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## Private Responses to the Crisis

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## SESSION 2: PRIVATE RESPONSES TO THE CRISIS

PROF. BLUM: I will turn the podium over now to Barbara Youngberg, who will continue with our general theme of private responses to the medical malpractice crisis.

MS. YOUNGBERG: I am here to talk about the institutional perspective. I hope, and I talked to Mark Schneider [Loyola University Chicago, Director of Insurance] at the break, to respond a bit more fully to his [earlier] question about the need to integrate risk management and claims management. Many of you come to the meeting with a 500-foot level perspective of the problem, and I think it's important to have that perspective. I would like to think that I come with about a foot-and-a-half perspective of the problem because I am in the member organizations that I work with on a very frequent basis, probably almost weekly. I am always enormously impressed with the things they have to balance to keep their organizations afloat.

I would suggest that many of you have chosen the profession of health law because you recognize its importance over other areas of law and are as impassioned and passionate about healthcare as I am. I think that some of my passion might unduly influence some of my remarks, so I will just apologize for that at the forefront.

What I see in your organizations and in healthcare organizations in general is that these are enormously economically difficult times. They are fueled in great part right now by the risk financing challenges that we face. I think, Max [General Counsel, Rush University Medical Center], [with respect to] your comment about the increased burden of self-insurance, the costs of excess insurance are for many organizations prohibitive. For some of [your organizations], and I am not sure if for Cook County this is exactly true yet, [the organizations] either cannot purchase insurance or can't afford it. [The organization] might have people willing to offer it, but they offer it at a price that's not affordable. I am going to talk a little bit about why I think that should compel you to think differently about what you are doing in your organizations.

I think that we often acknowledge that the tort system is out of control and I must say I appreciated greatly the comments this morning because I think that we need to step back and say we can't really influence the tort

problem in Illinois. I am an attorney in Cook County. I certainly don't think we can influence it here. I think we have what we have for a lot of reasons. Our ability to influence is going to be predicated on our ability to control what we can control and that's the healthcare organizations that we work for or with.

I think that wherever I go, and I must say I think I work with some of the best healthcare organizations in the country, I am quietly told by leaders that they are concerned that their organizations are not safe. Although we have a lot of dialogue about the data, and the IOM report,<sup>1</sup> and the accuracy of the numbers, I think we all know that there are things in our organizations going on that we are not proud of and that we wish were different. So, we have a compelling reason to change the work that we do, or at least the manner in which we do it.

I think someone asked the question about the status of federal tort reform. Unfortunately, there are some compelling other concerns that the legislature is dealing with right now. But, I think the real [problem] with the federal bill was that it had momentum until the Jessica Santillan case hit the news. Those of you who work in this area know [the case]; it was the young girl that was given an organ transplant in error at a prestigious university. [There was also] the recent case at Boston Children's of the small child that died while five specialists stood around his bed, none of whom knew that they had the authority or the responsibility to act. I think it's hard to reconcile, if you are a legislator or you are the public, that you should be immunizing people or organizations from liability while those things are still happening [and that is one reason why the federal bill died]. I think that that is a problem we are not going to be able to overcome until we find a way to make our system safer.

So how do we begin? I think of risk management. I have worked in risk management for about twenty years. I am going to go over briefly the three major attributes of the practicing risk manager, talk about where they have evolved from, and perhaps, provide you with [an idea of] where I think they should evolve to. I will tell you, just categorically, I don't think risk management is any longer about the transferring of risk. You cannot transfer the risk at a price you can afford. If you buy all the coverage that you need, an insurance carrier will probably charge you a million dollars for a million dollars worth of coverage, or something close to that. You cannot transfer all of the risk away.

It's no longer about defending the organization only and seeing the organization as your primary asset. When I was preparing for this talk I went through reams of old risk management job descriptions and

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

organizational plans that I had collected from our members, and some of the older ones said the role of the risk manager is really to protect the financial assets of the organization by aggressively defending physicians and employees. Although I would certainly agree with that concept when there is no negligence, I think we need to begin [to recognize] that the patients are also the assets of our organization. How we as attorneys shape our organizations and facilitate a structure that can accommodate the discussion of error is equally an important role and a responsibility that we all have.

