

**RETHINKING THE TORT LIABILITY SYSTEM AND
PATIENT SAFETY: FROM THE CONVENTIONAL WISDOM
TO LEARNING FROM LITIGATION**

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I. INTRODUCTION

This paper examines the relationship between the current tort-based medical liability system and patient safety. The predominant view, which critics refer to as the conventional wisdom, suggests that tort litigation hinders the pursuit of patient safety.¹ The core rationale for the conventional view is that the threat of litigation discourages medical professionals from being open and transparent about their mistakes.² Without openness and transparency, it is difficult to develop a culture of patient safety in which providers actively learn from mistakes and improve upon them.³ However, the validity of this assumption has been challenged in recent years.

¹ See generally David Hyman & Charles Silver, *The Poor State of Health Care Quality in the US: Is Malpractice Liability Part of the Problem or Part of the Solution*, 90 CORNELL L. REV. 893 (2005) (arguing that the conventional wisdom has never been proven and the tort liability system may actually contribute to the pursuit of patient safety by internalizing the cost of preventable medical errors and in this way generating economic pressure on providers to change their behaviors). See also Joanna C. Schwartz, *A Dose of Reality for Medical Malpractice Reform*, 88 N.Y.U. L. REV. 1224, 1239-43 (2013) (outlining the underlying concerns of the conventional wisdom that tort litigation prevents transparency and communication in the healthcare system).

² See Schwartz, *supra* note 1. “To Err Is Human,” for example, mentioned that “[p]atient safety is also hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors. The discoverability of data under legal proceedings encourages silence about errors committed or observed. Most errors and safety issues go undetected and unreported, both externally and within health care organizations.” INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 43 (1999) [hereinafter TO ERR IS HUMAN]. Also, David Studdert, Michelle Mello, and Troyen Brennan in their article, *Medical Malpractice*, indicated that “[t]here is a deep-seated tension between the malpractice system and the goals and initiatives of the patient-safety movement. At its root, the problem is one of conflicting cultures: trial attorneys believe that the threat of litigation makes doctors practice more safely, but the punitive, individualistic, adversarial approach of tort law is antithetical to the nonpunitive, systems-oriented, cooperative strategies promoted by leaders of the patient-safety movement.” David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 286 (2004).

³ *Id.*

David Hyman and Charles Silver criticized the conventional wisdom as unproven in their 2005 article, *The Poor State of Health Care Quality in the US: Is Malpractice Liability Part of the Problem or Part of the Solution* (hereinafter *The Poor State*).⁴ Rather, evidence suggests that patient safety can actually benefit from the tort liability system.⁵ In particular, Hyman and Silver pointed

⁴ See Hyman & Silver, *supra* note 1, at 914-17 (arguing that the conventional wisdom had been widely embraced only due to its seeming plausibility).

⁵ In *The Poor State*, Hyman and Silver outlined several pieces of evidence challenging the conventional wisdom. Examples of these pieces of evidence include the following. First, the famous Harvard Medical Practice Study found an inverse relationship, though statistically insignificant, between “the magnitude of the malpractice risk and the rate of negligent injuries.” Second, anesthesia, traditionally viewed as one of the most risky specialties, has successfully overcome rising malpractice costs by making the practice safer and more reliable. In addition, Hyman and Silver indicated that recent improvements in safety and quality achieved by Veteran Affairs Hospitals could in part be attributed to the external pressure of malpractice litigation. Also, there had been no conclusive evidence on the existence of defensive medicine, and the medical community, despite the lack of tort reform in recent years, has continued to disclose information to patients and investigate adverse incidents. *Id.* at 916-23, 933-47. See generally Troyen Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 *NEW ENG. J. MED.* 370 (1991) (commonly referred to as the Harvard Medical Practice Study) (estimating that 3.7% of hospitalizations in the studied population developed adverse events, 26% of which were the result of substandard care).

Other observers have also increasingly cautioned that the fear of lawsuits may be blown out of proportion. See Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, *STUDENT SCHOLARSHIP PAPERS*, 36 (2006), available at http://digitalcommons.law.yale.edu/student_papers/30 (last visited Jan. 12, 2015) (noting that physicians tend to overestimate the risk of litigation). Lucian Leape also argues that “[t]he fear of litigation may also be overblown.” Lucian Leape, *Patient Safety: Reporting of Adverse Events*, 347 *NEW ENG. J. MED.* 1633, 1635 (2002). See also, Bernard S. Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 *J. EMP. L. STUD.* 207 (2005) (arguing that the frequency of malpractice claims and the amount of jury awards were actually stable during the research period); Catherine Cravens and Jo Anne L. Earp, *Disclosure and Apology: Patient-Centered Approaches to the Public Health Problem of Medical Error*, 70 *N.C. MED. J.* 140, 142

to stories of the anesthesia profession, which transformed itself into one of the safest medical specialties in response to rising malpractice costs in the 1980s, as proof that the external pressure of malpractice costs can lead to safety and quality improvement.⁶

In her 2013 article, *A Dose of Reality for Medical Malpractice Reform* (hereinafter *A Dose of Reality*), Joanna Schwartz also criticized the conventional wisdom as not reflecting the reality of medical practice.⁷ Schwartz presented the result of a combined interview/survey study on healthcare providers' attitudes toward medical malpractice.⁸ The results suggested a changing industry in which healthcare providers increasingly embrace the value of transparency and utilize the process of malpractice dispute resolution to identify and strengthen weak spots of the delivery system.⁹ This discovery lent further credence to Hyman and Silver's critique of the conventional wisdom, as it supports the idea that the pressure of litigation may have prompted providers to engage in safety and quality improvement activities.

This paper refers to the trend discovered by Schwartz, where providers increasingly view litigation as an opportunity to improve patient safety, as the phenomenon of Learning from Litigation (LFL).¹⁰ The paper then reviews literature related to this emerging phenomenon, and outlines how healthcare organizations actually turn litigation into safety lessons. Examples of these specific learning activities include using claim data to: 1) strengthen

(Mar./Apr. 2009) (observing that “[p]erhaps the greatest barrier to full disclosure is the fear of legal repercussions, including medical malpractice suits. To date, however, we could find no evidence to suggest that full disclosure increases the risk of negative consequences for physicians.”).

⁶ Hyman & Silver, *supra* note 1, at 917-23.

⁷ *See generally* Schwartz, *supra* note 1 (observing that tort litigation today may actually be playing a productive role in revealing valuable information about patient safety).

⁸ For the study methodology, *see id.* at 1246-51.

⁹ *Id.*

¹⁰ Joanna C. Schwartz, *Leaning from Litigation*, N.Y. TIMES (Mar. 16, 2013).

error reporting systems; 2) identify causes and develop solutions to individual adverse events; and 3) combine individual claim data into larger datasets that can be used to identify the patterns and trends of error.¹¹ By outlining these learning activities, this paper attempts to shed new light on the current tort reform debate and proposes a new reform direction that emphasizes making the tort system a more conducive vehicle to encourage these activities.

This paper consists of the following: Section II sets the stage for the debate over the conventional wisdom by embedding the concept of patient safety in the broader context of the Patient Safety Movement (PSM) and the Patient Protection and Affordable Care Act (ACA).¹² The discussion is followed by Section III, which points out that the ACA adopts an indirect approach to tort reform that encourages state demonstration projects to identify alternatives to the current tort liability system.¹³ The paper argues that such an indirect approach is a logical extension of the conventional wisdom that believes tort litigation actually harms patient safety. Section III then outlines the underlying arguments that are commonly used to support the conventional wisdom.¹⁴

Section IV explores the phenomenon of LFL as a counterargument to the conventional wisdom. In particular, it highlights the role of the campaign to promote disclosures and apologies as one of the driving forces behind the growing trend of LFL.¹⁵ A central focus of this campaign is the communication-and-resolution program (CRP). The communication-and-resolution program refers to a claim management model pioneered by healthcare organizations such as the University of Michigan Health System (UMHS).¹⁶ The model typically consists of four basic elements: 1) immediate disclosure of harm; 2) timely

¹¹ See *infra* Part IV.A.

¹² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

¹³ See *infra* Part III.

¹⁴ See *infra* Part III.A and III.B.

¹⁵ See *infra* Part IV.C.

¹⁶ See *infra* Part IV.C.

expression of sympathy and apology; 3) commitment to investigation and prevention efforts; and 4) a quick offer of compensation if negligence is discovered during investigation.¹⁷ Pioneers of CRPs saw not only the number of claims and payouts reduced, but also an improvement in the adverse event investigation process.¹⁸

Based on these findings, the final section of the paper argues that in the era of LFL, the best approach to reforming the medical liability litigation system is actually to encourage early resolution via CRPs to prevent disputes from developing into legal claims. The paper argues that such a strategy has multiple advantages over other tort reform proposals. It is relatively politically feasible, it has the potential to reduce providers' financial burdens, and expand the pool of patients eligible for compensation. Most importantly, the strategy helps create a better culture of safety in which providers are motivated to learn from errors and disputes. The proposed approach, in turn, can be assisted by policies that: 1) reward providers' commitment to patient safety and lower the cost of litigation discovery; 2) help overcome the cultural, legal, economical barriers against the idea of early resolution; and 3) incorporate CRP ideas into the pre-trial settlement negotiation process.

II. REGULATING PATIENT SAFETY IN THE ERA OF THE AFFORDABLE CARE ACT

Today, the pursuit of patient safety has become one of the guiding principles for modern healthcare management.¹⁹ The growing significance of patient safety

¹⁷ See *infra* Part IV.C.

¹⁸ Thomas Gallagher et al., *Disclosing Harmful Medical Errors to Patients*, 356 N. ENGL. J. MED. 2713, 2716 (2007) (discussing that the University of Michigan Health System, in particular, saw “the cost and frequency of litigation decreased substantially in the 5 years after the implementation of an open-disclosure program, with annual litigation expenses reduced from \$3 million to \$1 million and the number of claims decreasing by more than 50%.”).

¹⁹ See TO ERR IS HUMAN, *supra* note 2, at 18 (identifying the three domains of healthcare quality as: (1) safe care; (2) “practice that is consistent with current medical knowledge;” and (3) customization);

can be traced back to the groundbreaking 1999 Institute of Medicine report, *To Err is Human*.²⁰ The report defined patient safety as “freedom from accidental injury,”²¹ and indicated that between 44,000 and 98,000 people die from preventable medical errors every year.²² Such haunting statistics helped raise public awareness of the preventable error pandemic, and the influential Patient Safety Movement was born.

As the catalyst for the movement, *To Err is Human* and its sequel, *Crossing the Quality Chasm*,²³ outlined some basic ideas of the PSM, many of which are still being pursued today. The cornerstone for these ideas is a different understanding of why errors occur.²⁴ Human

INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (2001) [hereinafter *CROSSING THE QUALITY CHASM*] (stating that its predecessor, *TO ERR IS HUMAN*, focused on the specific quality concern of patient safety, whereas the 2001 report “focuse[d] more broadly on how the healthcare delivery system can be designed to innovate and improve care”).

²⁰ See generally *TO ERR IS HUMAN*, *supra* note 2 (exposing the severity and prevalence of preventable medical errors and advocating a systematic approach to these errors).

²¹ *Id.* at 4, 18.

²² *Id.* at 1, 26.

²³ See generally *CROSSING THE QUALITY CHASM*, *supra* note 19 (outlining recommendations to redesign the healthcare system in ways that encourage innovation and improve healthcare quality).

²⁴ “*To Err is Human*” explored the complex dynamics behind medical errors and arguing that “preventing errors and improving safety for patients require a *systems approach* in order to modify the conditions that contribute to errors (emphasis added).” *TO ERR IS HUMAN*, *supra* note 2, at 49-68.

To do so, “*To Err is Human*” made a distinction between *active* and *latent* errors. Active errors refer to incidents that “occur at the level of the frontline operator, and their effects are felt almost immediately.” Latent errors, conversely, “tend to be removed from the direct control of the operator and include things such as poor design, incorrect installation, faulty maintenance, bad management decisions, and poorly structured organizations.” *TO ERR IS HUMAN*, *supra* note 2, at 55 (taking air traffic accident as an example and stating that “[t]he active error is that the pilot crashed the plane [...], while] the latent error is that a previously caused the plane to roll unexpectedly in a way the pilot could not control and the plane crashed”).

With this distinction, “*To Err is Human*” proposed a system approach to medical errors, which gives priority to identifying and

nature typically attributes errors to individual negligence. However, *To Err is Human* stresses that errors are often the consequence of flawed system design instead of purely individual misbehavior.²⁵ Hence there is a limitation on how much blaming individuals can benefit the pursuit of patient safety.²⁶ Therefore, a more efficient strategy to achieve real and sustainable reductions in error rates is to utilize preventable errors as opportunities to identify the hidden system factors that are the root cause of the

eradicating latent errors that are caused by ill-designed system over punishing individuals who commit visible active errors. The report argued that in a complex setting such as the healthcare system, individuals, no matter how professional they are, have only limited control over the whole process. However, the dominant responses to medical errors tend to focus on preventing recurrence of the active error by punishing people who commit that specific mistake. Although punitive measures are necessary in situations such as intentional misconduct, punishment alone often is unable to prevent recurrence. Countering this human instinct, the report declared that “[b]laming an individual does not change these factors and the same error is likely to recur.” Also, “[p]eople working in health care are among the most educated and dedicated workforce in any industry. The problem is not bad people; the problem is that the system needs to be made safer.” *TO ERR IS HUMAN*, *supra* note 2, at 49.

