft solutions to improve patient safety.²⁰⁹ All patient safety information gathered by PSOs is

²⁰¹ Telephone Interview with M.F.2, *supra* note 183.

²⁰² Telephone Interview with S.N.1, *supra* note 193.

²⁰³ *Id.*

²⁰⁴ *TO ERR IS HUMAN*, *supra* note 1, at 43.

²⁰⁵ Levy et al., *supra* note 44, at 402.

²⁰⁶ See GAWANDE, *supra* note 12, at 57 (describing morbidity and mortality conferences).

²⁰⁷ See Barton, *supra* note 98, at 844–45 (describing protections of root cause analyses).

²⁰⁸ See Journal's Editorial Staff, *A National Survey of Medical Error Reporting Laws*, 9 *YALE J. HEALTH POL'Y L. & ETHICS* 201, 214 (2009) (surveying medical error reporting laws).

²⁰⁹ See Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. §§ 299b-21 to -26 (2006). For a description of the provisions of the Act, see generally AM. MED. ASS'N, *THE PHYSICIAN'S GUIDE TO PATIENT SAFETY ORGANIZATIONS*, 2009, available at <http://www.ama-assn.org/ama1/pub/upload/mm/370/patient-safety-organizations.pdf>.

confidential, privileged, and not subject to disclosure in litigation.²¹⁰

Interviewees were most certainly aware of the scope of evidentiary protections in their jurisdictions and guided internal communications about adverse events and lawsuits, when possible, to conform to those protections.²¹¹ Interviewees in states with broad evidentiary protections expressed little concern that information discussed amongst hospital personnel about problem events or lawsuits would be ordered produced. In California, for example, records created by any committee responsible for the “evaluation and improvement of the quality of care rendered,” including peer review, are not discoverable.²¹² The chief risk officer of a California hospital reported that she did not worry about communication within the hospital becoming discoverable because “the bench really does respect . . . Evidence Code 1157 protection when it’s appropriate. So, if you are truly working to mitigate harm for patient[s] . . . I’ve yet to have anyone rule that [internal communications] should be disclosed.”²¹³

Interviewees in states with limited evidentiary protections reported limiting their internal discussions to avoid creating discoverable evidence. In South Carolina, for example, physician peer reviews of adverse events are protected from disclosure, but peer reviews conducted by nurses are discoverable.²¹⁴ As a result, the risk manager of a small for-profit hospital in South Carolina reported that her facility does not conduct nurse peer reviews, even though they could be very

²¹⁰ See 42 U.S.C. § 299b-22 (describing protections of patient safety data).

²¹¹ Several interviewees described ensuring their interviews and other conduct conformed with their states’ evidentiary protections. See, e.g., Telephone Interview with L.N.7 and L.N.8, *supra* note 148 (“We’ve gone to great lengths to make sure that how we operate will still maintain the [evidentiary] protections that are afforded to us.”); Telephone Interview with M.F.1, *supra* note 193 (reporting that disclosure rules do, at times, affect the structure of risk management and decisions about information flows); Telephone Interview with M.F.4, *supra* note 157 (describing broad protections of root cause analysis documents and “anything attached to quality peer review” but “walking the tightrope” on occurrence reports); Telephone Interview with S.F.1, *supra* note 151 (“[I]f I get a lawsuit then I’m like ‘this doesn’t ring any bells with me’ then I will investigate it and review the chart and conduct some interviews myself but I’m careful about doing that because then you don’t have the privilege that attaches.”); Telephone Interview with S.F.2, *supra* note 193 (reporting that the hospital complies with state incident reporting requirements but asks employees to write their additional comments on a separate piece of paper that is not discoverable); Telephone Interview with S.N.1, *supra* note 193 (reporting weighing the value of sharing information with the likelihood that it will be discoverable and sharing the information if it is “compelling enough”).

²¹² CAL. EVID. CODE § 1157(a) (West 2009).

²¹³ Telephone Interview with L.G.2, *supra* note 156; see also Telephone Interview with M.F.4, *supra* note 157 (observing that his hospital conducts root cause analyses and can “identify processes for improvement” that they will not have to produce because his state protects these records).

²¹⁴ See Telephone Interview with S.F.1, *supra* note 151.

useful in improving patient safety.²¹⁵ And, as is described in the next Part, two hospitals in my study previously limited their discussions of the details of open lawsuits for fear of creating discoverable information, but have recently become patient safety organizations (with federal protection of patient safety information) and so have more frequent and more detailed discussions of open cases.²¹⁶ In these hospitals, strong evidentiary protections associated with becoming a PSO have encouraged greater transparency about error.

The conventional wisdom is that malpractice litigation promotes a secret and adversarial culture and, therefore, impairs patient safety initiatives. This view is not unfounded; it was, until relatively recently, an accurate description of hospitals' responses to litigation risk. Yet, in recent years, the openness and transparency promoted by patient safety advocates appear to have influenced hospital risk management culture and practices. Hospitals in my study increasingly disclose errors to patients and internally discuss information about lawsuits and other adverse events as a way of improving patient safety. Study participants attribute these changes to a number of factors that have overcome historical resistance to openness and transparency. Laws and accreditation requirements mandating disclosure and the demonstrated reduction of claims and litigation costs appear to have increased transparency with patients. Growing interest by risk management in proactively improving patient safety through assessment of past errors and confidentiality protections for hospitals' internal discussions appear to have increased transparency within hospitals. The apparent result of this combination of mandates, protections, and incentives is that hospital malpractice litigation today is less shrouded in silence and secrecy—and therefore less likely to impair patient safety advancements—than when *To Err Is Human* was published.

V

THE ROLE OF LITIGATION DATA IN QUALITY AND SAFETY EFFORTS

In the previous Part, I showed that malpractice litigation is not the impediment to patient safety efforts that some imagine it to be. In this Part, I show that malpractice lawsuits can help a hospital understand its weaknesses and inform improvements in care. Although lawsuit data have long been kept separate from quality and safety

²¹⁵ *Id.*

²¹⁶ See *infra* notes 240–43 and accompanying text.

efforts,²¹⁷ study participants report that the historical isolation of malpractice data is eroding. The vast majority²¹⁸ of interviewees and survey participants report using data from each stage of malpractice litigation for patient safety and quality purposes. And the vast majority of interviewees and survey participants believe that lawsuit data offer useful and previously unknown information relevant to patient safety.

A. *How Hospitals Learn from Lawsuits*

Survey respondents were asked how often information from notices of claim and lawsuits is used in their patient safety and quality efforts and were allowed four possible responses: “often,” “sometimes,” “rarely,” and “never.” As Figure 1 reflects, survey respondents overwhelmingly reported “often” or “sometimes” reviewing notices of claim and complaints, discovery, and closed case files for performance and safety lessons.

Consistent with the survey responses, interviewees reported evaluating information generated at each stage of litigation for lessons. An overview of hospital practices follows.

1. *Review of Notices of Claim and Legal Complaints*

Eighty-six percent of survey respondents reported “often” or “sometimes” using information in notices of claim and legal complaints for performance and safety lessons. Additionally, all risk managers I interviewed reported using information in notices of claim and legal complaints for several purposes related to patient safety. When a risk manager learns of a lawsuit, she will first determine whether she previously knew about the allegations.²¹⁹ If she did not previously know of the allegations, the risk manager may try to figure out why: whether the claim was of the type that could not have been

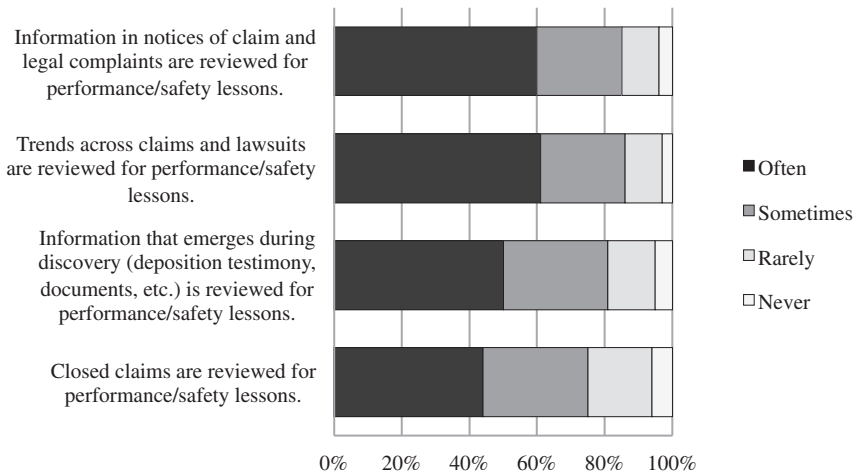
²¹⁷ See *supra* notes 186–91 and accompanying text (describing historical separation of malpractice litigation data from patient safety efforts).

²¹⁸ Just 4.6% of survey respondents (nineteen respondents total) reported “never” or “rarely” using litigation data for patient safety and quality purposes. Further research should examine the causes of distinctions across hospitals in the uses and values placed on litigation data. See Part VI for further discussion of these and other outstanding questions.

²¹⁹ See, e.g., Telephone Interview with L.G.7, *supra* note 193 (stating that upon receiving the lawsuit, interviewee reviews the claim to see if he previously knew of the allegations); Telephone Interview with L.N.2, *supra* note 148 (explaining that when a new claim is filed, “I’m looking at them to see if this is something that I knew about”); Telephone Interview with L.N.7 and L.N.8, *supra* note 148 (“So if we get a lawsuit, one of the first things we look at it is, did we know about this lawsuit before it was filed?”); Telephone Interview with M.N.1, *supra* note 144 (stating that when a lawsuit is filed, interviewee looks to see whether the claim was previously identified in the hospital’s computer system).

FIGURE 1

“How often are notices of claim and lawsuits filed against your facility used in patient safety/quality improvement efforts?”



anticipated, or whether an internal reporting protocol had not been followed.²²⁰

If the incident was previously reported to the hospital, the risk manager will review existing information about the claim.²²¹ Next, the allegations in the complaint are investigated.²²² Medical records are sequestered and reviewed; involved staff and doctors are interviewed; and, in some facilities, outside experts are sometimes consulted to determine whether those involved acted reasonably.²²³ These

²²⁰ See Telephone Interview with L.G.7, *supra* note 193. See *infra* Part V.B.1.a for a discussion of the frequency with which lawsuits concern previously unknown allegations.

²²¹ There may already have been, for example, a peer review of the event or a root cause analysis of the event. See *supra* notes 43–49 and accompanying text (describing hospitals’ internal procedures). See also, e.g., Telephone Interview with L.N.7 and L.N.8, *supra* note 148 (noting that when reviewing past investigations of allegations in lawsuits, hospital staff ask: “What did we learn? What fixes did we put in place? And are those fixes currently in place?”).

²²² Most risk managers reported conducting this internal investigation themselves, although a few reported that insurers, third-party claims administrators, or outside counsel led investigations. See, e.g., Telephone Interview with L.G.2, *supra* note 156 (noting that a third-party administrator conducts the initial investigation and a litigation report); Telephone Interview with L.G.6 (May 14, 2010) (same). In one facility with separate claims and risk personnel, the head of claims conducts this investigation. See Telephone Interview with L.N.5, *supra* note 172.

²²³ See Interview with L.G.1, *supra* note 149 (explaining that after getting notice of a claim, “I will put everyone on notice, we will sequester the medical record, notify our carrier, and then we do initial interviews with those key players that we’ve identified, asking them their recollection, their perception of the case”); Telephone Interview with L.N.5, *supra* note 172 (“I’m lucky [to] be at an academic center where I can have access to

investigations are conducted not only to defend against the legal claim, but also to identify patient safety issues. As one risk manager explained, her goals in an initial investigation are to “figure out what the criticisms are, figure out if the criticisms . . . are valid from the patient safety standpoint, and then at that point in time, make sure that the conditions . . . that led to that lawsuit are no longer present and if they’re present, how do we fix them?”²²⁴

In larger hospitals with multiple people responsible for risk, safety, and quality, relevant information may be communicated by risk managers to those who design and implement patient safety initiatives.²²⁵ In hospitals with a single person responsible for both risk management and patient safety, that person can utilize useful information uncovered during investigations to further patient safety goals.

2. Trend Analysis

Eighty-six percent of survey respondents reported “often” or “sometimes” reviewing trends across claims and lawsuits for performance and safety lessons.²²⁶ And most interviewees reported regularly reviewing notices of claim and legal complaints in the aggregate for troublesome trends such as groups of lawsuits involving a particular department or protocol.²²⁷ With that information in hand, hospital personnel may investigate further by talking with involved individuals

experts to do an internal review [before outside experts are retained to serve as defense witnesses].”).