I am going to talk a little bit more about the three areas of risk management and where they were at and where I think they need to go. Loss prevention is probably what most of you would consider the proactive side of risk management. It's trying to find the problem before it hits the patient. It's doing the assessments of the organization. It's going into that doctor's office and finding out where there are vulnerabilities in that office that might ultimately hinder the quality of care provided to a patient.

Who has that responsibility has been often a point of dissension in organizations. Should the risk manager be out there doing these assessments? Is that quality management's responsibility? Is that infection control's responsibility? Is that the responsibility of a peer review protected committee looking at mortality? What we have been left with are many organizations that do this kind of work all over the house. Everyone is coming up with different recommendations, different findings, and very often not integrating those findings into the fabric of the organization because they are worried about protecting what they learn, not sharing the information in a meaningful way so that the organization can progress.

What you might have is problems found out in an intensive care unit or an emergency department that are really characteristic of organizational problems throughout the house, including staffing problems, poor training, and equipment that doesn't facilitate the provider to provide care. The problem is fixed somewhere, but the organization isn't nimble enough to translate those fixes throughout the organization. So, a system that proactively is able to look event-by-event at episodes and fix them, is not really [able to] make sustained organizational improvements.

Since there are legislators in the room I would be remiss in not saying that one of the biggest things in Illinois is disenfranchisement [of organizations and patients] by very poor protective legislation in the area of patient safety and the learning that can be afforded to organizations by facilitating the sharing of that data.

Probably everyone in this room knows that the Joint Commission [on Accreditation of Healthcare Organizations] called for a program a number of years ago where they asked organizations to share the sentinel events that they were experiencing with the Joint Commission. I think the purpose was

well-intended. [The Joint Commission] believed, and I certainly have anecdotal evidence from work we have done at my organization, that you only really understand error when you see more than one thing happen. When each of you look at your sentinel events, that one event doesn't really tell you much about anything other than that event. But, if you can aggregate data, you can really begin to learn and move forward.

Unfortunately, the fear of the inability to protect that information once it leaves your organizations really caused that program [of the Joint Commission] to come to a screeching halt. Although [organizations] can now send that information voluntarily, you can imagine not many do, or [organizations] can be forced to send the information in if the Joint Commission learns of an event. The whole idea behind the process was to really facilitate discussion around error for the purposes of moving us all forward. I would argue we do not have legislation in Illinois that consistently is able to protect information that would greatly benefit us and allow us to move forward.

Claims management in healthcare risk management requires that you saw your job—and I can tell you many risk managers still do see their job—as being first and foremost protecting the physician, the nurse, and the assets of the organization. Although you probably are aware that the Joint Commission recently enacted a policy saying [organizations] have to disclose to patients when an event happens to them, we still have organizations that are very timid about the characterization of this disclosure.

Dr. Hickson, the physician from Vanderbilt who was mentioned by Barry early on, has done some really good work not only in looking at how personality issues impact an organization's propensity for being sued, but also looking at the data in the second graph that was shown<sup>2</sup> and asking, if eighty-six percent of the population doesn't sue, why don't they sue? What is it that makes a person sue other than their desire to get money? What he learned is that most people who sue say that they sue because they want information. They feel that the hospital is not being forthright with them. Sometimes when the personality comes into mind, they sue for revenge. They don't like the person that took care of them and they want that person to feel as bad as he has made them or their family feel. So, there are a lot of reasons why people don't sue, and I think we would be well-served to pay more attention to those [reasons] than to focus on why people do sue.

I would advocate again that in the area of claims management we need to more carefully sort out the claims that are brought against our organizations or the [potential] claims that might be brought. Where there is negligence,

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2. See App. A, Graph: The Tort System Undercompensates Victims of Negligence.

where there is a preventable medical error, we need to acknowledge that to the patient and his family, and we need to stop believing that it is appropriate to fight those cases.