The reason why punishing individuals has limited impact on safety and quality is because large system breakdowns often result from different latent errors coming together and compounding each other in specific and often unexpected circumstances. “Since the same mix of factors is unlikely to occur again, efforts to prevent specific active errors are not likely to make the system any safer.” From this perspective, it is the latent errors that are greater threats to patient safety, because they can, in unexpected scenarios, result in other active errors. The report therefore concluded that “[d]iscovering and fixing latent failures, and decreasing their duration, are likely to have a greater effect on building safer systems than efforts to minimize active errors at the point at which they occur.” *TO ERR IS HUMAN*, *supra* note 2, at 56.

²⁵ *Id.*

²⁶ *Id.*

mistakes.²⁷ It is these lessons, PSM activists believe, that will lead to real reform of the current system.²⁸

This paper refers to such a strategy as systemic learning, and the million-dollar question for PSM activists has long been how to institutionalize learning within healthcare organizations. The historical—and still widely used—mechanisms for learning from prior mistakes in healthcare organizations have been morbidity and mortality conferences (M&M) as well as clinical peer review. However, neither was viewed as sufficiently effective at the dawn of the PSM.²⁹ As a result, PSM activists initially turned their attention to error reporting systems as a promising alternative.³⁰

The idea behind this proposal is to replicate the success of the Aviation Safety Reporting System (ASRS), a voluntary and no-blame system that many believe helps

²⁷ *Id.* at 49 (“Preventing errors and improving safety for patients require[s] a *systems approach* in order to modify the conditions that contribute to errors.”) (emphasis added); *see also* CROSSING THE QUALITY CHASM, *supra* note 19, at 4, 8, 62, 78-79 (promoting the idea that safety and quality are a systemic property).

²⁸ *Id.*

²⁹ The major critique of M&M meetings has been that they are often conducted in ways that avoid tough issues. The reason for such avoidance is to reduce interpersonal confrontations that may result from publicly discussing the potential role of a colleague in an adverse event. *See* Jay D. Orlander et al., *The Morbidity and Mortality Conference: The Delicate Nature of Learning from Error*, 77 ACADEMIC MED. 1001, 1004 (2002) (observing that in M&M meetings, “[t]he ‘tough issues’ are often avoided because it is inherently difficult to face mistakes”). The clinical peer review, on the other hand, has often been conducted following a paradigm called quality assurance that emphasizes punishing individuals. Critics believe this paradigm actually pushes medical professionals away from the ideal of ensuring better safety in the healthcare delivery system. *See* Marc T. Edwards et al., *A Longitudinal Study of Clinical Peer Review’s Impact on Quality and Safety in U.S. Hospitals*, 58 J. HEALTH MGMT. 369 (2013) (examining whether hospitals in the US have been shifting away from the quality assurance model of peer review for the past 30 years, and moving toward the quality improvement model that is more consistent with the systemic approach to medical error).

³⁰ TO ERR IS HUMAN, *supra* note 2, at 8-10 (recommending the establishment of a nationwide mandatory reporting system and encouraging the development of voluntary reporting efforts).

make aviation the safest mode of transportation today.³¹ Since it was established, the ASRS has been widely credited for successfully bringing down the accident rate in the aviation industry.³² Following the example of the ASRS, To Err is Human recommended the federal government establish a national mandatory reporting system that targets serious events, while in the meantime encourages the establishment of multiple voluntary reporting systems that focus on less serious incidents and “near misses,” events that involve human errors but do not lead to injuries or other consequences.³³

However, the federal government did not follow the recommendation to establish a national mandatory reporting system. The federal government largely leaves states and the private sector to take the initiative. Today, there are four major types of reporting systems that co-exist in the US, with each covering different categories of events and offering different degrees of legal protection for reported information:³⁴ 1) intra-organizational systems; 2) state-run systems, most of which require mandatory reporting of listed events;³⁵ 3) nationwide voluntary systems, the most famous example of which is the Sentinel Event Report System (SERS) run by the Joint Commission for

³¹ The Aviation Safety Reporting System, <http://asrs.arc.nasa.gov/index.html> (last visited Feb. 12, 2015). *See also*, STEPHEN C. REDHEAD, CONG. RESEARCH SERV., RL31983, HEALTH CARE QUALITY: IMPROVING PATIENT SAFETY BY PROMOTING MEDICAL ERRORS REPORTING 12 (2005).

³² STEPHEN C. REDHEAD, *supra* note 31, at 9-10; TO ERR IS HUMAN, *supra* note 2, at 95-97.

³³ TO ERR IS HUMAN, *supra* note 2, at 9-10, 87.

³⁴ STEPHEN C. REDHEAD, *supra* note 31, at 4-9.

³⁵ *See*, JILL ROSENTHAL & MARY TAKACH, NAT'L ACAD. FOR STATE HEALTH POLICY, STATE HEALTH POLICY SURVEY REPORT: 2007 GUIDE TO STATE ADVERSE EVENT REPORTING SYSTEMS 7 (2007), *archived at* <http://perma.cc/V2GS-447F> (discussing that as of 2007, there have been twenty-seven state run adverse-event reporting systems in place. Among them, only one chose a voluntary system. The other twenty-five states and the District of Columbia all have mandatory reporting requirements. Furthermore, twenty-three of all these systems are supported by heightened legal protections against unwanted disclosure of reported information in the courts.).

Accreditation of Health Care Organizations (JACHO);³⁶ and finally 4) voluntary systems run by patient safety organizations certified under the Patient Safety and Quality Improvement Act of 2005 (PSQIA).³⁷

For PSM activists, error-reporting systems are simply the starting point for a comprehensive strategy for patient safety and healthcare quality. Productive and continuous systemic learning is predicated on the ability to compare healthcare outcomes and identify trends and patterns of error. These comparisons and identifications are often made possible by using analytical tools such as advanced statistics.³⁸ To facilitate rigorous statistical analysis, it is

³⁶ *Sentinel Event*, THE JOINT COMMISSION, archived at <http://perma.cc/QYY7-HV7L> (defining sentinel event as unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof"); see also, STEPHEN C. REDHEAD, *supra* note 31, at 12-13.

³⁷ Public Law No. 109-41, 119 Stat. 424 (codified at 42 U.S.C. § 299 et. seq.).

³⁸ The reliance of the Patient Safety Movement on statistics reflects the movement's deep intellectual connection with the philosophy of the Total Quality Movement/Continuous Quality Improvement (TQM/CQI), a line of industrial engineering ideas that errors in production processes are often attributes of system design rather than individual misbehaviors. The origin of the TQM/CQI can be traced back to the 1920s. At the time, Walter Shewhart, who many credit as the pioneer of TQM/CQI, first discovered that statistical tools could be used to detect the existence and causes of unnecessary variations in product quality. Shewhart observed that quality measures such as defect rates often remain relatively constant over time. This suggested that "[t]he statistical distribution of defect rates was often a highly predictable characteristic of the process of production itself," and the existence of defects cannot always be attributed to specific causes like individual misbehaviors. TROYEN A. BRENNAN & DONALD M. BERWICK, *NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE* 127-30 (1996); Curtis McLaughlin & Arnold Kaluzny, *Defining Quality Improvement*, IN *CONTINUOUS QUALITY IMPROVEMENT IN HEALTH CARE: THEORY, IMPLEMENTATIONS, AND APPLICATIONS* 21, 127 (Curtis McLaughlin & Arnold Kaluzny eds., 3rd ed., 2006). In the field of healthcare, however, the power of statistical tools was not taken seriously until the emergence of the outcome research movement in the 1970s. A leading figure in this movement was John E. Wennberg, a prominent professor at Dartmouth College. Wennberg was one of the pioneers in studying the phenomenon of small area variations, or the differences in the use of healthcare procedures between localities that

essential to generate and distribute large amounts of quantifiable performance data on different aspects of the healthcare delivery process. The results of these analyses, often coming in the form of clinical guidelines or best practices, will also need to be properly distributed and implemented by individual providers to yield real impact on patient safety.³⁹

Consequently, the PSM is also commonly associated with the following policy items: 1) wider adoption of health information technology (HIT) to modernize the documentation and sharing of medical data; 2) more

cannot be justified by medical or scientific reasons. Recognizing the power of statistical tools, Wennberg was able to achieve “a level of precision and a sophistication of statistical adjustment in the study of these variations that left no doubt about the extraordinary pervasiveness and the lack of epidemiologic explanation for these ‘small area variations’ in the use of medical resources.” TROYEN A. BRENNAN & DONALD M. BERWICK, at 117. Also, *see generally* John E. Wennberg and A. Gittelsohn, *Small Area Variations in Healthcare Delivery: A population-based health information system can guide planning and regulatory decision-making*, 182 SCI. 1102 (1973) (arguing that “[e]xperience with a population-based health data system in Vermont reveals that there are wide variations in resource input, utilization of services, and expenditures among neighboring communities”).

Wennberg’s scholarship later inspired the evidence-based medicine (EBM) movement. The central component of this movement is the promulgation and distribution of clinical practice guidelines (CPGs) that are supported by scientific research to have higher comparative effectiveness. These guidelines are often produced through systematic reviews of randomized controlled trials (RCTs), a method of experimentation in which statistical analyses are conducted to examine the data and draw conclusion. *See* INST. OF MED., CLINICAL PRACTICE GUIDELINES WE CAN TRUST 31-34 (2011) (discussing RCTs as the scientific basis for EBM and CPGs). The legacy of both outcome research and EBM were later inherited by the Patient Safety Movement, and many of their key ideas, including the reliance on statistical analyses, are still clearly visible today.

³⁹ CROSSING THE QUALITY CHASM, *supra* note 19, at ix (outlining a series of changes that will be explored in the report for achieving a better healthcare systems, which included “setting national priorities for improvement, creating better methods for disseminating and applying knowledge to practice, fostering the use of information technology in clinical care, crating payment policies that encourage innovation and reward improvement in performance, and enhancing educational programs to strengthen the healthcare workforce”).

investment on research that measures performance and outcomes of healthcare delivery (i.e., outcome or comparative effectiveness research); 3) better utilization of the result of outcome or comparative effectiveness research to develop and disseminate clinical guidelines or best practices; and 4) reform of payment mechanisms (i.e., pay-for-performance) to incentivize providers to follow these guidelines or practices developed through rigorous scientific research.⁴⁰

All these policy proposals have become national policies since the passage of the American Recovery and Reinvestment Act of 2009 (ARRA),⁴¹ the so-called “stimulus package,” and the Patient Protection and Affordable Care Act of 2010.⁴² The \$19 billion ARRA funding for implementing electronic health records represents one of the largest IT investments in US history.⁴³ The legislation also supported comparative effectiveness research,⁴⁴ a policy continued by the ACA that establishes the Patient-Centered Outcomes Research Institute (PCORI) to oversee federal investment in such research.⁴⁵ The ACA also provides various alternative performance-based payment models for providers to experiment with, the most famous one being the Accountable Care Organization model.⁴⁶ Last, but not

⁴⁰ *Id.*

⁴¹ American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat 115 (2009).

⁴² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

⁴³ *Electronic Medical Records*, MASSACHUSETTS MEDICAL SOCIETY, archived at <http://perma.cc/6S9T-HUSW>.

⁴⁴ American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 804, 123 Stat 115, 187, 42 USC 299b-8 (2009) (establishing a federal coordinating council for comparative effectiveness research); American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat 115, 176-77 (appropriating funding for the Agency for Healthcare Research and Quality to support comparative effectiveness research).

⁴⁵ Patient Protection and Affordable Care Act, Public Law 111-148, § 6301, 124 Stat. 119, 727, 42 U.S.C. § 1320e.

⁴⁶ The essential idea of the ACO model is to combine quality benchmarking with the global budget system, a system in which providers operate under the constraint of a pre-determined expenditure target. In other words, if a provider saves money by reducing the cost

least, the massive legislation creates “four streams of pressure that converge toward measurable and specific standards of care in practices.”⁴⁷ The four streams of pressure include: 1) the research and development of outcome measures; 2) the research and development of best practices; 3) the development and dissemination of clinical practice guidelines based on these research findings; and finally 4) all these findings, including research on outcomes, best practices and guidelines, are required to be quickly disseminated to practice settings.⁴⁸

III. THE CONVENTIONAL WISDOM ON TORT AND PATIENT SAFETY

Compared with other policy proposals of the PSM, one policy field where there has been a lack of clear national direction is tort law. The ACA does not contain provisions to make national policies of traditional tort reform proposals, which continue to be popular at the state level.⁴⁹ Many of

while meeting certain quality standards, the provider may keep some of the savings as a reward. For additional information on various attempts under the ACA, including the ACO model, to increase the integration and coordination of healthcare and their implication on malpractice liability, see BARRY FURROW ET AL., HEALTH CARE REFORM SUPPLEMENT MATERIALS 97-101 (2012 ed.).

⁴⁷ Barry Furrow, *Regulating Patient Safety: The Patient Protection And Affordable Care Act*, 159 U. PA. L. REV. 1727, 1770 (2011).