²²⁴ Telephone Interview with L.N.7 and L.N.8, *supra* note 148.

²²⁵ See *supra* notes 195–98 and accompanying text for a description of meetings between risk management and patient safety. See also Telephone Interview with L.N.5, *supra* note 172 (describing meetings with medical directors about information learned during internal investigations of claims “so they can start any improvement practices that need to be put into place”).

²²⁶ When identifying trends, some hospitals review notices of claim and legal complaints in isolation, while others review legal filings with other data, including patient complaints, adverse event reports, and the like. Compare Telephone Interview with S.N.1, *supra* note 193 (“[W]e look at not only . . . the [patient complaints] that we have to, but we look at all of our safety events, we look at our medication errors, we . . . trend all of them. And then we report on those at all of our meetings . . . and we talk about our action plans.”), with Interview with L.G.1, *supra* note 149 (describing separate databases for lawsuits and other information).

²²⁷ See, e.g., Telephone Interview with L.G.7, *supra* note 193 (“[W]e do all kinds of stuff in reviewing the claim and we track and trend that stuff, and we look for a commonality. . . . [We are] constantly surveying issues within the claims to look for common themes that connect even to our cases that don’t have claims.”); Telephone Interview with L.N.5, *supra* note 172 (“We look at what department [claims] come from, what types of claims we’re seeing from each department.”); Telephone Interview with S.F.2, *supra* note 193 (describing quarterly reviews of trends in legal claims and grievances).

to understand the source of the problem²²⁸ or bringing in outside consultants to assess the situation.²²⁹

3. *Review of Discovery*

Eighty-one percent of respondents reported “often” or “sometimes” using information that emerges during discovery—including deposition testimony, documents, and the like—for performance and safety lessons. Many interviewees described directly participating in depositions and discovery or regularly reviewing information generated during discovery for lessons.²³⁰ In smaller facilities, with one person responsible for patient safety and risk management, information learned during discovery can be used immediately to advance patient safety. As one interviewee responsible for both patient safety and risk management described, information unearthed during discovery about policy or performance errors “naturally flows over into the patient safety side.”²³¹

In larger organizational settings, information must be communicated from those on the front lines of the litigation to those responsible for patient safety. A few risk managers reported frequently reviewing information from discovery for performance lessons. In one large non-profit hospital, for example, defense counsel provides the hospital risk manager with updates on a shared computer folder so that the risk manager “can go back to her department chair or go back to her providers and her department, to apprise them . . . of what is being learned, what is being developed throughout the lawsuit, and . . .

²²⁸ See Telephone Interview with L.N.5, *supra* note 172 (explaining that after identifying a trend in claims, risk management will speak with the involved individuals to understand “why we’re seeing these things and where would the problem be and then what the solution could be as we go forward”).

²²⁹ See Telephone Interview with L.G.6, *supra* note 222 (noting that when bringing in consultants to examine high-risk areas, “they may go on site, they may take a look at the units, they’ll take a look at our closed claims, to see with fresh eyes if they see some issues”).

²³⁰ See, e.g., Telephone Interview with L.G.6, *supra* note 222 (describing reports from defense attorneys about what doctors said during their depositions); Telephone Interview with L.N.5, *supra* note 172 (indicating that the interviewee reviews litigation “throughout the discovery process [to learn] where did we fall down, where are our weaknesses”); Telephone Interview with M.F.1, *supra* note 193 (describing attending depositions of hospital staff); Telephone Interview with S.F.2, *supra* note 193 (describing reviewing depositions to see whether staff have misinterpreted hospital procedures); Telephone Interview with S.N.1, *supra* note 193 (reporting reviewing documents from the litigation as they are provided by the lawyers); Telephone Interview with S.N.2, *supra* note 158 (same).

²³¹ Telephone Interview with M.F.2, *supra* note 183; see also *supra* note 193 (describing the practice of having a single employee responsible for both patient safety and risk management, particularly in smaller hospitals).

any deviations . . . that need to be fixed.”²³² In a large government hospital, the hospital’s litigation manager reports reviewing deposition summaries and periodic updates from defense counsel for any troubling issues that risk or quality needs to investigate further.²³³

Other hospitals have quarterly or monthly meetings in which defense attorneys update medical staff, risk management, and quality personnel about pending litigation.²³⁴ As one claims manager described these meetings, the attorney handling the case “presents information from our expert, our expert’s review, and then the committee is charged with recommending whether we want to take the case to trial or settle it.”²³⁵ Although this exchange is meant to help the attorney understand the strengths of the case and evaluate litigation strategy, information from these meetings is also used to advance patient safety: Patient safety and quality personnel may participate in these discussions,²³⁶ and participants may consider cases “for potential peer review, quality improvement, and educational opportunities.”²³⁷

A few risk managers stated that they do not discuss detailed information about lawsuits while litigation is pending for fear that discussion of the open cases could be discoverable. A concern, as one risk manager explained, is “if a case is already in litigation, we do not want to disrupt the integrity of the case by discussing it so that any information or patient safety work product would be discoverable to a plaintiff[’s] attorney.”²³⁸ As a result, this risk manager has more general discussions of open lawsuits with her medical staff. “[W]e basically keep it at a very high level. . . . [O]ur claims manager, without getting into too much detail [], give[s] the leadership of the organization some understanding where active litigation stands.”²³⁹ This interviewee anticipated having freer discussions in the near future because her hospital has recently been designated a PSO and so would be able

²³² Telephone Interview with L.N.7 and L.N.8, *supra* note 148.

²³³ See Telephone Interview with L.G.2, *supra* note 156.

²³⁴ See, e.g., Interview with L.G.1, *supra* note 149 (describing periodic meetings with defense counsel, risk management, and the quality improvement director); Telephone Interview with L.G.2, *supra* note 156 (“[W]e have a risk management committee where physicians from various disciplines sit. We review some of the claims We bring in our attorneys, we review some of the expert testimony, we get their input . . . on the standard of care, allocation of potential negligence, those types of things.”); Telephone Interview with L.N.3, *supra* note 190 (reporting that the insurer—not the risk manager—serves as the intermediary between defense counsel and hospital staff and provides quarterly updates about the progress of ongoing litigation); Telephone Interview with L.N.4, *supra* note 154 (describing a committee of doctors who review active and potential claims).

²³⁵ Interview with L.G.1, *supra* note 149.

²³⁶ *Id.*

²³⁷ Boothman et al., *supra* note 169, at 137 (describing periodic meetings at UMHS).

²³⁸ Telephone Interview with L.N.9 (Mar. 28, 2011).

²³⁹ *Id.*

to gather and analyze patient safety information with federal protection from disclosure.²⁴⁰

Another risk manager agreed that the PSO designation has allowed their internal discussions of error to become “more transparent.”²⁴¹ Before the hospital became a patient safety organization, when lawsuits revealed important safety information, “[t]hat information would be shared only on [a] need-to-know basis,” and if there was a policy or procedure change made as a result of that information, “we would not broadcast why we were making that change.”²⁴² Becoming a PSO, this risk manager believes, allows her in “real time to discuss what [their] issues are instead of waiting until [the case is] closed.”²⁴³

4. *Review of Closed Claims Data*

Seventy-six percent of survey respondents reported “often” or “sometimes” reviewing closed malpractice claims files—containing both litigation records and the hospital’s internal records²⁴⁴—for performance and safety lessons. Almost all hospital risk managers I interviewed reported reviewing closed litigation files for patient safety lessons.²⁴⁵ Closed cases are also used as part of physician education

²⁴⁰ See *supra* notes 209–10 and accompanying text for a description of patient safety organizations.

²⁴¹ Telephone Interview with M.F.2, *supra* note 183.

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ See Frederick W. Cheney, *The American Society of Anesthesiologists Closed Claims Project: What Have We Learned, How Has It Affected Practice, and How Will It Affect Practice in the Future?*, 91 *ANESTHESIOLOGY* 552, 552 (1999) (describing closed anesthesia claims files as containing “the hospital record, the anesthesia record, narrative statements of the involved healthcare personnel, expert and peer reviews, deposition summaries, outcome reports, and the cost of settlement or jury awards”).

²⁴⁵ See, e.g., Interview with L.G.1, *supra* note 149 (“[E]ach time a claim is resolved . . . there’s always a lesson learned . . . and there is a statement that must be completed by my office . . . and it often talks about how we change our practices or our processes and then those are always fed back to our Quality Improvement department.”); Telephone Interview with L.G.2, *supra* note 156 (describing discussions of closed cases and action plans from those cases); Telephone Interview with L.G.7, *supra* note 193 (“[E]very case we have I analyze the heck out of and I create a list of lessons learned from each case to take back to the medical staff and the residents to teach them.”); Telephone Interview with L.N.5, *supra* note 172 (“[A]t the close of a case, I always meet with the chairs again to discuss what we found, what happened, why we couldn’t settle the case”); Telephone Interview with M.F.4, *supra* note 157 (“[A]fter a case is, whether it’s settled, whether it’s dismissed . . . I like going back and critiquing the case and then coming up with any types of loss prevention recommendations”); Telephone Interview with M.G.1, *supra* note 172 (describing facility’s requirement to create a “formal corrective action plan” when litigation is concluded); Telephone Interview with M.N.2, *supra* note 194 (describing hospital’s practice of forming a team to “do a root cause analysis” and produce an action plan).

and training.²⁴⁶ One risk manager described incorporating trial exhibits into “mandatory education” for staff, and structuring the session so that it feels “just like if the person had come to the courtroom and sat there and listened.”²⁴⁷ Hospitals have also used closed claims as the subject of teaching videos that have been shared with groups of doctors around the country.²⁴⁸

Closed claims data play another significant, though more indirect, role in efforts to improve hospital safety and quality: Researchers, medical associations, insurers, and multi-hospital systems review large numbers of closed claims in the aggregate for patient safety lessons. The most lauded closed claims study is that begun by the American Society of Anesthesiologists (ASA) in 1983, prompted by the high rates of malpractice claims against the specialty.²⁴⁹ By studying closed claims, researchers were able to identify trends in and causes of underlying errors. Approximately ten years after the closed claims study began, anesthesia error rates had declined from 1 in every 10,000 to 20,000 administrations to 1 in every 200,000 administrations.²⁵⁰ Anesthesia is now considered an “exceptionally safe” disci-

²⁴⁶ See, e.g., Telephone Interview with L.G.6, *supra* note 222 (describing using a closed obstetrical case to show staff “why the case needed to be settled, what they needed to look for when they took care of a patient,” and the financial impact of the case on the institution); Telephone Interview with M.F.2, *supra* note 183 (“I would generally hold trainings at least once a year and discuss the cases we had settled . . . [including] what the case is about, what the focus of the case was, what could’ve helped us defend ourselves, what were the things that were good about our case.”); Telephone Interview with M.N.4, *supra* note 192 (describing using closed claims as teaching tools for residents); Telephone Interview with S.F.1, *supra* note 151 (describing using closed claims “in presentations when I’m doing education and when I’m doing safety initiatives and trying to get positive change within the organization”); Telephone Interview with S.F.2, *supra* note 193 (“What we started doing here recently is just putting a case study together every quarter and we give examples of maybe our documentation or some lessons learned or some new ideas, new processes that came out of that case or we want to come out of that case”); see also Mark S. Hochberg et al., *Perspective: Malpractice in an Academic Medical Center*, 86 *ACAD. MED.* 365 (2011) (describing a seminar for surgical residents developed from closed malpractice cases).

²⁴⁷ Telephone Interview with M.F.2, *supra* note 183.

²⁴⁸ For example, the University of Illinois created an educational DVD about informed consent based on a malpractice case. See *THE FACES OF MEDICAL ERRORS . . . FROM TEARS TO TRANSPARENCY: THE STORY OF MICHAEL SKOLNIK* (Transparent Learning 2010). As another example, UMHS created a video based on a closed malpractice case that was shared with doctors around the country. See Boothman et al., *supra* note 169, at 151–58.

²⁴⁹ See Cheney, *supra* note 244, at 553–54 (describing the ASA closed claims study, in which closed medical malpractice claims are reviewed, coded, and entered into a database that is analyzed for trends).

