Annals of Health Law

Volume 13
Issue 2 *Summer 2004*

Article 12

2004

An Institutional Perspective on the Medical Malpractice Crisis

Sarah Guyton
Loyola University Chicago, School of Law

An Institutional Perspective on the Medical Malpractice Crisis

*Introduction by Sarah Guyton**

As Vice President of Insurance, Risk, Quality Management & Legal Services for the University HealthSystem Consortium (UHC), Barbara J. Youngberg is a national expert in healthcare risk management and patient safety. Her position at the UHC supports risk reduction, patient safety, quality management, and legal, regulatory, and compliance services for numerous academic medical centers across the United States, Japan, Australia, and Switzerland. She is also responsible for the design and management of group professional liability and provider excess insurance programs for the UHC. In addition to serving as Vice President at UHC, Ms. Youngberg is an adjunct professor at Loyola University Chicago School of Law and has written numerous books and articles on nursing ethics, risk finance, insurance, patient safety, and healthcare law.

Speaking at Loyola University Chicago School of Law's Annual Health Law and Policy Colloquium, Ms. Youngberg addressed the current medical malpractice crisis from an institutional perspective. Acknowledging the depth and breadth of the crisis, Ms. Youngberg urged healthcare institutions to seek solutions internally via risk management. With twenty years of knowledge and experience in the field, Ms. Youngberg discussed the evolution of risk management and specifically focused on its functions of loss prevention, claims management, and risk financing. Ms. Youngberg concluded by offering the key to overcoming the medical malpractice crisis: an institutional risk management system designed to eliminate all preventable medical errors.

I. OVERVIEW

The rising cost of medical malpractice insurance coverage and the escalation of malpractice verdicts and settlements have attracted increasing attention over the last few years. Although there is much speculation about the causes of the crisis, the problems are typically attributed to a legal tort

* Student, Loyola University Chicago School of Law, class of 2005. Ms. Guyton is a member of the *Annals of Health Law* and will be the Editor-in-Chief for 2004-05.

system badly in need of reform coupled with an insurance industry that engages in sub-optimal underwriting practices or is unable to manage its investments.[1] Historically, healthcare providers, administrators, and legislators have blamed the deficiencies of the legal system and the insurance industry for high malpractice insurance premiums,[2] the exodus of healthcare organizations from certain specialties,[3] and a lower level of quality in patient care.[4] Now, having survived two prior medical malpractice crises and in the midst of a third,[5] healthcare providers are still focusing on issues beyond their control instead of directing their efforts toward those aspects of the problem they can control.[6] Instead of enacting changes within the healthcare organizations at-large, providers are allowing themselves to become preoccupied with errors inherent in the human condition such as individual forgetfulness, inattention, and carelessness—errors which generally give rise to malpractice claims.[7]

In addition, by shifting blame to scapegoats of the past—the legal system and the insurance industry—healthcare providers are failing to ask the appropriate questions which may alleviate the crisis. They are failing to consider their own role in the current system of injury and compensation. They are minimizing patient safety practices in light of competing economic pressures and are refusing to disclose preventable medical errors for fear of inciting litigation. This may actually be fueling the malpractice crisis. They are not questioning or seeking to improve the aspects of running a healthcare business that allow for the delivery of safe and effective care. These oversights, against the highly publicized backdrop of tragedy which results from preventable medical error, make it difficult to blame the current crisis on the legal system and the insurance industry entirely.

The Institute of Medicine (IOM) report, *To Err Is Human*, suggests that between 44,000 and 98,000 patient deaths are attributable to preventable

1. David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 284-88 (2004).

2. *See* Michelle M. Mello et al., *The New Medical Malpractice Crisis*, 348 NEW ENG. J. MED. 2281, 2283 (2004) (highlighting premium increases in high-risk specialties such as obstetrics, emergency medicine, general surgery, and radiology).

3. *Id.* at 2281.

4. Stephen C. Schoenbaum & Randall R. Bovbjerg, *Malpractice Reform Must Include Steps to Prevent Medical Injury*, 140 ANNALS INTERNAL MED. 51, 51 (2004).

5. Mello et al., *supra* note 2, at 2281.

6. James Reason, *Human Error: Models and Management*, 320 BRIT. MED. J. 768, 768 (2000) (describing the two approaches to human fallibility—the person approach and the system approach—and advocating the latter).