⁴⁸ *Id.* at 1770-71.

⁴⁹ Observers typically divide various tort reform proposals into two generations. See generally Eleanor D. Kinney, *Malpractice Reform in the 1990s: Past Disappointments, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99 (1995) (introducing different approaches under the two generations of reforms and indicating that, while the second generation reforms seem to hold greater promise, the federal and state legislation has centered on the first generation reforms and been reluctant to pursue 2nd generation policies). See also Rogan Kersh, *Medical Malpractice and the New Politics of Health Care*, in MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 44-49 (William Sage & Rogan Kersh ed., 2006) (introducing the historical context of the malpractice reform debate, including its relation with the political landscape in the state and federal level).

The first generation reforms mostly follow the example of state responses, in particular that of the State of California, to the sudden spike in malpractice insurance premiums in the 1970s, also known as

these proposals are modeled on California's Medical Injury Compensation Reform Act of 1975 (MICRA).⁵⁰ These proposals, most notably caps on non-economic and/or punitive damages, typically "aim to change the behavior of litigants...by making it more difficult for claimants to sue or try to control the frequency or severity of claims."⁵¹

Instead of making these proposals national policy, the ACA adopts an indirect approach to tort reform. The main ACA provision regarding tort reform, section 10607, encourages the states to find viable alternatives to the

the first malpractice crisis. The second-generation reforms emerged primarily in the late 1980s and early 1990s. Eleanor Kinney observed that "[t]his generation includes proposals developed by scholars and interested constituencies that are explicitly intended to make the malpractice adjudication and compensation systems more rational and efficient without necessarily controlling claim frequency or severity (emphasis added)." Kinney, *supra* note 49, at 100. Examples include proposals like: (1) use of medical practice guidelines to set the standard of care; (2) enterprise liability; (3) mandatory alternative dispute resolution mechanisms; and (4) various no-fault approaches. Kinney, *supra* note 49, at 103 (Figure 2).

The current status of malpractice reform can be summarized by the following observations. First, compared with the state governments, the federal government is relatively silent on malpractice reform. Rogan Kersh wrote in 2006 that "[s]ince malpractice first appeared on political agendas in the 1960s, Congress and successive administrations have been unable to decisively address the issue." Kersh, *supra* note 49, at 43. The second observation is that policy makers tend to favor the first-generation reforms over the second-generation ones. Kinney pointed out that "nearly all states adopted some first-generation reforms in the 1970s and 1980s, and they continue to do so in the 1990s." Kinney, *supra* note 49, at 110. At the same time, state implementation of second-generation reforms, such as the use of guidelines to establish the standard of care and the no-failure compensation systems, has either been delayed by legal challenges or failed to produce promised results. Kinney, *supra* note 49, at 110-12. These developments led to a reform approach that heavily relies on state-led efforts, with the emphasis on first-generation reforms aiming at controlling the frequency or severity of tort compensation claims. The results of such an approach have been disappointing, as empirical studies indicated that first-generation reform legislations generally had an insignificant impact on malpractice insurance premium levels. Kersh, *supra* note 49, at 46.

⁵⁰ CAL. CIV. CODE §§ 3333.1, 3333.2.

⁵¹ Kinney, *supra* note 49, at 101.

existing tort-based medical liability system.⁵² Section 10607 of the ACA is titled State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation.⁵³ The provision authorizes the Secretary of the Department of Health and Human Services (DHHS) to “award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.”⁵⁴

There are two popular narratives to explain the indirect approach of section 10607: the interest group politics narrative and the patient safety movement narrative. During the legislative fight for the ACA, the narrative of interest group politics dominated public discourse.⁵⁵ Under this narrative, section 10607 is viewed by critics as a political gesture by the ruling Democratic Party to pretend they are committed to the important issue of tort reform, while in reality their real goal was shielding trial lawyers, a powerful political ally of the Democratic Party, from Republican attempts to limit patients’ access to litigation, a position supported by physician groups.⁵⁶

While the narrative may have captured the political reality to a certain extent, the interest group politics narrative overlooks the important fact that section 10607

⁵² Patient Protection and Affordable Care Act, Public Law 111–148, § 10607, § 399V-4, 124 Stat. 119, 1009 (codified as amended in scattered sections of 42 USC 280g et seq.).

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ See Philip K. Howard, *Why Medical Malpractice Is Off Limits*, WALL ST. J., Oct. 15, 2009, <http://online.wsj.com/article/SB10001424052970204488304574432853190155972.html> (arguing that the political power of trial lawyers limited the Democratic Party from considering the idea of tort reforms); See also *2012 Republican Party Platform and “Tort Reform”*, MED. MALPRACTICE LAWYERS (Aug. 31, 2012, 11:50 AM), <http://medicalmalpracticelawyers.com/blog/medical-malpractice-lawyers/2012-republican-party-platform-and-tort-reform/> (challenging the Republican position that “[f]rivolous medical malpractice lawsuits have ballooned the cost of healthcare for the average American”).

⁵⁶ *Id.*

also has its intellectual root in the PSM. The effort to find alternatives to tort litigation is a logical extension of the PSM idea that the tort liability system actually hurts the pursuit of patient safety.⁵⁷ Scholars often refer to this view as the conventional wisdom.⁵⁸ At its core, the conventional wisdom is that the threat of litigation makes medical professionals hesitant to embrace openness and transparency, which in turn are the key preconditions for encouraging systemic learning.⁵⁹

The following section of this paper outlines two lines of critique that support the conventional wisdom. The first line of critique is a general discussion on the inability of the tort system to achieve its institutional goals of compensation and deterrence. The second highlights specific institutional weaknesses of the litigation process that makes the tort system ill suited for learning from preventable errors. Examples of these institutional weaknesses include hindsight biases and the narrow focus of causation. As a result, many PSM activists believe the tort system as currently constructed reinforces the dominant medical culture that prioritizes secrecy over transparency in order to minimize the potential exposure to litigation.

⁵⁷ Hyman & Silver, *supra* note 1. Influenced by the conventional wisdom, many PSM activists advocate for the no-trial approach to medical malpractice. The core idea of the approach is to move medical dispute resolution away from the court to ensure transparency and openness. Proponents of this no-trial approach often call for state demonstration projects to experiment alternatives to the current tort liability system; see, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*, INST. OF MED., (2002) (advocating for state demonstration projects that “would create injury compensation systems outside of the courtroom that are patient-centered and focused on safety.”); see also Public Law 111–148, § 10607, § 399V-4, 124 Stat. 119, 1009 (codified as amended in scattered sections of 42 USC 280g et seq.) (authorizing “demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.”).

⁵⁸ Hyman & Silver, *supra* note 1.

⁵⁹ Schwartz, *supra* note 2.

A. *Inability to Deter and Compensate*

Tort law has long been viewed as having two major institutional goals: 1) providing fair compensation to injured persons; and 2) deterring similar negligent behaviors from reoccurring in the future.⁶⁰ In recent years, a growing number of scholars have come to the conclusion that, in the context of medical malpractice, the tort system is simply not designed to successfully achieve these goals.⁶¹ Numerous empirical studies have shown that only a very small percentage of injured patients choose to file a claim, and there is a lack of evidence supporting the claim that the tort system actually deters negligent behaviors and improves overall healthcare quality.⁶²

On the *compensation* side, Michelle M. Mello and David M. Studdert argue that the current medical liability system “does not perform well either in compensating eligible patients or in avoiding claims by those who are not eligible.”⁶³ The seminal Harvard Medical Practice Study (HMPS), for example, found that “the fraction of medical negligence that leads to claims is probably under 2 percent.”⁶⁴ Also, “only about a sixth of the claims that were filed involved both negligence and a cognizable injury.”⁶⁵ A similar conclusion was reached by another influential report that examined medical errors in the states of Utah and Colorado commonly known as the Utah-Colorado Medical

⁶⁰ See Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*, MEDICAL MALPRACTICE AND THE US HEALTH CARE SYSTEM: NEW CENTURY, DIFFERENT ISSUES, 15-23 (outlining a list of criteria for evaluating the performance of the medical liability system which includes compensation, deterrence, corrective justice, and efficiency; and then evaluating the performance of the current tort-based medical liability system against the four criteria outlined.).

⁶¹ *Id.*

⁶² *Id.* at 18.

⁶³ *Id.* at 17.

⁶⁴ 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, 249 (1991).

⁶⁵ Mello & Studdert, *supra* note 60, at 16.

Practice Study.⁶⁶ It revealed that only 2.5% of those injured due to negligence actually chose to bring a claim.⁶⁷

There are also troubling signs that courts may not have the ability to consistently distinguish meritorious from non-meritorious claims. Troyen Brennan et al., found 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.”⁶⁸ Overall, empirical studies often show that a significant portion of meritorious claims is left uncompensated, whereas non-meritorious ones received unjustified payment.⁶⁹ Combining this with the fact that only a small percentage of eligible patients file claims, Mello and Studdert concluded that “the weight of the evidence points to a liability system that is deeply flawed in terms of its ability to direct compensation to its intended beneficiaries.”⁷⁰

The low percentage of injured patients who actually file lawsuits compromises the other institutional goal of the tort liability system: *deterrence*. As Mello and Studdert pointed out, “[t]he overall picture that emerges from the existing studies of the relationship between malpractice claims experience and medical errors is that evidence of a

⁶⁶ Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE 261 (2000).

⁶⁷ David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior In Utah and Colorado*, 38 MED. CARE 250 (2000).

⁶⁸ Troyen Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963 (1996).

⁶⁹ Mello & Studdert, *supra* note 60, at 17 (arguing that the current medical liability system “does not perform well either in compensating eligible patients or in avoiding claims by those who are not eligible.”). A similar study conducted by Studdert and colleagues also showed that “only a small fraction of claims lacked documented injuries. However, approximately one third of claims were without merit in the sense that the alleged adverse outcomes were not attributable to error. Claims without merit were generally resolved appropriately: only one in four resulted in payment. When close calls were excluded, claims without evidence of injury or error accounted for 13 percent of total litigation costs.” David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2029 (2006).

⁷⁰ Mello & Studdert, *supra* note 60, at 17.

deterrent effect is (1) limited and (2) vulnerable to methodological criticism.”⁷¹ Several factors may contribute to this phenomenon. First, the legal standard of care often looks unclear to physicians, which may confuse them about what they should do to avoid medical liability.⁷² Second, the market of malpractice insurance is rarely experience-based, which limits the economic power of insurance premiums to alter physician behaviors.⁷³ In addition, only a small portion of the costs associated with medical errors are internalized by providers. Instead, public and private medical insurers as well as patients absorb much of the burden.⁷⁴ The lack of cost internalization further weakens the connection between tort liability and physicians’ behavioral change.

B. Discouraging Systemic Learning

The second line of criticism that supports the conventional wisdom relates to the inability of the tort system to facilitate systemic learning. Specifically, the tort system often contains hindsight bias⁷⁵ and applies a narrow understanding of causation.⁷⁶ Hindsight bias is a human tendency to treat incidents that involve high risk and uncertainty at the time as destined to happen and easily avoidable.⁷⁷ *To Err Is Human* suggests that such biases may “mislead” a reviewer into simplifying the causes of an accident, highlighting a single element as the cause and overlooking multiple contributing factors.”⁷⁸ As a system that retroactively assigns responsibility and liability to

⁷¹ *Id.* at 19-20.

⁷² *Id.* at 20.

⁷³ *Id.*

⁷⁴ *Id.* at 20-21.

⁷⁵ *TO ERR IS HUMAN*, *supra* note 2, at 53-54 (referring to hindsight bias as “things that were not seen or understood at the time of the accident [which] seem obvious in retrospect”).

⁷⁶ *See* Sydney Dekker, *JUST CULTURE: BALANCING SAFETY AND ACCOUNTABILITY* 108-09 (2nd ed. 2012) (discussing how legal professionals narrow down related facts and stories to create truth relevant to legal claims).

⁷⁷ *TO ERR IS HUMAN*, *supra* note 2, at 53-54

⁷⁸ *Id.*

actions that already occurred, the tort liability system inevitably implies the risk of hindsight biases. Such a risk, in turn, may help explain the questionable performance of the tort system to distinguish legitimate claims from illegitimate ones.⁷⁹

Another institutional weakness of the tort system that hinders systemic learning is its narrow understanding of causation. The causal relationship established in the courts is often focused on the direct or proximate connection between the visible, so-called sharp-end, error and the individual who committed that particular error.⁸⁰ This conceptualization of causation runs against the premise of the PSM that visible errors often are just symptoms, rather than the root cause, of larger systemic problems. Under such a narrow conceptualization, however, factors related to latent errors but unrelated to the particular legal claim may be seen as being irrelevant and out of the equation.

Both weaknesses reflect a deeper structural issue of the US adversarial system. In the adversarial system, information is treated as a weapon to win the litigation battle rather than a resource that, when shared, can help develop real solutions to real life problems.⁸¹ In order to win the battle of litigation, it is critical for each party to ensure that their opponent has as few weapons at their disposal as possible. Sharing information, therefore, is inherently against the self-interest of both parties. A critical function of depositions, particularly those of expert witnesses, is hence to determine what information can and

⁷⁹ Studdert et al., *supra* note 69.