²⁵⁰ See Leape, *supra* note 30, at 1856 (describing the effects of the ASA studies on anesthesiology malpractice claims); Ellison C. Pierce, Jr., Letter to the Editor, *Anesthesia: Standards of Care and Liability*, 262 *JAMA* 773 (1989) (citing British source for similar statistics).

pline;²⁵¹ lawsuits have become less frequent and malpractice liability premiums have declined.²⁵² And closed claims review is considered the main cause for the precipitous decrease in errors, lawsuits, and payouts.²⁵³

Inspired by the success of the ASA's closed claims study, other medical specialties have begun reviewing closed claims as a means of understanding and improving behavior. In recent years, closed malpractice claims studies have been used to identify the causes of error in emergency room diagnoses, obstetric errors, and surgical errors.²⁵⁴

Insurers also use closed claims as a way of identifying performance problems and improving care. RMF Strategies—a division of CRICO/RMF, the insurer and risk management organization associated with Harvard-affiliated hospitals—analyzes and compares closed claims data from hospitals around the country as a way of reducing risk.²⁵⁵ RMF Strategies has coded all claims and suits brought against Harvard-affiliated hospitals for the past thirty years.²⁵⁶ Other hospitals have begun contracting with RMF Strategies to have their claims and suits coded as well: RMF Strategies's closed claims data now include 30% of all malpractice cases nationwide.²⁵⁷ RMF Strategies uses this aggregated data to identify vulnerabilities in individual hospitals and across all of its member hospitals.²⁵⁸ Because all claims are coded through the same taxonomy, RMF Strategies can compare closed claims data of hospitals with similar profiles.²⁵⁹ Several

²⁵¹ Hyman & Silver, *supra* note 9, at 918.

²⁵² See *id.* at 918–19 (citing studies showing the decline in anesthesia-related malpractice claims and premiums).

²⁵³ See *supra* note 113 (citing scholarship describing the positive effects of the ASA closed claims study).

²⁵⁴ See, e.g., M. Ennis & C.A. Vincent, *Obstetric Accidents: A Review of 64 Cases*, 300 BRIT. MED. J. 1365 (1990) (study of closed obstetric claims); Atul A. Gawande et al., *Risk Factors for Retained Instruments and Sponges After Surgery*, 348 NEW ENG. J. MED. 229 (2003) (studying, through closed claims, incidence of retained sponges after surgery); Graham Neale, *Risk Management in the Care of Medical Emergencies After Referral to Hospital*, 32 J. ROYAL C. PHYSICIANS LONDON 125 (1998) (study of claims of medical emergencies in general medicine and gastroenterology).

²⁵⁵ See Telephone Interview with L.N.9, *supra* note 238 (describing RMF Strategies). For additional information about RMF Strategies, see Baker & Lytton, *supra* note 113, at 242, and Schlanger, *supra* note 21, at 33.

²⁵⁶ Telephone Interview with L.N.9, *supra* note 238.

²⁵⁷ *Id.*

²⁵⁸ See Schlanger, *supra* note 21, at 34 (describing RMF Strategies's evaluation of a hospital through closed claims data); Telephone Interview with L.N.9, *supra* note 238 (describing quarterly meetings where RMF Strategies reviews each hospital's malpractice experience and compares data to similar hospitals).

²⁵⁹ RMF Strategies calls this its Comparative Benchmarking System (CBS). See *Comparative Benchmarking System (CBS)*, CRICO STRATEGIES (2012), http://www.rmf.harvard.edu/~media/Files/_Global/KC/PDFs/Comp%20Benchmarking%202012.pdf.

interviewees who work in multi-hospital systems described similar closed claims reviews: Individual hospitals provide their closed claims information to a central office that analyzes data across all hospitals and communicates areas of concern back to the individual facilities.²⁶⁰

B. *What Hospitals Learn from Lawsuits*

Although hospitals have historically hidden litigation data from view, my study strongly suggests that the divide between lawsuit information and patient safety information is closing. The vast majority of interviewees and survey participants integrate initial claims, discovery, and closed claims data into their hospitals' quality and safety initiatives. Moreover, most hospital personnel I interviewed believe litigation data offer useful and previously unknown information relevant to patient safety and quality.

One might think that hospitals would have little to learn from lawsuits given the multiple extra-litigation mandates to report, investigate, and analyze medical error.²⁶¹ Indeed, survey participants overwhelmingly consider these non-litigation processes to be useful in identifying and addressing safety and quality concerns in their facilities.²⁶² Interviewees also strongly praised root cause analyses, morbidity and mortality conferences, and peer reviews for their ability to unearth and address hospital weaknesses.²⁶³

Yet the vast majority of study participants also believe that lawsuits are a source of valuable information. Survey respondents were asked how useful they found various sources of information in identifying and addressing safety and quality concerns, and were allowed four possible responses: "very useful," "somewhat useful," "rarely useful," and "never useful." As Figure 2 shows, respondents considered non-litigation reporting processes—including adverse incident

²⁶⁰ E.g., Telephone Interview with M.F.1, *supra* note 193 (describing that the central office in the hospital corporation shares information about other facilities in the corporation and regional division); Telephone Interview with M.F.4, *supra* note 157 (explaining that the Hospital Corporation of America trends claim activity in hospitals throughout the company and gives participating hospitals targets to improve safety); Telephone Interview with M.G.1, *supra* note 172 ("[C]entral office reviews all settlements in such a bigger picture and then they give us that feedback of what we settle for, what went wrong and what we can do to make sure it doesn't happen again.").

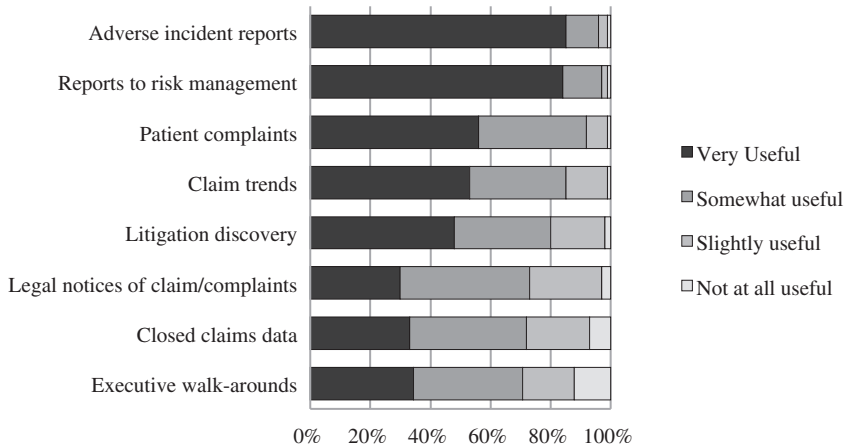
²⁶¹ See *supra* notes 45, 47–51 and accompanying text for a description of these policies and practices.

²⁶² See *infra* Figure 2.

²⁶³ See, e.g., Interview with L.G.3 and L.G.4 (Mar. 17, 2011) (discussing the value of internal hospital reporting systems, peer review, and morbidity and mortality conferences); Telephone Interview with M.N.2, *supra* note 194 (asserting that information about error "usually" comes through peer review and root cause analyses although sometimes "it has come as a result of a lawsuit").

FIGURE 2

“How useful do you find each of these sources of information in identifying and addressing safety/quality concerns in your facility?”



reports, reports to risk management, and patient complaints—to be the most valuable sources of information. But the vast majority of survey respondents (more than 95%) reported that litigation data (notices of claim and legal complaints, claim trends, information that emerges during discovery, and closed claims data) are also “very useful” or “somewhat useful” for these purposes. Just fifteen survey respondents, accounting for less than 5% of people who answered this question, stated that all types of litigation data were “rarely” or “never” useful.²⁶⁴ This Subpart examines why litigation data might be valuable in identifying and addressing hospital quality and safety concerns.

1. *Legal Claims*

Seventy-three percent of survey respondents reported that lawsuits and notices of claim were “somewhat useful” or “very useful” in identifying and addressing safety and quality concerns in their facilities. A primary value of notices of claim and suits appears to be that they reveal allegations of medical negligence previously unknown to the hospital.

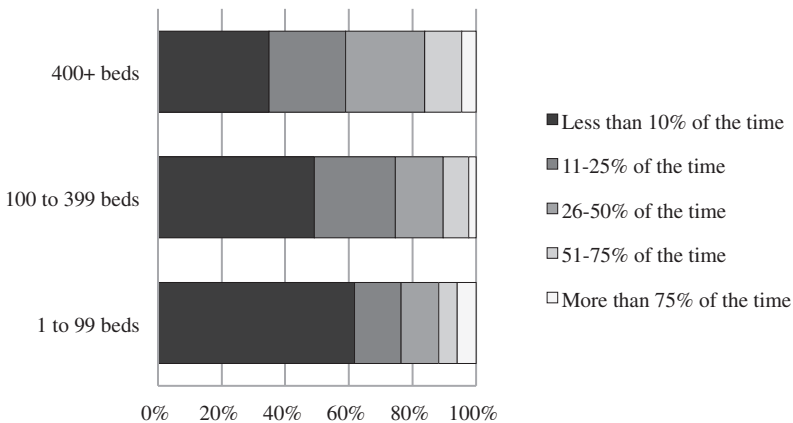
²⁶⁴ A few interviewees shared this belief. *E.g.*, Telephone Interview with M.N.2, *supra* note 194 (“I can’t even think of a time [we learned new information from a lawsuit] and I’ve been here 13 years.”); Telephone Interview with M.N.4, *supra* note 192 (“We use the information that we gather from the event reporting system, which is more valuable than information that we would get from lawsuits.”).

a. Revealing Incidents of Medical Error

Survey respondents were asked how frequently notices of claim and lawsuits concern allegations of medical negligence about which they were previously unaware. The majority of respondents (58%) reported that lawsuits reveal previously unknown allegations of medical negligence more than 10% of the time.²⁶⁵ Larger hospitals in the study appear especially likely to learn of allegations of medical error through lawsuits.²⁶⁶ As Figure 3 reflects, in hospitals with more than 400 beds, almost 60% of respondents reported learning of new allegations of medical error through lawsuits more than 10% of the time. In contrast, in the smallest hospitals, with fewer than 100 beds, just 35% of respondents reported that lawsuits notified them of new allegations of medical error more than 10% of the time.

FIGURE 3

“Approximately how frequently does a notice of claim or lawsuit concern an allegation of medical negligence about which you were previously unaware?” (by hospital bed size, measured by number of beds)



Combined with other available data, my study suggests that lawsuits reveal previously unknown allegations of medical negligence

²⁶⁵ See *infra* Figure 3. A total of 269 survey respondents answered both question 5 (number of beds in the facility) and question 11 (frequency with which lawsuits concern previously unknown allegations).

²⁶⁶ See *infra* Figure 3. The correlation between hospital size and the frequency with which lawsuits concerned previously unknown allegations was measured using Kendall’s tau-b because both variables were measured on an ordinal scale. The test revealed a significant positive association between the size of the hospital and the respondent’s lack of awareness of negligence, $\tau = .144, p < .01$. This indicates that as the size of the hospital increases, it is more common for the hospital to discover medical negligence for the first time through a lawsuit.

because suits fill gaps in the design and implementation of hospital reporting systems.²⁶⁷ I describe each of these gap-filling roles in turn.

i. Filling Gaps in Hospital Reporting Systems' Designs

When lawsuits notify hospitals of new allegations of medical error, they overwhelmingly concern allegations of missed diagnoses, delayed diagnoses, and treatment errors. Survey respondents were asked how often each of seven types of medical error were revealed through lawsuits and were allowed four possible responses: “never,” “rarely,” “sometimes,” or “often.” As seen in Figure 4, respondents reported that when lawsuits reveal previously unreported claims, they most frequently concern diagnostic and treatment errors.²⁶⁸

Consistent with these findings, a recent study of reporting systems at Brigham and Women’s Hospital found that malpractice claims were more likely than other information sources to concern delayed and missed diagnoses and treatment errors.²⁶⁹ In the study, researchers examined incidents of possible medical error reported through multiple different avenues: “an incident reporting system, reports to hospital risk management, a patient complaints database, executive walk rounds, and malpractice claims.”²⁷⁰ Researchers found that almost 25% of the malpractice claims reviewed included allegations that physicians erred in diagnosis and treatment. Similar allegations made up just 12% of patient complaints, 7% of incidents identified by risk management, 1.1% of incidents in the hospital’s reporting system, and were never identified in executive walk rounds.²⁷¹

²⁶⁷ A handful of interviewees suggested that lawsuits reveal new allegations of medical error only when the claims are frivolous and, therefore, could not previously be known to the facility. This explanation may account for some, but far from all, newly revealed allegations. There are undoubtedly meritless lawsuits filed by patients that could not have been anticipated by hospital staff or administration because they are created out of thin air. Yet a recent study of over 1400 closed malpractice cases found that approximately two-thirds of the claims filed had merit. Studdert et al., *supra* note 174, at 2029. Of the meritless claims, almost half had “slight-to-modest” evidence or were a “close call.” *Id.* Presumably, most of the incidents underlying the meritorious cases should have been reported through hospital incident reporting systems. And even when there is no legal basis for a finding of medical negligence, many incidents—particularly if supported by “slight-to-modest evidence” or a “close call”—should have been reported as well. *Id.*

²⁶⁸ Between 283 and 296 survey respondents answered whether each of these types of errors were “never,” “rarely,” “sometimes,” or “often” revealed through lawsuits. The percentages in Figure 4 reflect the percentage of those who filled in data regarding each type of error.

