Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions

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SUMMARY • In mid-2001 and early 2002, the University of Michigan Health System systematically changed the way it responded to patient injuries and medical malpractice claims. Michigan adopted a proactive, principle-based approach, described as an "open disclosure with offer" model, built on a commitment to honesty and transparency. Implementation was followed by steady reduction in the number of claims and various other metrics, such as elapsed time for processing claims, defense costs, and average settlement amounts. Though the model continues to evolve, it has retained its core components and the culture it nurtured while spurring other initiatives such as a unique approach to peer review. In this article we review our experience, identify the essential practical components of our model, offer suggestions for tailoring the approach to other settings, and present some thoughts as to the future of this approach.

FEATURE

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For decades, the medical community has bitterly complained about the adversarial climate surrounding adverse clinical outcomes, but this community has offered no suitable alternatives (Mello, Studdert, and Brennan 2003). Today's generation of healthcare leaders has known nothing else and has been offered few other ways of handling adverse outcomes. Before 2001, University of Michigan Health System (UMHS) was like many self-insured health systems in the country. Historically, it adhered to a deny-and-defend approach to claims arising from unanticipated medical outcomes. The UMHS changed its approach after questioning whether deny and defend best served all of its interests. Despite the fact that the state of Michigan had enacted no recent tort reform, the University of Michigan shifted its approach in late 2001 and early 2002 to favor honesty, transparency, and proactivity. This approach has shown promising results.

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UMHS History: Pre 2001

The University of Michigan became self-insured in 1985 and has since internally controlled its defenses. With the exception of a brief period during which risk management controlled litigation, litigation management was largely the province of the health system legal office, staffed by lawyers in the university's Office of General Counsel. Throughout this time, the UMHS had relationships with multiple private defense trial law firms in the belief that competition would yield more favorable hourly rates. Independent trial lawyers were regularly assigned new lawsuits and were expected to investigate cases, retain independent experts, and prepare defenses to liability, causation, and damage components of their cases. For the most part, their work was overseen and "managed" by lawyers (or earlier, risk managers) who had no personal trial experience in the defense of malpractice actions. Despite a compulsory pre-suit notice period instituted in Michigan in the spring of 1994, potential claims were rarely worked up before litigation was filed. Most assignments to trial lawyers occurred only after the suit's notice period had expired. Before 2001, trial lawyers routinely denied and defended the vast majority of the UMHS's claims, consistent with the expected deny-and-defend approach.

The internal claims management architecture reflected the commitment to deny and defend: Two committees reviewed claims at the end of the process, typically just before cases were set to start trial. One committee reviewed medical defense strategies, and the other, a traditional claims committee, approved settlements or trial decisions. The UMHS was consciously ethical and risk-averse in responding to patient claims. Those responsible sought to do "the right thing" in decisions to settle claims, though most decisions occurred near the end of lengthy and costly litigation and most cases were settled, not tried, regardless of the claims' merits.

Deny and Defend: Communication Barriers

The prevalence of deny and defend has often been blamed on trial lawyers, but multiple factors may have spawned the approach (Boothman et al. 2009). The healthcare community, hardwired as all humans with a fight-or-flight reflex, may have gravitated too eagerly to the trial lawyers' natural instinct to defend assigned claims.

Physicians and healthcare executives who were advised not to talk about adverse events with a patient or family willingly obliged, but at the expense of stimulating a robust climate in which patient safety is the prevailing priority. Trial lawyers' perspectives and advice largely go unchallenged when litigation is managed internally by risk managers or lawyers with no trial experience, as they give little consideration to the way in which deny and defend might inhibit patient safety goals. Regardless of the reason, it is no secret that the medical community has avoided disclosing medical errors to patients, with an estimated one in four errors disclosed (Wu et al. 1993; Blendon et al. 2002; Lamb et al. 2003; Gallagher et al. 2003; Kronman, Paasche-Orlow, and Orlander 2011; Kaldjian et al. 2008). In addition, it is estimated that less than 2 percent of negligent medical errors lead to malpractice litigation, suggesting that litigation is not as pervasive as most physicians believe and patients injured by medical errors are infrequently compensated through litigation (Meyers 1987; Localio et al. 1991; Studdert et al. 2000). As the competing interests swirled, the UMHS openly questioned whether deny and defend was the strategy to serve its needs.