⁸⁰ Medical malpractice cases follow the general rule of tort law that requires meeting four elements to establish negligence liability: duty, breach of duty, causation, and damages. RICHARD A. EPSTEIN, *CASES AND MATERIALS ON TORTS* 145-6 (10th ed. 2012). Among these four elements, causation is further divided into causation in fact and proximate causation, and the latter is often interpreted by using the but-for rule, i.e., whether the damages would have happened 'but for' the alleged negligence. National Medical Consultants, P.C., *Medical Malpractice: An Overview*, <http://www.nationalmedicalconsultants.com/> (follow "Resources" hyperlink; then follow "Medical Malpractice: An Overview" hyperlink) (last visited April 19, 2015).

⁸¹ See Studdert et al., *supra* note 2.

cannot be included as evidence. As a result, information being presented to the court inevitably becomes piecemeal, and the final decision on the question of fact has to be determined within the confines of this fragmented information.⁸²

Collectively, these structural weaknesses fuel medical professionals' animosity against the tort liability system. Medical professionals often have the impression that the legal system treats the medical profession unfairly and does not respect or is unwilling to understand the nuances of medical science. As a result, many providers, when encountering medical errors, passively rely on legal teams to manage their exposure to legal risk, or choose to keep total silence in the hope that the incident will eventually go away without triggering litigation.⁸³ These common strategies thus create a cultural barrier against openness and transparency,⁸⁴ commonly known as the *code-of-silence*.⁸⁵

The code-of-silence is not a new phenomenon. Rather, it has been passed down from one generation of medical professionals to another via the implicit influence of both the medical school education and acculturation in the working environment. Some describe this influence as the *hidden curriculum*, which refers to the phenomenon that new generations of medical professionals learn how to deal with medical errors by imitating their predecessors whose main, if not only, approach to these incidents is to not talk

⁸² See Daniel Shuman, *Expertise in Law, Medicine and Healthcare*, 26 J. HEALTH POL. POL'Y & L. 267, 270 (2006) (noting that one critique of the adversary system is that "the information presented to the courts by privately retained experts is biased because attorneys seek out experts who will best assist their case and not necessarily because the experts represent mainstream science").

⁸³ See Wei, *supra* note 5, at 16-34 (arguing that the medical community shares a culture of silence against not only disclosure to patients, but to colleagues and external error reporting systems).

⁸⁴ See Studdert et al., *supra* note 2.

⁸⁵ 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, 1413-18 (2009) (discussing the medical culture that follows the code of silence and the recent actions taken by actors in the healthcare system to change that culture).

about them at all.⁸⁶ Today, the fear that admitting errors will bring significant legal, financial, professional, and emotional consequences remains very real.⁸⁷ Fair or not, this fear has continued to be cited as the main reason for the medical community's resistance to many patient safety initiatives.⁸⁸

IV. FROM CONVENTIONAL WISDOM TO LEARNING FROM LITIGATION

Since the beginning of the PSM, the conventional wisdom that tort hinders the pursuit of patient safety has been widely embraced.⁸⁹ In recent years, however, an emerging body of literature has challenged this conventional view.⁹⁰ The literature indicates a healthcare system where providers increasingly treat the litigation process as a useful source of information for various safety and quality improvement activities.⁹¹ This paper terms this nascent phenomenon as *Learning from Litigation* (LFL).⁹² The following section offers a brief description of the phenomenon by discussing: 1) examples of tort-facilitated learning activities; 2) the cultural change in healthcare organizations that underlies the emergence of Learning from Litigation; and 3) the campaign to promote disclosure

⁸⁶ See NANCY BERLINGER, *AFTER HARM: MEDICAL ERROR AND THE ETHICS OF FORGIVENESS* 24-26 (2005) (arguing that each generation of medical students, by observing their predecessors, learn that the proper way to deal with mistakes is to keep them secret, a hidden curriculum which prevents them from sharing information with patients).

⁸⁷ Such a mentality is often the result of a medical culture that views physicians as experts that never make mistakes. Physicians therefore often fear that admitting errors might lead to legal liability, financial burdens, and even endangerment of their careers. See Lucian L. Leape, *Error in Medicine*, 272 *JAMA* 1851, 1851-52 (1994) (criticizing the concept of infallibility that permeates the culture of medical practice and motivates physicians to be dishonest and cover up their mistakes).

⁸⁸ See *supra* notes 2 and 5 and accompanying text.

⁸⁹ TO ERR IS HUMAN, *supra* note 2, at 43; Studdert et al., *supra* note 2, at 286.

⁹⁰ Schwartz, *supra* note 1, at 1239-43.

⁹¹ *Id.* at 1246-51.

⁹² Schwartz, *supra* note 10.

and apology, which is one of the driving forces behind this cultural change in healthcare organizations.

A. How Providers Learn from Litigation

At the core of LFL is the growing awareness that the malpractice litigation process actually produces many byproducts that contain useful information for the purpose of safety and quality improvement. Examples of these byproducts include: 1) potential claim files, i.e., documents prepared by risk management personnel in anticipation of potential litigation; 2) actual notices of claims and legal complaints that are filed by injured patients against the providers; 3) closed claim files, which typically are maintained by hospitals themselves or their liability insurance companies; and 4) litigation discovery, where expert witnesses are tasked with analyzing files and documents pertaining to the disputed incidents.⁹³

These valuable sources of information in turn allow providers to engage in various systemic learning activities to identify weaknesses in their delivery systems. These analytical and learning activities, which produce specific knowledge on what went wrong and how to fix it, hold the key to materializing the potential of the tort liability system to improve patient safety. The following section explores three notable examples of these activities, including: 1) filling the gaps in error reporting systems; 2) identifying causes to individual adverse events and their solutions; and 3) turning individual claim data into broader datasets for statistical analysis to identify the hidden patterns and trends of preventable errors.

1. Strengthening Reporting Systems

The information collected through potential claims, actual claims, closed claims, and litigation discovery often exposes the gaps in error reporting systems. Here, “gap” refers to the underreporting of incidents that are due to either flaws in the reporting system’s design or problems in

⁹³ Schwartz, *supra* note 1, at 1267-75.

its implementation; malpractice claims help combat both in several ways.⁹⁴ First, malpractice claims help capture errors with delayed manifestation; that is, mistakes that cause injuries which develop overtime. Most reporting systems are designed to capture errors that immediately or quickly lead to visible injuries.⁹⁵ Errors with delayed manifestation, in particular those involving delayed diagnoses, missed diagnoses, and treatment errors, can often evade reporting systems.⁹⁶

These errors are often disproportionately brought to healthcare organizations' notice by legal claims.⁹⁷ A recent study of Brigham and Women's Hospital, for instance, compared what the hospital learns from various data sources,⁹⁸ including error reporting systems, internal reports to risk management, walk arounds, patient complaints, and actual malpractice claims.⁹⁹ The study observed that 24.3% of actual malpractice claims contained allegations that physicians committed errors of clinical judgment, a category that covers various types of errors with delayed manifestation.¹⁰⁰ In comparison, only 12.3% of patient complaints, 7.3% of risk management reports, and 1.1% of hospital's incident reporting database contained such information.¹⁰¹

Secondly, there is often poor coordination between hospitals' internal reporting systems and other internal databases for patient complaints and occurrence reports, i.e., the reports commonly filed by nurses to risk managers to

⁹⁴ *Id.* at 1277-83.

⁹⁵ *Id.* at 1279.

⁹⁶ *Id.* at 1279-80.

⁹⁷ *Id.* at 1280-81.

⁹⁸ See generally Osnat Levtzion-Korach et al., *Integrating Incident Data from Five Reporting Systems to Assess Patient Safety: Making Sense of the Elephant*, 36 JOINT COMM'N J. ON QUALITY & PATIENT SAFETY 402, 405-06 (2010) (discussing that each of the five reporting systems studied had its own patient safety issues, which lead to the conclusion that "hospitals should use a broad portfolio of approaches and then synthesize the messages from all individual approaches into a collated and cohesive whole").

⁹⁹ *Id.* at 403-04.

¹⁰⁰ *Id.* at 405-06.

¹⁰¹ *Id.*

notify the occurrence of unusual events, many of which involve injuries.¹⁰² Malpractice claims, therefore, often become the first time when hospitals learn of many errors that should have been brought to their attention through other internal channels. Lori Andrews, in her 2005 ethnographic study of how errors are discussed in hospitals, reported that only 13.49% of patients in the study who filed a lawsuit were documented in an occurrence report.¹⁰³ There is also a weak connection between hospitals' reporting systems and other error-detecting mechanisms such as walk arounds and morbidity and mortality meetings. In her study, Andrews further discovered that many errors discussed in walk arounds and morbidity and mortality meetings do not get forwarded to error reporting systems and hospital management.¹⁰⁴ As a result of this disconnect, healthcare organizations, particularly larger ones with more layers of bureaucracy, must often rely on litigation claims to broaden their monitoring web of medical errors.

2. *Finding the Root Cause of Individual Incidents*

Information obtained from litigation also allows healthcare organizations to unearth the real causes of specific events and develop solutions to address them. This particular learning activity can be done in various ways. For example, risk managers nowadays often review closed claims for safety lessons and action plans, and then forward obtained lessons to safety and quality departments for correction and improvement.¹⁰⁵ Also, it has increasingly become a common practice to feed information obtained during discovery back to healthcare organizations for potential safety lessons.¹⁰⁶ In smaller hospitals, the feedback process may occur more quickly and smoothly since the same people and offices might oversee legal representation, claims management, as well as

¹⁰² Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 368-69 (2005).

¹⁰³ *Id.* at 369.

¹⁰⁴ *Id.* at 367-68.

¹⁰⁵ Joanna Schwartz, *supra* note 1, at 1272.

¹⁰⁶ *Id.* at 1270-72.

safety and quality improvement.¹⁰⁷ In larger hospitals, however, people who actually participate in litigation need to develop ways to communicate the information back to the organization.¹⁰⁸ Such a communication can be done informally between defense attorneys and risk managers.¹⁰⁹ In some organizations, there are regular meetings where defense attorneys representing hospital personnel present what they learned in discovery.¹¹⁰ In addition, potential and actual claims often expose providers to events previously unknown.¹¹¹ These events can then become the subject of internal error-reviewing mechanisms such as morbidity and mortality conferences, clinical peer review, and root cause analysis (RCA), or be further reported to external reporting systems that include RCA as part of standard procedure.

Among the various internal error-reviewing mechanisms, RCA is often hailed by the PSM as an effective way to turn errors into safety lessons.¹¹² Root cause analysis refers to a structured method to identify underlying latent factors that contribute to the occurrence of visible sharp-end errors. The Agency for Healthcare Research Policy (AHRQ) describes the process of RCA as follows:

RCAs should generally follow a prespecified protocol that begins with data collection and reconstruction of the event in question through record review and participant interviews. A multidisciplinary team should then analyze the sequence of events leading to the error, with the goals of identifying how the event occurred (through identification of active errors) and why the event occurred (through systematic identification and analysis of latent errors).¹¹³

¹⁰⁷ *Id.* at 1270.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 1271.

¹¹⁰ *Id.*

¹¹¹ See discussion *supra* Part IV.A.

¹¹² See AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *Patient Safety Primers: Root Cause Analysis*, (2014).

¹¹³ *Id.*

Root cause analyses can be initiated by healthcare organizations themselves, or be triggered by external error reporting systems. For example, The Joint Commission's Sentinel Event Reporting System requires reporting facilities to submit RCA reports and develop action plans.¹¹⁴ Some state-run and nationwide systems include a similar requirement.¹¹⁵ Systems run by many patient safety organizations (PSOs), on the other hand, may conduct root cause analysis for the reporting facilities and provide them with safety improvement recommendations.¹¹⁶ Many PSOs later also aggregate RCA reports, which are analyses of individual events, into larger databases to facilitate another type of litigation-facilitated learning activities: the identification of the patterns and trends of preventable errors.¹¹⁷

3. *Identifying the Patterns and Trends of Errors*

Another way for providers to utilize the information collected through litigation is to identify the patterns and trends of medical errors. There are multiple ways to produce this information. One common practice is to review the aggregated pool of notices of claims and legal complaints to search for troublesome trends.¹¹⁸ *A Dose of Reality*

¹¹⁴ *Id.* Although the decision to report to the SERS is voluntary, in situations where the Joint Commission discovers the existence of sentinel events, the organization is still required to provide a RCA report as well as an action plan. If, after review, the analysis and plan are viewed as unacceptable, the organization may be placed on the watch list regarding its accreditation status until an acceptable plan is submitted.

¹¹⁵ See generally Editorial Staff, *A National Survey of Medical Error Reporting Laws*, 9 YALE J. HEALTH POL'Y L. & ETHICS 201, 218 (2008) (reporting the result of a national survey conducted to catalogue the statutes and regulations related to error reporting systems in each of the twenty-seven states).

¹¹⁶ See CENTER FOR ASSESSMENT OF RADIOLOGICAL SCIENCES, *Patient Safety Work Product (PSWP)*, RADIO THERAPY INCIDENT REPORTING & ANALYSIS SYSTEM, http://cars-pso.org/patient_safety_work_product.aspx (last visited Feb. 20, 2015).