Patients should not have errors committed upon them when they come to us for care. I know we will have questions about how do you really define error. Sometimes we get patients that have unintended consequences. Are those errors? We need to better define what we are talking about when we are talking about error. [Additionally], we need to disclose those things to patients that we know should not have happened. I believe this will facilitate a relationship that will make a patient more likely to come to you [the risk manager] and to his physician for advice, as opposed to seeking out a plaintiff's attorney for that same advice.

I also think we need to aggressively defend claims where there isn't negligence. I think another particularly unique problem in Cook County right now is that we have many organizations in Cook County that were insured by St. Paul, and many of them have claims coming to maturity. I know, because I have read in the paper and I have seen some of your name badges, that many of you feel there are claims being settled well in excess of their value. I think it is true that St. Paul is dumping their claims because they don't want to continue to employ claims people in [certain] areas. They want to get rid of their book of claims.

So, we do have at this point artificially inflated verdicts and settlements in Cook County that we probably cannot control, but that's because the claims are there and the injuries are there. These claims that I am reading about are not claims where there are not injured people. They might be claims where the damages are grossly disproportionate to the injury, or they might be claims where the issue of actual negligence is in question, but they are clearly claims where people have been injured. So, part of my strategy for getting ahead of this problem is to focus more on the injury than the claim.

Finally, the risk financing component is really the third hat that most risk managers wear, and that has again evolved. It used to be that you would try to get rid of the risk by finding someone foolish enough to take it off of your hands. You would let an insurance provider and an underwriter assess what the cost of doing that business would be. Obviously, the whole point of this conference today is that there are very few insurance companies now willing to do that.

We must recognize, I think fundamentally, that the insurance industry is not a philanthropic organization. [Insurance companies] are not interested in taking business where they are not going to make money. When their underwriters look at your claims, they are going to set a price so that they believe at the end of the day they are going to make money. I have had

some of our members at organizations that I have worked with say to me, “we have blown through our retention five years in a row, or three years in a row, but we still think that price is too high.” Fundamentally, if you are not willing to take the risk for yourself, why would you expect an organization that has frictional costs of shareholders to take that risk for you?

So what do you need to do? I think you need to recognize that there is a lot of great science that looks at high hazard activities, of which healthcare is one, and complex organizations, of which healthcare is one, and learn from the research out there on how you can actually create more reliability, both as a risk manager and a healthcare attorney. I think what you first need to recognize is that risk management can no longer be centralized with one person or in one office in the organization.

Every single person you employ that walks through your door needs to recognize that he is the risk manager for that organization, that he is the patient safety representative, and that the risk manager’s role will be to facilitate and translate the learning throughout the organization. [Each risk manager must] also recognize that although patient safety says it’s a systems problem, not an individual problem, occasionally individuals need to be held accountable for their actions. The role of the risk manager is to make sure that that happens.

One of the primary tenets of reliability is that we need to become more transparent as organizations. Transparency means we need to be able and willing to have the dialogue with patients when they have been harmed by us. We need to find a way to share what is going on in our organization so that others can learn from us and so that learning can be translated across the industry. Again, I mentioned the model the Joint Commission proposed. I think more protective legislation might help us to facilitate that sharing, and I think the benefits from that would be enormous.

We also need to recognize that we shouldn’t aggressively defend claims where we acknowledge there is negligence. We should just try to aggressively defend the value that is paid [out]. I would challenge each of you: go to your lost runs and look at how many of your claims you believe could have been prevented had you corrected a systems problem that you were aware of in your organization. Then count the number of claims that are frivolous, or look at your closed cases and look at those where the valuation of the claim was grossly disproportionate to the injury. You probably can’t influence that last category, but I can bet you will be able to influence the first two categories if you become more focused on the systems perspective.

If you recognize [that] the insurance industry is mismanaged and that it is not strategic or that it’s predatory in pricing, then we must think more

strategically about how we manage our own risk and how we finance for our own risk. Ultimately I think the only way to overcome or get ahead of the malpractice crisis is to design systems and a structure where preventable medical errors are eliminated, because when that is done, the number of cases against your organizations are going to decline as well. Thank you.