Correspondence

Hospital Claims: A Risk Manager's Perspective

Dear Editors:

Professor Irwin Press, in his article, *The Predisposition to File Claims: The Patient's Perspective*, published in the April issue, correlates a rise in costs relative to the prevention and management of the increasing number of medical malpractice claims, with hospitals' use of mechanical means to prevent these claims. He implies that such "reactive measures" as incident investigation used by hospitals are not only costly, but are also not the answer to claims prevention. Press supports his argument by mentioning that, despite reactive measures taken to prevent claims, the number of suits filed continues to rise. He submits that hospitals ought to pay attention to how patients perceive their illnesses and the care which they receive in the hospital. Then, suggests Press, patients would not be as likely to sue. I believe that Press has failed to give credence to factors, other than patients' perception of care, hospital personnel's lack of courtesy and physical surroundings, which also cause patients to bring suit. Moreover, I think that Press underestimates the usefulness of some of the "reactive measures" which hospitals have adopted in their attempts to improve patient care as well as to prevent claims.

Hospital risk managers who have assisted with handling claims are aware of the necessary ingredients for a patient to bring suit: injury (or bad outcome) and anger with the care provided. This combination, however, does not account for the fairly common situation in which a patient has sustained an iatrogenic injury: the hospital offers compensation, but the patient declines, saying, "I think that your offer is probably fair, but friends and neighbors have told me that I can get a lot more (money) if I get a lawyer." Nor does this formula for potential suits consider the influence of attorneys who use the media to invite the public to sue.

Furthermore, the economic status of a society seems to have some bearing on the amount of litigation in general. Some attorneys who specialize in litigating civil matters believe that in times of a depressed economy, suits of all kinds increase. Apparently, people think that one way to make the proverbial "quick buck" is to find an attorney who accepts clients on a contingency fee basis.

One poll of the American people taken by the Health Insurance Association of America showed results indicative of other reasons why people sue. According to the results of that survey, 63 percent of the people polled believe that public awareness has caused an increase in litigation; 55 percent believe that the public's eagerness to make money has caused the rise in litigation; and 52 percent blame increased litigation on attorneys who are trying to make money by encouraging people to sue.[1] Here again, public perception is a factor in causing increased claim activity. However, this perspective differs from that which Press suggests. Thus, if hospitals were to subscribe exclusively to Press's theory and were to establish new programs designed to improve patient perception in hopes of reducing claim activity, they might be merely applying a bandage to a gaping wound which really needs a tourniquet.

What is more disturbing, however, is Press's final comment: good patient perception equals good medicine. In other words, as long as a patient perceives his or her care to be good, good medicine has been practiced. Yet, in the same breath, he cites evidence which suggests that "as many as one-third of all patients may experience an iatrogenic incident." I would hope that Press is just as concerned about the significant number of patients who sustain iatrogenic injury, and what is being done insofar as prevention is concerned, as he seems to be about how patients perceive their illnesses and care. Hospital risk managers are concerned about both, and they are "reacting" accordingly.

One tool which risk managers use to prevent claims and improve patient care is the incident report. The report, *per se*, is not designed to prevent patients from bringing suit. Rather, it is used to bring about improved care; this includes altering attitudes which might affect patients' perception of care. The reports advise hospital management of unusual events, whether they are actual or are perceived as such by patients. After the report has been completed, an investigation is conducted to determine exactly what did occur, and how, if at all, similar events might be prevented. Whenever a patient's perception is believed to be a factor, contact is made with the patient by one of the many individuals within the hospital who act as patient advocates. Admittedly, most often this intervention with patients takes place after the incident occurs. However, the perceptions which people have are as unique as the individuals themselves. Therefore, oftentimes there is no way to determine how a particular person will perceive a situation until it occurs.

Risk managers also use information gleaned through incident investigation to teach personnel about controlling loss to patients and hospitals. Subjects include documentation and informed consent. One can infer from Press's article that instructing people about documentation is a costly waste of time. Perhaps Press is unaware of the caveat: If you didn't document it, you didn't do it, at least insofar as the courts are concerned. Perhaps he is not cognizant, either, of the fact that hospitals have had to pay claims because of the lack of documented evidence rather than as a result of negligence. Risk managers teach other topics as well, not the least of which is the emphasis on the influence of a patient's perception of illness and care in determining his or her particular needs, and whether or not a patient will bring suit.

Press's points regarding medical malpractice claims and their prevention do have some merit. I would

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even agree that on occasion, physicians and hospital administrators are insensitive to patients' cultural and emotional needs. However, to overlook other factors which might account for medical malpractice claims—factors which are beyond the control of physicians and hospital administrators—as well as to discredit the efforts which hospitals have made to improve care and reduce claims, is to paint only half of the picture, and to paint that portion in a jaded fashion.

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Professor Press Replies

This is precisely the kind of response that demonstrates the importance of the perspective which I propose. It is a plea for business as usual. It passes the buck by blaming greedy lawyers and a depressed economy for the continuing malpractice crisis. Such a view ignores the fact that only someone who is predisposed to sue in the first place can be affected so easily by the pressures of others or by economic need. The gist of my article is precisely that such "obvious" factors as clinical errors, attorney pressure, or economic conditions have not been shown to be predictive of claims (particularly of who will claim). Ultimately, regardless of outside pressures, the decision to claim is a personal one, and what I am attempting to do is to call attention to the qualitative factors which clinicians can utilize to affect this personal decision.

Rader's appeal to public opinion polls and incident reports hardly bolsters her argument. Polls of people who have not sued, produce no data of relevance to the motives of people who *have* sued. Competent sociological research has long recognized that the opinions of one group are not predictive of the acts or motives of another. Whereas many Americans may indeed believe that others sue for malpractice because of greedy lawyers or the quick buck, their motives when they decide to sue may be quite different. Frankly, we still do not know why ex-patients sue, but the hard data that we are accumulating point more solidly to attitudinal factors than to economic conditions or legal pressures.

Rader further demonstrates naiveté when she suggests that incident reports reflect the nature of maloccurence and patients' attitudes. Most incident reports are generated by staff, not patients, and thus can give us little insight into patients' perceptions. These reports, in truth, represent only staff opinion as to what should be reported, not actual errors and events (staff are required to "tell on them-

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