¹¹⁷ AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *supra* note 112.

¹¹⁸ Schwartz, *supra* note 1, at 1269.

reported that eighty-six percent of respondents replied that they either often or sometimes review trends across notices of claims and legal complaints to acquire performance and safety lessons.¹¹⁹

Another productive method to extract useful information from malpractice claims is to analyze closed claims. Files of closed claims may include data and records prepared and maintained by attorneys, hospitals, and liability insurers.¹²⁰ This paper refers to such examinations as closed claims analyses (CCAs). *A Dose of Reality* reported seventy-six percent of respondents either often or sometimes review closed claims for safety and quality improvement purposes.¹²¹ *A Dose of Reality* also reported that closed claims are commonly used for educational and training purposes.¹²²

Individual providers can conduct CCAs in collaboration with their malpractice insurers. In certain specialties, CCAs are being done at a large scale via collaborations between professional organizations, malpractice insurers, and volunteer physicians.¹²³ The most successful attempt to conduct a large scale CCA has been within the specialty of anesthesiology. The inception of this effort can be traced back to 1984, when the Anesthesia Closed Claims Project (ACCP) was put into practice.¹²⁴ The ACCP is a multidisciplinary project aimed at “identify[ing] safety concerns in anesthesia, patterns of injury, and develop[ing]

¹¹⁹ *Id.*

¹²⁰ *Id.* at 1272.

¹²¹ *Id.*

¹²² *Id.* at 1272-73.

¹²³ See generally Frederick W. Cheney et al., *Standard of Care and Anesthesia Liability*, 261 JAMA 1599 (1989) (examining and evaluating the experience of the American Society of Anesthesiologists in studying closed malpractice claims in order to learn from mistakes and reduce anesthesia-related injuries).

¹²⁴ 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); see also ANESTHESIA CLOSED CLAIMS PROJECT, *Welcome to the Anesthesia Closed Claims Project and Its Registries*, <http://depts.washington.edu/asaccp/> (last visited Feb. 20, 2015).

strategies for prevention in order to improve patient safety.”¹²⁵ The beginning of the ACCP coincided with a period of time when anesthesiology was widely considered to have the highest liability risk among specialties. Liability insurance premiums skyrocketed as a result, which motivated stakeholders in anesthesia to get behind the ACCP initiative. The idea was that once the overall practice of anesthesia become safer, the legal and financial risk would correspondingly drop due to fewer incidents.¹²⁶

The ACCP functions by trained anesthesiologists reviewing and ultimately turning closed claim files provided by malpractice insurance companies into standardized summaries.¹²⁷ Currently, the project has more than 10,000 claims for events from 1970-2012. There are twenty to twenty-five reviewers who spend fifty to sixty days annually reviewing claim files. Twenty-one insurance companies, insuring approximately 13,000 anesthesiologists, currently participate.¹²⁸

The data collected is then turned into detailed case summaries that become available for research, particularly in the area of statistical analysis. Information contained in these standardized summaries may include “patient information, surgical procedure and positioning, anesthetic evaluation and technique, events leading to the injury or claim, type and severity of injury, outcome of litigation, and

¹²⁵ ANESTHESIA CLOSED CLAIMS PROJECT, *supra* note 124.

¹²⁶ *See* Cheney, *supra* note 124, at 552 (suggesting that the perception that reducing errors will lead to lower litigation risk is the motivation behind the ACCP project); Karen L. Posner, *Closed Claims Project Shows Safety Evolution*, ANESTHESIA PATIENT SAFETY FOUND., *available at* <http://www.apsf.org/newsletters/html/2001/fall/02closedclaims.htm> (last visited Feb. 20, 2015) (stating that the motivation behind the project was the awareness that “[i]f anesthesia became safer and patient injuries were reduced, malpractice premiums should follow suit.”).

¹²⁷ ANESTHESIA CLOSED CLAIMS PROJECT, *Anesthesia Closed Claims Project*, <http://depts.washington.edu/asaccp/projects/anesthesia-closed-claims-project> (last visited Feb. 20, 2015).

¹²⁸ ANESTHESIA QUALITY INSTITUTE, <http://www.aqihq.org/closedclaims.aspx> (last visited Feb. 20, 2015).

physician evaluations of potential for prevention and appropriateness of anesthesia care.”¹²⁹

Due to the fact that most minor incidents claims are resolved early without in-depth investigation, files of these incidents tend to lack detailed information. The ACCP database therefore has a strong bias toward severe injuries.¹³⁰ The bias is consistent with the nature of the current tort system. Due to the high financial cost to file a lawsuit, claims involving severe injuries are more likely to progress further into litigation due to the higher probability of obtaining a large jury award to justify the investment.¹³¹

The bias toward severe injuries has both positive and negative implications. On the negative side, this bias means that other means are necessary to capture safety concerns associated with less severe injuries.¹³² On the positive side, however, the severe injury bias also allows researchers to tackle issues with serious consequence first.¹³³ Severe incidents typically occur very rarely and are unfit for statistical study. By compiling data of individual events into a larger database, the ACCP allows researchers to apply statistical methodology to the studies of these incidents.¹³⁴

The results of the ACCP have been presented at meetings and conferences, and distributed via publications of the American Society of Anesthesiologists (ASA). Since 1984, the project has produced fifty peer-reviewed journal publications, seventy ASA newsletter articles, and numerous presentations and training sessions.¹³⁵ These studies have helped the anesthesiology specialty to identify weaknesses in anesthesia practice, as well as the changing profile of anesthesia liability.¹³⁶ Over the years, anesthesia

¹²⁹ ANESTHESIA CLOSED CLAIMS PROJECT, *Projects*, <http://depts.washington.edu/asaccp/projects> (last visited Aug. 20, 2014).

¹³⁰ Posner, *supra* note 126.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ ANESTHESIA CLOSED CLAIMS PROJECT, *supra* note 124.

¹³⁶ *See* Posner, *supra* note 126. For more journal articles and newsletters on the Closed Claims Project, *see* ANESTHESIA CLOSED

mortality rates have dropped from two deaths every 10,000 anesthetics administered to around one death every 200,000–300,000 anesthetics administered, an achievement noted in *To Err Is Human* as an example for other members of the healthcare system to follow.¹³⁷

B. The Changing Culture of Healthcare Organizations

Ultimately, the trend toward broader utilization of information obtained from tort litigation is supported by gradual but fundamental changes in hospitals' organizational culture. In *A Dose of Reality*, Joanna Schwartz outlined three major changes: 1) changing self-perception of risk managers; 2) growing transparency within hospitals; and 3) increasing transparency with patients and their families.¹³⁸

Risk managers are positions traditionally held by lawyers. They report to the general counsel, and have long viewed themselves as responsible only for handling legal risks.¹³⁹ Influenced by the Patient Safety Movement, the self-perception of risk managers has changed. Today, risk managers increasingly view their work as being connected with the broader effort to improve safety and quality.¹⁴⁰ This changing perception coincides with the overall shift of healthcare organizations' attitudes toward transparency.¹⁴¹

CLAIMS PROJECT, *supra* note 124 (follow "Publications" hyperlink; then follow "Closed Claims Project Overview" hyperlink). Meghan F. MacRae, however, cautions that it is important to recognize that malpractice claims as a sample do not reflect the actual composition of medical errors. It is therefore necessary not to overstate the effect of closed claims analysis in calculating risks and predicting trends in anesthesia errors. *Cf. generally*, Meghan F. MacRae, *Closed Claims Studies in Anesthesia: Literature Review and Implications for Practice*, 75 AM. ASS'N NURSE ANESTHETISTS J. 267 (2007), available at <http://www.aana.com/newsandjournal/Documents/macraep267-275.pdf> (last visited Apr. 19, 2015).

¹³⁷ TO ERR IS HUMAN, *supra* note 2, at 144-45.

¹³⁸ See Schwartz, *supra* note 1, at 1251-66.

¹³⁹ *Id.* at 1261.

¹⁴⁰ *Id.* at 1251-66.

¹⁴¹ *Id.* at 1254-66.

Joanna Schwartz indicated that a high percentage of the risk managers she interviewed were receptive to the ideal of transparency.¹⁴² This growing receptiveness to transparency applies to disclosures to patients and information-sharing within healthcare organizations.¹⁴³ In particular, there is increasing communication and collaboration between risk management and safety and quality improvement personnel.¹⁴⁴ The sentiment remains strong even in states with weaker apology law protections.¹⁴⁵

Such a change echoes the broader shift in the role played by legal professionals in healthcare organizations. In the past, the role of legal professionals in healthcare organizations was viewed simply as setting boundaries for physicians as to what legally can and cannot be done, even when such things may be convenient or effective from a medical or managerial perspective. In an era when healthcare has become one of the most highly regulated industries, lawyers have increasingly been relied upon to offer strategic advice related to the direction of the organization's future development.¹⁴⁶

¹⁴² *Id.* at 1254-55.

¹⁴³ *Id.* at 1254-66. The increasing transparency with patients coincides with the growing interest in the communication-and-resolution programs (CRP) in the healthcare industry. For the historical background and current status of CRP programs, *see* discussion *infra* Part IV(C).

¹⁴⁴ Typically it is physicians and nurses who serve as safety/quality improvement personnel. While risk managers often report to the Office of General Council, safety/quality personnel often report to the medical department, or in some cases to offices specifically designated to monitor safety/quality related efforts.

¹⁴⁵ *See* Schwartz, *supra* note 1, at 1260.

¹⁴⁶ *See* Louise G. Trubek et al., *Transformations in Health Law Practice: The Intersections of Changes in Healthcare and Legal Workplaces*, 12 IND. HEALTH L. REV. __ (2015) (describing the changing landscape post-ACA for health law practice, in which health lawyers, including both those practice in-house or in corporate law firms, are increasingly relied upon to deal with quality improvement, regulatory compliance, and strategic planning issues, and assume greater involvement in shaping the direction of healthcare organizations' development).

The shifting role of legal professionals in healthcare organizations adds an additional dimension to the debate over the relationship between tort and patient safety. With the changing perception of their role, legal professionals today are playing an active role in encouraging healthcare organizations to learn from litigation by using information gathered from lawsuits to improve patient safety. In serving such a function, legal professionals may help gradually alleviate the strong animosity between trial lawyers and patients on one hand and the medical community on the other. Moreover, these legal professionals may also help to transform the aforementioned litigation-induced learning activities into standardized policy packages that can be applied more broadly, or even allow them to be institutionalized as legal or regulatory policies.

C. Disclosure, Apology, and Communication-and-Resolution

One of the driving forces behind the changing medical culture, in which providers increasingly embrace the value of tort litigation for patient safety, is the campaign to promote full disclosure and apology in medical dispute resolution, which began to gain popularity in the early 2000s.¹⁴⁷ The campaign has been a multi-prong effort. In 2001, for example, the Joint Commission added a requirement to disclose adverse outcomes to patients to their accreditation process.¹⁴⁸ Also, in the past decade, scholars, policymakers, and non-profit organizations (most famously the Sorry Works! Coalition) have continued to promote the idea of “apology laws.”¹⁴⁹ Apology laws are statutes that shield disclosed information and apologetic or

¹⁴⁷ See Schwartz, *supra* note 1, at 1256-58 (citing the growing awareness of the benefits of disclosure and apology as one of the major reasons for the trend toward transparency with patients).

¹⁴⁸ *Id.* at 1255-56; 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) (discussing the new accreditation requirement).

¹⁴⁹ SORRY WORKS!, <http://sorryworkssite.bondwaresite.com> (last visited Feb. 20, 2015).

sympathetic remarks made by medical professionals following the incidence of adverse events from being used as evidence against the medical professional in any later litigation.¹⁵⁰ Today, thirty-six states provide such protections to various degrees.¹⁵¹ By offering these legal protections, it is hoped that medical professionals will become more inclined to disclose their mistakes, offer sympathy, and apologize when necessary.¹⁵²

Against the broader backdrop of the campaign to promote full disclosure and apology, one specific initiative has stood out as the most promising and has garnered increasing attention: communication-and-resolution programs (CRP). In addition to the CRP, other labels such as disclosure-and-offer or early settlement programs are also commonly used to describe these initiatives.¹⁵³ The CRP typically refers to a comprehensive claims management model pioneered by the University of Michigan Health System (UMHS).¹⁵⁴ In 2001, the UMHS

¹⁵⁰ SORRY WORKS!, *Apology Laws*, <http://sorryworkssite.bondwaresite.com/apology-laws-cms-143> (last visited Feb. 20, 2015).

¹⁵¹ *Id.*

¹⁵² *Cf.* William M. Sage et al., *How Policy Makers Can Smooth The Way For Communication-And-Resolution Progress*, 33 HEALTH AFF. 11, 14 (2014) (stating that apology laws “seem more important to the adoption of new CRPs than to the operation of existing ones”).