The foundational assumptions supporting deny and defend create a self-perpetuating spiral that suppresses consideration of alternative approaches. Underpinning deny and defend are the dual assumptions that (a) when a patient is injured in the course of an adverse event, a fight is inevitable and (b) a fight is the institution's most prudent way of responding to the patient's complaints. However, patients mainly hire lawyers because of the lack of knowledge they have about their adverse event (Vincent, Young, and Phillips 1994). As a result of being stonewalled by their caregivers,

patients reach conclusions about their care without all of the facts and often lack the medical knowledge to make sense of what happened. Caregivers and hospitals rarely act to correct patients' and families' misconceptions about their care or attempt to fill in gaps to promote understanding. The medical community more often views a complaint as a threat, not an opportunity to reach an understanding based on honesty and openness. Because deny and defend cannot envision communication with aggrieved parties while the issues are fresh, it is not surprising that patients find silent reinforcement for their own conclusions and instinctively turn to their own lawyers for answers (Studdert and Brennan 2001).

Trial lawyers also act on incomplete information. They see themselves as advocates, not mediators, and aggressively look to create a case in the context of an assumed adversarial relationship with those they view as prospective defendants. These lawyers, governed in part by the exigencies of running a law firm, are compelled to consider the costs and benefits of taking a case. Lawsuits are filed before either side knows if they have a true conflict, and hospital executives rarely stop to analyze whether litigating each case actually serves their organization's interests. Clinicians seem relieved to learn from their trial lawyers that they should not talk to aggrieved patients or families, but that short-term liberation comes at the cost of longer-term misunderstanding. This failure of communication predictably results in litigation of questionable necessity with significant costs to both sides. A recent study (Golann 2011) showed that plaintiffs drop 58.6 percent of medical malpractice cases, mainly due to information accumulated during investigation that shows the plaintiff has a weak or frivolous case. In the end, the dearth of communication among

caregivers, patients, and trial lawyers affords little chance that the parties will achieve an understanding short of litigation; the fact that the understanding occurs in the course of litigation only reinforces the visceral impression in the healthcare community that unanticipated clinical outcomes spawn adversarial proceedings. The spiral is self-sustaining.

Deny and Defend: Safety Barriers

The adversarial posturing between patients and their caregivers under the deny-and-defend approach is especially unfortunate given the seriousness and prevalence of injuries that arise from clinical medicine. The Institute of Medicine's pronouncement that nearly 100,000 lives were being lost through medical error each year helped create national awareness about the prevalence of medical errors, and based on this knowledge the UMHS started investing more resources into patient safety efforts (Kohn, Corrigan, and Donaldson 2000). In fall 2002, Darrell Campbell Jr., MD, (an author of this piece), then chief of staff, publicly pronounced his aspiration for the UMHS "to become the safest hospital in the United States" (Anstett 2004). Deny and defend was a barrier to that goal.

One of the most significant costs of deny and defend is the chilling effect it has on patient safety. Deny and defend elevates the goal of protecting the institution against the anticipated claim at the cost of putting present and future patients at risk for similar injuries. Trial lawyers, driven myopically by their instinct to control the flow of information in order to maximize

Casting apology as a claims management tactic only undervalues the model and the pivotal role honesty plays in patient safety, functionally and culturally.

their courtroom chances, routinely defend clinical care that should not be defended and instruct caregivers not to talk with anyone about their claim for fear of having an unprotected admission find its way into evidence. Thus, any impulse to use a medical injury to improve care and prevent future similar errors is snuffed. Deny and defend chills even the most robust safety intentions.

Patient safety efforts are further compromised by poor communication among caregivers, their patients, and attorneys. Unlike other types of personal injury litigation, medical outcomes caused by medical error rarely are immediately distinguishable from those that occurred despite reasonable care. A paradigm that discourages communication breeds needless litigation, as the patient, caregivers, and health system all act on an incomplete understanding of the event. Litigation focuses energy away from improving care and preventing future errors. In mid-2001, deny and defend no longer made sense to an organization that viewed itself as ethical and determined to be the safest hospital in the nation. Thus, in early 2002, having already started the change in its claims management approach, the UMHS moved to reconcile its twin goals by creating the Michigan Model.