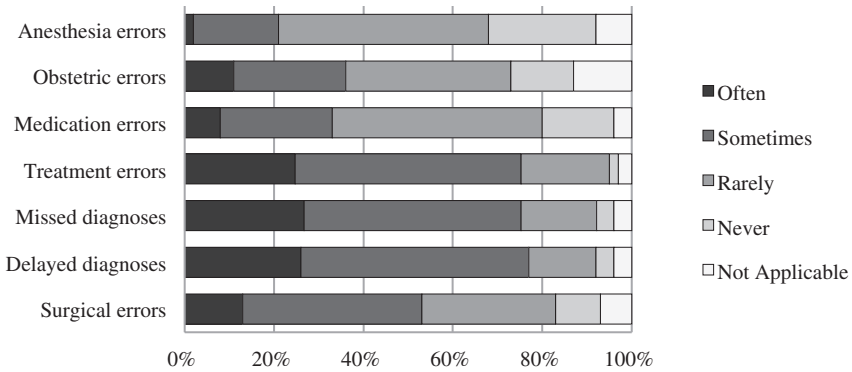
²⁶⁹ Levtzion-Korach et al., *supra* note 47.

²⁷⁰ *Id.* at 403.

²⁷¹ *Id.* at 405–06.

FIGURE 4

“When notices of claim or lawsuits concern allegations of medical negligence about which you were previously unaware, approximately how often do they concern the following types of allegations?”



Why might a disproportionately large number of claims of missed and delayed diagnoses and treatment errors be identified through lawsuits but not other means?²⁷² One explanation, supported by my interviews, is that hospital reporting systems are not designed to capture errors with delayed manifestations. Hospital reporting systems are designed, instead, to capture information about immediately obvious errors.²⁷³ Medical staff are instructed to input observable incidents into reporting systems at the moment they occur. Executives on walk rounds will similarly be able to identify only those errors that they observe or learn about through discussions with staff. Patient complaints are most likely to be filed before the patient is discharged from the hospital or within a few months of release.²⁷⁴

²⁷² One might think that the large number of diagnostic and treatment errors revealed in lawsuits simply reflects the large number of suits filed containing these allegations. But available data do not support this hypothesis. Although there are no studies that examine trends in lawsuit allegations filed, there are studies of trends in the types of cases resulting in payments reported to the National Practitioner Data Bank (NPDB), a national databank that collects information about settlements and judgments against individual doctors. One recent study found that surgical error was the most common claim asserted in cases involving in-patient care reported to the NPDB, accounting for 34% of payouts. See Bishop et al., *supra* note 117, at 2430. Diagnostic error and treatment error were the second and third most common claims, accounting for 21.1% and 20.3% of payouts, respectively. *Id.* But my survey responses suggest that the average rate at which surgical errors are revealed in lawsuits is lower than that reported for both diagnostic error (including delayed or missed diagnoses) and treatment error.

²⁷³ See generally WACHTER, *supra* note 45, at 233–38 (describing the qualities of hospital reporting systems); Levzion-Korach, *supra* note 47, at 403–04 (same).

²⁷⁴ See Telephone Interview with L.N.2, *supra* note 148 (observing that the hospital gets complaints “about three months afterwards when they get the bill,” and hypothesizing that

If a doctor has improperly diagnosed a patient, neither the doctor nor the patient will know to report the error at the moment it occurs. Misdiagnoses may only be identified after many years and consultations with many doctors. When the error is revealed, the medical personnel that made the incorrect diagnosis may no longer be treating the patient.²⁷⁵ Incident reports, executive walk rounds, and patient complaints are therefore unlikely to capture the error. Accordingly, the doctor may first learn of the incident when he is served with a summons and complaint.²⁷⁶

In interviews, many risk managers and claims personnel offered this reasoning to explain why delayed and missed diagnoses are often first revealed through lawsuits.²⁷⁷ The vice president of claims, litigation, and risk management for a hospital's captive insurer offered an illustrative story:

So the patient comes to us, if they're being treated we do an X-ray, we read it as normal, three years later the patient comes back with shortness of breath, he has lung cancer, they pull up the old X-ray; because the X-ray was misread as normal, there was never an incident report, there was never any indication for us to even know about the particular case.²⁷⁸

"[i]f the patients are in a vulnerable spot and they don't often want to complain too much when they're here, so then they complain when they leave").

²⁷⁵ This may be particularly true in the case of emergency room care because treating doctors "seldom have a continuous relationship with the patients they treat, and the continuous nature of an [emergency department] necessitates a perpetual cycle of shift changes and handoffs." Allen Kachalia et al., *Missed and Delayed Diagnoses in the Emergency Department: A Study of Closed Malpractice Claims from 4 Liability Insurers*, 49 ANNALS EMERGENCY MED. 196, 196–97 (2007).

²⁷⁶ Some hospitals have attempted to address the lack of information about missed diagnoses before any lawsuit is filed. One interviewee reported that hospitals in his area have begun informing each other when they learn of information suggesting an error. If, for example, a patient comes to one hospital's emergency room with abdominal pain, a surgeon operates and finds a retained object and realizes that the last time anyone was "in the belly" was at a hospital "down the street, we're going to let them know" with a phone call. Telephone Interview with L.G.7, *supra* note 193.

²⁷⁷ See, e.g., Telephone Interview with L.N.2, *supra* note 148 ("[I]f somebody was seen here in 2000 and . . . [we] took out their appendix, and they had an incidental finding on a chest X-ray . . . and no one noticed. . . . [F]ive years later, the person has metastatic lung cancer. We would not know . . . until it's asserted [in a lawsuit] . . ."); Telephone Interview with M.G.1, *supra* note 172 (explaining that delayed diagnoses are often claims revealed in lawsuits "because they're slowly cooking away, you know, for a year or two and it's not until [later] that you can see that the pictures of the puzzle weren't put together"); Telephone Interview with S.N.2, *supra* note 158 ("[I]f a baby dies you know right then and there, right? But sometimes with surgical things like say if there was a sponge . . . retained, you're not going to know that [until] they figure it out two, three, four years down the line when they go in for something else.").

²⁷⁸ Telephone Interview with L.N.7 and L.N.8, *supra* note 148.

The chief risk officer for a government health system reported that she relies on lawsuits to notify her of improper or missed diagnoses because in those cases, “[t]he patient doesn’t come back to us but it is diagnosed elsewhere—we may never know that we failed to diagnose a cancer until we’re sued on it.”²⁷⁹ The director of patient safety for another academic hospital similarly observed that they know about the claims where “we injured somebody when they were here,” but lawsuits claiming delays in diagnosis “usually do take you by surprise.”²⁸⁰

Lawsuits are often criticized as a source of information because suits can be brought months or years after an injury occurs and take many more months and years to resolve.²⁸¹ Yet the time delays associated with filing suit make lawsuits better able than hospitals’ reporting systems to capture errors with delayed manifestations of harm.

ii. Filling Gaps in Hospital Reporting Systems’ Implementation

Lawsuits may also concern incidents that staff were required to report but did not. Multiple studies have shown that doctors, nurses, and other staff regularly underreport error.²⁸² In focus groups, doctors and nurses have offered several reasons for their reluctance to report adverse incidents, including fear of sanctions, lack of time, lack of confidentiality, and skepticism about the patient safety benefits of reporting adverse events.²⁸³ Although some scholars argue that doctors do not report error for fear of liability, studies have found no meaningful correlation between the threat of litigation and underreporting.²⁸⁴ Whatever the reason, underreporting is indisputably widespread.

Lori Andrews’s ethnographic study of error and reporting in a hospital found that many errors discussed by doctors in morbidity and mortality conferences and other clinical meetings were never entered into the hospital’s reporting systems and, therefore, were unknown to hospital administrators. Andrews found that “new medical residents were actually told by more senior doctors *not* to fill out occurrence

²⁷⁹ Telephone Interview with L.G.6, *supra* note 222.

²⁸⁰ Telephone Interview with L.N.2, *supra* note 148.

²⁸¹ See *infra* note 345 and accompanying text (describing this critique).

²⁸² See *supra* note 103 (describing studies of the extent of underreporting).

²⁸³ For studies of the causes of patient error underreporting, see, for example, Donna Beth Jeffe et al., *Using Focus Groups to Understand Physicians’ and Nurses’ Perspectives on Error Reporting in Hospitals*, 30 JOINT COMM’N J. ON QUALITY AND SAFETY 471 (2004); Claudia L. Uribe et al., *Perceived Barriers to Medical-Error Reporting: An Exploratory Investigation*, 47 J. HEALTHCARE MGMT. 263 (2002); Douglas S. Wakefield et al., *Understanding Why Medication Administration Errors May Not Be Reported*, 14 AM. J. MED. QUALITY 81 (1999).

²⁸⁴ See *supra* notes 104–07 and accompanying text (describing these studies).

reports.”²⁸⁵ As a result, most adverse event reporting “was generally undertaken by nurses and generally focused on the most mundane errors”—incidents involving “medications and complications.”²⁸⁶ Andrews examined the hospital’s data collection over a two-year period and found that only “13.49% of the patients who brought claims had an occurrence report filed about them.”²⁸⁷

Andrews found that risk managers’ potential claims files “did a better job of capturing problems in diagnosis, surgery, and treatment,” although they also “dramatically underreported the full range of serious errors discussed at rounds and meetings.”²⁸⁸ Indeed, “more than half of the people with serious errors . . . that were discussed at rounds or meetings were not brought to the attention of the hospital through either of the existing mechanisms.”²⁸⁹

Because many adverse events discussed by doctors in their morbidity and mortality conferences and other meetings were not reported to risk managers and other hospital administrators, the hospital was limited in its efforts to “recognize the incidence and nature of errors and develop preventative strategies.”²⁹⁰ Another team of researchers surveyed a large group of physicians and reached a similar conclusion: “[P]hysicians were more likely to communicate their knowledge of errors by word of mouth to colleagues, creating lost opportunities to implement effective system-level solutions to prevent future error.”²⁹¹ As a result of the disinclination to report observed by Andrews and others, even when medical staff know about and have discussed a medical error amongst themselves, hospital administrators may only learn of the incident when it is described in a lawsuit.

Andrews’s and others’ observations may explain why larger hospitals more frequently learn of allegations of medical negligence through lawsuits. Risk managers in small hospitals may be less dependent on reporting systems to learn of adverse events because they have a better sense of what is happening in their facility. When, for example, a troublesome incident is discussed in a morbidity and

²⁸⁵ Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 369 (2005); see also Orley H. Lindgren et al., *Medical Malpractice Risk Management Early Warning Systems*, LAW & CONTEMP. PROBS., Spring 1991, at 23, 25 (“Because physicians seldom participate [in the reporting process] and because many fear subsequent discovery of the information through the legal process, more serious occurrences typically go unreported.”).

²⁸⁶ Andrews, *supra* note 285, at 369.

