

Risk Management: Extreme Honesty May Be the Best Policy

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This paper reviews a humanistic risk management policy that includes early injury review, steadfast maintenance of the relationship between the hospital and the patient, proactive full disclosure to patients who have been injured because of accidents or medical negligence, and fair compensation for injuries. The financial consequences of this type of policy are not yet known; however, one Veterans Affairs medical center, which has been using humanistic risk management since 1987, has had encouragingly moderate liability payments. The Department of Veterans Affairs now requires such a policy for all of its facilities; therefore, comprehensive experience may be only a few years away.

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In the context of hospital operations, the term *risk management* usually refers to self-protective activities meant to prevent real or potential threats of financial loss due to accident, injury, or medical malpractice. When a malpractice claim is made against an institution in the private sector, risk managers coordinate the defense against patients, their dependents, and their attorneys. The medical institution and the patient often become adversaries, and patients and attorneys frequently seek punitive as well as loss-based damages.

One can assume that, as in divorce proceedings, anger at a perceived betrayal of trust is part of patients' motivation. Hickson and colleagues (1) found that of 127 families who sued their health care providers after perinatal injuries, 43% were motivated by the suspicion of a cover-up or by the desire for revenge. In a survey of 149 randomly selected patients in an academic internal medicine practice, Witman and coworkers (2) found that almost all of the respondents wanted their physicians to acknowledge even minor errors; many stated that they would respond to an unacknowledged moderate or severe mistake by filing a lawsuit. Other authors have cited breakdowns in physician-patient (3) and hospital-patient (4) relationships as motivation for litigation.

Medical lawsuits are expensive. Press and DeFrances (5) studied all of the federal tort trials and verdicts (including those involving the Veterans Affairs system) that occurred during 1994 and 1995 (5). They found that 90 of the 283 federal medical malpractice cases that reached verdicts (32%) re-

sulted in awards to the plaintiff. Of the 90 awards made, the median amount was \$463 000, 26 exceeded \$1 million, and 12 exceeded \$10 million.

Under the Federal Tort Claims Act (6), the United States is not liable for punitive damages. However, federal judges have wide discretion in determining awards. The upper limit on the size of an award is determined by the plaintiff's claim and by the applicable state law of damages. In cases that involved egregious negligence and resulted in awards of millions of dollars, we inferred that the high assessments were substitutes for punitive awards. Press and DeFrances (5) found that a mean of more than 2 years was spent in litigation in each of the 283 cases studied; this length of time represents additional expense and effort for all participants. For the entire Veterans Affairs medical system, the average cost of liabilities between 1990 and 1997 was \$720 000 for court judgments, approximately \$205 000 for cases settled at suit or by general counsel, and \$35 000 for local settlements. Lower payments are associated with locally negotiated settlements; therefore, it makes financial sense to avoid litigation.

A special report from the Bureau of Justice Statistics (7) studied the 75 largest counties in the United States. In these counties, 403 medical malpractice cases were won by plaintiffs; the mean award was \$1 484 000, and 24.8% of the awards exceeding \$1 million. Although much of this award money was meant to compensate plaintiffs for economic losses, a substantial proportion was undoubtedly intended to punish defendants for perceived gross negligence or outrageous behavior.

The self-protective model of risk management is not universal. In 1989, the Board of Directors of the Royal Victoria Hospital in Montreal, Quebec, Canada, approved guidelines for disclosing medical errors to patients and their families (8). The guidelines, which proposed honesty about errors, were produced by the hospital's clinical ethics committee to provide a framework that would enable staff to disclose incidents to patients in a helpful manner.

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Currently, significant incidents continue to be disclosed to patients or families in accordance with the guidelines. However, no system has been used to track practitioners' adherence to the guidelines or to examine the guidelines' financial consequences (O'Rourke P. Personal communication).

Wu and colleagues (9) comprehensively reviewed the benefits of telling patients the truth and reviewed the possible consequences to the physician and the patient under various circumstances. They did not specifically address the responsibility of the medical institution; however, because health care institutions, like physicians, serve the patient, the ethics of their activities should be similar.

In 1995, the Department of Veterans Affairs rewrote the section of its policy manual that dealt with risk management policies; this material is now incorporated into a section called Patient Safety (10). Referring to patient injury caused by accidents or negligence, the new wording stated that "the medical center will inform the patient and/or the family, as appropriate, of the event, assure them that medical measures have been implemented, and that additional steps are being taken to minimize disability, death, inconvenience, or financial loss to the patient or family." The manual also stated that "District Counsel will advise the medical center Director about informing the patient and/or family of their right to file . . . Application for Compensation and Pension . . . or to file an administrative tort claim. . . ." In circumstances involving malpractice or accidental injury, the Department of Veterans Affairs requires its facilities to continue their safeguarding relationships with patients and to provide advice about the available remedies, which may include claims against the government. Although this policy is ethically laudable, its financial effects could be counterproductive. However, one Veterans Affairs facility, the Veterans Affairs Medical Center at Lexington, Kentucky, has operated under such a policy since 1987. We examined the use of this policy at the Lexington facility from 1990 through 1996 and found that on the basis of this center's experiences, the economic outcome could be positive.