7. *Id.* at 768.

medical error.[8] Although the exact figures remain controversial,[9] the dramatic statistics were not surprising to those that have long recognized the frailties of the current healthcare delivery system. Over the years, healthcare has become increasingly complex; Medicare and Medicaid reimbursement is less predictable, operating costs are less manageable, workforce issues are more challenging, and the continuum of care is increasingly fragmented.[10] These complexities contribute to a healthcare system that is not as safe as it should be. Preventable medical errors as well as the often unavoidable consequences associated with current high-risk healthcare services contribute to a dangerous delivery system. Despite this, many risk managers continue to meet resistance from within healthcare organizations as they struggle to create a culture of safety and to eliminate preventable medical errors. As one heavily entrenched in the struggle, Ms. Youngberg suggested that a new way of thinking is required to solve the problems of the current high-hazard healthcare environment.

II. A REVIEW OF THE TRADITIONAL APPROACH TO RISK MANAGEMENT

The principles of risk management have historically been centered upon three specific functions: loss prevention, claims management, and risk financing.[11] These functions were generally addressed by a single risk management department and had little, if any, overlap with the other departments of the larger organization.[12] Risk managers tended to be tactic-oriented and had little appreciation for the long-term strategic goals of the organization. The three functions were handled separately because the managers failed to appreciate the concept of risk management as a whole.

The risk financing function of risk management is grounded in the premise that an organization should transfer as much risk as it can afford to transfer to a third party, especially in years when the insurance market is both available and affordable.[13] When insurance was affordable, and perhaps more importantly, available, most healthcare systems transferred all their risk. This was particularly true when insurance prices were stable and

8. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (2000).

9. Clement J. McDonald et al., *Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report*, 283 JAMA 93, 93 (2000). *See also* Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors, Preventability Is in the Eye of the Reviewer*, 286 JAMA 415, 415 (2001).

10. *See generally* PAUL STARR, SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

11. Barbara J. Youngberg, *Setting up a Risk Management Department*, *in* THE RISK MANAGER'S DESK REFERENCE 13, 13-18 (Barbara J. Youngberg ed., 1994).

12. *Id.* at 18-23.

13. *Id.* at 14. *See also* A. Michele Kuhn, *Introduction to Risk Management*, *in* THE RISK MANAGER'S DESK REFERENCE 1, 1 (Barbara J. Youngberg ed., 1994).

the market was competitive for an expanding insurance industry.[14] Although a healthcare organization's transfer of risk provided its chief financial officer with security by protecting the financial interests of the organization, it compromised and diminished the importance of risk management within the very organization it tried to protect.

While risk financing focused on transferring risk, the claims management function of risk management addressed patient demands on the healthcare organization, often via their attorneys, for monetary compensation when negligence was alleged. When a claim was filed, or when the organization believed that a claim might be filed, risk management carefully guarded any and all information uncovered throughout the course of internal investigations.[15] To avoid exacerbation of damages for a particular claim, risk managers often discouraged their organizations from sharing information; the patient, the patient's family, and even individual departments within the organization itself, who may have benefited from such information, were instead kept in the dark.[16] The risk managers' task was isolated to managing the claim itself, and resolving the claim with minimal cost to the organization. Risk managers often failed to appreciate the deleterious impact of ignoring the underlying need for organizational improvement.[17] In addition, because risk management prioritized representation of the healthcare organization or provider, patients often felt alienated and became angry and, understandably, litigious.[18] Recent studies have shown that many patients file malpractice claims in order to obtain information about their injuries.[19]

A part of the claims management function of risk management is the maintenance and design of the healthcare organization's incident reporting system.[20] Historically, this process included receiving copies of incident reports completed by caregivers and establishing a claim file for those incidents that seemed likely to give rise to claims. Near-miss events were generally ignored or went unreported, and reported incidents that failed to give rise to compensable claims were forgotten.

---

14. Kuhn, *supra* note 13, at 1.

15. Eric B. Larson, *Measuring, Monitoring, and Reducing Medical Harm from a Systems Perspective: A Medical Director's Personal Reflections*, 77 ACAD. MED. 993, 996 (2002).

16. Barbara J. Youngberg, *Integrating Patient Support Services with Risk Management, in* THE RISK MANAGER'S DESK REFERENCE 105, 106-08 (Barbara J. Youngberg ed., 1994).

17. *Id.* at 106.

18. Youngberg, *supra* note 11, at 17.

19. Gerald B. Hickson et al., *Factors That Prompted Families to File Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1361 (1992).

20. Susan West et al., *Risk Management Program Development, in* THE RISK MANAGER'S DESK REFERENCE 35, 36 (Barbara J. Youngberg ed., 1994).

Moreover, loss prevention focused on educating caregivers about basic principles of risk management.[21] Typically, risk managers utilized closed claims that had given rise to national lawsuits to discuss ways in which such claims could be avoided, especially those involving high-risk specialties as identified by insurance providers.[22] Areas such as obstetrics, emergency medicine, and anesthesiology were often the focus of risk management education, regardless of whether those specialties were particularly problematic for the individual healthcare organization.