²⁸⁷ *Id.*

²⁸⁸ *Id.*

²⁸⁹ *Id.*

²⁹⁰ *Id.*

²⁹¹ Garbutt et al., *supra* note 105, at 251.

mortality conference, the risk manager in a small facility may be more likely to hear about the incident through informal interactions with staff. In larger facilities, with more staff and more layers of bureaucracy and physical separation, hospital administrators may rely more heavily on adverse incident reporting to notify them of potential suits.

b. Other Values of Legal Claims

Even when lawsuits do not concern previously unknown allegations of medical malpractice, interviewees suggest that lawsuits can make four additional contributions to patient safety efforts. First, lawsuits can reveal safety and quality concerns that do not meet the legal standard of medical negligence. In my interviews, for example, several risk managers reported learning through legal claims about a doctor's inability to communicate effectively with patients:

Even if it's a frivolous case, there's a reason that the patient filed the suit, and if it's because they had unreasonable expectations about the surgical outcome, we'll go back and talk to the physician and ask, "What did you disclose to the patient during the informed consent process? What was your interaction with the patient? Did the patient just not like you because you were not communicating?" There's always something to be learned in every case.²⁹²

Studies confirm that doctors are more likely to be sued if they are poor communicators with patients.²⁹³ And malpractice suits are also more likely than most other forms of reporting to capture incidents related to communication problems between medical personnel and patients.²⁹⁴

Second, lawsuits can be a useful tool for auditing the effectiveness of other hospital data sources. One risk manager offered this explanation, reporting that lawsuits rarely notified her of incidents about which she was not previously aware. She, nevertheless, found that lawsuits serve as "a good way to know whether you have any big blind spots in your patient safety program."²⁹⁵

²⁹² Interview with L.G.1, *supra* note 149; *see also* Telephone Interview with L.N.1, *supra* note 193 (observing that, even "in the cases that 'go away,' there may have been no malpractice but questionable services provided to the patient").

²⁹³ For studies illustrating the connection between poor communication skills and malpractice claims, see Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1359 (1992); Gerald B. Hickson et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care*, 272 JAMA 1583, 1583 (1994).

²⁹⁴ The Brigham and Women's study of multiple types of hospital reporting systems found that communication problems were alleged in 17% of the malpractice claims reviewed by the study but accounted for only 10% of the executive walk rounds and 5% of incident reports. Levtzion-Korach et al., *supra* note 47, at 406.

²⁹⁵ Telephone Interview with L.N.2, *supra* note 148.

Third, even when a hospital already knows about an allegation of medical negligence, the financial threat of a lawsuit can focus particular attention on the case. Interviewees referred to the threat of damages as a “hammer”²⁹⁶ that “focuses one’s attention”²⁹⁷ and creates “leverage” within the hospital to make big changes.²⁹⁸

Fourth, the litigation process may break through what David Hyman and Charles Silver have called “the culture of medicine’s tolerance for mistakes.”²⁹⁹ When a serious medical injury occurs, hospitals may call for peer review. Yet, hospital peer review has been criticized for insufficient rigor. As Robert Wachter and Kevin Shojania have written, “hospitals *do* have a tendency to protect their own, sometimes at the expense of patients.”³⁰⁰ In most hospitals, outside expert review of an incident may not occur unless a lawsuit is filed.³⁰¹ And it may be that the outside expert will identify lapses in care not seen, or perhaps ignored, by peer reviewers.

The vice president of claims for an academic hospital’s captive insurer described one such case, in which a lawsuit was brought against a doctor related to the death of a patient by maternal hemorrhage.³⁰² The hospital’s peer review of the event found that the outcome, while “unfortunate,” was not caused by malpractice.³⁰³ Yet, when investigating the allegations after the lawsuit was filed, the hospital could not find an expert to validate the obstetrician’s conduct. After consulting with three or four outside experts, each of whom criticized the medical care provided, the insurer presented the experts’ findings to the chief medical officer. She used her inability to find a

²⁹⁶ Telephone Interview with L.N.7 and L.N.8, *supra* note 148 (“[S]ometimes, unfortunately, you need a hammer to make people do the right thing and the one thing that gets people’s attention is money.”).

²⁹⁷ Telephone Interview with L.G.8, *supra* note 144 (“[L]awsuits . . . focus[] one’s attention in ways that . . . few other things . . . do. It’s a learning tempered by fear and anger which to some extent improves learning and to some extent gets in the way. It’s not a particularly conducive environment [for] learning, but it does focus one’s attention.”); *see also* Telephone Interview with L.N.5, *supra* note 172 (“[M]oney talks. . . . [Lawsuits are] not really the carrot to make people want to improve quality but [they are] a mechanism to get people’s attention.”).

²⁹⁸ Telephone Interview with L.G.7, *supra* note 193; *see also* Telephone Interview with M.F.3, *supra* note 194 (observing that getting sued “does wake people up”).

²⁹⁹ Hyman & Silver, *supra* note 53, at 427.

³⁰⁰ ROBERT M. WACHTER & KEVIN G. SHOJANIA, INTERNAL BLEEDING: THE TRUTH BEHIND AMERICA’S TERRIFYING EPIDEMIC OF MEDICAL MISTAKES 322 (2004).

³⁰¹ *See supra* notes 234–37 (describing internal discussions of experts’ analyses during litigation); *cf.* Telephone Interview with L.N.5, *supra* note 172 (describing the practice in her hospital, where experts are brought in to review adverse events before any litigation is filed, as relatively rare).

³⁰² Telephone Interview with L.N.7 and L.N.8, *supra* note 148.

³⁰³ *Id.*

supportive expert as grounds to urge changes in obstetric care (and more rigorous peer reviews).³⁰⁴

2. Claim Trends

Eighty-four percent of survey respondents reported that claim trends are “very useful” or “somewhat useful” in identifying and addressing safety and quality concerns. Interviewees report that, by looking at incidents in the aggregate, it is possible to see whether there are clusters of claims against certain departments or claims involving certain protocols.³⁰⁵ When one non-profit hospital system sees a cluster of claims in a particular department or procedure, they conduct focus groups with individuals in the unit to get a better understanding of why the events are occurring, what the problem is, and what the strategy should be moving forward.³⁰⁶ With that information, the hospital can put in place initiatives that address department-wide concerns.³⁰⁷

Interviewees described several troublesome practices identified and corrected through review of claim trends. For example, when one non-profit hospital saw that it had a number of claims regarding pulmonary embolisms, the hospital redesigned protocols to deal with the situation, including changing electronic health records, changing

³⁰⁴ Other interviewees made similar observations about the power of lawsuits to focus administrators’ and providers’ attention. *See, e.g.*, Telephone Interview with M.F.3, *supra* note 194 (“[A]s a risk manager, you can sit there and tell your people you shouldn’t do that . . . but then when they’re hit with a lawsuit and you get all these [experts] in and then they’re bringing in all their research and . . . the different points of view, it’s very helpful . . .”); Telephone Interview with S.F.1, *supra* note 151 (observing that “oftentimes people know something is wrong but they are afraid to say anything,” and so safety meetings focused on lawsuits have helped the hospital “put emphasis on changing our policies and structure to empower the staff to speak up, and we’re starting to see positive results”).

³⁰⁵ *See, e.g.*, Interview with L.G.1, *supra* note 149 (describing trend analysis as useful to identify problems with individuals and procedures); Telephone Interview with L.G.6, *supra* note 222 (noting that the multi-hospital system tracks trends in claims and will address trends when they develop); Telephone Interview with L.N.1, *supra* note 193 (describing a database that identifies trends across claims and systems that can be improved); Telephone Interview with L.N.4, *supra* note 154 (describing a periodic report analyzing trends in preventable errors); Telephone Interview with L.N.5, *supra* note 172 (describing trend analysis of claims in which the hospital “look[s] at what department [the claims] come from, what types of claims we’re seeing from each department” and noting that “we’ve actually put in focused initiatives to address larger department-wide concerns or trends”); Telephone Interview with L.N.9, *supra* note 238 (describing reviewing malpractice suits for trends); Telephone Interview with M.F.2, *supra* note 183 (same); Telephone Interview with M.F.4, *supra* note 157 (noting that the multi-hospital system tracks trends in claims and will address trends when they develop); Telephone Interview with M.G.1, *supra* note 172 (same); Telephone Interview with M.N.3, *supra* note 144 (describing reviewing malpractice suits for trends).

³⁰⁶ *See* Telephone Interview with L.N.5, *supra* note 172 (describing this process).

³⁰⁷ *Id.*

computerized order entries, and establishing forcing functions that would require medical staff to assess patients for clots and then put in place appropriate treatment.³⁰⁸ These changes have been “hugely effective” at reducing the number of pulmonary embolisms and related claims.³⁰⁹

Another non-profit hospital system puts notices of claim in a database that it uses to identify trends in types of incidents and involved personnel.³¹⁰ A separate committee meets to review this data and identify systems that could be improved. When, for example, the committee found a cluster of lawsuits relating to prostate cancer diagnoses, it concluded that although doctors were properly diagnosing patients, patients were inconsistently following up on the diagnoses. As a result, the hospital system created a safety net to ensure patients received necessary care.³¹¹

Claim trends can also be used to identify medical personnel who are regularly sued. For example, the risk manager for an academic hospital recalled that one physician at her hospital had been sued a number of times within a single year.³¹² Through interviews of the plaintiffs, the risk management team learned that the doctor had not been communicating effectively with his patients.

And so we said, look, we don't want to do anything to your surgical privileges because you're technically a good surgeon. But we think you need to learn some communication skills. So we sent him to a program to develop his communication skills. He's not had one lawsuit since. That was nine years ago. So those are the sorts of lessons you learn out of cases, even if there's no merit to the litigation.³¹³

As another risk manager explained:

[If] you start to see a doctor's name coming up more and more and more with a lot of complications, you may have to act upon it. . . . I would say to the medical director, we are beginning to see a number of cases involving doctor X. And he would then get in touch with the medical director at the facility, and then they would have to take a look at his file and his practice.³¹⁴

When departments, protocols, and practitioners are repeatedly the subject of lawsuits, hospital risk managers in my study look more carefully at these trends, identify the cause for the cluster of suits, and craft interventions to improve care.

³⁰⁸ Telephone Interview with L.G.7, *supra* note 193.

³⁰⁹ *Id.*

³¹⁰ Telephone Interview with L.N.1, *supra* note 193.

³¹¹ *Id.*

³¹² Interview with L.G.1, *supra* note 149.

³¹³ *Id.*

³¹⁴ Telephone Interview with L.G.6, *supra* note 222.

3. Information Generated During Discovery

Although interviewees were generally very impressed with the thoroughness of their hospitals' root cause analyses and peer reviews,³¹⁵ 80% of survey respondents reported that information that emerges during litigation discovery (depositions, documents, and the like) is "very useful" or "somewhat useful" in identifying and addressing safety and quality concerns.³¹⁶ And 72% of respondents report that discovery "often" or "sometimes" reveals new and useful information relevant to safety and quality.³¹⁷ Why, given thorough root cause analyses and peer reviews, might litigation discovery reveal valuable and previously unknown details about incidents of medical error?

Several interviewees suggested that the deposition process can unearth information about errors never reported to risk management and gaps in staff members' knowledge.³¹⁸ Another interviewee who regularly reviews medical malpractice data for patient safety initiatives believes that "stuff comes out in the depositions that you don't have anywhere in the medical records of the document" because, "when you raise your right hand, it's amazing the stuff you'll say versus what you may document in the chart."³¹⁹

Lawyers may also find more relevant information in the medical file than do hospital staff during root cause analyses. As one risk manager commented:

³¹⁵ See *supra* notes 262–63 and accompanying text (describing survey participants' and interviewees' views of the strengths of non-litigation reporting systems).

³¹⁶ Survey participants were asked how useful information that emerges during discovery is in identifying and addressing safety/quality concerns in their facility and given four options: "very useful," "sometimes useful," "rarely useful," and "not at all useful." A total of 302 survey participants responded to this question, and 80% of those respondents identified discovery information as "very useful" or "somewhat useful." See Survey Dataset, *supra* note 164.

³¹⁷ Survey respondents were asked how often new and useful information about safety/quality is revealed during review of information that emerges during discovery and were given four possible responses: "never," "rarely," "sometimes," and "often." A total of 309 survey participants responded to this question, and 72% of those respondents reported that discovery "often" or "sometimes" reveals new and useful information. See *id.*

³¹⁸ See, e.g., Telephone Interview with L.G.2, *supra* note 156 (reporting that depositions can reveal gaps in staff knowledge because if a witness is shown an established hospital policy and says "I've never seen that before in my life," the risk manager will realize that information about the policy needs to be disseminated more effectively); Telephone Interview with S.F.1, *supra* note 151 (reporting learning during depositions about equipment failures, charting deficiencies, and the fact that a staff member knew about a problem but did not report it to superiors); Telephone Interview with S.F.2, *supra* note 193 (reporting learning during depositions that nurses were not following hospital policy because "not being on the floor, next to a lot of the nurses that might be new to our association or something, you know I haven't heard all of that stuff").

³¹⁹ Telephone Interview with L.G.7, *supra* note 193.