¹⁵³ *See generally*, Michelle M. Mello et al., *Communication-And-Resolution Programs: The Challenges And Lessons Learned From Six Early Adopters*, 33 HEALTH AFF. 20 (2014) [hereinafter *Lessons Learned From Six Early Adopters*] (discussing communication-and-resolution programs); Michelle M. Mello et al., *Implementing Hospital-Based Communication-And-Resolution Programs: Lessons Learned in New York City*, 33 HEALTH AFF. 30 (2014) [hereinafter *Lessons Learned in New York City*] (discussing communication-and-resolution programs); Allen Kachalia & Michelle M. Mello, *New Directions in Medical Liability Reform*, 364 NEW ENG. J. MED. 1564, 1569 (2011) (referring to four demonstration projects funded by the Agency for Healthcare Research and Quality “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 (discussing the positive impact of a disclosure and apology policy adopted by the University of Illinois Medical Center in 2006).

¹⁵⁴ HEALTH SYSTEM: UNIVERSITY OF MICHIGAN, <http://www.uofmhealth.org/> (last visited Feb. 20, 2015); *see also*, Mike

launched a new dispute resolution model, which consisted of four basic elements: 1) immediate disclosure of harm; 2) timely expression of sympathy and apology; 3) commitment to investigation and prevention efforts to identify and address the root cause of the incident; and 4) a quick offer of compensation if investigation demonstrates potential negligence.¹⁵⁵

By bundling the four elements, the CRP constitutes a unique and increasingly popular approach to implementing full disclosure and apology. The uniqueness comes in at least two fronts: first, the CRP is predicated on the willingness of health systems to make a quick offer of compensation when negligence is involved.¹⁵⁶ Second, by including investigation and prevention efforts in the package, the CRP has the potential to encourage providers to incorporate systemic learning into the medical dispute resolution process.¹⁵⁷ The commitment to the CRP

Mitka, *Disclosing Medical Errors Does Not Mean Greater Liability Costs, New Study Finds*, 304 JAMA 1656, 1657 (2010) (discussing the disclosure policy of the UMHS, under which “the institution admits fault and offers compensation when an internal investigation uncovers medical error”); Hillary R. Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205, 2207 (2006) (citing the reduced time and money spent on resolving malpractice claims under the UMHS model).

Another often cited pioneer of this type of policy is the Veteran Affairs Hospital in Lexington, Kentucky. For discussion on the VA story, see e.g., Steve S. Kraman & Ginny Hamm, *Risk management: Extreme Honesty May be the Best Policy*, 131 ANNALS INTERN. MED. 963, 964 (1999); Jennifer K. Robbennolt, *Apologies and Medical Error*, 467 CLIN. ORTHOP. RELAT. RES. 376, 380 (2009).

¹⁵⁵ HEALTH SYSTEM: UNIVERSITY OF MICHIGAN, *supra* note 154.

¹⁵⁶ This element is often the most difficult for providers to embrace. See, *Lessons Learned in New York City*, *supra* note 153, at 35 (2014) (evaluating the performance of a New York State demonstration project funded by the federal Agency for Healthcare Quality and Research to implement the UMHS model and reporting that, while participants improve their commitment to internal investigation of adverse events and external communication with patients, most participants are reluctant to make quick compensation in fear that, among other things, doing so may actually increase their liability exposure).

¹⁵⁷ The emphasis, if properly implemented, has the potential to move hospital culture towards transparency and self-learning. *Id.* at 34 (citing increasing communication with patients and better tracking of

approach is often supported by the awareness that early resolution, without disputes developing into legal claims, is the future of medical malpractice reform.¹⁵⁸ Early resolution, in turn, can best be achieved when providers are committed to honest investigation, sincere apology, and information transparency.

To a certain extent, the uniqueness of the CRP limits its application. Whereas most hospitals today have disclosure policies in place as required by the Joint Commission, the implementation of such policies varies significantly from organization to organization and there are only a small number of hospitals that fully implement all four elements of the CRP.¹⁵⁹ In particular, many healthcare organizations are quite hesitant to make early settlement offers, unless

adverse events as areas of success in the New York State demonstration project).

¹⁵⁸ The author interviewed a Risk Management Director of a large urban Wisconsin hospital that employs a disclosure policy similar to the Michigan model. When asked about whether the hospital has policies similar to the CRPs in place, the Director replied: “We do have a disclosure policy. We expect any sentinel event to be fully disclosed to the patient and family and the medical record documentation to include the relevant facts of the discussion. Our malpractice climate is so different from Chicago or Michigan, but if we have a situation where we have clear liability, we work with the family. We won’t make them hire an attorney but let them know that it is certainly their right to do so if they choose. We feel very strongly that disclosure and early resolution is best practice.” When asked about when the shift toward early resolution started taking place, the Director responded that “I would say over the past five to seven years more healthcare organizations have adopted the philosophy that early disclosure and apology is the way to go.” Interview with Risk Management Director, Large Urban Wisconsin Hospital (August 20, 2014).

¹⁵⁹ In addition to the UMHS and the VA-Lexington, other so-called “early adopters” of policies akin to the UMHS model include the Stanford University Medical Indemnity and Trust Insurance Company (SUMIT) and the University of Illinois Medical Center at Chicago (UIMCC). *See generally Lessons Learned From Six Early Adopters, supra* note 153; Kachalia & Mello, *supra* note 153 (discussing that in 2010, the federal Agency for Healthcare Quality and Research funded a series of state demonstration projects to “test[] expansions of the disclosure-and-offer approach championed by the University of Michigan Health System.”).

they are in situations where there is nothing to lose.¹⁶⁰ Hospitals often fear that making early offers may actually heighten their exposure to litigation and monetary compensation.¹⁶¹ Another common fear is that early offers may not be welcomed by liability insurance companies, many of which prefer the providers to take a strong and adversarial stance against claimants.¹⁶² Therefore, early offers in these scenarios may lead to conflicts between the insurer and the insured.¹⁶³

Despite its limited application, the impressive financial benefits of the UMHS policy quickly turned the CRP into an attractive policy option that PSM activists are eager to apply elsewhere. In the five years after the implementation of its claims management model, the UMHS observed a sharp decrease in the cost and frequency of litigation.¹⁶⁴ Specifically, the annual expenses on litigation reduced from three million dollars to one million dollars, while the number of malpractice claims dropped by more than half.¹⁶⁵ Thus, it is no surprise that the basic framework of the CRP was later repeated in various health policy proposals. The 2005 White Paper of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), for example, envisioned that a well-functioning liability system would include the following components: (1) prompt disclosure of errors; (2) apology when necessary; (3) preventive efforts; (4) early compensation; and (5)

¹⁶⁰ *Lessons Learned in New York City*, *supra* note 153, at 35 (discussing the dynamic between providers and their insurance companies that may lead providers to be hesitant in making settlement offers); *See also*, Interview with Risk Management Director, Large Urban Wisconsin Hospital (August 20, 2014) (acknowledging that “sometimes insurance companies would drive [provider] posture”). In certain situations, admitting errors may even void the contract with the insurance company.

¹⁶¹ *Lessons Learned in New York City*, *supra* note 153, at 35 (“Hospitals, insurers, and surgeons all reportedly worried that early settlement offers might heighten their liability exposure”).

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ Thomas H. Gallagher et al., *Disclosing Harmful Medical Errors to Patients*, 356 N. ENGL. J. MED. 2713, 2716 (2007)

¹⁶⁵ *Id.*

alternative dispute resolution mechanisms that resolves the dispute in a swift and fair manner.¹⁶⁶

The UMHS story further inspired legislative efforts at the federal level to make the CRP national policy. In 2006, then United States Senator for Illinois, Barack Obama teamed up with Hillary Clinton, then United States Senator for New York, to introduce a bill titled the National Medical Error Disclosure and Compensation (MEDiC) Act.¹⁶⁷ The bill specifically referred to the UMHS experience as its inspiration. Its main provisions provided financial incentives and legal protections to encourage doctors, hospitals, and health systems to participate in the MEDiC program, which essentially replicates the UMHS model.¹⁶⁸ The MEDiC bill eventually failed to pass in Congress in 2006. President Obama's election in 2008, however, injected new energy into the effort at the national level to promote the CRP. Heeding the call of President Obama in a speech delivered before a joint session of Congress in the fall of 2009, the federal Agency for Healthcare Research and Quality (AHRQ) in 2010 awarded seven state demonstration projects to develop alternatives to the current tort liability system.¹⁶⁹ Among the seven state demonstration projects, five incorporated elements of the CRP.¹⁷⁰

An important function of these AHRQ projects is to provide research opportunities to examine whether the implementation of the CRP can help create a better culture of safety and encourage providers to learn from errors and litigation; with preliminary evidence showing positive signs. As one of the seven demonstration projects funded by AHRQ in 2010, the New York State (NYS) project included a cooperative agreement with a research team led by Michelle Mello of the Harvard Law School to evaluate the

¹⁶⁶ WILLIAM M. SAGE, *Malpractice Reform as a Health Policy Problem*, in MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 41-42 (William M. Sage & Rogan Kersh eds., 2006).

¹⁶⁷ S. 1784, 109th Cong. (2005)

¹⁶⁸ Clinton & Obama, *supra* note 154, at 2206.

¹⁶⁹ AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, MEDICAL LIABILITY REFORM AND PATIENT SAFETY INITIATIVE PROGRESS REPORT 3-7, *archived at* <http://perma.cc/733P-F8A9>.

¹⁷⁰ *Id.*

performance of the project.¹⁷¹ The evaluation was conducted by, among other methods, interviewing key participants, and the result was published in *Health Affairs* in early 2014.¹⁷² The article reported that, among the four CRP components, participating hospitals underachieved in their commitment to making early settlement offers.¹⁷³ Also, the article identified several areas for improvement for future implementation of the CRP, such as leadership support, physician buy-in, and more financial and personnel resources.¹⁷⁴ The overall experience of the project, however, displayed that the CRP can help change the culture of participating hospitals in the following ways. First, participating hospitals show better communication with patients.¹⁷⁵ More importantly, the experience of implementing the CRP often pushes risk managers and safety/quality personnel to track and monitor adverse events more thoroughly and systemically. Resources and procedures such as additional staff, electronic systems, and regular meetings are being added to review and follow adverse incidents.¹⁷⁶ These efforts may lead to better coordination of various players involved in the dispute resolution process, and a more streamlined investigation process.¹⁷⁷

¹⁷¹ GRANT PROPOSAL, NEW YORK STATE MEDICAL LIABILITY REFORM AND PATIENT SAFETY MODEL 15-20, *archived at* <http://perma.cc/D2PH-L3FL>. For the results of this research collaboration, *see* HARVARD SCHOOL OF PUBLIC HEALTH, <http://www.hsph.harvard.edu/michelle-mello/> (last visited Mar. 28, 2015).

¹⁷² HARVARD SCHOOL OF PUBLIC HEALTH, *supra* note 170; William M. Sage et al., *supra* note 152; *Lessons Learned From Six Early Adopters*, *supra* note 153; *Lessons Learned in New York City*, *supra* note 153.

¹⁷³ *Lessons Learned in New York City*, *supra* note 153 at 35.

¹⁷⁴ *Id.* at 35-37 (citing the necessity to obtain physician and leadership support as critical lessons learned from the NYS project).

¹⁷⁵ *Id.* at 34-35 (citing improved communication with patients and between clinicians and risk management as two areas of success of the NYS project).

¹⁷⁶ *Id.* (reporting that participating hospitals in the NYS project see improved tracking of events, which allow timely communication with patient and more rigorous analysis of potential problems).

¹⁷⁷ *Id.* (arguing that “hospitals’ improvements in disclosure, reporting, and follow-up are important elements of ‘enabling’ a climate and culture of patient safety,” in which “clinicians felt they could speak

**V. TORT REFORM IN THE AGE OF LEARNING FROM LITIGATION:
EARLY RESOLUTION VIA COMMUNICATION-AND-RESOLUTION
PROGRAMS AS A FOUNDATION FOR THE FUTURE**

The emerging phenomenon of LFL sheds new light on the tort reform debate. It is increasingly clear that conventional wisdom does not capture the full reality.¹⁷⁸ Today, healthcare organizations have the capacity and choice to respond to the external pressure of tort liability by decreasing error rates and improving performance. Such improvement, in turn, can be achieved by engaging in systemic learning activities outlined in the previous section, with many providers having already chosen to commit to these activities.¹⁷⁹ The commitment to these learning activities holds the key to unlocking the previously underdeveloped potential in tort law to deter future mistakes.¹⁸⁰ Therefore, any serious tort reform proposal aiming to promote patient safety should focus on systemically connecting the dispute resolution process with these analytical and learning activities.

A major question that remains is how this goal can be achieved in a sustainable fashion. Despite the fact that medical malpractice reform is one of the most politically sensitive subjects, the answer to this question seems surprisingly simple. In the era of PSM and LFL, there is a growing recognition that the best approach to reforming the tort litigation system is actually to encourage *early resolution* via the CRP to prevent disputes from ever

openly about adverse events, and it bolstered a shared perception of the value of the safety-enhancing practices of disclosure and reporting”) (footnotes omitted).

¹⁷⁸ What it does is reflect a popular sentiment among medical professionals that the liability system is a game rigged against them. The sentiment, provable or not, remains strong and prevalent today, and needs to be understood and empathized when having serious health policy debates.

¹⁷⁹ This development seems to support Hyman and Silver’s argument that tort law can actually help make a business case for quality to providers by adding the cost of preventable errors into hospitals’ financial consideration. See Hyman & Silver, *supra* note 1, at 957-63.