Experiences of One Veterans Affairs Medical Center

The Veterans Affairs Medical Center in Lexington is affiliated with the University of Kentucky College of Medicine and provides primary, tertiary, and long-term care to approximately 18 000 veterans. During the study period, services performed included invasive cardiologic procedures, orthopedic procedures, cardiac surgery, and neurosurgery. Ninety residents support the activities of the clinical

services, and approximately 400 physicians have staff privileges. The Lexington facility is one of two Veterans Affairs medical centers in Kentucky and is a tertiary care referral center for patients from smaller nearby Veterans Affairs facilities. Available beds (excluding nursing home beds) have decreased from 924 to 407 over the past 10 years.

In 1987, after losing two malpractice judgments totaling more than \$1.5 million (partly because of inadequately prepared defenses), the management of the Lexington center decided to use a more proactive policy in cases that could result in litigation. This new policy was intended to better prepare the risk management committee to defend malpractice claims by identifying and investigating apparent accidents and incidents of medical negligence. However, when investigation identified an incident of negligence of which the patient or next of kin was apparently unaware, ethical issues arose. The committee members decided that in such cases, the facility had a duty to remain in the role of caregiver and notify the patient of the committee's findings (Appendix). This practice continues to be followed because administration and staff believe that it is the right thing to do and because it has resulted in unanticipated financial benefits to the medical center.

Since this policy has been in place, many settlements have been made. Five settlements involved incidents that caused permanent injury or death but would probably never have resulted in a claim without voluntary disclosure to patients or families. Many other settlements involved patients who had expressed dissatisfaction with an outcome; after investigation, the committee agreed with the patient and initiated a settlement. All cases were negotiated on the basis of reasonable calculations of actual loss. Thorough, timely case reviews allowed the committee to defend against nuisance claims—claims without merit that institutions sometimes settle without contest only to avoid the cost and work of a lawsuit.

During the 7-year period that we examined in detail (1990 through 1996), the Lexington facility had 88 malpractice claims and paid out an average of \$190 113 per year (a total of \$1 330 790 for 7 years). The average payment per claim was \$15 622. Seven claims proceeded to federal court and were dismissed before trial. One claim proceeded to trial and was won by the government.

The financial consequences of this somewhat radical policy of full disclosure seem moderate. Although satisfied with this outcome, we attempted to determine the facility's position on the liability scale as a result of this risk management policy. It is difficult to compare the risk liability of different health care facilities without comparing workload, inpatient days, size and complexity of the facility, numbers and types of surgical procedures, and regional dif-

ferences in propensity to sue. Because much of this information was unavailable, robust comparisons were not possible. Instead, we compared the tort claim experience of the Lexington facility with that of all similar Veterans Affairs medical centers located east of the Mississippi River ($n = 38$) during the same 7-year period. Complete information on tort claims was unavailable from 1 of these hospitals, and 1 hospital had opened only recently; therefore, we based our comparison on the remaining 35 facilities. All of these facilities, including the Lexington facility, primarily perform tertiary care and are closely affiliated with medical schools.

We obtained tort claim data from the Department of Veterans Affairs Tort Claim Information System (Office of General Counsel, Department of Veterans Affairs) and reviewed the data from 1990 through 1996. We estimated exposure to risk by examining the 1996 complexity-adjusted facility workload for each of these medical centers. This is at best a rough measure, but more accurate indicators,

such as inpatient days and number and kinds of surgical procedures, were not available for the period in question. Results of our assessment are shown in the **Figure**.

We also contacted the risk managers or regional counsels of the other 35 facilities to ask about their risk management processes. Two of the facilities currently manage accident and negligence cases in a manner similar to that used at the Lexington facility; however, from 1990 through 1996, no centers used a similar method. Risk managers stated that they encouraged physicians to be honest and forthcoming with patients, but it seemed that no organized effort was made to standardize or track the notification of affected patients.