It's just truly amazing that you get into some of these cases and you pick up on things and you are saying whoa, why didn't we pick that up during the root cause analysis. . . . You are dissecting the case even more so than you would probably at the root cause analysis so you pick up on some things.³²⁰

Another risk manager believes lawyers have a unique ability to unearth valuable details. As the risk manager, himself a lawyer, explained, a value of legal training is an ability "to respectfully peel the onion back and get more information than just somebody reviewing the medical record."³²¹

4. *Closed Claims*

Seventy-three percent of survey respondents reported that closed claims are "very useful" or "somewhat useful" in identifying and addressing safety and quality concerns.³²² Closed claims serve multiple roles in hospital quality improvement efforts. Hospitals use their own closed claims files as sources of additional information about allegations of medical negligence and as teaching tools. And medical associations, researchers, insurers, and hospital systems use closed claims across hospitals for broader research and analysis.

Hospitals might rely on closed claims files instead of contemporaneous review of discovery information for a few reasons. Risk managers in large hospital systems or hospitals with outside insurers may have limited interaction with defense attorneys during the course of litigation and, therefore, have minimal access to litigation information until the case is closed. For hospitals worried that internal discussion of a claim alleged in an open lawsuit could lead to disclosure of that information or otherwise "jeopardiz[e] the integrity of a case," closed malpractice claims may be an attractive source of information.³²³

Hospitals consider closed claims to be useful teaching tools because the data they contain is so rich.³²⁴ By the time a malpractice claim file is closed, it contains information from the patient's medical chart, internal investigations of the incident, and litigation documents

³²⁰ Telephone Interview with M.F.4, *supra* note 157.

³²¹ Telephone Interview with L.G.7, *supra* note 193; *see also* Telephone Interview with M.F.1, *supra* note 193 (observing that lawyers are "looking at it from . . . somewhat of a different perspective, and coming at it from a different perspective sometimes than, you know, just clinical").

³²² Several interviewees who identified closed claims as "somewhat useful" in their surveys noted during their interviews that, because they reviewed discovery information during the course of litigation, the closed claims did not provide much additional data.

³²³ Telephone Interview with L.N.9, *supra* note 238.

³²⁴ *See* Telephone Interview with M.N.4, *supra* note 192 (observing that there is a "richness" of closed claims data that makes it useful).

including depositions, interrogatories and other discovery, expert reports, and the case disposition.³²⁵ Although risk managers and quality improvement personnel could gather the data themselves from these multiple sources, the closed medical malpractice claim file has consolidated the most relevant information from all sources into a single location.

Closed claims have the added benefit of being true-to-life.³²⁶ Interviewees noted that it was easier to get the attention of residents, nurses, and other staff with actual stories than with dry recommendations about policy and strategies.³²⁷ As Eric Alper and Robert Wachter have observed: “It seems logical to believe that actual malpractice cases would be effective teaching vehicles, given that such cases are usually dramatic, memorable, and, yes, good vehicles for instilling some fear and humility into our learners.”³²⁸ The risk manager for a small for-profit hospital echoed this point of view when explaining why she uses closed claims as teaching tools: “[A]s my father used to say, ‘There’s nothing wrong with a little healthy fear.’”³²⁹

Medical associations, researchers, insurers, and hospital systems rely on closed claims data for some of the same reasons identified by hospital risk managers. Closed claims are a source of rich and detailed data about medical errors: “[B]y drawing together documentation from both formal legal documents, such as depositions and interrogatories, and confidential internal investigations, claim files present a substantially richer body of information about the antecedents of medical injury than the medical record alone.”³³⁰ Researchers consider closed claims reviews less onerous than other data-gathering

³²⁵ See Cheney, *supra* note 244, at 552 (describing contents of closed claims files).

³²⁶ See Telephone Interview with L.G.6, *supra* note 222 (“[W]e take the closed cases . . . because they are real life.”).

³²⁷ See Telephone Interview with S.F.1, *supra* note 151 (explaining that she uses closed claims files for teaching because, even though individual practitioners at the hospital are insured, “going through the whole process of being served and then being interviewed by a lawyer and then having to go through deposition and all of that actually has more impact I think than me just telling the tale of something that happened that didn’t involve a lawsuit”).

³²⁸ Alper & Wachter, *supra* note 34, at 282.

³²⁹ Telephone Interview with S.F.1, *supra* note 151.

³³⁰ Selwyn O. Rogers, Jr. et al., *Analysis of Surgical Errors in Closed Malpractice Claims at 4 Liability Insurers*, 140 SURGERY 25, 26 (2006); see also Kachalia et al., *supra* note 275, at 197; Richard L. Kravitz et al., *Malpractice Claims Data as a Quality Improvement Tool: I. Epidemiology of Error in Four Specialties*, 266 JAMA 2087, 2087–88 (1991) (“[M]alpractice claims data are accessible, contain clinically detailed information, and may hold lessons the medical profession ought to learn.”).

methods.³³¹ And researchers believe that allegations of wrongdoing are more clearly articulated in medical malpractice claim files, and thus easier to understand.³³²

Closed claims studies are also particularly well suited to identify information about rare but serious errors. This is a benefit of closed claims reviews identified by the former chairman of the ASA when trying to understand the causes of error in their field: “Because significant anesthesia injury is a relatively rare occurrence, it is difficult to study prospectively or by retrospective medical record review, even from multiple institutions.”³³³ As an example, in the ASA’s analysis of the first 900 closed claims it gathered, researchers found fourteen cases where patients had experienced sudden cardiac arrest.³³⁴ Cardiac arrest was so rare that researchers and practitioners had not previously identified it as an area of concern. Yet review of a large sample of cases allowed the pattern to be revealed.³³⁵ Others in my study agree that researchers can better understand the root causes of rare events by reviewing large numbers of closed claims in the aggregate.³³⁶

C. *The Weaknesses of Malpractice Litigation Data*

Although the vast majority of survey respondents and interviewees regularly review litigation data and find the information useful, lawsuits are, undoubtedly, a flawed source of information about medical error. Only a very small percentage of people who have been negligently injured (between 2% and 10%) ever sue.³³⁷ And

³³¹ See Rogers, Jr. et al., *supra* note 330, at 26 (describing the burdensomeness of chart review, observational studies, interview studies, and in-depth investigations).

³³² See Lindgren et al., *supra* note 285, at 25 (studying closed claims and noting that incident reports “often define the incidents unclearly” and “often lack information about the nature and extent of the reported injuries”).

³³³ Cheney, *supra* note 244, at 552.

³³⁴ *Id.* at 554.

³³⁵ See *id.* at 552–54 (“[T]hese files provide a concentrated collection of information on the relatively rare events leading to anesthesia-related injury.”).

³³⁶ See, e.g., Interview with L.G.3 and L.G.4, *supra* note 263 (observing that closed claims studies are useful for understanding events where the incidence is low); Telephone Interview with L.N.9, *supra* note 238 (observing that closed claims “are an aggregation of what is considered to be relatively rare events . . . that without malpractice, you couldn’t study the root cause of these because you’d never be looking at them in an aggregated format”).

³³⁷ One of the earliest studies examining the relationship between medical error and litigation, commissioned by the U.S. Department of Health, Education, and Welfare, estimated that just 6% of people who had been negligently injured filed lawsuits. See Leon S. Pocincki et al., *The Incidence of Iatrogenic Injuries*, in APPENDIX: REPORT OF THE SECRETARY’S COMMISSION ON MEDICAL MALPRACTICE 50, 62 (1973) (projecting 6% as many claims as instances of negligence in 1972). Patricia Danzon’s early study of adverse medical events in California found that about 10% of the victims of medical malpractice

studies have shown that about one-third of medical malpractice claims are brought by people who have not been negligently injured.³³⁸ Once a claim is filed, the “right” result is reached most of the time.³³⁹ But the amount of damages a plaintiff receives may have more to do with the severity of the plaintiff’s injury than with the egregiousness of the defendants’ conduct.³⁴⁰ Lawsuits also tend to focus on the wrongdoing of individual medical providers, overlooking the systemwide failures that contribute to harm.³⁴¹

Researchers reviewing closed claims have long made clear that they are aware of the limitations of lawsuit data and account for those limitations in their studies. Study results are often qualified in recognition of the fact that many meritorious negligence claims are never

filed claims. PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 23–24 (1985). The Harvard Medical Practice Study reached even starker results: They found that only approximately 2% of those negligently injured ultimately sued. See A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 *NEW ENG. J. MED.* 245, 247, 249 (1991) (finding that “[n]inety-eight percent (weighted rate) of all adverse events due to negligence in our study did not result in malpractice claims” and, therefore, “the fraction of medical negligence that leads to claims is probably under 2 percent”). Researchers of medical malpractice in Utah and Colorado reached similar results: Only 2.5% of those injured by medical negligence brought claims. David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 *MED. CARE* 250, 254–55 (2000).

³³⁸ E.g., Studdert et al., *supra* note 174, at 2027–28.

³³⁹ See FRANK A. SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE* 166–68 (1993) (finding correlation between actual outcomes of cases and independent evaluations of medical liability); Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 *RAND J. ECON.* 199, 200 (1991) (finding that negligence is an “extremely important determinant of defendants’ medical malpractice liability”); Studdert et al., *supra* note 174, at 2028 (finding that 73% of claims had outcomes commensurate with their merit and that false negatives were 1.6 times more likely than false positives); Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 *ANNALS INTERNAL MED.* 780, 782 (1992) (finding that payments in unmeritorious medical malpractice cases are rare).

³⁴⁰ Multiple studies have found that “the best predictor of the size of an award is the severity of disability, not whether there was negligence, or an adverse event.” David A. Hyman, *Commentary, Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 *TEX. L. REV.* 1639, 1643–44 (2002); see also Randall R. Bovbjerg et al., *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?*, *LAW & CONTEMP. PROBS.*, Winter 1991, at 5, 7 (finding malpractice damage awards correlate to severity and duration of injury); Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 *NEW ENG. J. MED.* 1963, 1963 (1996) (concluding that “the severity of the patient’s disability, not the occurrence of an adverse event or an adverse event due to negligence, was predictive of payment to the plaintiff”).

³⁴¹ See Arlen, *supra* note 108, at 987 (2010) (noting that patients often have difficulty recovering for injuries resulting from systematic failures); Mello & Brennan, *supra* note 19, at 1624 (arguing that the “key to using malpractice claims as a tool for deterrence is to . . . focus on the organization as the unit of liability and deterrence”).

brought, and other claims are filed when there was no negligence.³⁴² Researchers have also acknowledged that “severe injuries are probably overrepresented because they are more likely to trigger litigation,” that “contributing factors may not have been discernible in claims file review,” and that “certain factors or breakdowns that lead to litigated missed diagnoses cases may differ systematically from the factors or breakdowns that lead to nonlitigated ones.”³⁴³

Interviewees and survey respondents in my study similarly recognize that few lawsuits are filed, that some suits are meritless, and that damages awarded will not always reflect the merits of the underlying claims.³⁴⁴ Several additionally emphasized in interviews and surveys that the time delay inherent in litigation limits the utility of lawsuit data.³⁴⁵ No one interviewed believed that litigation was the best source of information about patient safety, and all relied on other information sources “as opposed to waiting for litigation to be the signal.”³⁴⁶ Despite these limitations, and for all the reasons described above, researchers and hospital personnel nonetheless use information from lawsuits in their patient safety research and initiatives.

Hospital risk managers lessen the skewed sampling effects of lawsuits by gathering information about incidents from multiple sources, including patient complaints, reports to risk management, adverse event databases, and executive walk rounds. Ninety-seven percent of the survey respondents who use lawsuits in assessing and improving patient safety and quality also review reports to risk management,

³⁴² See Kravitz et al., *supra* note 330, at 2087 (describing limitations of medical malpractice claims data).

³⁴³ Kachalia et al., *supra* note 275, at 202.

³⁴⁴ E.g., Survey Response #3 (Apr. 24, 2012) (on file with the *New York University Law Review*) (“Work related to [patient] safety and quality is vast and continuous, lawsuits are a very small part of those efforts and often involve no such issues. Lawsuits tend to involve a bad outcome from the patient’s perspective . . . as well as poor interpersonal relationships amongst involved parties.”); Telephone Interview with M.G.1, *supra* note 172 (“I think that past tort claims are really relevant in what is going to get us into trouble going forward and we better make sure we correct those, but of course, it’s only a small slice of what actually happens out there for adverse events.”).