¹⁸⁰ *Supra* note 60.

evolving into legal claims.¹⁸¹ The CRP, along with closed claims analysis projects such as the Anesthesia Closed Claims Project, are two patient safety initiatives that have proven to be both productive and cost-efficient in turning medical disputes into patient safety lessons.¹⁸² Unlike traditional tort reform proposals that focus on controlling the severity and frequency of claims,¹⁸³ initiatives like the CRP more directly aim to control the severity and frequency of errors.¹⁸⁴ Specifically, as mentioned above, the implementation of the CRP often pushes providers to reform their internal adverse events investigation processes, hence creating a better safety culture and working environment that enables providers to more effectively learn from mistakes and past litigation.¹⁸⁵

In addition to the patient safety potential, the CRP also has two notable strengths compared to other tort reform proposals. The first strength is that the CRP is often less politically sensitive than other proposals. The implementation of the CRP, which is essentially a dispute resolution policy at the individual organizational level, typically requires minimal legislative action.¹⁸⁶ The limited

¹⁸¹ *Supra* note 158.

¹⁸² *Supra* note 137 and Gallagher et al. *supra* note 165.

¹⁸³ *Supra* note 49.

¹⁸⁴ *See generally* Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125 (2009) (arguing that the Michigan model, which emphasizes honesty and transparency, is superior to the traditional approach in that it attacks the underlying driver of medical malpractice). *Cf.* Michael D. Greenberg et al., RAND INSTITUTE FOR CIVIL JUSTICE, *Is Better Patient Safety Associated with Less Malpractice Activity? Evidence from California* 15 (2010), available at http://www.rand.org/pubs/technical_reports/TR824.html (last visited Mar. 28, 2015) (investigating, by using administrative data and measures, the relationship between patient safety outcome and malpractice claims filed against hospitals in California, and suggesting that “county-level safety performance in California . . . is significantly associated with changes in the volume of malpractice claims occurring in the same counties during the same years”).

¹⁸⁵ *See supra* Part IV.C.

¹⁸⁶ The NYS project, for example, was initially a response to an earlier failed attempt to enact tort reform in 2009 in the State. Michelle M. Mello et al., *Implementing Hospital-Based Communication-And-*

legislative involvement not only makes it easier to initiate a CRP experiment and accumulate practical experience, but also shields the CRP away from unnecessary partisan politics.¹⁸⁷ In addition, the CRP also yields significant financial benefits for providers and patients. In the current tort litigation system, very few claimants, typically only those with severe injuries, can obtain compensation via litigation.¹⁸⁸ Encouraging providers to reach early settlement with patients may broaden the pool of patients able to receive fair compensation. This is achieved by allowing those with lesser means or those only modestly injured to also receive monetary payment or other types of support. Together, these comparative strengths make the CRP a solid foundation for tort reform in the era of LFL. The AHRQ, for example, has signaled its intention to disseminate the CRP to the whole nation.¹⁸⁹

Despite these potential benefits, broader pursuit of early resolution will face at least two challenges. First, there are various institutional barriers that must be overcome to increase providers' receptiveness toward the idea of early resolution via the CRP. Second, it is simply unrealistic to expect that the CRP can capture all medical disputes. It is thus critical to contemplate how the tort litigation process can be reformed in ways that facilitate, rather than discourage, the efforts to promote early resolution. In this last section, the paper discusses these two challenges. In particular, the paper argues that there are two different approaches to reforming the litigation process that are consistent with the broader ideal of patient safety. The first is to change the structure of the tort litigation system to (1) reward providers' effort to pursue patient safety; and (2) reduce the cost of litigation discovery. The second is to incorporate CRP ideas into the litigation process, in

Resolution Programs: Lessons Learned in New York City, *supra* note 153, at 31.

¹⁸⁷ *Id.*

¹⁸⁸ See discussion *supra* Part III.A.

¹⁸⁹ *Lessons Learned in New York City*, *supra* note 153, at 37 (“AHRQ has signaled interest in moving toward nationwide dissemination of the CRP approach”).

particular during the pre-trial settlement negotiation stage. Specifically, such a goal can be achieved by applying ideas such as collaborative law and judge-directed negotiation to the process.¹⁹⁰

A. *Overcoming Barriers Against Early Resolution*

Although individual providers can decide to follow the example of the UMHS and pursue the CRP at their own initiative, large-scale implementation of these programs still requires government involvement to help overcome numerous institutional obstacles. Examples of these barriers include: (1) malpractice reporting requirements, (2) the structure of liability insurance, and (3) the contingency fee system. In addition to overcoming these barriers, policies such as apology laws and pre-suit notification laws also have the potential to ease the resistance against early resolution. Apology laws play an important role in building physicians' confidence in adopting new CRPs,¹⁹¹ while pre-suit notification laws provide a cooling-off period in which alternative methods of dispute resolution such as the CRP may be employed.¹⁹²

Physicians often cite the legal requirement to report any settlement payment to the National Practice Data Base and state licensing boards as a major hurdle that affects their willingness to settle.¹⁹³ The fear is that such records will affect their reputation and career development. Some providers are looking for ways to circumvent these requirements. For example, settlement payments can be made under the name of the healthcare organization instead of individual physician. Also, in some cases compensation can take the form of a fee waiver or care support in order to avoid being reported.¹⁹⁴ In the long run,

¹⁹⁰ See discussion *infra* Part V.C.

¹⁹¹ *Supra* note 152.

¹⁹² Sage et al., *supra* note 152, at 13 (discussing that pre-suit notification laws “create cooling-off periods intended to give both parties time to resolve their dispute in other ways, and . . . can help maintain the spirit of cooperation needed for CRPs to operate well”).

¹⁹³ *Id.* at 16.

¹⁹⁴ *Id.*

however, it will likely be necessary to enact policies to allow settlement payments reached through procedures such as the CRP to be exempt from these reporting requirements.

The second obstacle involves the role of liability insurers. The support of medical malpractice liability insurers is critical to successfully implementing the CRP. In the case of the UMHS, an academic hospital, the UMHS directly employs its physicians as university faculty and provides them liability coverage by a captive insurance company of the healthcare organization.¹⁹⁵ The hospital thus has more leeway in using its insurance coverage as an incentive to encourage physicians' to embrace the culture of transparency.¹⁹⁶ In hospitals that have different employment structures, however, there may be multiple liability insurers involved in the same dispute.¹⁹⁷ Each insurer may have different financial arrangements with the insured, and their interests may conflict with other insurers or even with the provider whose liability they are supposed to cover.¹⁹⁸ This factor adds another layer of complexity to the already delicate dynamic of settlement negotiations.¹⁹⁹

¹⁹⁵ Mitka, *supra* note 154, at 1657 (mentioning that the medical staff at UMHS "comprises faculty members employed by the University of Michigan Medical School; the system and its employees have professional liability coverage provided by an established captive insurance company").

¹⁹⁶ *Lessons Learned From Six Early Adopters*, *supra* note 153, at 26 (suggesting that having a captive insurer is an advantage in implementing CRPs, as such arrangements yield hospitals "a relatively high degree of control over their hospital's medical staff, since the same institution both employed and provided medical malpractice liability insurance to these physicians.").

¹⁹⁷ *Id.* at 27 (suggesting that "in cases involving multiple insurers, each insurer may seek to shift financial responsibility to others" and "may have different philosophies about settlement").

¹⁹⁸ For example, several participating hospitals in the NYS project have the same organization, offering both risk and claim management and liability insurance. Participants in CRPs in these hospitals reported that they were reluctant to make early settlement offers in fear that doing so would run against the interests of this outside risk management organization. See *Lessons Learned in New York City*, *supra* note 153, at 35; see also *supra* note 160.

¹⁹⁹ *Id.*

Finally, the contingency fee system may also spell trouble for early settlements. It should be reasonable to surmise that, in some situations, plaintiff attorneys may be disinterested in negotiating early settlement under the contingency fee system. This is either because the amount of compensation is usually significantly smaller than what may otherwise be obtained in adjudication, or due to the patient's unwillingness to pay a significant portion of the settlement for legal representation since the offer is already on the table and less legal work is involved.²⁰⁰ To encourage more trial lawyers to pursue early settlement would require the participation of attorneys who are willing to charge hourly fees.²⁰¹ Such a change may also open the door for experimenting with collaborative law practices in the area of medical malpractice.²⁰²

B. Reforming the Tort Litigation System

Despite the various benefits of early resolution, the CRP will not resolve all disputes. Eventually, many disputes will fail to reach early resolution and enter litigation, and it is often these remaining disputes that are the most costly and tough on the parties. Reforming the litigation process itself will continue to be a critical part of the tort reform discussion.

The existing tort reform proposals often focus on controlling the input (i.e., access to justice) and output (i.e., amount of compensation) of the litigation process.²⁰³ Often

²⁰⁰ Sage et al., *supra* note 152, at 15; *Lessons Learned in New York City*, *supra* note 153, at 38.

²⁰¹ Sage et al., *supra* note 152, at 15; *Lessons Learned in New York City*, *supra* note 153, at 38. In particular, Sage et al. referred to the AHRQ project in Washington State where the possibility for a system of hourly legal representation has been examined by an official task force comprised of patient advocates, attorneys, and risk management experts.

²⁰² Collaborative law attorneys typically work on hourly fees.

²⁰³ Many suggest that these reforms, in particular damages caps, can help produce a malpractice environment more favorable to CRPs by lowering the fear and financial burden of litigation on providers. *Cf.* Sage et al., *supra* note 152, at 12-13 (pointing out that CRPs can and have been successfully implemented in states without damage caps).

overlooked by these proposals, however, are two issues that may have an even greater potential to change the relationship between tort and patient safety. These issues are: (1) how to reward providers' efforts to pursue patient safety; and (2) how to reduce the cost of acquiring information.

Since the beginning of the movement, PSM activists have long searched for realistic ways to channel the pressure of tort liability to incentivize the pursuit of patient safety. There are three potential approaches to achieve this goal. The first is to adopt the widely embraced yet rarely implemented proposal of enterprise liability.²⁰⁴ The second is the idea of a *safety bonus*, that is, to reward providers with good safety track records by modifying the standard of care or reducing the amount of compensation. In *The Poor State of Health Care Quality*, for example, Hyman and Silver advocated the use of limitations on non-economic damages as carrots to encourage providers to improve error reporting and error reduction.²⁰⁵

Another widely discussed proposal to incentivize the pursuit of patient safety is the idea of using evidence-based medicine, often in the form of clinical practice guidelines (CPGs),²⁰⁶ as either evidence to establish a standard of care or defense against liability.²⁰⁷ The idea behind the proposal

²⁰⁴ Enterprise Liability is part of the second wave tort reform efforts. *Supra* note 49; see LAWRENCE O. GOSTIN & PETER JACOBSON, LAW AND THE HEALTH SYSTEM 460-61 (2006) (discusses literature on the proposal of enterprise liability); see also Kinney, *supra* note 49, at 101-10; Studdert et al., *supra* note 2, at 287-90 (details enterprise liability within the context of different waves of tort reform).

²⁰⁵ Hyman & Silver, *supra* note 1, at 985-87.

²⁰⁶ INSTITUTE OF MEDICINE, GUIDELINES FOR CLINICAL PRACTICE: DIRECTIONS FOR A NEW PROGRAM 8 (Marilyn J. Field & Kathleen N. Lohr eds., 1990) (defining CPGs as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.").

²⁰⁷ Hyman & Silver, *supra* note 1, at 990 (arguing for the use of evidence-based medicine as an absolute against legal liability).

In actual legal practice, CPGs have been used in courts by plaintiffs and defendants for both exculpatory and inculpatory purposes. See, Mello, *supra* note 28, at 648, 666-67. The inculpatory use typically involves plaintiffs introducing CPGs as evidence to establish the

is that, since CPGs are produced using up-to-date scientific research, having medical practices adhere to these behavioral guidelines should improve the overall quality of healthcare delivery. However, the past experiences of using the CPGs as a legal defense have failed to live up to that promise.²⁰⁸ Critics often attribute the failure to the inconsistency of the quality of the CPGs, as well as the vagueness of their language.²⁰⁹ The vagueness of the CPGs

standard of care. *Id.* at 677-94. The exculpatory use, on the other hand, often relates to so-called safe-harbor legislation, which are state statutes designed to allow physicians to apply CPGs as affirmative defenses, but block a plaintiff's rights to use similar guidelines as support for their claims. *Id.* at 695-707. Overall, Michelle Mello criticized both exculpatory and inculpatory uses of CPGs, as CPGs are often too vague to yield a definite answer and are untrustworthy due to the numerous and unregulated sources of these guidelines. *See generally* Michelle M. Mello, *Of Swords and Shields, The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645 (2001) (suggesting that "the best course of action, at least at this point in time, is to restrict their use by both plaintiffs and defendants").

²⁰⁸ *See generally* *Swords and Shields*, *supra* note 207.