THE MICHIGAN MODEL: BEGINNINGS

Creating the Michigan Model was stimulated by a set of simple but forceful realizations:

- By relying on trial lawyers to drive the institution's response to patient injuries, the UMHS predictably found itself in a fight in the majority of claims.
- With its resources, the UMHS did not need litigation to determine the

difference between reasonable and unreasonable care.

- Litigation, with its uncertainty and high financial, emotional, and productivity costs, should be avoided except as a last resort.
- Settling cases in which the clinical care was reasonable or did not cause injury blurred core corporate principles and left clinical staff demoralized.
- Most important, defending care that was below the UMHS's standard of practice generated both significant unnecessary costs and undermined institutional quality and safety culture goals, sending the wrong message to the staff and public.

Beginning in the fall of 2001, three principles were circulated for approval among those involved in UMHS claims management:

1. Compensate patients quickly and fairly when unreasonable medical care caused injury.
2. If the care was reasonable or did not adversely affect the clinical outcome, support caregivers and the organization vigorously.
3. Reduce patient injuries (and therefore claims) by learning through patients' experiences.

The principles drew no opposition, and they remain universally incontestable. A decade into the UMHS's experience, they continue to serve as the foundation of the UMHS's response to patient injury and medical errors.

The Michigan Model: Backbone

The Michigan Claims Management Model has been well-described in journals (see Boothman et al. 2009 for further detail). The model has also been described in the popular press, although it is almost invariably shortchanged by headlines that carry some derivation of "Apologies Save Money" (Tanner 2009; Gotbaum 2007; Koranda 2010; Arbogast 2004). Apologies *can* save money and an honest approach *does* work to improve claims management numbers, but highlighting the role of apology in that way cheapens it as little more than a claims management strategy. Casting apology as a claims management tactic only undervalues the model and the pivotal role honesty plays in patient safety, functionally and culturally. To understand the Michigan Model, it is critical to understand that the claims management process is only the public face of an organic culture shift that seeks to elevate patient safety to the foreground and relegate claims considerations to the background.

The UMHS's approach was molded by many intrinsic and extrinsic factors. Its history, culture, idiosyncrasies, resources, jurisdiction, and the relationship the institution has with the courts and the plaintiffs' bar all affect its architecture (Boothman et al. 2009). Every healthcare system will create an approach that meets its own needs, but after ten years, the UMHS's approach can be distilled to identifiable elements that, if included in any approach for handling adverse medical outcomes, should yield similar results. (See Kachalia et al. 2010 for results.) Before reviewing the model's elements, an organization interested in designing its own alternative to deny and defend would be well-served by minding some basic realities.

Accountability: At the heart of the Michigan Model is a different mindset about patient injuries—one that lifts heads previously

cowering in the trenches waiting for a lawsuit to drop, and states unflinchingly: "We own patient injuries. News of a patient's injury does not represent a threat to us but creates an obligation we must meet and address in a straightforward, principled way so it never happens again."

Caregivers have convinced themselves that they are victims of a perverse and broken system (Sage 2005; Studdert, Mello, and Brennan 2004). The sense of victimhood is strong and causes stress and palpable fear (Wu 2000). Accountability requires a determination to take control over the dialogue surrounding adverse patient outcomes within the framework of ethical, corporate, and professional principles. It viscerally recoils from the old practice of deferring to others (e.g., lawyers, regulators) for an assessment of whether an outcome occurred through negligence or reasonable care. Seizing control over this dialogue diminishes anxiety and encourages a positive culture of patient safety. In this mindset, defense attorneys are valuable tools to be used selectively when warranted, not ersatz leaders driving corporate ethics.

Leadership's firm commitment to change can temper resistance from the considerable body of doubters embedded in any system subscribed to deny and defend.

Honesty: At the very core of the model is honesty. The model's three foundational principles demand an assessment as to whether the care giving rise to an unanticipated clinical outcome was reasonable; therefore, the prerequisite commitment must be to honesty in these evaluations. The first disclosure is always the one we make to ourselves. This is not a new concept: Alcoholics Anonymous led its 12-step program with that commitment to personal honesty in the 1930s (AA 2002).