³⁴⁵ See Survey Response #4 (Apr. 25, 2012) (on file with the *New York University Law Review*) (“Though lawsuits do occur, they are often filed years after the event. Enhancements to patient safety and improved processes arise from occurrence/incident reporting. . . . We find [these reports] to be much more timely and of greater benefit.”); Survey Response #5 (Apr. 24, 2012) (on file with the *New York University Law Review*) (“Given the lifespan of a claim, the fact that we know about the overwhelming majority of issues before a claim is filed and the fact that quality reviews are usually completed well before this time, we do not rely heavily on claims for these purposes.”); Telephone Interview with L.N.7 and L.N.8, *supra* note 148 (observing that lawsuits are “certainly not the best means by which to model your patient safety program simply because so much time has gone past”).

³⁴⁶ Telephone Interview with L.N.2, *supra* note 148.

adverse incident reports, and patient complaints for the same purpose. By reviewing information from multiple sources, gathered by different people and at different times, hospitals can accommodate the limitations of each type of data.³⁴⁷

Researchers and hospital personnel also discount or ignore case outcomes when examining a lawsuit for lessons. When physicians review litigation files as part of a closed claims study, they are generally instructed to ignore the outcome of the case. As authors of one study explained: “Training sessions [for the physician reviewers] stressed that the study definition of error is not synonymous with the legal definition of negligence and that a mix of factors besides merit influences whether claims are paid during litigation.”³⁴⁸

Hospital risk management and patient safety personnel similarly limit the attention they pay to case outcomes, given their inaccuracies.³⁴⁹ As one hospital risk manager explained, lessons learned from closed malpractice cases have “nothing to do with the money spent,” but instead are based on “what did our experts tell us, where we deviated from the standard of care, what’s the community practice, what did we do right, what did we do wrong, what do we need to change. It’s not financially driven at all”³⁵⁰

Lawsuits are unquestionably underinclusive and flawed sources of information about medical error. Yet hospitals find that suits fill gaps in their other, also imperfect, sources of information. Lawsuits concern previously unreported allegations—particularly concerning diagnosis and treatment errors—that other reporting systems are not designed to detect. And lawsuits concern adverse events that medical personnel should have reported but did not. Claim trends identify clusters of troublesome incidents. Discovery unearths details of events that did not surface in root cause analyses and peer reviews. And closed claims serve as valuable teaching tools for hospitals and as the data source for important research about medical error.

³⁴⁷ See Levtzion-Korach et al., *supra* note 47, at 409 (“To obtain a comprehensive picture of their patient safety problems and to develop priorities for improving safety, hospitals should use a broad portfolio of approaches and then synthesize the messages from all individual approaches into a collated and cohesive whole.”).

³⁴⁸ Kachalia et al., *supra* note 275, at 198.

³⁴⁹ See, e.g., Telephone Interview with L.G.6, *supra* note 222 (explaining that the wrongful death case for a ninety-nine-year-old will result in a lower payout than for a thirty-five-year-old, but that those differences should not guide risk assessment); Telephone Interview with L.N.1, *supra* note 193 (observing that there may be no correlation between the money paid on a case and the quality of service, and noting that wrongful death cases often have high payouts but the payout correlates to the harm and not the wrongdoing); Telephone Interview with M.F.1, *supra* note 193 (“We don’t really look at [lawsuits] . . . based on damages or monetary values here.”).

³⁵⁰ Interview with L.G.1, *supra* note 149.

VI

RECONSIDERING THE RELATIONSHIP BETWEEN MALPRACTICE
LITIGATION AND PATIENT SAFETY

In this Part, I consider the implications of my findings for understandings of the relationship between malpractice suits and patient safety and for the many recommendations for reform.

A. Reconsidering Descriptions

My data strongly support two observations that challenge the conventional wisdom that malpractice litigation is incompatible with hospital patient safety efforts.

First, my research contradicts the view that medical malpractice litigation cannot coexist with patient safety initiatives. This view appears once to have been accurate: Interviewees acknowledged that risk managers historically discouraged open discussion of error in an effort to reduce malpractice liability. Yet many reported an evolution in the ways in which hospitals respond to the threat of litigation.³⁵¹ Interviewees reported increased transparency with patients and medical staff and increased coordination between risk management and patient safety.³⁵² The disclosure and transparency promoted by patient safety advocates is being adopted by risk management and increasingly reflects hospitals' responses to malpractice litigation.

Second, although malpractice data were historically kept apart from patient safety data, over 95% of hospitals in my study now integrate information from medical malpractice lawsuits into hospital patient safety efforts.³⁵³ And, moreover, most participants in my study believe that malpractice lawsuits generate unique and valuable information relevant to patient safety.³⁵⁴ Malpractice claims regularly concern previously unknown allegations of malpractice, and the discovery process can unearth useful details about malpractice and other safety and quality concerns.³⁵⁵ Those relying on malpractice claims have also shown they are adept at recognizing and limiting the effects of their weaknesses and inaccuracies.³⁵⁶

³⁵¹ See *supra* Part IV.A.

³⁵² See *supra* Part IV.B–C.

³⁵³ See *supra* note 218 (reporting that only 4.6% of respondents reported “never” or “rarely” using litigation data for patient safety and quality purposes).

³⁵⁴ See *supra* Part V.B (describing the value study participants place on litigation data).

³⁵⁵ See *id.* (describing how previously unknown information is reportedly revealed through malpractice claims, complaints, and discovery).

³⁵⁶ See *supra* Part V.C (describing weaknesses of litigation data and the ways in which study participants and researchers have mitigated these weaknesses).

It is impossible, based on my data, to make a confident estimate of the prevalence of these practices and policies. My study represents the practices of just a small fraction of hospitals nationwide.³⁵⁷ There may be selection bias because study participants chose to respond to interview requests and the survey and were able to choose which survey questions they would answer. But, given the uniformity of responses across a diverse range of personnel and hospitals, there is good reason to think that the data are reasonably representative and reflective of hospital practices more generally.

Even if the hospitals represented in my study are somehow outliers in adopting this perspective on risk and malpractice, my findings nonetheless rebut the assumption that there is something fundamentally incompatible about the cultures of malpractice and patient safety. In the vast majority of hospitals in my study, malpractice litigation and patient safety are increasingly linked. The secretive and adversarial culture criticized by the Institute of Medicine and others is, therefore, not an inalienable attribute of malpractice litigation. The threat of malpractice need not—and does not, in most hospitals in my study—hang like a Damoclean sword over the heads of doctors, risk managers, and other hospital personnel, stifling patient safety discussions.

It is also impossible to test the assertions of interviewees and survey respondents; it may be that some have offered overly rosy pictures of their practices. Yet because the interviewees and survey respondents were promised anonymity, it is less likely that study participants would offer self-serving accounts. Even if survey respondents and interviewees did at times overstate the closeness of the tie between malpractice litigation and patient safety in their hospitals, their aspirational statements would reflect an evolved understanding about how the relationship between malpractice litigation and patient safety should function. And this is no small matter; as organizational sociologists have long understood, it is the perspectives of these types of key professionals that guide institutional norms and practices.³⁵⁸

B. *Reconsidering Prescriptions*

The “conventional wisdom” about the negative effects of malpractice litigation on patient safety efforts has been used in support of

³⁵⁷ For a description of the study methodology and its limitations, see *supra* Part III.

³⁵⁸ See, e.g., Lauren B. Edelman, Sally Riggs Fuller & Iona Mara-Drita, *Diversity Rhetoric and the Managerialization of Law*, 106 AM. J. Soc. 1589, 1591 (2001) (“[M]anagerial rhetorics, especially when they concern law or issues central to law, may have the potential to transform how managers think about law and ultimately how law is implemented in organizational settings.”).

dramatic proposals that would change the face of compensation and deterrence of medical errors. In 2001, the Institute of Medicine advocated for “[a]lternative approaches to liability, such as enterprise liability or no-fault compensation” on the grounds that these approaches “could produce a legal environment more conducive to uncovering and resolving quality problems.”³⁵⁹ Advocates for malpractice caps and other tort reforms argue that their proposals would reduce litigation’s inhibiting effects on patient safety.³⁶⁰ And those advocating for “health courts” (administrative bodies that would adjudicate malpractice claims outside the court system) similarly argue that a no-fault system would encourage more open discussions of medical error.³⁶¹

My findings suggest that hospitals can find and have found ways to de-adversarialize the culture surrounding malpractice litigation without these dramatic interventions. It might be that, in a world without medical malpractice lawsuits, hospitals and healthcare providers would disclose more adverse events and be more self-reflective. Yet given evidence that providers’ underreporting is not attributable to the threat of litigation,³⁶² eliminating medical malpractice lawsuits seems unlikely to achieve this goal. Moreover, it appears that hospitals have found ways to increase transparency even in the existing legal climate. Although this Article offers no opinions about the myriad other arguments made in favor of and against reforms,³⁶³ the need to overcome malpractice lawsuits’ supposed silencing effects seems insufficient justification for restructuring the tort system.

Recommendations to reform the medical malpractice system should also take into account the positive effects of medical malpractice data on patient safety efforts. My research shows that hospitals consider malpractice suits a valuable source of information about

³⁵⁹ COMM. ON QUALITY HEALTHCARE IN AM., INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 219 (2001).

³⁶⁰ See *supra* notes 91–93 and accompanying text.

³⁶¹ Mello et al., *supra* note 14, at 471–74.

³⁶² See *supra* notes 103–07 and accompanying text (describing studies of underreporting).

³⁶³ Compare, e.g., Mello et al., *supra* note 14, at 470 (describing benefits of health courts, including efficiency, speed, and accuracy), and Studdert et al., *supra* note 76, at 286 (“Approximately 60 cents of every dollar expended on the system is absorbed by administrative costs (predominantly legal fees), an amount that is twice the overhead rate for an average workers’ compensation scheme.”), with Freeman L. Farrow, *The Anti-Patient Psychology of Health Courts: Prescriptions from a Lawyer-Physician*, 36 AM. J.L. & MED. 188, 189 (2010) (arguing that health courts have an inherent pro-medical industry bias), Philip G. Peters, Jr., *Health Courts?*, 88 B.U. L. REV. 227, 229–30 (2008) (arguing that lawmakers should not create a system of health courts as they are currently proposed), and Emily Chow, Note, *Health Courts: An Extreme Makeover of Medical Malpractice with Potentially Fatal Complications*, 7 YALE J. HEALTH POL’Y L. & ETHICS 387, 393 (2007) (arguing that the risks associated with health courts outweigh their benefits).

medical error. Lawsuits reveal claims of medical error unreported through other avenues, and the information developed during the course of discovery and trial is considered more complete than information available in medical files. Moreover, lawsuits are viewed as valuable teaching tools precisely because they are associated with possible malpractice liability. Damages caps and other tort reform would, conceivably, reduce the number of claims brought and thereby limit these beneficial effects of malpractice suits. Accordingly, these benefits of malpractice suits should be included in any calculation of the relative costs and benefits of tort reform on patient safety.

I do not contend that the current malpractice system produces more valuable information than would health courts, were they to be implemented. Health court proposals feature administrative systems designed to increase knowledge about error. Yet, proponents of health courts justify their proposals in part on the ground that malpractice suits offer minimal patient safety benefits.³⁶⁴ My research shows, in contrast, that the current tort system generates information that risk management, patient safety, quality, and claims personnel consider valuable to hospital patient safety efforts. Although this study makes no effort to quantify the patient safety or financial benefits of litigation data, the American Society of Anesthesiology's closed claims study is widely recognized to have reduced dramatically the harms and litigation costs associated with anesthesiology.³⁶⁵ And anecdotal evidence from my study suggests that lawsuits are often used to identify patient safety weaknesses and craft hospitalwide interventions—although it is difficult to calculate the degree to which these patient safety initiatives have changed provider behavior. Those promoting health courts should take account of the positive effects of malpractice data on hospital patient safety programs when developing their proposed reforms.

It is less clear what lessons should be taken from interviewees' and survey respondents' perspectives on the necessity of protections for apologies. Although the majority of states protect apologies to patients in some manner,³⁶⁶ scholars advocate for even broader evidentiary protections to facilitate communication between doctors and

³⁶⁴ See, e.g., Mello et al., *supra* note 14, at 470–71 (noting criticisms that the current system inadequately addresses patient safety).

³⁶⁵ See *supra* notes 249–53 and accompanying text (describing the ASA study and its effects).

³⁶⁶ See Mastroianni et al., *supra* note 94, at 1612–13 (noting that most states with apology laws protect only expressions of sympathy, not discussions of the underlying causes of error or fault).

patients.³⁶⁷ This study does not examine whether medical staff are more likely to follow hospital policy and apologize when their apologies are protected from disclosure. But hospitals' decisions to have an apology policy appear independent of whether the jurisdiction allows disclosures and apologies to be used in litigation.³⁶⁸ Consistent with this finding, interviewees asserted that apologizing is the right thing to do and makes good business sense, regardless of whether the apologies could be used in litigation.