The fact that medical error continues to be a significant problem for healthcare organizations and providers suggests that past efforts have not been uniformly successful. In addition, the increasing complexity of the healthcare environment suggests that perhaps new techniques are required to manage the current crisis.

III. THE NECESSITY OF FULL DISCLOSURE

Healthcare providers continue to struggle with the concept of disclosure of errors or untoward events. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandates full disclosure of such incidents,[23] but although most hospitals now claim to have implemented policies complying with JCAHO's requirements, there is reason to believe that true disclosure is not actually taking place.[24] As an organization whose mission is to improve the safety and quality of care provided to the public through healthcare accreditation and related services that support performance improvement in healthcare organizations, JCAHO regulations assume that improvement in patient safety will be achieved by reducing the number of medical errors that cause harm to patients. To achieve a reduction in medical errors and to improve patient safety, JCAHO regulations provide guidance and advise that organizations do the following:

- Identify the errors that occur.

21. Youngberg, *supra* note 11, at 17-20.

22. *See* Marie Anne Dizon, *Developing a Comprehensive Quality Management Program in Obstetrics*, *in* THE RISK MANAGER'S DESK REFERENCE 395 (Barbara J. Youngberg ed., 1994); Barbara Grand Sheridan, *Risk Management in a Pediatric Setting*, *in* THE RISK MANAGER'S DESK REFERENCE 427 (Barbara J. Youngberg ed., 1994); Barbara J. Youngberg, *Risk Management Issues Associated with Anesthesia*, *in* THE RISK MANAGER'S DESK REFERENCE 455 (Barbara J. Youngberg ed., 1994).

23. *See* Joint Comm'n on Accreditation of Healthcare Orgs., *Reporting of Medical/Health Care Errors*, *at* http://www.jcaho.org/accredited+organizations/patient+safety/medical+errors+disclosure/index.htm (last visited May 10, 2004) [hereinafter JCAHO Position Statement].

24. Studdert et al., *supra* note 1, at 287.

- Analyze each error to determine the underlying factors—the "root causes"—that, if eliminated, could reduce the risk of similar errors in the future.
- Compile data about error frequency and type and the root causes of these errors.
- Disseminate information about these errors and their root causes to permit health care organizations, where appropriate, to redesign their systems and processes to reduce the risk of future errors.
- Periodically assess the effectiveness of the efforts taken to reduce the risk of errors.[25]

In mandating error reporting from various healthcare organizations, JCAHO hopes to identify root causes of error, make suggestions for system redesign, and track the effectiveness of such efforts to reduce or eliminate error over time.[26] According to JCAHO, an effective error reporting system would require that:

- Reported events be well-defined and limited to serious adverse events.
- Reports include the findings of root cause analyses of adverse events.
- All information reported be legally protected from disclosure; however, legitimate healthcare oversight bodies must have full and timely access to data in the reporting system without waiver of disclosure protection.
- Legitimate healthcare oversight bodies play a central role in the evaluation of root cause analyses and in the dissemination of information to other healthcare institutions in order to facilitate improvement of patient safety.[27]

Any lack of compliance with JCAHO's reporting mandates may be due to lack of physician understanding of disclosure requirements coupled with fear of litigation.[28] Events often deemed "complications" by one physician may be considered preventable errors by another physician, the healthcare organization, or JCAHO. The IOM defines error as "the failure of a planned

25. JCAHO Position Statement, *supra* note 23.
26. *Id.*
27. *Id.*
28. Leslie D. Goode et al., *When Is "Good Enough"? The Role and Responsibility of Physicians to Improve Patient Safety*, 77 ACAD. MED. 947, 948 (2002).

action to be completed as intended or the use of a wrong plan to achieve an aim."[29] Regardless, the semantics of terminology is detrimental to the objective of full disclosure. Despite the enormous body of work published regarding the importance and impact of disclosure to victims of medical error, some risk managers, healthcare attorneys, administrators, and physicians persist in the belief that such candor will "provide a roadmap for a plaintiff's attorney,"[30] create confusion for the patient and the patient's family, and have dire economic consequences for the healthcare organization.[31] In light of these fears, disclosure regulations must withstand subpoena, discovery, introduction of evidence, testimony, or any other form of disclosure in connection with a civil or administrative proceeding under federal or state law, or under the Freedom of Information Act.[32]

The IOM reports estimate the number of victims that suffer or die annually from medical errors.[33] These estimations are the subject of much debate, but many would suggest that the actual statistics are less important than the fact that *anyone* is the victim of preventable medical error.

Another IOM report, *Crossing the Quality Chasm*, states that "[t]rying harder will not work. Changing systems of care will."[34] The current healthcare system has persistent safety and quality problems because it relies on outmoded systems of work. Poor designs promote failure in the workforce; fragmentation and the hierarchical structure of most healthcare organizations impede the organization's ability to make true and lasting progress. These barriers are compounded by the fact that risk management functions in a manner divorced from the organization's overall structure. Lack of integration translates to episodic-focused changes in lieu of sustainable, organization-wide improvement.