Neither claim gains nor patient safety improvements are possible without honesty. Litigating claims that should be resolved is abusive to all concerned—patients, healthcare providers, and institutions. Denying and defending claims that arise from true medical errors wastes opportunities to lower malpractice costs, freezes initiatives for improving care, and undermines attempts to instill a rigorous culture promoting safety and clinical quality. Conversely, paying on groundless claims also undermines efforts at culture change. The practice erodes the morale of healthcare providers who work in an intrinsically risky environment. It encourages patients to believe that every undesirable outcome was the result of medical error, encourages plaintiffs' lawyers to see lawsuits as risk-free, and encourages courts to believe that the most effective way of clearing their dockets is to lean on the healthcare institution to pay regardless of merit. Worse, the practice reinforces the idea that malpractice claims are inevitable, simply a cost of doing business and valueless as a barometer of patient safety. Paying groundless claims erodes accountability just as effectively as misguidedly defending medical errors does.

Principles: The approach requires courageous, though not blind, adherence to the model's three central principles. Generally, adherence to principles creates consistency and predictability in behavior, processes, and operations, which are important in redirecting all those with a stake in unanticipated outcomes. The benefits of consistency and predictability to frontline stakeholders, such as the patient, family, and caregivers, are obvious, but a considerable number of others also benefit from a predictable institutional response to

adverse medical events. That list includes the local legal community, judges, regulatory and accrediting agencies, lienholders, medical and claims staffs of other hospitals, and the surrounding community. It is easy to miss the broad audience and the degree to which one health system's pattern of response to medical injuries can affect other caregivers and other health systems. Predictability becomes credibility, which stimulates robust engagement of all stakeholders and feeds both the patient safety and claims management activities.

Dismissing Fear: Fear is the single most powerful factor suppressing exploration of more constructive alternatives (Lamb et al. 2003)—fear of inviting litigation, fear of complicating litigation, and fear of making a mistake that will lead to a catastrophic claims outcome. Physicians fear the patient's reaction, and some rationalize away the need to tell a patient about an error if the patient does not seem aware of it already—essentially, the doctrine of "Let sleeping dogs lie" (Wu et al. 1997; Gallagher et al. 2003; Studdert et al. 2000). Fear prompts the medical community to rely almost exclusively on a legal system that does not serve their needs and is expensive financially and emotionally. Overcoming fear is always a prerequisite to paradigm shifting. Leadership must communicate priorities clearly and create a safe environment for its claims management professionals to explore an approach they've spent their careers avoiding. Leadership's firm commitment to change can temper resistance from the considerable body of doubters embedded in any system subscribed to deny and defend. Securing solid expertise in the trenches ameliorates fears by building confidence of those who rely on institutional claims management.

Gaining Support for Implementing a New Model

Consider the following before creating your institution's version of the Michigan Model.

Board of Directors: Consider presenting the paradigm shift to the board first. If the program is seen as a low priority or if the board resists, build evidence by starting small and publicizing the gains. With enough success, support for the program should rise because "leadership" follows success in many institutions. As boards generally feel compelled to be more involved in an issue when presented with data, building board support can lessen fear among medical staff and those in claims management of doing something considered dangerous or counterintuitive to the institution's goals.

Medical Leadership: Identify caregiver champions. Align the program with medical leadership. One of the first cases to come up for trial after the UMHS shift involved the chair of a major department, who assumed his case would be settled consistent with the traditional deny-and-defend approach. Once the chair understood the importance of adhering to principles, the case, deemed groundless, proceeded through a lengthy but successful trial. The department chair saw the value of the program and immediately communicated the new paradigm to other physician leaders in the system. Additionally, Dr. Campbell, the incoming chief of staff at the time, openly promoted the program among the medical staff and hospital leadership while fighting for its implementation politically. Support from medical leadership was key in overcoming objections from the university's legal circles.

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Department chairs must understand how the model supports the quality and safety missions of their departments. Patient safety trends should be discussed to develop annual goals of improvement and strategies for achieving those goals. Cultivating a sense of control and accountability feeds departmental safety goals and aligns them with claims reductions. At the UMHS, that clear alignment helped direct the medical department to proactively tailor departmental patient safety and educational efforts.

Communicating the model to the medical staff at large is important. Reassuring the staff that meritorious claims will be resolved and non-meritorious claims avoided should appeal to their immediate interests. Connecting directly with patient safety improvement appeals to the very reason they entered their profession. Over time, as data accumulates and confidence increases, medical staff will support the initiative. Without support from key physician leaders, the UMHS would have lapsed to the security of the status quo.