My findings do suggest that broad peer review protections encourage more open discussions of error amongst hospital staff. Interviewees were acutely aware of the scope of evidentiary protections in their jurisdictions and tailored their procedures and documentation to protect internal deliberations.³⁶⁹ These observations seem to favor stronger peer review protections and increased evidentiary protections more generally. But more study is necessary to assess how strong protections need to be in order to encourage open discussion.³⁷⁰ There is always the danger that increased evidentiary protections of hospital documents will harm plaintiffs' ability to bring and prevail on meritorious claims; accordingly, a complete understanding of the impact of evidentiary protections should account for how these protections affect malpractice litigation and rates of medical error more generally.³⁷¹

There are, without doubt, additional modifications that could strengthen the relationship between medical malpractice litigation and patient safety efforts. Proposals offered by those most closely involved in the mechanics of hospital risk, safety, and quality merit closer inspection. For example, one risk manager suggested that patterns in lawsuits be studied by regulatory bodies and used to model safety initiatives.³⁷² Another suggested that the National Practitioner Data

³⁶⁷ See *supra* note 96 and accompanying text (describing an argument for greater protections of apologies).

³⁶⁸ See *supra* note 179 and accompanying text (describing this study's finding that hospitals in states with evidentiary protections were not statistically more likely to have disclosure policies).

³⁶⁹ See *supra* notes 211–15 and accompanying text (describing interviewees' responses to states' evidentiary protections of internal discussions of medical error).

³⁷⁰ See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-281, PATIENT SAFETY ACT: HHS IS IN THE PROCESS OF IMPLEMENTING THE ACT, SO ITS EFFECTIVENESS CANNOT YET BE EVALUATED 19 (2010) (concluding that as of January, 2010, it is impossible to evaluate the effectiveness of the Patient Safety Act, as few licensed PSOs had begun receiving data).

³⁷¹ See Landsman, *supra* note 104, at 236 ("If confidentiality is to be justified, a robust program that empirically assesses the impacts of error report and error admission evidence in malpractice cases would be useful.").

³⁷² See Telephone Interview with M.N.3, *supra* note 144 ("So [lawsuits are] almost like the consumer's view of safety. I don't think that the regulatory bodies are focusing on what the family sees of the safety event. . . . [W]e're not using lawsuit patterns in America as a

Bank—which currently tracks information about settlements and judgments entered against doctors—be modified to include only cases in which there was actual physician error (and to omit cases where system failures were the primary cause of error).³⁷³ Another believed that more hospitals would improve their technology and data collection and integrate risk management and patient safety personnel if they had the money to do so; she suggested that hospitals leverage malpractice insurance dollars to make patient safety advances in their facilities that would in turn reduce litigation costs.³⁷⁴

Additional insights may result from closer study of the small group of hospitals in my study that do not gather and analyze information from lawsuits for patient safety and quality lessons. It would be useful, as well, to uncover those barriers that prevent hospitals aiming to merge risk and patient safety from fully realizing their goal. Finally, it makes sense to learn further from those hospitals that have most successfully linked risk and safety functions. Each of these modest steps seems an advisable precursor to more dramatic reforms.

CONCLUSION

In recent years, heeding the call of the Institute of Medicine's report, hospitals across the country have implemented multiple systems to gather information about patient errors, understand the causes of those errors, and change policies and practices to improve patient safety. But the belief stated by the Institute of Medicine and echoed by many others—that malpractice litigation cannot coexist with patient safety innovations—has proven false. The conventional wisdom is that the secrecy surrounding malpractice litigation impairs efforts to have open conversations about error. Although this appears to have once been true, the openness and transparency promoted by the patient safety movement have pried open the historically secretive world of malpractice litigation. In hospitals across the country, malpractice suits are treated as another source of information to be gathered, analyzed, and acted upon. And risk, quality, and claims personnel believe litigation produces information about previously

primary source to focus our safety initiatives.”). My interviews suggest that individual hospitals and hospital systems are, however, using lawsuit trends as a basis for safety initiatives. See *supra* notes 305–11 and accompanying text.

³⁷³ Telephone Interview with L.G.7, *supra* note 193. Several interviewees were dissatisfied with the National Practitioner Data Bank for various reasons. See, e.g., Telephone Interview with L.N.1, *supra* note 193 (opining that the NPDB is a highly imperfect data source, particularly for a large organization, because attribution of actual fault to individual actors is very difficult); Interview with L.G.1, *supra* note 149 (criticizing the NPDB because the details of the suit are not taken into account).

³⁷⁴ See Telephone Interview with M.N.3, *supra* note 144.

unknown instances of medical error and valuable details of events. Each of these findings should inform current understandings of the effects of lawsuits on patient safety and debates about malpractice reform.

APPENDIX A: SURVEY DESCRIPTIVE STATISTICS

Selected descriptive statistics	(%)	(N)
Do you work in a healthcare setting?		
Yes	90	
No	10	
Complete cases (Missing cases)		412 (1)
Field of work		
Risk management	71	
Quality improvement	3	
Claims management	3	
Patient safety	4	
Other	18	
Complete cases (Missing cases)		412 (1)
Type of facility		
Not for profit	67	
For-profit	25	
Government	9	
Complete cases (Missing cases)		406 (7)
Number of beds in the facility		
1-99	11	
100-399	40	
400 or more	33	
N/A	17	
Complete cases (Missing cases)		398 (15)
Is your facility self-insured?		
Yes	65	
No	21	
Other	14	
Complete cases (Missing cases)		392 (21)
Who do you insure at your facility? (Check all that apply)		
Doctors		303
Nurses		343
Pharmacists		305
Counselors		224
Social workers		290
Other		123

APPENDIX B: REPRESENTATIVENESS OF DATA SET

	Nonprofit	For-Profit	Gov't	Total
Small (1–99 beds)	22%	17%	15%	54%
Medium (100–399)	22%	8%	8%	38%
Large (400+)	6%	1%	2%	8%
Total	50%	25%	25%	100%
n=	3141	1601	1592	6334

Table 1.1: All Hospitals in the United States³⁷⁵

Hospital Type			Hospital Size		
Nonprofit	2904	50%	Small (1–99 beds)	2922	51%
For-profit	1013	18%	Medium (100–399)	2299	40%
Government	1281	22%	Large (400+)	533	9%
Unspecified	556	10%			
n=	5754	100%	n=	5754	100%

Table 1.2: All Registered Hospitals in the United States³⁷⁶

	Nonprofit	For-Profit	Gov't	Total
Small (1–99 beds)	7%	3%	2%	12%
Medium (100–399)	33%	11%	3%	47%
Large (400+)	32%	4%	5%	41%
Total	73%	17%	9%	100%
n=	248	59	32	339

Table 1.3: Hospitals in Survey³⁷⁷

³⁷⁵ AM. HOSP. ASS'N, AHA HOSPITAL STATISTICS (2011) (on file with author).

³⁷⁶ This data is drawn from a table entitled “2010 U.S. Registered Hospitals: Utilization, Personnel, and Finances,” *id.* at 8, and the AHA website, AM. HOSP. ASS'N, *Fast Facts on U.S. Hospitals*, AHA.ORG (Jan. 3, 2012), <http://www.aha.org/research/rc/stat-studies/101207fastfacts.pdf>. See Am. Hosp. Ass'n, *Registration Requirements for Hospitals*, AHA.ORG, http://www.aha.org/aha/resource-center/Statistics-and-Studies/REGISTRATION_FY_08.pdf (last visited Aug. 7, 2013), for a description of the difference between registered and non-registered hospitals.

³⁷⁷ Although there are 413 survey respondents, only 339 provided data about both their size and profit status. Most survey respondents that did not include this information do not work in healthcare facilities—they are insurers, lawyers, etc.—and so are properly excluded from these survey results.

	Nonprofit	For-Profit	Gov't	Total
Small (1-99 beds)	8%	4%	4%	16%
Medium (100-399)	20%	16%	4%	40%
Large (400+)	20%	0%	24%	44%
Total	48%	20%	36%	100%
n=	12	5	8	25

Table 1.4: Hospitals in Interviews

APPENDIX C: SURVEY QUESTIONS

1. Do you work in a healthcare setting?
 - Yes
 - No
2. In what field do you work?
 - Risk Management
 - Quality Improvement
 - Claims Management
 - Patient Safety
 - Other _____
3. What categories best describe your facility (select all that apply)?
 - Acute Care Medical Center
 - Academic Medical Center/Teaching Hospital
 - Ambulatory Care
 - Critical Access Hospital
 - Integrated Delivery System
 - Long-Term Care (e.g., home care, assisted living, skilled nursing facility, continuing care)
 - Military/VA Hospital
 - Multi-Service Healthcare Facility
 - Pediatric Hospital
 - Psychology/Behavioral Healthcare
 - Rehabilitation Facility
 - Specialty Hospital (e.g., cardiac, orthopedic, surgical)
 - Other _____
4. What is your facility type?
 - Not for Profit
 - For Profit
 - Government (Federal/Non-Federal)
5. How many beds are in your facility?
 - 6–24
 - 25–49
 - 50–99
 - 100–199
 - 200–299
 - 300–399
 - 400–499
 - 500 or more
 - N/A

6. Who do you insure for claims of medical negligence at your facility? Select all that apply.

- Doctors
- Nurses
- Pharmacists
- Counselors
- Social Workers
- Other (please specify) _____

7. Is your facility self-insured?

- Yes
- No
- Other _____

8. Please identify the types of reporting systems your facility uses for the purpose of assessing and improving patient safety/quality. Check all that apply.

- Adverse Incident Reports
- Reports to Risk Management
- Executive Walk-Arounds
- Patient Complaints
- Notices of Claim
- Lawsuits
- Closed Claims
- Other _____

9. How often are notices of claim and lawsuits filed against your facility used in patient safety/quality improvement efforts?

	Never	Rarely	Sometimes	Often
Information in notices of claim and legal complaints are reviewed for performance/safety lessons.				
Trends across claims and lawsuits are reviewed for performance/safety lessons.				
Information that emerges during discovery (deposition testimony, documents, etc.) is reviewed for performance/ safety lessons.				
Closed claims are reviewed for performance/safety lessons.				
Other (please specify)				

10. How useful do you find each of these sources of information in identifying and addressing safety/quality concerns in your facility?

	Very useful	Somewhat useful	Slightly useful	Not at all useful
Notices of claim and legal complaints				
Claim trends				
Information that emerges during discovery				
Closed claims data				
Adverse incident reports				
Reports to risk management				
Executive walk-arounds				
Patient complaints				
Other (please specify)				

11. Approximately how frequently does a notice of claim or lawsuit concern an allegation of medical negligence about which you were previously unaware?

- Never
- Less than 10% of the time
- 11–25% of the time
- 26–50% of the time
- 51–75% of the time
- More than 75% of the time
- Unknown

12. When notices of claim or lawsuits concern allegations of medical negligence about which you were previously unaware, approximately how often do they concern the following types of allegations?

	Never	Rarely	Sometimes	Often	N/A
Surgical errors					
Delayed diagnoses					
Missed diagnoses					
Treatment errors					
Medication errors					
Obstetric errors					
Anesthesia errors					
Other (please specify)					

13. Approximately how often is new and useful information about safety/quality revealed during:

	Never	Rarely	Sometimes	Often	N/A
Review of information that emerges during discovery (deposition testimony, documents, etc.)					
Review of closed claims data					

14. Please estimate what percentage of malpractice lawsuits filed against your facility and/or personnel are without merit. _____

15. Thinking only about the meritless lawsuits mentioned in the previous question, approximately what percentage are resolved in each of the following manners?

- _____ Monetary compensation to the plaintiff
- _____ Non-monetary benefit to the plaintiff
- _____ No compensatory or other benefit to the plaintiff

16. Does your facility have a policy of apologizing to patients upon concluding that care was unreasonable?

- Yes
- No

17. Please complete the information below. This is to ensure that each facility is counted independently; reporting of survey results will remain anonymous.

Facility Name _____
 City _____

18. Would you be willing to participate in a brief telephone interview? Doing so would enhance our understanding of your practices and views, and enable us to get your perspective on our preliminary findings from this survey. If so, please provide us with your e-mail address below. As before, all responses are confidential.

Email Address _____

19. Please include here any additional comments about the role of lawsuits in your facility’s safety and quality efforts.