IV. SUGGESTIONS FOR A MODERN APPROACH TO RISK MANAGEMENT

Currently, the goal of a successful and safe healthcare organization should be to achieve status as a high-reliability organization.[35] High

29. Robert A. McNutt et al., *Patient Safety Efforts Should Focus on Medical Errors*, 287 JAMA 1997, 1998 (2002) (citing INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH CARE SYSTEM FOR THE 21ST CENTURY (2001)).

30. Barbara Youngberg, *The Columbia Disaster from a Risk Manager's View*, 22 J. HEALTHCARE RISK MGMT. 3, 3-8 (2002).

31. *Id.*

32. JCAHO Position Statement, *supra* note 23.

33. Hayward, *supra* note 9, at 415.

34. INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH CARE SYSTEM FOR THE 21ST CENTURY 4 (2001).

35. Reason, *supra* note 6, at 769 (describing high reliability organizations as "systems operating in hazardous conditions that have fewer than their fair share of adverse events").

reliability organizations anticipate adverse events and prepare themselves to react to setbacks at all levels of the organization.[36] Such organizations have recognized that errors or mishaps are patterned and linked to specific systemic or environmental characteristics. It does not appear to matter whether different people are involved; the same set of circumstances can provoke similar errors. Accordingly, "[t]he pursuit of great safety is seriously impeded by an approach that does not seek out and remove the error provoking properties within the system at large."[37]

High reliability organizations have determined that incident reporting and communication are critical to risk reduction and risk management.[38] These organizations address the individual and system reluctance to adhere to reporting mandates by shifting the culture of the organization from blaming individuals or simply reporting incidents to an arena of seeking answers and patterns in order to shelter the organization from future risks.[39] This response is in sharp contrast to those organizations that tend to promote an environment of fear of litigation and focus strictly on incentivizing individual physicians to comply with reporting requirements.[40] Instead of viewing physicians as troublesome non-compliants to risk management, high reliability organizations incorporate physician leadership and promote a partnership between the organization and the individual physician.[41] In addition, risk management becomes recognized as the job of all employees in the organization and becomes decentralized to each department. With enhanced communication within the structure of the organization, issues of concern are identified, shared, discussed, and either modified or eliminated.[42] With these system safeguards and reforms in place, healthcare organizations can move beyond the preventable medical errors themselves and focus on the larger picture. Malpractice claims can be routed through "structured mediation, administrative law hearings, or medical courts."[43] Organizations are then better equipped to defend claims where there is obvious negligence and to negotiate acceptable settlements. In this way, high reliability healthcare

36. *Id.* at 770.

37. *Id.* at 769.

38. Larson, *supra* note 15, at 996. *See also* Kathleen M. Sutcliffe et al., *Communication Failures: An Insidious Contributor to Medical Mishaps*, 79 ACAD. MED. 186, 194 (2004).

39. Larson, *supra* note 15, at 997.

40. *See* Linda O. Prager, *Legal System Could Offer Safety Incentives*, AMNEWS, June 12, 2000, *available at* http://www.ama-assn.org/amednews/2000/06/12/prsb0612.htm

41. David C. Classen & Peter M. Kilbridge, *The Roles and Responsibility of Physicians to Improve Patient Safety Within Health Care Delivery Systems*, 77 ACAD. MED. 963, 966 (2002).

42. *See generally* Sutcliffe et al., *supra* note 38, at 193.

43. Studdert et al., *supra* note 1, at 289.

organizations are better able to take control over aspects of healthcare that can be controlled, create environments of patient safety, and better manage risk.

V. CONCLUSION

The current medical malpractice crisis has led to much speculation about its cause and potential solutions. The legal system, insurance industry, and healthcare institutions have each been under attack to solve the problem quickly and with minimal cost. Individual blame is masked well by the larger, faceless institutions deemed responsible.

At Loyola University Chicago School of Law's Annual Health Law and Policy Consortium, Ms. Barbara Youngberg urged listeners to examine the individual faces within the problem and to seek crisis solutions closer to home. She urged healthcare institutions to focus their risk management efforts in the hope of alleviating the medical malpractice crisis. By acknowledging preventable medical errors and seeking institution-wide solutions for eliminating them, she challenged each healthcare organization to achieve accountability and increase patient safety. In doing so, she articulated that healthcare institutions will become high reliability organizations, thereby integrating loss prevention, claims management, and risk financing effectively. Thus, Ms. Youngberg's solution to the current medical malpractice crisis is efficient risk management.