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ESSENTIAL ELEMENTS OF THE MODEL

In *The Seven Habits of Highly Effective People*, Stephen R. Covey (1989) admonishes us to "begin with the end in mind." If there were an ideal system for resolving patient disputes that arise from clinical care without the vagaries and expense of the legal system, while instilling a culture focused on patient safety and quality clinical care, what would it look like? The UMHS has seen promising results as it

works to answer that question. Though the manner in which they are created might differ from institution to institution, after ten years of experience, the following elements seem indispensable to the dual purposes of enhancing patient safety and reducing litigation costs.

1: Capturing Clinical Issues. Problems cannot be fixed if problems are not known. The problem's magnitude is not clear if close calls and adverse events are not collected and analyzed. Thus, it is important to strategically approach data collection.

Voluntary reporting is limited by a variety of factors, including caregivers' reluctance to report due to fear of implicating themselves or their peers, lack of training on what should be reported, insensitivity to the importance of reporting, and a history of unresponsiveness that dampens any sense that reporting a complaint will lead to improvement in the quality of care (Levinson 2012; Farley et al. 2010; Rowlin et al. 2008; Kaldjian et al. 2008). All healthcare systems have pockets of information that can and should be tapped proactively.

Healthcare providers themselves are a valuable source of safety data, but they are famously reluctant to complain proactively about their colleagues' behavior (Levinson 2012; Kaldjian et al. 2008). Witness the relatively anemic performance of most peer review systems, which too often do not engage until a provider proves too dangerous to be ignored (Baldwin et al. 1999). All caregivers have personal lists of processes and people that represent genuine, potential patient safety threats; how can that information be tapped? Billing data that tap patient safety indicators such as blood loss, hemorrhage after surgery, and readmission rates are fertile sources

of safety information. Seeing the vast potential for further safety improvements, the UMHS has been working on systems for effectively capturing clinical data (Bahl et al. 2008). Tapping unused pockets of information can reveal potential safety issues and unlock valuable opportunities for improvement.

Speed is important. Collecting information as soon as the adverse event or close call occurs is critical because it promotes immediate action to correct the root cause of an event and prevents errors from repeating. Speed also provides a valuable claims management opportunity, because quickly engaging patients and families with accurate information can help them understand what happened before misimpressions form and they feel the need for an advocate.

2: Identification of Medical Errors. Healthcare providers work in a dangerous world with no promises that their clinical interventions will have the intended effect or that they won't cause harm as they try to help. Unanticipated outcomes alone do not equate to medical mistake. Organizations need a reliable means of distinguishing unfortunate clinical outcomes that warrant compensation from adverse outcomes that occurred despite reasonable care. In a deny-and-defend model, unreasonable and reasonable care *are* eventually distinguished through litigation, but the result is vulnerable to irrelevant factors such as how witnesses perform for the jury, and results come with extraordinary cost and delay. Determining when care has met professional and institutional expectations is fundamentally a clinical, not a legal, question; the most reliable assessments are derived from robust and honest evaluations by clinicians who subscribe

to the critical importance of honesty, not defensiveness. Making credible determination of reasonable or unreasonable care is central to the model and key to developing a sense of control and accountability.

3: Communication. Communication among patients, families, and caregivers demands a mix of skills. In the acute phase following an adverse event, compassionate and careful listening is vital to understand the patient's or family's perspective and help them realize the institution will support their needs. Setting reasonable expectations is also key, as too much unexplained delay creates a sense that critical information is being concealed. The same challenges apply to communications with caregivers, most of whom experience a complex mix of emotions that includes betrayal, guilt, fear, and shame (Wolf et al. 2000; Newman 1996; Wu 2000). Sensitive listening and clear and compassionate communication are essential to moving the adverse events to constructive grounds. The UMHS risk management consultants all have formal mediation training and legal resources readily available.

Once a disclosure is made, however, it is difficult to undo if it is later discovered to be inaccurate or false. Admissions can rarely be retracted; denials that turn out to be erroneous undermine credibility going forward. The UMHS risk management consultants have learned the importance of being disciplined about sharing facts, not speculation.