Discussion

Despite following a policy that seems to be designed to maximize malpractice claims, the Lexing-

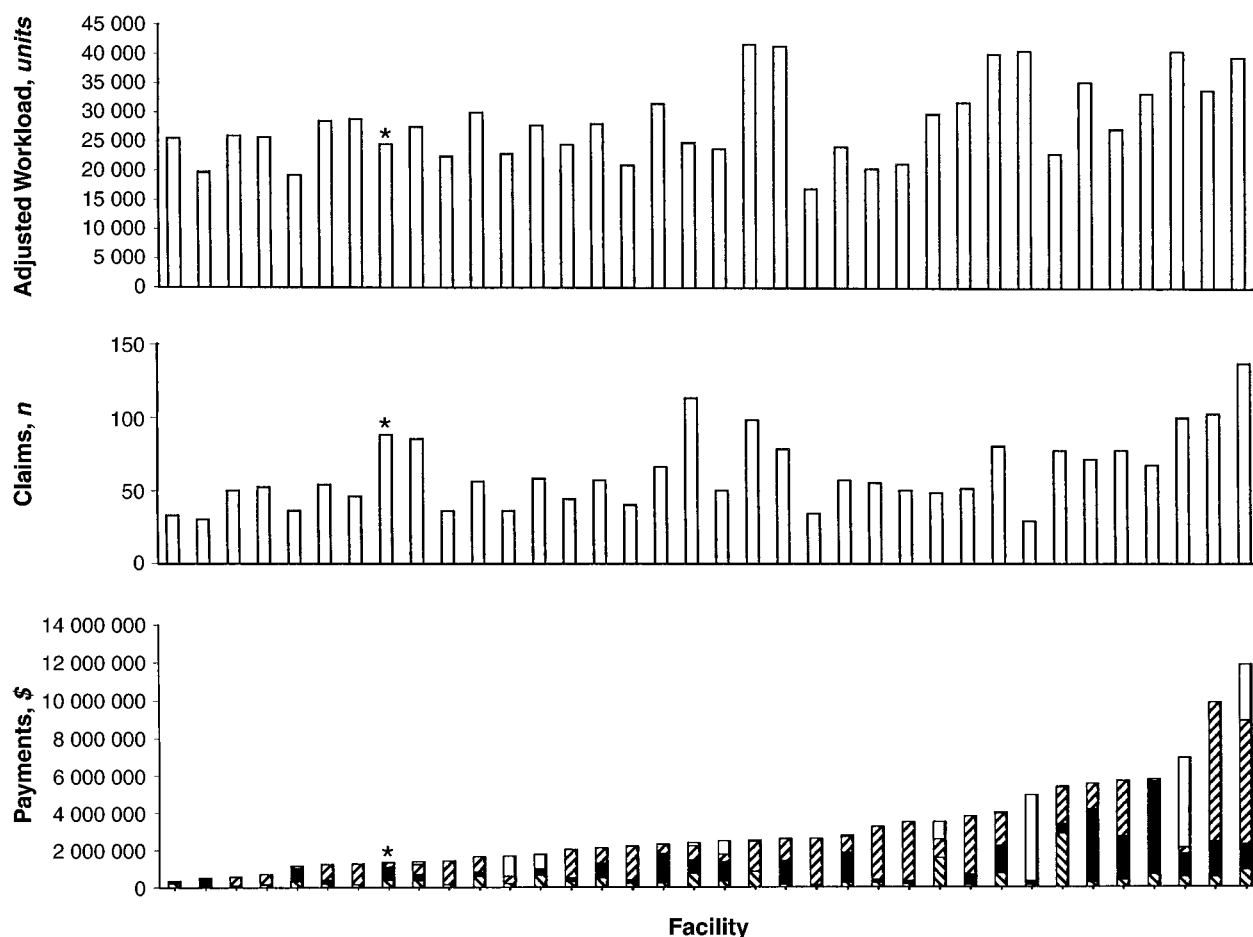


Figure. Total malpractice claims and liability payments made from 1990 through 1996 by 36 Veterans Affairs medical centers located east of the Mississippi River. Workload was calculated by the Allocation Resource Center (Budget Office, Department of Veterans Affairs) and is adjusted for sharing, referrals, and patient complexity. In bottom panel, white filler represents payments that resulted from court judgments; left-slanting diagonal lines represent claims settled during litigation before a judgment was made; black filler represents claims settled at the national level by Veterans Affairs general counsel; right-slanting diagonal lines represent claims settled locally by Veterans Affairs district or regional counsel. *Veterans Affairs Medical Center, Lexington, Kentucky.

ton facility's liability payments have been moderate and are comparable to those of similar facilities. We believe this is due in part to the fact that the facility honestly notifies patients of substandard care and offers timely, comprehensive help in filing claims; this diminishes the anger and desire for revenge that often motivate patients' litigation (3). In our experience, plaintiffs' attorneys, after first confirming the accuracy of the clinical information volunteered by the facility, are willing to negotiate a settlement on the basis of calculable monetary losses rather than on the potential for large judgments that contain a punitive element. This can benefit a facility by limiting settlement costs to reasonable amounts. It also fairly compensates patients who have been injured because of accident or error. This is important because such compensation is deserved but is infrequently offered (11).