²⁰⁹ *Id.* A 2011 Institute of Medicine report also concluded that, although it is encouraging that there is significant advancement in this field, the CPGs still "suffer from shortcomings in the guideline development process, often compounding limitations inherent in their scientific evidentiary bases." To address these concerns, the report recommended reforming the process of CPG generation to alleviate the concern over conflicts of interest and make these guidelines more credible to medical professionals. INSTITUTE OF MEDICINE, CLINICAL PRACTICE GUIDELINES WE CAN TRUST 2 (2011). *See also* BARRY FURROW ET AL., HEALTH CARE REFORM SUPPLEMENT MATERIALS 78-79 (2012) (discussing the continuing legal debate over the trustworthiness of CPGs).

In addition, one of the pioneers of the CPG movement, Dr. David Eddy, cautions that medical science might have entered the terrain of individualized CPGs based on human genome technology. As a result, the traditional population-based CPGs, which can only offer broad instructions because they have to apply to a broad population, might no longer represent the best possible care. David M. Eddy et al., *Individualized Guidelines: The Potential for Increasing Quality and Reducing Costs*, 154 MED. & PUB. ISSUES 627, 633 (2011) (arguing that the availability of more personalized genomic data enables the development of "a new generation of guidelines that are more clinically realistic and that may deliver higher quality at lower cost than has been possible in the past").

reduces their usefulness in the courts, as legal answers often demand a clear degree of certainty. For the proposal to serve a meaningful function, the process of generating the CPGs will need to be reevaluated and improved, which is an issue that has also been addressed by the ACA.²¹⁰

The second often-overlooked issue involves the cost of obtaining information in the litigation process. A major contributor to the costliness of tort litigation is the expense of acquiring expert testimony. The contingency fee system, however, only allows trial lawyers to recoup these sunken costs after winning a case. These factors thus generate a strong bias toward cases with serious injury, as these cases have the potential for greater amounts of compensation which justify these risky investments. Changing the cost structure of tort litigation by reducing the cost of expert testimony has the potential, at least theoretically, to alter lawyers' attitudes toward tort litigation in at least two ways. First, trial lawyers may be more willing to take less serious cases if the investment becomes smaller, which may help broaden the pool of patients with access to compensation. Second, lawyers may be less insistent on obtaining adjudication and more receptive to earlier and smaller settlements, which opens the door for broader adoption of the CRP or even collaborative law practice.

This paper argues that there are two possible ways to reduce the cost of acquiring expert testimony. The first is the broader involvement of judges, possibly through assigning their own experts, in assessing the validity of evidence. This proposal is consistent with the famous Supreme Court case *Daubert v. Merrell Dow Pharmaceuticals*,²¹¹ in which the court noted that “[f]aced with a proffer of expert scientific testimony . . . the trial judge must determine at the outset . . . whether the expert

²¹⁰ For example, Section 10303(c) of the ACA requires the Secretary of the Department of Health and Human Services to identify existing and new clinical practice guidelines. The Patient Protection and Affordable Care Act of 2010, Public Law 111–148, § 6301, 124 Stat. 119, 728, 42 U.S.C. § 1320e(c). It remains uncertain, however, how much impact this provision can have on the quality and trustworthiness of CPGs.

²¹¹ *Daubert v. Merrell Dow Pharms.*, 509 U.S. 579 (1993).

is proposing to testify to (1) scientific knowledge that (2) will assist the trier of fact to understand or determine a fact in issue.”²¹² Such a duty in turn requires the trial judge to conduct “a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts in issue.”²¹³ Specifically, the assessment should include consideration of testability, peer review and publication, and known or potential error rates of the scientific knowledge or technique.²¹⁴

Most trial judges, however, have generally not followed the *Daubert* test.²¹⁵ A common explanation for this reluctance is that American judges typically have profound faith in both the competence of the jury system and the democratic values represented by such a system.²¹⁶ American judges, therefore, have been generally very reluctant to tinker with parties’ access to evidence unless under extreme circumstances.²¹⁷ A possible, and maybe only feasible, alternative is for the medical community and trial lawyers bar associations to work together. The idea is to create a system to identify experts that can be trusted by both sides. The availability of this information may indirectly reduce the cost of discovery by limiting the number of experts that are needed for both sides to prove their cases.

²¹² *Id.* at 592.

²¹³ *Id.* at 592-93.

²¹⁴ *Id.* at 593-94.

²¹⁵ See generally Daniel Shuman, *Expertise in Law, Medicine and Healthcare*, 26 J. HEALTH POL. POL’Y & L. 267 (2001) (discussing the factors behind trial judges and lawyers’ resistance to the principles laid out in *Daubert*).

²¹⁶ *Id.* at 271.

²¹⁷ For example, the use of judge-appointed experts has been very rare. *Id.* at 270.

*C. Incorporating CRP Ideas Into the Pre-Trial
Settlement Process*

This paper further argues that, in situations where disputes fail to reach early resolution and enter litigation, the four components of the CRP (i.e., disclosure, apology, investigation, and quick offer) can be incorporated and replicated in the litigation process to make the process more conducive for the pursuit of patient safety. This goal can be achieved by applying different approaches to settlement negotiations that occur after the lawsuits are filed. Examples of these approaches include *collaborative law* and *judge-directed negotiation* (JDN).

Collaborative law refers to a growing style of practice in family law.²¹⁸ The approach uses the settlement process as a venue to pool resources together and develop solutions that better fit the family situation. Collaborative law attorneys work with the other side with the shared goal of reaching a settlement agreement.²¹⁹ Outside experts, such as psychologists and social workers, are often brought in to provide professional help.²²⁰ If a settlement cannot be reached, these attorneys are forbidden by signed agreement to take the case to trial; which is a key feature of the collaborative law practice.²²¹

This paper suggests that the same style of practice can be applied to the area of medical malpractice. By attorneys

²¹⁸ Pauline Tesler is often credited as pioneering the collaborative law practice. *See generally* PAULINE H. TESLER, *COLLABORATIVE LAW: ACHIEVING EFFECTIVE RESOLUTION IN DIVORCE WITHOUT LITIGATION* (2nd ed. 2008) (offering a comprehensive introduction to the collaborative model, including the necessary skill sets, proper mentality, documents and forms, and other legal issues); *see, e.g.*, William H. Schwab, *Collaborative Lawyering: A Closer Look at an Emerging Practice*, 4 PEPP. DISP. RESOL. L. J. 351 (2004); James K. L. Lawrence, *Collaborative Lawyering: A New Development in Conflict Resolution*, 17 OHIO ST. J. ON DISP. RESOL. 431 (2002); John Lande, *Possibilities for Collaborative Law: Ethics and Practice of Lawyer Disqualification and Process Control in a New Model of Lawyering*, 64 OHIO ST. L. J. 1315 (2003).

²¹⁹ TESLER, *supra* note 218.

²²⁰ *Id.*

²²¹ *Id.*

concentrating on reaching settlement agreement and promising not to bring the dispute to trial, a space for dialogue can be created where both sides can have an open and less confrontational conversation. Ideally, providers during this process should follow the principles of CRP; that is, they should be transparent about their records and investigation results, and a settlement offer should be made if negligence is discovered by the investigation. Outside experts trusted by both parties can also be brought in to analyze the evidence and allow claimants to assess the prospect of their case.

There are, of course, significant barriers to transplanting the collaborative law approach from family law to medical malpractice. For example, people may fear that the lack of trust and relationship between defense and plaintiff attorneys in this area of law makes the cooperation between them enormously difficult. Also, collaborative law attorneys typically charge hourly fees, and there will be an issue of whether trial lawyers in medical malpractice cases would be interested in this kind of payment system. These obstacles will need to be sufficiently addressed before attorneys on both sides can seriously consider the possibility of engaging in collaborative law practice.

Another possible approach that is already being experimented with is the JDN approach. Judge Directed Negotiation refers to a program pioneered by Bronx County, New York Judge Douglas McKeon.²²² Since its implementation, the program has been credited with producing speedier resolutions and lower costs for malpractice disputes in the experimental regime.²²³ As a result, the program was later incorporated into the demonstration project of the NYS project, which expanded

²²² NEW YORK STATE MEDICAL LIABILITY REFORM AND PATIENT SAFETY MODEL, *supra* note 171, at 5.

²²³ *Id.* (stating that the number of open claims where the JDN was initially being experimented dropped from 1400 in the year 2003 to slightly over 1000 in the year 2009. The program also achieved savings of up to \$50 million every year in costs associated with medical malpractice disputes resolution.).

JDN to Manhattan, Brooklyn, and later Erie County, where Buffalo is located.²²⁴

In the NYS project, the JDN program is implemented to catch claims that cannot be resolved through the CRP, which the project calls the Disclosure and Early Settlement Program.²²⁵ The JDN program features, among other things, specially trained judges to guide parties all the way through the settlement negotiation process.²²⁶ These designated judges are assisted by a Medical Advisor/Program Coordinator, who are often registered nurses, and their main duty is to coordinate and moderate regular meetings between attorneys and the parties themselves.²²⁷ These meetings typically begin early in the litigation process before the plaintiff's attorney develops a strong commitment, both financially and otherwise, to the case.²²⁸ The program also encourages the designated judge, to the extent it does not violate the parties' trust, to share his or her preliminary assessment on the case, so as to allow litigants to evaluate the realistic prospect of their case.²²⁹ Since its launch, both the plaintiff and defense bar associations have endorsed the program.²³⁰

The main goal of the JDN program is to facilitate early resolution of disputes, not to encourage systemic learning. The participation of the Medical Advisor/Program Coordinator, however, has great potential on that front. These registered nurses are familiar with how healthcare organizations handle mistakes and claims. With proper training, they have the potential to serve the role of outside coordinators who observe or even nudge providers to thoroughly investigate the event and properly communicate

²²⁴ *Id.*; see also MEDICAL LIABILITY REFORM AND PATIENT SAFETY INITIATIVE PROGRESS REPORT, *supra* note 169, at 6.

²²⁵ NEW YORK STATE MEDICAL LIABILITY REFORM AND PATIENT SAFETY MODEL, *supra* note 171, at 7-14.

²²⁶ *Id.* at 12.

²²⁷ *Id.*

²²⁸ *Id.*

²²⁹ *Id.* at 13.

²³⁰ *New York State Shows Benefits of CRP Demonstration Project*, BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS, archived at <http://perma.cc/99KA-47W5>.

with patients. In addition, having specifically trained judges allows them to become repeat players in medical malpractice cases.²³¹ Such experience may give them greater awareness of the PSM ideas and allow them to play the role of a champion and advocate for patient safety.

VI. CONCLUSION

This paper examined the changing landscape of the debate over the relationship between tort law and patient safety. In doing so, the paper explains that in recent years there has been a growing trend among providers to utilize claim and litigation data as opportunities to improve the performance of the delivery system, a trend referred to by this paper as the phenomenon of *Learning from Litigation*. By exploring this phenomenon, in particular how healthcare providers actually turn malpractice litigation into safety lessons; this paper argues that the best approach to tort reform in the age of *Learning from Litigation* is to encourage early resolution via communication-and-resolution programs. This approach not only has financial benefits in the form of reduced claims and payouts from providers and an expanded pool of patients eligible for compensation, but also yields patient safety benefits by shaping a more transparent and safer medical culture. The proposed approach, in turn, can be supported by policies that reward providers' commitment to patient safety; reduce the cost of discovery; and help overcome the cultural, legal, and economical barriers against early resolution.

The proposed reform approach that focuses on early resolution can be further supported by encouraging another relatively easy, cheap, and uncontroversial patient safety initiative: closed claims analyses. Due to its focus on claims that have already been resolved, rather than open claims that are still being litigated, CCAs are rarely treated as a serious tort reform proposal. The successful experience of the Anesthesia Closed Claims Project,²³² however, shows

²³¹ NEW YORK STATE MEDICAL LIABILITY REFORM AND PATIENT SAFETY MODEL, *supra* note 171, at 13.

²³² See discussion *infra* Part 4.A.

that CCAs may actually have great potential to indirectly alleviate the malpractice crisis by making medical practice safer without having to substantially alter the existing legal framework of tort law. Also, similar to the CRP, CCAs do not require prior legislative authorization, and can be conducted by healthcare organizations on their own initiative.

Eventually, the pursuit of early resolution of medical disputes via the CRP demands a new type of attorney, that is, one that views each case as a problem to solve rather than adversarial battles to win. These “new lawyers” must also be willing to work with the other side to develop solutions if necessary, and must be open to a different type of payment mechanism such as an hourly charge.²³³ In addition, there are also legally trained individuals working within healthcare organizations, such as in-house counsel and risk managers, who play instrumental roles in turning litigation data into safety improvement lessons. The collaboration between these legal professionals, as well as with other types of professionals in healthcare organizations, plays a critical role in making learning from litigation possible.

²³³ This demand echoes the gradual emergence, highlighted by Julie Macfarlane, of an alternative conception of advocacy referred to by Macfarlane as ‘conflict resolution advocacy.’ The new lawyer, Macfarlane argued, “will conceive of her advocacy role more deeply and broadly than simply fighting on her client’s behalf. This role comprehends both a different relationship with the client—closer to a working partnership . . . and a different orientation toward conflict.” Conflict resolution advocacy, therefore, means “working with clients to anticipate, raise, strategize, and negotiate over conflict and, if possible, to implement jointly agreed outcomes.” *See* JULIE MACFARLANE, *THE NEW LAWYER: HOW SETTLEMENT IS TRANSFORMING THE PRACTICE OF LAW* 109 (2008).