4: Compensation. Lucian L. Leape (2009) has said, "Apology without compensation is like taking a shower in a raincoat. You're doing the right thing, but you don't get wet and you're still dirty." Compensating patients

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for injuries caused by medical errors is an important component of the model. It avoids expensive and needless litigation, provides patients and staff needed closure, and quickly establishes critical organizational credibility. Unwillingness or inability to provide compensation signifies a lack of sincerity, suggesting that apologies are little more than a claims management stratagem.

Valuing a case can be difficult. Case value is affected by many intangible elements, such as the strength of liability and causation elements, shock value, subjective pain and suffering, and economic components affected by a myriad of assumptions. Valuing cases is an art, not a science. The UMHS uses economic experts, financial planners, life care planners, and benefit specialists in the patients' areas of need to calculate a just monetary figure. Adequacy of compensation is often measured against a sense for what a case might bring in a courtroom, so there must be understanding of the claim's value in the context of litigation. This need not bind any program, but failing to heed this value could cause aggrieved patients to feel the hospital is taking advantage of them with an attempt at early but cheap intervention.

The greatest value of proactivity is to ensure that future patients are not harmed while an individual's claim is being adjusted.

5: Learning from Mistakes. The patient injured by medical error represents an immediate financial exposure to the organization. The greatest value of proactivity is to ensure that future patients are not harmed while an individual's claim is being adjusted. Submitting future patients and caregivers to the same risk of injury is not just imprudent, it is unethical. When preventable injury occurs, the organization and its staff are changed. None are naïve to the risk that a patient can be injured. That new knowledge imposes an urgent duty to ensure that future patients are not similarly injured. The system must be hard-wired so that knowledge of the safety risk is disseminated to those who can implement change and be accountable for taking steps to ameliorate the risk as quickly as possible. Doing so in a legally protected way will ensure that addressing the root causes of medical errors becomes an organizational habit, not a risk in itself.

6: Measurement. Data collection drives modern medicine. It provides evidence of effective change and facilitates return-on-investment analyses that enable an organization to determine whether to devote resources to an approach, change aspects of the tactic, or pursue another model. The UMHS collected data on the parameters of its model and has constantly tweaked the model and gauged its effect on improvements (Kachalia et al. 2010). With each year of data, new five-year plans are developed to further lower the number of claims filed, diminish costs, and reduce patient safety events. Without measurement, analyzing the success of a new approach on cost reduction or quality of care outcomes would not be possible.

7: Resources. The resources needed to implement an institution's version of the Michigan Model will vary by institution and evolve over time. One can start by simply deploying defense counsel differently without increasing overhead. In implementing the model, ensure the right people are in the right roles.

## Michigan's Experience with the Model

In one of the most famous moments in US presidential debate history, Ronald Reagan turned to the audience and bluntly posed a memorable question: "Ask yourself, are you better off now than you were four years ago?" The changes the UMHS has enacted have not completely rid the health system of malpractice claims and lawsuits, but it is clear that the health system is better off now than it was ten years ago. As for its claims experience, between 1995 and 2007, when comparing before and after implementation of the Michigan Model, the UMHS lowered its average monthly cost rates for total liability, patient compensation, reserves, and non-compensation legal costs (Kachalia et al. 2010). The UMHS also reduced its average monthly rate of new claims from 7.03 to 4.52 claims per 100,000 patient encounters, decreased the average monthly rate of lawsuits from 2.13 to 0.75 per 100,000 patient encounters, and reduced the time between claim reporting and resolution (Kachalia et al. 2010).

The UMHS widely communicated its approach to the plaintiffs' bar and Michigan courts at the outset. In the program's first year, plaintiffs' lawyers changed the way they approached the UMHS about claims. They now openly engage the UMHS before claims are asserted and before a suit is contemplated. With open dialogue, plaintiffs' lawyers are able to make better choices about the cases they elect to file and the UMHS is able to resolve most meritorious claims without litigation.