The hidden expenses of litigation are also substantial. We estimate that it costs the government \$250 000 for a single malpractice case (from initiation through an appeal, including costs of medical experts, travel, and other incidental expenses). A local settlement, however, involves only an attorney, a paralegal specialist, and a few other hospital employees.

We realize that many factors affect the number of negligence claims, settlements, and litigation judgments involving medical facilities. Although none of the other Veterans Affairs facilities used the same risk management process as the Lexington facility during the period in question, some facilities may have used one or more similar components. We also acknowledge the limitations of an analysis of only one facility. For obvious reasons, health care facilities are reluctant to publish their experience in this area, and we are aware of no previous report that describes the details of a consistent risk management philosophy and its results.

Malpractice payments are determined by many factors that are unrelated to medical care, such as the patient's willingness to sue, the expertise of the attorneys representing the medical facilities, the attorneys' willingness to negotiate settlements, and the presence or absence of publicity that could stimulate patients' interest in litigation. It is difficult to accurately compare the Veterans Affairs experience with that of the private sector, but the special report from the Bureau of Justice Statistics (7) indicates that the average medical malpractice judgment in the private sector (\$1 484 000) is considerably greater than that in the Veterans Affairs system (\$720 000).

Would a policy of full disclosure be acceptable in the private sector? Federal and private employment in the health care industry differ in several important ways. The Veterans Affairs medical system provides comprehensive, virtually free universal coverage. The system can also offer such benefits as

remedial treatment and even monthly disability payments by designating that the patient is "service connected" because of injuries caused by Veterans Affairs-administered treatment. Such remedies are not dependent on a lawsuit and are unavailable in the private sector. Government health care practitioners are protected from personal liability by the Federal Tort Claims Act and are not personally named in cases of negligence that occurs during the ordinary course of their activities. In addition, they pay no malpractice premiums. However, when they are involved in a payment resulting from negligence or malpractice, government physicians are reported to the National Practitioner Data Bank and state licensure boards and must acknowledge their involvement with malpractice cases on all future employment applications. Repeated or egregious incidents of negligence can, as in nongovernmental facilities, result in limitation, suspension, or revocation of clinical privileges, which can also be reported to the National Practitioner Data Bank and to state licensure boards.

If there is a barrier to the adoption of a humanistic risk management policy by nongovernmental hospitals, it may be the involvement of many private malpractice insurers, each of which is interested in paying as little money in settlements as possible. We believe that these insurers would have to be convinced of the economical benefits of such a policy before they would consider adopting it.

The experience of the Lexington facility suggests but does not prove the financial superiority of a full disclosure policy, and we hope that this report will spur a more detailed examination of the issue. The Veterans Affairs medical system is the largest integrated health care system in the country, and current policy mandates a risk management process similar to that used in the Lexington facility. If this type of process is implemented and followed, more convincing data on this question may become available within the next few years.

We conclude that an honest and forthright risk management policy that puts the patient's interests first may be relatively inexpensive because it allows avoidance of lawsuit preparation, litigation, court judgments, and settlements at trial. Although goodwill and the maintenance of the caregiver role are less tangible benefits, they are also important advantages of such a policy.

Appendix

Notifying a Patient of Negligence

When the risk management committee identifies an instance of accident, possible negligence, or malpractice, it investigates the facts. This investigation includes an

interview with the involved physicians, the chief of the relevant clinical service, and other personnel, as appropriate. If the committee finds that malpractice or substantial error resulted in loss of a patient's function, earning capacity, or life, plans are made to notify the patient or next of kin. The patient, surrogate, or next of kin is called (usually by the chief of staff), is told that there was a problem with the care in question, and is asked to come to the medical center at his or her convenience for an explanation. The telephone conversation provides only enough details to indicate the seriousness of the matter (including, if necessary, a statement that a medical mistake was made and that an attorney may accompany the patient or family if desired).

Face-to-Face Meeting

The subsequent meeting is with the chief of staff, the facility attorney, the quality manager, the quality management nurse, and sometimes the facility director. At the meeting, all of the details are provided as sensitively as possible, including the identities of persons involved in the incident (who are notified before the meeting). Emphasis is placed on the regret of the institution and the personnel involved and on any corrective action that was taken to prevent similar events. The committee offers to answer questions and may make an offer of restitution, which can involve subsequent corrective medical or surgical treatment, assistance with filing for service connection under 38 United States Code, section 1151 (a law that confers service connection on the basis of disability resulting from medical care), or monetary compensation.

Claims Assistance

After the meeting, the patient, surrogate, or next of kin is assisted in filing any necessary forms and is given the names and numbers of contact persons who can answer any additional questions. If the patient or next of kin has not already retained counsel, they are advised to do so. The committee is then equally forthcoming with the plaintiff's attorney so that the attorney's review of the

medical record will confirm the information that was volunteered. The facility's attorney and the patient's attorney work to reach an equitable settlement on the basis of reasonable calculation of loss.

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