Settlements of non-meritorious (cases in which the UMHS felt the standard of care was met) claims occurred frequently before 2001 as depicted in Exhibit 1. Since

Exhibit 1 UMHS FY Claims by Incident Date; Number of Settlements Paid by UMHS Standard of Care Assessment

SOC = Standard of Care
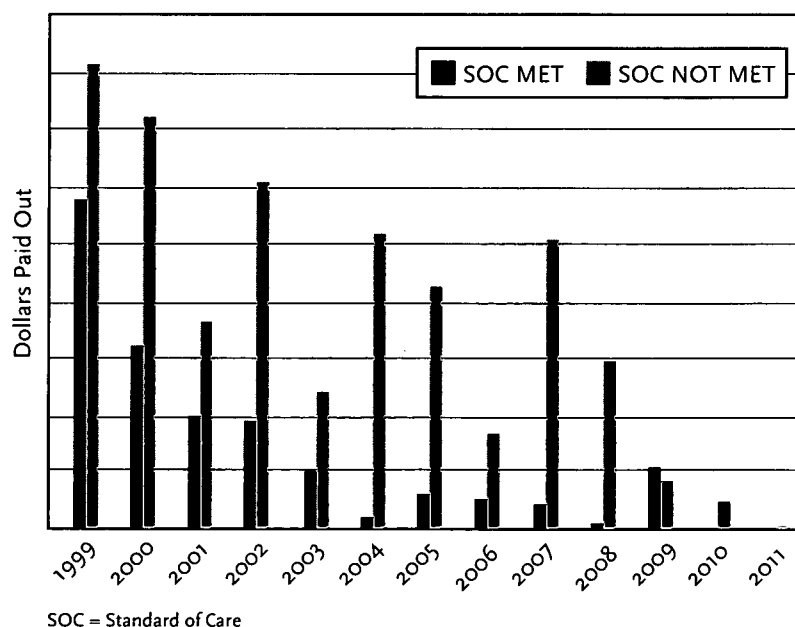
the adoption of a principled approach, the number of non-meritorious settlements has significantly decreased, leaving meritorious claims (in which the UMHS agrees the standard of care was not met) to make up the majority of settlements. This experience has resulted in overall lower claims numbers because the UMHS is now largely spared the need to defend non-meritorious claims. The importance of this experience transcends claims savings alone. Unlike other institutions that regard malpractice as an inevitable cost of doing business and not an indication of the quality of care, the UMHS has a strong sense of accountability for the remaining claims. Though the financial cost of true medical errors is sobering and disappointing, the clarity that results from analysis presents opportunities for positive change. We can delve deeply into the remaining claims for patterns to strategically target those areas in which errors have occurred and further reduce the number of claims through patient safety improvements.

Isolating legitimate claims allows the health system to precisely examine patterns of behavior, staff members, and processes that signal fixable problems.

The UMHS can no longer blame predatory lawyers and opportunistic patients for its malpractice losses. Isolating legitimate claims allows the health system to precisely examine patterns of behavior, staff members, and processes that signal fixable problems. The UMHS can at least put a partial price tag on the cost of failure to provide patients the quality of care they deserve. This engenders a sense of accountability and a greater sense that the health system can control its malpractice costs through improvements in patient safety. The direct link between patient safety and medical malpractice has historically been elusive for most institutions; one of the most salient benefits derived from the Michigan Model is the graphic demonstration of that clear link, which is often obscured by the "noise" of litigation over complications that arise in spite of reasonable clinical care.

FUTURE INITIATIVES

Aside from focusing on specific clinical issues and problematic staff members identified through analysis of claims, broader realizations have emerged from the UMHS's decade of experience.

New Process to Effectuate Changing Culture

The UMHS has made measurable progress toward its overall goals of changing culture, improving patient safety, and further reducing malpractice costs. The model has contributed to a culture of patient safety that is presently driving a radical redesign of the institution's patient safety architecture along a functional flow intended to

- strategically collect clinical information,
- methodically assess and analyze that information to establish institutional priorities,
- assign responsibility for change,
- measure effectiveness and communicate institutional priorities, and
- share successful changes to stimulate greater understanding of and interest in our priorities and efforts throughout the organization.

The work is moving apace without defensiveness. The old distinctions between risk management, quality improvement, and customer relations have blurred as

the health system tackles patient safety enterprise-wide. Focusing on safe and high-quality clinical care strongly suggests that these concepts, previously considered severable, are actually inseparable ideas along a continuum of care. As a consequence of the UMHS's clearer focus on safer patient care, a functional flow for isolating and approaching clinical safety concerns has emerged, which transcends the old definitions and boundaries with the promise of true clinical improvement. The algorithm is shown in Exhibit 2.

Shared Decision Making

The experience of hundreds of "disclosures" graphically proves that caregiver communication lags behind patient needs and expectations. As the healthcare community moves at a glacial pace from physician-centric to patient-centric care, patients' expectations about their own direct involvement with healthcare decisions are moving much faster, hastened by access to information through the Internet and media. From a medical malpractice perspective, greater patient control over medical decision making should yield greater patient accountability for clinical outcomes, but clarifying physicians' personal accountability depends directly on the quality of the communication. The UMHS experience highlights the urgency

to adopt an organically different view of the relationship among patients, caregivers, and the healthcare system. Embedding concepts of shared decision making seems to be the inevitable step toward strengthening the notion that "we're in this together," a cultural shift that can only strengthen the therapeutic relationship and lower the likelihood that patients turn to the legal system first to deal with unexpected outcomes.

Peer Review

Most healthcare systems struggle with peer review. Historically considered a discipline tool, peer review too often is invoked only after a caregiver bottoms out" and becomes a problem that can no longer be ignored (Brennan 1999). As a direct consequence of its embrace of honesty and transparency, the UMHS continues to boldly refine its innovative approach to peer review. Reasoning that peer review should be relevant and proactive, departments were challenged to identify events particular to their practice that would mark potential patient safety concerns. Those events, described as patient safety indicators, are keyed to billing and other retrievable data (Bahl et al. 2008). In many departments, caregivers' clinical performances are measured directly against those of their colleagues, and outliers can be identified and corrected

EXHIBIT 2 Flow for Capturing, Prioritizing, and Addressing Safety Concerns
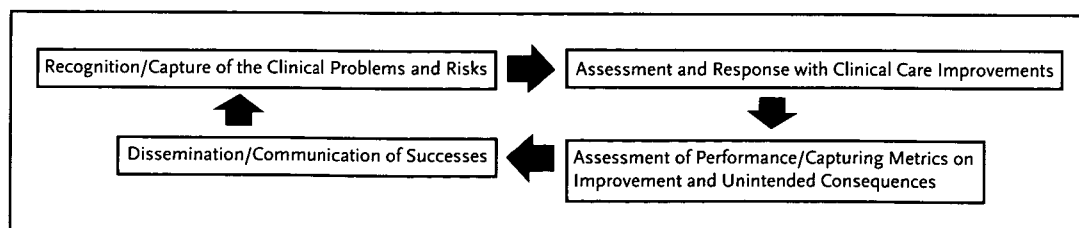
earlier than ever before. As the metrics are clinically relevant, the system is embraced as an integral part of departmental quality initiatives. The approach loses its disciplinary feel with earlier intervention and its promise to embrace and improve. This kind of peer review would not be possible in a deny-and-defend environment.

Health System Cultural Benefits

The tangible benefits of the UMHS approach to medical liability claims may be linked to a profoundly more important, but less tangible, benefit concerning an institution's overall safety culture. Many aspects of the UMHS approach to medical error are highly visible to the thousands of UMHS employees who care for patients and arguably set the tone for other circumstances in which the core values of honesty and trust are of paramount medical importance. One could argue that if implementation of the UMHS approach to liability had an important ripple effect on other aspects of medical care within the system, it should be manifest in an improving safety culture. Indeed, overall safety culture scores at UMHS, as measured by the biannual Safety Attitudes Questionnaire, have improved steadily over the past six years. While admittedly it is hard to prove cause and effect, an improving safety culture is another important metric, in addition to claims data, that supports the value of the UMHS approach to liability. If this is true, the liability approach has value far in excess of its impact on claims.

> *Recent studies demonstrate that despite the attention created by the Institute of Medicine's estimates of needless human injury and death, the quality of medical care in the United States has not improved.*

HEALING MEDICINE

The collateral damage from deny and defend has been underappreciated. Its impact has long obscured the direct connection between lapses in patient safety and medical malpractice litigation. Its direct, albeit unintended, consequences include a fundamental failure to accept responsibility for patient injuries caused by true medical error, and that failure in turn accounts for decades of needless litigation and all of its attendant personal, financial, and ethical costs. Recent studies demonstrate that despite the attention created by the Institute of Medicine's estimates of needless human injury and death, the quality of medical care in the United States has not improved (Landrigan et al. 2010). Abandoning deny and defend can be a critical first step to recovery.

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